Verification of Event ICD Codes
Question by Question Instructions – 2025

I. General Instructions

The Verification of Event ICD Codes (VER) form is completed in the Data Management system (CDART) for all eligible Emergency Department (ED) visits and hospitalizations in the HCHS/SOL Main Study.

The VER has a dual function. The first is to record the ICD-10 codes (or ICD-9 codes, for older cases) listed in the Coding Summary or within the medical records of each eligible event.

The second function is to serve as a checklist to confirm that the required documentation for outcomes of interest has been collected and reported on the coversheet that is transmitted to the Coordinating Center (CC) along with the medical records.

II. Detailed Instructions

Item 0a – Date Completed. Enter the date the VER form is completed, updating this field each time changes to the form are made.

Item 0b – Staff ID. Enter the ID of the staff member entering the form, updating this field each time changes to the form are made.

Item 0c – Event ID. The Event ID is loaded into this field automatically via CDART for each eligible case. This field cannot be altered. If you have or discover a VER form without a pre-loaded Event ID in this field, please contact the CC. The form may not be valid for investigation.

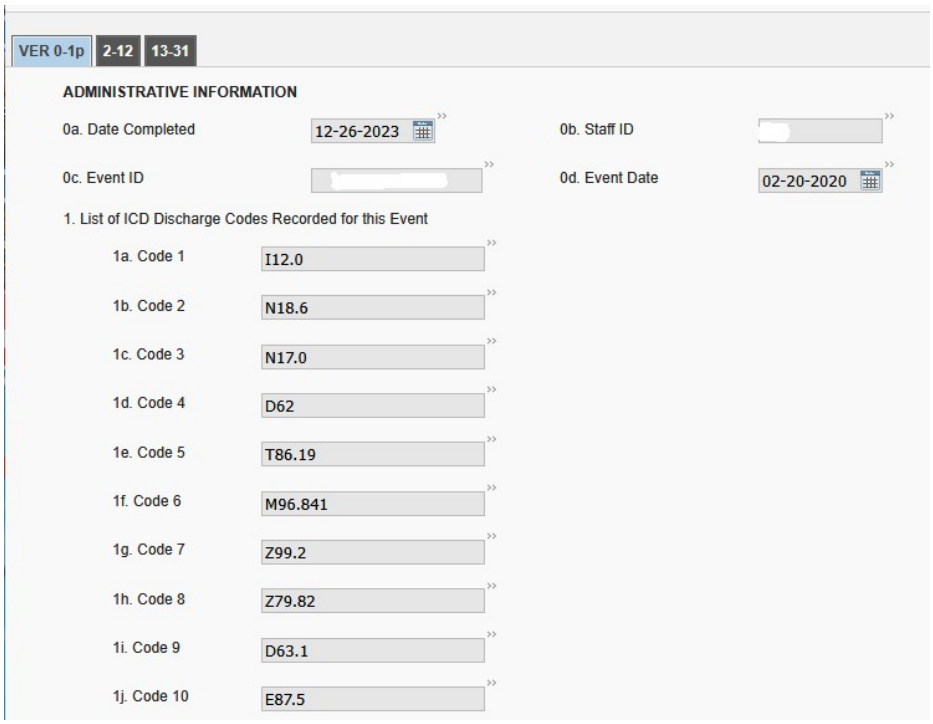
Item 0d – Event Date. The event date is entered in the VER according to the date of ED visit or hospitalization reported in the HOE/S form. However, if the reported date is found to be inaccurate after receipt of the medical records, the Event Date in Item 0d should be corrected to reflect the accurate date. The date of event should also be corrected in the corresponding HOE/S occurrence accordingly. If the HOS is recorded under an AFU year that is closed, there is no need to request the CC to provide temporary access to the form to update the date.

Items 1a-1p ICD Discharge Codes. The ICD diagnosis discharge codes found in the Coding Summary or within the medical records indicate the health conditions that caused or contributed to an event.

As of 2018, the ICD diagnosis discharge codes are listed as ICD-10 codes although, occasionally, ICD-9 codes may also be listed alongside them. If the case is from before 2018, it will have ICD-9 codes (NNN.Nx pattern). ICD-10 codes are preferred and should be entered in Items 1a-1p before entering any ICD-9 diagnosis discharge codes that are present.

The pattern for ICD-10 codes is a letter, two numbers and a decimal, followed by various combinations of numbers and letters.

Example of ICD-10 codes entered correctly into a VER form:



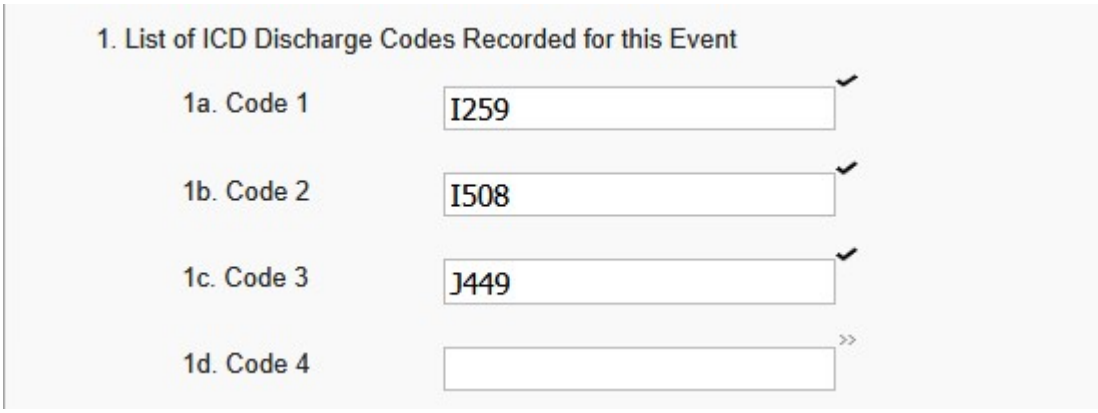
In order for the VER form algorithm to accurately display the required document set for each outcome type (Pulmonary, Heart Failure, Myocardial Infarction and Stroke), codes must be input in the VER using the established ICD-10 pattern of LNN**.**xxxx.

If the ICD codes are listed in the Coding Summary or medical records without the required decimal, add the decimal after the first three characters unless there are only three characters (Example: I10 – Essential Hypertension, which is usually expressed with only these three characters).

If an ICD-10 code is entered in the VER without the decimal, an Invalid Code error displays:

This is the signal that the entered data does not meet the programmed standard.

If this error is overridden, the result is a VER form that looks like this,



and the form algorithm to create the required document list and coversheet will not work as intended.

Enter all ICD-10 diagnosis discharge codes from the Coding Summary and the documents in Items 1a – 1p. If there are still blank fields available after the ICD-10 codes are recorded, enter any ICD-9 diagnosis discharge codes that are included in the Coding Summary or within the documents.

If in doubt about whether a code found in the medical records is an ICD diagnosis code (not to be confused with procedure codes, which should be labeled as such in the record), please transmit an image of the medical record page in question to the CC via LiquidFiles and the CC Endpoints team will be happy to help you make a determination.

Items 2-31 Medical Records for this Event. Based on the ICD diagnosis discharge codes entered in Items 1a-1p, use Items 2-31 to report the status of the required documentation for outcomes identified in the medical records: Received, Pending, or Not Available.

Missing Fields Report and Coversheet. When data entry in Items 2-31 is complete, click the Save button at the bottom of the form and run the Missing Fields report. This will list any open fields that have been missed.

Once all VER fields have been completed, click the Save button again and create the Medical Records Documents Shipping Cover Sheet. Export the coversheet page(s) and save as a PDF and add to the front of the medical records case. Then, follow normal transmission procedures to the CC via LiquidFiles, remembering to update the ETR investigation status to “Shipped”.