GENERAL SURGERY MEASURES GROUP OVERVIEW

2014 PQRS OPTIONS FOR MEASURES GROUPS:

2014 PQRS MEASURES IN GENERAL SURGERY MEASURES GROUP:
#354. Anastomotic Leak Intervention
#355. Unplanned Reoperation within the 30 Day Postoperative Period
#356. Unplanned Hospital Readmission within 30 Days of Principal Procedure
#357. Surgical Site Infection (SSI)
#358. Patient-Centered Surgical Risk Assessment and Communication

INSTRUCTIONS FOR REPORTING:

• The general surgery measures group is relevant to the following surgical procedures:
  o Ventral Hernia
  o Appendectomy
  o AV Fistula
  o Cholecystectomy
  o Thyroidectomy
  o Mastectomy +/- Lymphadenectomy or Sentinel Lymph Node Biopsy (SLNB)
  o Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB
  o Bariatric Laparoscopic or Open Roux en Y Gastric Bypass
  o Bariatric Sleeve Gastroctomy
  o Colectomy

• It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group-specific intent G-code has been created for registry only measures groups for use by registries that utilize claims data.

G9237: I intend to report the General Surgery Measures Group

• Report the patient sample method:
  20 Patient Sample Method: 20 unique procedures (a majority of which must be Medicare Part B FFS [fee for service] patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2014 OR July 1 through December 31, 2014).

• Patient sample criteria for the General Surgery Measures Group are patients aged 18 years and older that have a specific surgical procedure performed:

  One of the following procedure codes indicating general surgery: 19101, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 36818, 36819, 36820, 36821, 36825, 36830, 43644, 43645, 43646, 43846, 43847, 43775, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44160, 44204, 44205, 44206, 44207, 44208, 44210, 44950, 44956, 44970, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391, 45392, 47562, 47563, 47564, 47600, 47605, 47610, 49560, 49561, 49565, 49566, 49567, 49572, 49585, 49587, 49590, 49652, 49653, 49654, 49655, 49656, 49657, 60200, 60210, 60212, 60220, 60225, 60240, 60252, 60254, 60260, 60270, 60271

• Report a numerator option on all applicable measures within the General Surgery Measures Group for each patient within the eligible professional's patient sample.

• Measure #354 need only be reported when the patient has a procedure performed specific to gastric bypass surgery or colectomy as indicated by the following CPT procedure codes: 43644, 43645, 43846, 43847,
• Instructions for qualifying numerator option reporting for each of the measures within the General Surgery Measures Group are displayed on the next several pages. The following composite Quality Data Code (QDC) has been created for registries that utilize claims data. This QDC may be reported in lieu of individual QDCs when all quality clinical actions for all applicable measures within the group have been performed.

**Composite QDC G9235:** All quality actions for the applicable measures in the General Surgery Measures Group have been performed for this patient

This measures group contains one or more inverse measures. An inverse measure is a measure that represents a poor clinical quality action as meeting performance for the measure. For these measures, a lower performance rate indicates a higher quality of clinical care. Composite codes for measures groups that contain inverse measures are only utilized when the appropriate quality clinical care is given.

The composite code for this measures group may be reported when codes in the summary table below are applicable for reporting of each measure within the measures group.

<table>
<thead>
<tr>
<th>Measure</th>
<th>QDC options for acceptable use of the composite QDC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#354*</td>
</tr>
<tr>
<td>G9305</td>
<td></td>
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<tr>
<td>G9307</td>
<td></td>
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<tr>
<td>G9309</td>
<td></td>
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<tr>
<td>G9311</td>
<td></td>
</tr>
<tr>
<td>G9316</td>
<td></td>
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</tbody>
</table>

*Indicates an inverse measure

• To report satisfactorily for the General Surgery Measures Group it requires all applicable measures for each patient within the eligible professional’s patient sample to be reported a minimum of once during the reporting period.

• Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.

• The General Surgery Measures Group will be reported as a surgeon-specific, risk-adjusted odds ratio. For a given surgeon, this odds ratio compares the odds of experiencing an event relative to the odds of experiencing this adverse outcome under the care of an average surgeon in the reporting population (i.e., the group of surgeons reporting on each surgical measure within the measures group). The odds ratio will be generated from a hierarchical regression model that adjusts for differences in case-mix and patient severity.

An odds ratio greater than 1.00 for a provider on each individual measure within the measures group means that the odds of experiencing an event are greater for this provider than for his/her peers. An odds ratio less than 1.00 means that the odds of experiencing this adverse outcome are lower for this provider than for his/her peers.
A 95% confidence interval (95% CI) around each odds ratio will be reported. The 95% CI provides the lower and upper bounds on the range of values within which the true value of the odds ratio lies, asymptotically speaking. A narrower confidence interval suggests a more precise estimate than a wide confidence interval. A confidence interval that does not include 1.00 suggests that the odds of experiencing an adverse outcome under a specific provider is statistically significantly better (if the odds ratio is <1.00) or worse (if the odds ratio is >1.00) than his/her peers.

**Risk Adjustment**

Case-mix adjustment is performed using the following variables (see table below): age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model. Thus, these patient characteristics must be reported. (Please see table at the end of this document)

- **NOTE:** The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option.
Measure #354: Anastomotic Leak Intervention

DESCRIPTION:
Percentage of patients aged 18 years and older who required an anastomotic leak intervention following gastric bypass or colectomy surgery.

NUMERATOR:
Intervention (via return to operating room, interventional radiology, or interventional gastroenterology) for presence of leak of endoluminal contents (such as air, fluid, GI contents, or contrast material) through an anastomosis. The presence of an infection/abscess thought to be related to an anastomosis, even if the leak cannot be definitively identified as visualized during an operation, or by contrast extravasation would also be considered an anastomotic leak.

Numerator Note: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:
- Intervention for presence of leak of endoluminal contents through an anastomosis required (G9306)
- OR
  - Intervention for presence of leak of endoluminal contents through an anastomosis not required (G9305)
Measure #355: Unplanned Reoperation within the 30 Day Postoperative Period

**DESCRIPTION:**
Percentage of patients aged 18 years and older who had any unplanned reoperation within the 30 day postoperative period

**NUMERATOR:**
Unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure

*Numerator Note:* A lower calculated performance rate for this measure indicates better clinical care or control.
- This measure is not intended to capture patients who go back to the operating room within 30 days for a follow-up procedure based on the pathology results from the principal operative procedure or concurrent procedure. Examples: Exclude breast biopsies with return for re-excisions; insertion of port-a-cath for chemotherapy.
- The return to the OR may occur at any hospital or surgical facility.

**Numerator Options:**
- Unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure (G9308)
- No return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure (G9307)
Measure #356: Unplanned Hospital Readmission within 30 Days of Principal Procedure

**DESCRIPTION:**
Percentage of patients aged 18 years and older who had an unplanned hospital readmission within 30 days of principal procedure

**NUMERATOR:**
Inpatient readmission to the same hospital for any reason or an outside hospital (if known to the surgeon), within 30 days of the principal surgical procedure

*Note:* A lower calculated performance rate for this measure indicates better clinical care or control.

**Numerator Options:**
Unplanned hospital readmission within 30 days of principal procedure *(G9310)*

**OR**
No unplanned hospital readmission within 30 days of principal procedure *(G9309)*
θ Measure #357: Surgical Site Infection (SSI)

DESCRIPTION:
Percentage of patients aged 18 years and older who had a surgical site infection (SSI)

NUMERATOR:
Number of patients with a surgical site infection

Note: A lower calculated performance rate for this measure indicates better clinical care or control.

Definition:
Superficial Incisional SSI: Superficial incisional SSI is an infection that occurs within 30 days after the operation and infection involves only skin or subcutaneous tissue of the incision and at least one of the following:
- Purulent drainage, with or without laboratory confirmation, from the superficial incision
- Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision
- At least one of the following signs or symptoms of infection: pain or tenderness, localized swelling, redness, or heat AND superficial incision is deliberately opened by the surgeon, unless incision is culture-negative
- Diagnosis of superficial incisional SSI by the surgeon or attending physician

Deep Incisional SSI: Deep Incision SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and infection involved deep soft tissues (for example, fascial and muscle layers) of the incision and at least one of the following:
- Purulent drainage from the deep incision but not from the organ/space component of the surgical site
- A deep incision spontaneously dehisces or is deliberately opened by a surgeon when the patient has at least one of the following signs or symptoms: fever (> 38 C), localized pain, or tenderness, unless site is culture-negative
- An abscess or other evidence of infection involving the deep incision is found on direct examination, during re-operation, or by histopathologic or radiologic examination
- Diagnosis of a deep incision SSI by a surgeon or attending physician

Organ/Space SSI: Organ/Space SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and the infection involves any part of the anatomy (for example, organs or spaces), other than the incision, which was opened or manipulated during an operation and at least one of the following:
- Purulent drainage from a drain that is placed through a stab wound into the organ/space.
- Organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space
- An abscess or other evidence of infection involving the organ/space that is found on direct examination, during re-operation, or by histopathologic or radiologic examination
- Diagnosis of an organ/space SSI by a surgeon or attending physician

Numerator Options:
Surgical site infection (G9312)
OR
No surgical site infection (G9311)
**Measure #358: Patient-Centered Surgical Risk Assessment and Communication**

**DESCRIPTION:**
Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon.

**NUMERATOR:**
Documentation of empirical, personalized risk assessment based on the patient’s risk factors with a validated risk calculator using multi-institutional clinical data, the specific risk calculator used, and communication of risk assessment from risk calculator with the patient and/or family.

**Numerator Instructions:**
The number of adult patients (age 18 and over) having had non-emergency surgery as defined by CPT codes during the reporting period who had their personalized risk of procedure-specific, 30-day postoperative complications assessed and documented by their surgeon prior to surgery using a clinical data-based, patient-specific risk-calculator* and who had a documented personal discussion with their surgeon about these risks. The procedure-specific, patient-specific, data-based risk calculator should be based on a validated, risk-adjusted statistical model predicting 30-day postoperative complications (detailed below) for the procedure that the patient is to undergo. Risk calculations should be based on preoperative patient-specific clinical data, and should include the following groups of variables: patient demographic characteristics (e.g., age, gender); relevant lifestyle and clinical risk factors (e.g., smoking status, American Society of Anesthesiologists class, body mass index); patient comorbidities (e.g., diabetes; neurologic event/disease; disseminated cancer); and procedure type.

Postoperative complications should include 30-day risk-adjusted mortality, 30-day risk-adjusted overall morbidity (superficial surgical site infection, deep incisional surgical site infection, wound dehiscence, pneumonia, deep venous thrombosis; pneumonia; renal failure; urinary tract infection; prolonged ventilator dependence; bleeding complications; sepsis; and pulmonary embolism), serious complications (cardiac arrest; myocardial infarction, pneumonia; progressive renal insufficiency; acute renal failure; pulmonary embolism; deep venous thrombosis; return to the operating room deep incisional surgical site infection; organ space surgical site infection; systemic sepsis; unplanned intubation; urinary tract infection; and wound dehiscence), surgical site infection, and average length of stay.

Risk calculators based on multi-institutional, validated clinical data are acceptable for this measure. ACS NSQIP now offers a risk calculator which can be used for operations in every surgical subspecialty (http://www.riskcalculator.facs.org ). Examples of other risk calculators acceptable for this measure include, but are not limited to the ACS NSQIP pancreatectomy risk calculator; the ACS NSQIP colorectal surgery risk calculator; and a recent bariatric surgery risk calculator based on ACS NSQIP data. Other risk calculators are available from the Society of Thoracic Surgery.

**Numerator Options:**
Documentation of patient-specific risk assessment with a risk calculator based on multi-institutional clinical data, the specific risk calculator used, and communication of risk assessment from risk calculator with the patient or family (G9316)

**OR**
Documentation of patient-specific risk assessment with a risk calculator based on multi-institutional clinical data, the specific risk calculator used, and communication of risk assessment from risk calculator with the patient or family not completed (G9317)
GENERAL SURGERY MEASURES GROUP RATIONALE AND CLINICAL RECOMMENDATION STATEMENTS

Measure #354 - Anastomotic Leak Intervention

Measure #355 - Unplanned Reoperation within the 30 Day Postoperative Period

Measure #356 - Unplanned Hospital Readmission within 30 Days of Principal Procedure

Measure #357 - Surgical Site Infection (SSI)

RATIONALE:
This is an adverse surgical outcome, which is often a preventable cause of harm, thus it is important to measure and report. It is feasible to collect the data and produces reliable and valid results about the quality of care. It is useful and understandable to stakeholders. As highlighted earlier, this measure was developed in a collaborative effort by the American College of Surgeons and the American Board of Surgery. This measure addresses the National Quality Strategy Priorities, and was identified by an expert panel of physician providers to be a critical outcome for this procedure. This measure addresses a high-impact condition as it is one of the most common procedures performed in the U.S. The measure aligns well with the intended use. The care settings include Acute Care Facilities/Hospitals. Data are being collected in a clinical registry that has been in existence for over 5 years, with over 4000 current users. Thus, we are requesting consideration of this measure in the “Registry Reporting” option. The level of analysis is the clinician/individual. All populations are included, except children. The measure allows measurement across the person-centered episode of care out to 30 days after the procedure whether an inpatient, outpatient, or readmitted. The measure addresses disparities in care. The risk adjustment is performed with a parsimonious dataset and aims to allow efficient data collection resources and data reporting. Measures have been harmonized when possible.

CLINICAL RECOMMENDATION STATEMENTS:
A modified-Delphi methodology using an expert panel of surgeons who are Directors of the American Board of Surgery identified this to be a critical outcome for this surgical procedure (Surgeon Specific Registry Report on Project for ABS MOC Part IV. Unpublished study by the American College of Surgeons in conjunction with the American Board of Surgery, 2011).

Measure #358 - Patient-Centered Surgical Risk Assessment and Communication

RATIONALE:
Preoperative risk assessment and communication between surgeons and patients is critical for effective informed consent and shared decision making in surgical care. Shared decision-making is considered an integral component of patient-centered care, especially for preference-sensitive issues. Evidence suggests that there is room for improving communication and the informed consent/shared decision-making processes between physicians and patients. Use of a risk calculator helps improve the quality of the informed consent/shared decision-making process by providing a personalized, customized, empirically-based estimate of a patient’s risk of post-operative complications. Moreover, evidence suggests that sharing numeric estimates of patient-specific risk may enhance patient trust in providers. Risk assessment and communication between surgeons and patients is critical to informed and shared decision-making processes in surgical care. Shared decision-making is considered an integral component of patient-centered care, particularly within accountable care organizations.

Evidence suggests that there is room for improving communication and informed/shared decision-making processes between physicians and patients.

Use of a risk calculator may help improve the quality of informed/shared decision-making by providing a personalized, empirically-based estimate of a patient’s risk of post-operative complications. Moreover, evidence suggests that sharing numeric estimates of patient-specific risk may enhance patient trust in providers.
CLINICAL RECOMMENDATION STATEMENTS:
Preoperative risk assessment and communication between surgeons and patients is critical for effective informed consent and shared decision making in surgical care. Shared decision-making is considered an integral component of patient-centered care, especially for preference-sensitive issues. Evidence suggests that there is room for improving communication and the informed consent/shared decision-making processes between physicians and patients. Use of a risk calculator helps improve the quality of the informed consent/shared decision-making process by providing a personalized, customized, empirically-based estimate of a patient’s risk of post-operative complications. Moreover, evidence suggests that sharing numeric estimates of patient-specific risk may enhance patient trust in providers.

<table>
<thead>
<tr>
<th>RISK FACTOR DEFINITIONS</th>
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<tbody>
<tr>
<td><strong>ASA Class</strong></td>
</tr>
</tbody>
</table>
| Record the American Society of Anesthesiology (ASA) Physical Status Classification of the patient’s present physical condition on a scale from 1-5 as it appears on the anesthesia record. Most likely there will be a 2nd assessment of the ASA class prior to anesthesia induction. If this is available, report this most recent assessment. Some hospitals may note the ASA classification as the ‘Acuity Code’. The classifications are as follows:

ASA 1 - Normal healthy patient
ASA 2 - Patient with mild systemic disease
ASA 3 - Patient with severe systemic disease
ASA 4 - Patient with severe systemic disease that is a constant threat to life
ASA 5 - Moribund patient who is not expected to survive without the operation
None Assigned – For cases performed under local anesthesia that meet inclusion criteria but do not have an ASA class assigned, report as ‘none assigned’.

| Emergent                |
| Emergency Case: An emergency case is usually performed within a short interval of time (typically <24 hours) between patient diagnosis or the onset of related preoperative symptomatology. It is implied that the patient’s well-being and outcome is potentially threatened by unnecessary delay and the patient’s status could deteriorate unpredictably or rapidly. The Principal Operative Procedure must be performed during the hospital admission for the diagnosis. Patients who are discharged after diagnosis and return for an elective, semi-elective, or urgent procedure related to the diagnosis would not be considered to have had an emergent case. The intent is to identify a patient population with heightened surgical risk due to an ongoing acute process that is currently having a negative impact on the patients’ health and for which continued, potentially rapid deterioration could occur. The increased risk might be partly due to the fact that the procedure is being performed with limited preoperative preparation time and the surgical team does not necessarily have the ability to optimize the patient’s status. The emergency case variable distinguishes between urgent/semi-elective/elective cases and true emergent surgeries. Urgent/semi-elective cases are not considered emergencies. Assign ‘YES’ if the surgeon and/or anesthesiologist report the case as emergent.

| Functional Status       |
| **Functional Health Status**: This variable focuses on the patient's abilities to perform activities of daily living (ADLs) in the 30 days prior to surgery. Activities of daily living are defined as ‘the activities usually performed in the course of a normal day in a person’s life’. ADLs include: bathing, feeding, dressing, toileting, and mobility. Report the best functional status demonstrated by the patient within the 30 days prior to surgery. Report the level of functional health status as defined by the following criteria.

(1) **Independent**: The patient does not require assistance from another person for any activities of daily living. This includes a person who is able to function independently with
(2) **Partially dependent:** The patient requires some assistance from another person for activities of daily living. This includes a person who utilizes prosthetics, equipment, or devices but still requires some assistance from another person for ADLs.

(3) **Totally dependent:** The patient requires total assistance for all activities of daily living.

(4) **Unknown:** If unable to ascertain the functional status prior to surgery, report as unknown.

All patients with psychiatric illnesses should be evaluated for their ability to function with or without assistance with ADLs just as the non-psychiatric patient. For instance, if a patient with schizophrenia is able to care for him/herself without the assistance of nursing care, he/she is considered independent.

If there is a change in the patient’s functional status, (i.e. improvement to worsening) within the 30 days prior to surgery, report the patient’s best functional status.

<table>
<thead>
<tr>
<th>Wound class</th>
<th>Wound Classification: Indicate whether the primary surgeon has classified the wound as:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Multiple surgical procedures performed with different incision sites = Assign wound classification based on the Principal Operative Procedure being reviewed.</td>
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<tr>
<td></td>
<td>Example: Principal Operative Procedure: Carotid Endarterectomy (clean) Other Procedure: I &amp; D of an infected right big toe (dirty/infected). The wound class assigned to this case would be clean.</td>
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<tr>
<td></td>
<td>Multiple surgical procedures performed through one incision (same operative space) = Assign wound classification based on the assessment of the overall operative space.</td>
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<tr>
<td></td>
<td>Example: Principal Operative Procedure: Lysis of adhesions (clean) Other Procedure: cholecystectomy with gross bile spillage (contaminated). The wound class would be contaminated, as the spillage is in the same operative space as the Principal Operative Procedure.</td>
</tr>
</tbody>
</table>

(1) **Clean:** An uninfected operative wound in which no inflammation is encountered and the respiratory, alimentary, genital, or uninfected urinary tract is not entered. In addition, clean wounds are primarily closed and, if necessary, drained with closed drainage. Operative incisional wounds that follow nonpenetrating (blunt) trauma should be included in this category if they meet the criteria.

Examples of “Clean” cases include mastectomy, vascular bypass graft, exploratory laparotomy, hernia repair, thyroidectomy, total hip or knee replacement, total hip replacements for avascular necrosis, removal of ‘old’ hardware without evidence of infection. 

*Note: Placement of any drain at the time of surgery does not change the classification of the wound.*

(2) **Clean/Contaminated:** An operative wound in which the respiratory, alimentary, genital or urinary tracts are entered under controlled conditions and without unusual contamination. Specifically, operations involving the biliary tract, appendix, vagina, and oropharynx are included in this category, provided no evidence of infection or major break in technique is encountered.
Examples of “Clean/Contaminated” cases include cholecystectomy, colectomy, colostomy reversals, roux-en-Y, laryngectomy, small bowel resection, transurethral resection of the prostate, Whipple pancreaticoduodenectomy.

(3) Contaminated: Open, fresh, accidental wounds. In addition, operations with major breaks in sterile technique or gross spillage from the gastrointestinal tract, and incisions in which acute, non-purulent inflammation is encountered including necrotic tissue without evidence of purulent drainage (for example dry gangrene) are included in this category.

Examples of “Contaminated” cases include appendectomy for inflamed appendicitis, bile spillage during cholecystectomy, or open cardiac massage. Open surgical wounds returning to the OR.

Examples of major break in sterile technique include but are not limited to non-sterile equipment or debris found in the operative field.

(4) Dirty/Infected: Old traumatic wounds with retained devitalized tissue and those that involve existing clinical infection or perforated viscera. This definition suggests that the organisms causing postoperative infection were present in the operative field before the operation.

Examples of “Dirty/Infected” cases include excision and drainage of abscess, perforated bowel, peritonitis, ruptured appendix.

Wound Class for Non-Skin Incision Surgeries (Natural Orifice): assign the wound classification based on which orifice was entered.

Example: appendectomy performed via the vagina would, at minimum, be a clean/contaminated wound class.

<table>
<thead>
<tr>
<th>Sepsis</th>
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<tbody>
<tr>
<td>Sepsis within 48 hours prior to surgery: Sepsis is a vast clinical entity that takes a variety of forms. The spectrum of disorders spans from relatively mild physiologic abnormalities to septic shock. The intent is to capture the patient population, whose physiology is compromised by an ongoing inflammatory or infectious process, thereby increasing the patient’s risk of complications during or after surgery. Please report the most significant level using the criteria below.</td>
</tr>
</tbody>
</table>

1. SIRS (Systemic Inflammatory Response Syndrome): SIRS is a widespread inflammatory response to a variety of severe clinical insults. This syndrome is clinically recognized by the presence of two or more of the following:
   - Temp >38°C (100.4 °F) or < 36 °C (96.8°F)
   - HR >90 bpm
   - RR >20 breaths/min or PaCO2 <32 mmHg(<4.3 kPa)
   - WBC >12,000 cell/mm³, <4000 cells/mm³, or >10% immature (band) forms
   - Anion gap acidosis: this is defined by either:
     - [Na + K] – [Cl + HCO₃ (or serum CO2)]. If this number is greater than 16, then an anion gap acidosis is present.
     - Na – [Cl + HCO₃ (or serum CO2)]. If this number is greater than 12, then an anion gap acidosis is present.

*If anion gap lab values are performed at your facilities lab, ascertain which formula is utilized
Sepsis: Sepsis is the systemic response to infection. Report this variable if the patient has clinical signs and symptoms of SIRS listed above and meets either A or B:

One of the following:
- Positive blood culture
- Clinical documentation of purulence or positive culture from any site for which there is documentation noting the site as the acute cause of sepsis.

OR

Suspected pre-operative clinical condition of infection or bowel infarction, which leads to the surgical procedure. The findings during the Principal Operative Procedure must confirm this suspected diagnosis with one or more of the following:
- Confirmed infarcted bowel requiring resection
- Purulence in the operative site
- Enteric contents in the operative site, or
- Positive intra-operative cultures

| Dyspnea | Dyspnea: Dyspnea may be symptomatic of numerous disorders that interfere with adequate ventilation or perfusion of the blood with oxygen and is defined as difficult, painful or labored breathing. The intent of this variable is to capture the usual or typical level of dyspnea (patient’s baseline), within the 30-days prior to surgery. The intent is not to include patients solely because of an acute respiratory condition leading to intubation prior to surgery, but rather to reflect a chronic disease state.

Characterize the patient's dyspnea status when they were in their usual state of health, prior to the onset of the acute illness, within the 30 days prior to surgery.

(1) No dyspnea
(2) Dyspnea upon moderate exertion (for example: unable to climb one flight of stairs without shortness of breath)
(3) Dyspnea at rest (for example: cannot complete a sentence without needing to take a breath)

Note: Acute pre-op dyspnea associated with the acute illness will be captured through other variables like pre-op vent dependence, emergency status or ASA Class. The previous requirement that the patient has to themselves state that they are symptomatic has been removed: not all patients are able to verbalize this symptomatology.

<p>| Ascites | Ascites within 30 days prior to surgery: The presence of fluid accumulation in the peritoneal cavity noted on physical examination, abdominal ultrasound, or abdominal CT/MRI within 30 days prior to the operation. Documentation should state either active or a history of liver disease (for example, jaundice, encephalopathy, hepatomegaly, portal hypertension, liver failure, or spider telangiectasia). Minimal or trace ascites would not qualify; however; malignant ascites (exclusive of liver disease) due to extensive cancer would qualify. |</p>
<table>
<thead>
<tr>
<th>Surgical approach- Laparoscopic vs. Open</th>
<th><strong>Operative Approach</strong>: Indicate the final surgical approach.</th>
</tr>
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<tbody>
<tr>
<td>(1) Open</td>
<td>(1) Open</td>
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<tr>
<td>(2) Laparoscopic/Robotic</td>
<td>(2) Laparoscopic/Robotic</td>
</tr>
<tr>
<td>(3) Laparoscopic/Robotic Hand Assisted</td>
<td>(3) Laparoscopic/Robotic Hand Assisted</td>
</tr>
<tr>
<td>(4) Laparoscopic/Robotic with Unplanned Conversion to Open</td>
<td>(4) Laparoscopic/Robotic with Unplanned Conversion to Open</td>
</tr>
<tr>
<td>(5) Unknown</td>
<td>(5) Unknown</td>
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</table>