



Section: Demog	raphics	Parent: Root
Element: 2000		Last Name
	Coding Instruction:	Indicate the patient's last name. Hyphenated names should be recorded with a hyphen.
	-	The value on arrival at this facility
Element: 2010		First Name
	Coding Instruction:	Indicate the patient's first name.
	Target Value:	The value on arrival at this facility
Element: 2020		Middle Name
	Coding Instruction:	Indicate the patient's middle name.
	Ū	Note(s):
		It is acceptable to specify the middle initial.
		If there is no middle name given, leave field blank.
		If there are multiple middle names, enter all of the middle names sequentially.
		If the name exceeds 50 characters, enter the first 50 letters only.
	Target Value:	The value on arrival at this facility
Element: 2050		Birth Date
	-	Indicate the patient's date of birth.
	Target Value:	The value on arrival at this facility
Element: 2030		SSN
	Coding Instruction:	Indicate the patient's United States Social Security Number (SSN).
		Note(s):
		If the patient does not have a US Social Security Number (SSN), leave blank and check 'SSN NA'.
	Target Value:	The value on arrival at this facility
Element: 2031		SSN N/A
	Coding Instruction:	Indicate if the patient does not have a United States Social Security Number (SSN).
	Target Value:	The value on arrival at this facility
Element: 2040		Patient ID
	Coding Instruction:	Indicate the number created and automatically inserted by the software that uniquely identifies this patient.
		Note(s): Once assigned to a patient at the participating facility, this number will never be changed or reassigned to a different patient. If the
		patient returns to the same participating facility or for follow up, they will receive this same unique patient identifier.
	Target Value:	The value on arrival at this facility
Element: 2045		Other ID
	Coding Instruction:	Indicate an optional patient identifier, such as medical record number, that can be associated with the patient.
	Target Value:	N/A
Element: 2060	<b>.</b>	Sex
	-	Indicate the patient's sex at birth.
	-	The value on arrival at this facility
	4.1.19376.1.4.1.6.5.19 Definition	Source Code Code Syste
		M HL7 Administrative Gend
Selection Male Female	Definition	





Section: Demo	graphics	Parent: Root
Element: 2065		Patient Zip Code
	Coding Instruction:	Indicate the patient's United States Postal Service zip code of their primary residence.
	••••••••	
		Note(s): If the patient does not have a U.S. residence, or is homeless, leave blank and check 'Zip Code NA'.
	Target Value:	The value on arrival at this facility
Element: 2066		Zip Code N/A
	Coding Instruction:	Indicate if the patient does not have a United States Postal Service zip code.
		Note(s):
	Towned Volues	This includes patients who do not have a U.S. residence or are homeless.
	Target value:	The value on arrival at this facility
Element: 2070		Race - White
	Coding Instruction:	Indicate if the patient is White as determined by the patient/family.
	-	Note(s):
		If the patient has multiple race origins, specify them using the other race selections in addition to this one.
	Target Value:	The value on arrival at this facility
	Supporting Definition:	
		Having origins in any of the original peoples of Europe, the Middle East, or North Africa.
		<b>Source:</b> U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity
Element: 2071		Race - Black/African American
	Coding Instruction:	Indicate if the patient is Black or African American as determined by the patient/family.
		Note(s):
		If the patient has multiple race origins, specify them using the other race selections in addition to this one.
	Target Value:	The value on arrival at this facility
	Supporting Definition:	Black/African American (race)
		Having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."
		Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity
Element: 2073		Race - American Indian/Alaskan Native
	Coding Instruction:	Indicate if the patient is American Indian or Alaskan Native as determined by the patient/family.
		Note(s): If the patient has multiple race origins, specify them using the other race selections in addition to this one.
	Target Value:	The value on arrival at this facility
	-	American Indian or Alaskan Native (race)
	5	Having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation
		or community attachment.
		<b>Source:</b> U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity
Element: 2072		Race - Asian
	Coding Instruction:	Indicate if the patient is Asian as determined by the patient/family.
		Note(s):
		If the patient has multiple race origins, specify them using the other race selections in addition to this one.
	Target Value:	The value on arrival at this facility
	Supporting Definition:	
		Having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
		Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity
Element: 2074		Race - Native Hawaiian/Pacific Islander





Section: Demographics	Parent: Root
Coding Instruction:	Indicate if the patient is Native Hawaiian or Pacific Islander as determined by the patient/family.
	Note(s): If the patient has multiple race origins, specify them using the other race selections in addition to this one.
Target Value:	The value on arrival at this facility
Supporting Definition:	Race - Native Hawaiian/Pacific Islander - Native Hawaiian
	Having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
	Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity
Element: 2076	Hispanic or Latino Ethnicity
Coding Instruction:	Indicate if the patient is of Hispanic or Latino ethnicity as determined by the patient/family.
	Note(s): If the patient has multiple hispanic or latin ethnicity, specify them using the other ethnicity selections in addition to this one.
Target Value:	The value on arrival at this facility
Supporting Definition:	Hispanic or Latino Ethnicity
	A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."
	Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity
Element: 14780	Original Patient ID
Coding Instruction:	This is the ID generated when the patient was first submitted to the Registry. This field will be provided to vendors as part of the participant vendor migration process for all patients currently in the Registry. For patients submitted to the Registry the first time by a vendor, it should be populated with the NCDR Patient ID assigned by the vendor.
Target Value:	N/A
Element: 14781	Original NCDR Vendor
Coding Instruction:	This is the vendor identifier of the vendor who first submitted the patient to the Registry. This field will be provided to vendors as part of the vendor migration process for all patients currently in the registry. For patients submitted to the Registry for the first time by a vendor, it should be populated with the Vendor Identifier of the submitting vendor.
Target Value:	N/A





Section: Episode I	nformation	Parent: Episode of Care		
Element: 2999		Episode Unique Key		
c	Coding Instruction:	Indicate the unique key associated with each patient episode record as assigned by the	EMR/EHR or your software a	pplication.
	Target Value:	N/A		
Element: 3000		Arrival Date		
c	Coding Instruction:	Indicate the date the patient arrived at your facility.		
	Target Value:	N/A		
v	endor Instruction:	Patient must be at least 18 years old at the time of Arrival Date (3000)		
		Arrival Date (3000) must be Less than or Equal to Discharge Date (10100)		
Element: 3005		Health Insurance		
c	Coding Instruction:	Indicate if the patient has health insurance.		
	Target Value:	The value on arrival at this facility		
Element: 3010		Health Insurance Payment Source		
c	Coding Instruction:	Indicate the patient's health insurance payment type.		
		Note(s): If the patient has multiple insurance payors, select all payors.		
		If there is uncertainty regarding how to identify a specific health insurance plan, please understand how it should be identified in the registry.	discuss with your billing depa	artment to
	Target Value:	The value on arrival at this facility		
Payor Category - 1.3.6.1	.4.1.19376.1.4.1.6.5.	5		
Selection	Definition	Source	Code	Code System
Private Health Insurance	provided throug by an individua company. A hea	nsurance is coverage by a health plan h an employer or union or purchased from a private health insurance alth maintenance organization (HMO) is ate health insurance.	5	PHDS
Medicare	Medicare is the health care cos	Federal program which helps pay ts for people 65 and older and for under 65 with long-term disabilities.	1	PHDS
Medicare Advantage		gram that gives you more choices https://www.cms.gov/apps/glossary/ lans. Everyone who has Medicare Parts	112000002025	ACC NCDF

Selection	Definition	Source	Code	Code System
Private Health Insurance	Private health insurance is coverage by a health plan provided through an employer or union or purchased by an individual from a private health insurance company. A health maintenance organization (HMO) is considered private health insurance.		5	PHDSC
Medicare	Medicare is the Federal program which helps pay health care costs for people 65 and older and for certain people under 65 with long-term disabilities.		1	PHDSC
Medicare Advantage	A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain exceptions apply). Medicare Advantage Plans used to be called Medicare + Choice Plans.	https://www.cms.gov/apps/glossary/ S	11200002025	ACC NCDR
Medicaid	Medicaid is a program administered at the state level, which provides medical assistance to the needy. Families with dependent children, the aged, blind, and disabled who are in financial need are eligible for Medicaid. It may be known by different names.		2	PHDSC
Military Health Care	Military Health care - Military health care includes TRICARE/CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) and CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), as well as care provided by the Department of Veterans Affairs (VA).		31	PHDSC
State-Specific Plan (non- Medicaid)	State Specific Plans - Some states have their own health insurance programs for low-income uninsured individuals. These health plans may be known by different names in different states.		36	PHDSC
Indian Health Service	Indian Health Service (IHS) is a health care program through which the Department of Health and Human Services provides medical assistance to eligible American Indians at IHS facilities. In addition, the IHS helps pay the cost of selected health care services provided at non-HIS facilities.		33	PHDSC
Non-US Insurance	Non-US insurance refers to individuals with a payor that does not originate in the United States.		100000812	ACC NCDR





Section: Episode Information	Parent: Episode of Care
Element: 12846	Medicare Beneficiary Identifier
Coding Instruction:	Indicate the patient's Medicare Beneficiary Identifier (MBI).
	Note(s): Enter the Medicare Beneficiary Identifier (MBI) for those patients insured by Medicare. Patients without Medicare will not have a MBI.
Target Value:	The value on arrival at this facility
Supporting Definition:	Medicare Beneficiary Identifier
	The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, requires us to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status.
	Source: https://www.cms.gov/Medicare/New-Medicare-Card/index.html
Element: 3020	Patient Enrolled in Research Study
Coding Instruction:	Indicate if the patient is enrolled in an ongoing ACC - NCDR research study related to this registry. Intended for future use.
Target Value:	Any occurrence between arrival at this facility and discharge
Supporting Definition:	Patient Enrolled in Research Study
	A clinical or research study is one in which participants are assigned to receive one or more interventions (or no intervention) so that researchers can evaluate the effects of the interventions on biomedical or health-related outcomes. The assignments are determined by
	the study protocol. Participants may receive diagnostic, therapeutic, or other types of interventions.





Section: Research Study	Parent: Episode of Care
Element: 3025	Research Study Name
Coding Instru	iction: Indicate the research study name as provided by the research study protocol.
	Note(s): If the patient is in more than one research study, list each separately. Intended for future use.
Target	Value: N/A
Vendor Instru	ction: Research Study Name (3025) must be a valid study name for LAAO.
	A Research Study Name (3025) may only be entered/selected once
Element: 3030	Research Study Patient ID
Coding Instru	iction: Indicate the research study patient identification number as assigned by the research protocol.
	Note(s): If the patient is in more than one research study, list each separately. Intended for future use.

Target Value: N/A





## Section: LAAO Intervention

Parent: Episode of Care

Element: 14791

Admission for Left Atrial Appendage Occlusion Intervention

Coding Instruction: Indicate if the patient was admitted to the hospital specifically for an Left Atrial Appendage (LAA) Occlusion Intervention.

Target Value: The value on arrival at this facility





Section: CHA2	DS2-VASc Risk Score	Parent: History and Risk Factors		
Element: 4005		CHA2DS2-VASc Congestive Heart Failure		
	Coding Instruction:	Indicate if the patient has been diagnosed with heart failure according to the CHA2DS2-VASc	definition.	
		Note(s): A diagnosis of heart failure must be specifically documented in the medical record and patient symptoms.	d not coded by the abs	tractor based upon
	Target Value:	Any occurrence between 30 days prior to the procedure and the procedure		
	Supporting Definition:	CHA2DS2-VASc Congestive Heart Failure		
		The presence of signs and symptoms of either right (elevated central venous pressure, hepato ventricular failure (exertionaldyspnea, cough, fatigue, orthopnea, paroxysmal nocturnal dyspne rhythm, pulmonary venous congestion) or both, confirmed by non-invasive or invasive measure of cardiac dysfunction.	ea, cardiac enlargemen	nt, rales, gallop
		<b>Source:</b> Refining clinical risk stratification for predicting stroke and thromboembolism in atrial approach: the euro heart survey on atrial fibrillation Lip GH, Nieuwlaat R, Pisters R, Lane DA, C		
Element: 4010		NYHA Functional Classification		
	Coding Instruction:	Indicate the patient's New York Heart Association (NYHA) Functional Classification based upo at the time of the current procedure.	n the physician docume	ented classification
		Note(s): The NYHA Functional Classification must be specifically documented in the medical record and patient symptoms.	d not coded by the abst	ractor based upon
	Target Value:	The highest value on the first procedure in this admission		
	Supporting Definition:	NYHA		
		The NYHA classes focus on exercise capacity and the symptomatic status of the disease.		
		<b>Source:</b> 2013 ACCF/AHA Guideline for the Management of Heart Failure; J Am Coll Cardiol. doi:10.1016/j.jacc.2013.05.019	2013;62(16):e147-e239	Э.
NYHA Functional O	Classification - 1.3.6.1.4.1.	19376.1.4.1.6.5.8		
Selection	Definition	Source	Code	Code Syste
Class I	limitations of ph	Ardiac disease but without resulting ysical activity. Ordinary physical activity Association. Nomenclature and Criteria for Diagnosis o undue fatigue, palpitation, or dyspnea. Diseases of the Heart and Great Vessels. 9th ed. Boston, Mass: Little, Brown & Co; 1994:253-256.	420300004 of	SNOMED (

of ordinary physical activity. Patient is comfortable at rest. Ordinary physical activity such as walking more than two blocks or climbing more than two blocks or climbing more (e.g., fatigue, palpitation, dyspnea, or anginal pain).       Association. Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Great Vessels. 9th ed. Boston, Mass: Little, Brown & Co; 1994:253-256.         Class III       Patient has cardiac disease resulting in marked limitation of physical activity. Patient is comfortable at rest. Less than ordinary physical activity (e.g., walking one to two level blocks or climbing one flight of stairs) causes fatigue, palpitation, dyspnea, or anginal pain.       The Criteria Committee of the New York Heart 420913000       SNOMED				/ Association. Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Great Vessels. 9th ed. Boston, Mass: Little, Brown & Co; 1994:253-256.		
limitation of physical activity. Patient is comfortable at rest. Less than ordinary physical activity (e.g., walking Diseases of the Heart and Great Vessels. 9th ed. Diseases of the Heart and Heart and Great Heart and Heart and Great Heart and Heart a	Class II	of ordinary phy rest. Ordinary p than two blocks than one flight o	rsical activity. Patient is comfortable at physical activity such as walking more s or climbing more of stairs results in limiting symptoms	Association. Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Great Vessels. 9th ed.	421704003	SNOMED CT
carry on any physical activity without discomfort.         Symptoms are present even at rest or minimal exertion.         If any physical activity is undertaken, discomfort is         increased.         Element: 4015       CHA2DS2-VASc LV Dysfunction         Coding Instruction:       Indicate if the patient has been diagnosed with Left Ventricular (LV) Dysfunction according to the CHA2DS2-VASc definition.         Target Value:       Any occurrence between 30 days prior to the procedure and the procedure         Supporting Definition:       CHA2DS2-VASc LV Dysfunction         Left Ventricular Ejection Fraction < 40 %.         Source:       Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest.2010;137(2):263-272.         Element: 4020       CHA2DS2-VASc Hypertension         Coding Instruction:       Indicate if the patient has been diagnosed with hypertension according to the CHA2DS2-VASc definition.         Target Value:       Any occurrence between 30 days prior to the procedure and the procedure	Class III	limitation of phy rest. Less than one to two leve flight of stairs)	ysical activity. Patient is comfortable at ordinary physical activity (e.g., walking el blocks or climbing one	Association. Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Great Vessels. 9th ed. Boston, Mass: Little, Brown & Co; 1994:253-256.	420913000	SNOMED CT
Coding Instruction:       Indicate if the patient has been diagnosed with Left Ventricular (LV) Dysfunction according to the CHA2DS2-VASc definition.         Target Value:       Any occurrence between 30 days prior to the procedure and the procedure         Supporting Definition:       CHA2DS2 -VASc LV Dysfunction         Left Ventricular Ejection Fraction < 40 %.         Source:       Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest.2010;137(2):263-272.         Element: 4020       CHA2DS2-VASc Hypertension         Coding Instruction:       Indicate if the patient has been diagnosed with hypertension according to the CHA2DS2-VASc definition.         Target Value:       Any occurrence between 30 days prior to the procedure and the procedure	Class IV	carry on any pł Symptoms are If any physical	hysical activity without discomfort. present even at rest or minimal exertion.		422293003	SNOMED CT
Target Value:       Any occurrence between 30 days prior to the procedure and the procedure         Supporting Definition:       CHA2DS2 -VASc LV Dysfunction         Left Ventricular Ejection Fraction < 40 %.       Source: Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest.2010;137(2):263-272.         Element: 4020       CHA2DS2-VASc Hypertension         Coding Instruction:       Indicate if the patient has been diagnosed with hypertension according to the CHA2DS2-VASc definition.         Target Value:       Any occurrence between 30 days prior to the procedure and the procedure	Element: 4015		CHA2DS2-VASc LV Dysfunction	1		
Supporting Definition:       CHA2DS2 -VASc LV Dysfunction         Left Ventricular Ejection Fraction < 40 %.       Source:         Source:       Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest.2010;137(2):263-272.         Element:       4020       CHA2DS2-VASc Hypertension         Coding Instruction:       Indicate if the patient has been diagnosed with hypertension according to the CHA2DS2-VASc definition.         Target Value:       Any occurrence between 30 days prior to the procedure and the procedure		Coding Instruction:	Indicate if the patient has been diagnos	sed with Left Ventricular (LV) Dysfunction according to the	e CHA2DS2-VASc def	inition.
Left Ventricular Ejection Fraction < 40 %.         Source:       Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest.2010;137(2):263-272.         Element: 4020       CHA2DS2-VASc Hypertension         Coding Instruction:       Indicate if the patient has been diagnosed with hypertension according to the CHA2DS2-VASc definition.         Target Value:       Any occurrence between 30 days prior to the procedure and the procedure		Target Value:	Any occurrence between 30 days prio	r to the procedure and the procedure		
Source:       Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest.2010;137(2):263-272.         Element:       4020         CHA2DS2-VASc Hypertension         Indicate if the patient has been diagnosed with hypertension according to the CHA2DS2-VASc definition.         Target Value:       Any occurrence between 30 days prior to the procedure and the procedure		Supporting Definition:	CHA2DS2 -VASc LV Dysfunction			
Element: 4020       CHA2DS2-VASc Hypertension         Coding Instruction:       Indicate if the patient has been diagnosed with hypertension according to the CHA2DS2-VASc definition.         Target Value:       Any occurrence between 30 days prior to the procedure and the procedure			Left Ventricular Ejection Fraction < 40 °	%.		
Coding Instruction:       Indicate if the patient has been diagnosed with hypertension according to the CHA2DS2-VASc definition.         Target Value:       Any occurrence between 30 days prior to the procedure and the procedure						
Target Value: Any occurrence between 30 days prior to the procedure and the procedure	Element: 4020		CHA2DS2-VASc Hypertension			
		Coding Instruction:	Indicate if the patient has been diagnos	sed with hypertension according to the CHA2DS2-VASc d	efinition.	
Supporting Definition: CHA2DS2-VASc Hypertension		Target Value:	Any occurrence between 30 days prio	r to the procedure and the procedure		
		Supporting Definition:	CHA2DS2-VASc Hypertension			





Section: CHA2DS2-VASc Risk Score	es Parent: History and Risk Factors
	A resting blood pressure >140mmHg systolic and/or >90mmHg diastolic on at least 2 occasions or current antihypertensive pharmacologic treatment.
	<b>Source:</b> Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest.2010;137(2):263-272.
Element: 4025	CHA2DS2-VASc Diabetes Mellitus
Coding Instruction:	Indicate if the patient has been diagnosed with diabetes mellitus according to the CHA2DS2-VASc definition.
Target Value:	Any occurrence between 30 days prior to the procedure and the procedure
Supporting Definition:	CHA2DS2-VASc Diabetes Mellitus
	Fasting plasma glucose level ≥7.0 mmol/L (126 mg/dL) or treatment with oral hypoglycemic agent and/or insulin.
	<b>Source:</b> Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest.2010;137(2):263-272.
Element: 4030	CHA2DS2-VASc Stroke
Coding Instruction:	Indicate if the patient has been diagnosed with an ischemic stroke according to the CHA2DS2-VASc definition.
	Note(s): Patients with a history of stroke documented as undetermined in origin may be coded, but patients with a history of stroke documented as hemorrhagic in origin should not be coded.
Target Value:	Any occurrence between birth and the procedure
Supporting Definition:	CHA2DS2-VASc Stroke
	Ischemic stroke is defined as a focal neurologic deficit of sudden onset as diagnosed by a neurologist, lasting > 24 h and caused by ischemia.
	<b>Source:</b> Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest.2010;137(2):263-272.
Element: 4035	CHA2DS2-VASc TIA
Coding Instruction:	Indicate if the patient has been diagnosed with a transient ischemic attack (TIA) according to the CHA2DS2-VASc definition.
Target Value:	Any occurrence between birth and the procedure
Supporting Definition:	CHA2DS2-VASc TIA
	Transient ischemic attack (TIA) is defined as a focal neurologic deficit of sudden onset as diagnosed by a neurologist, lasting < 24 h.
	<b>Source:</b> Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation. Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest. 2010;137(2):263-272.
Element: 4040	CHA2DS2-VASc Thromboembolic Event
Coding Instruction:	Indicate if the patient has been diagnosed with a thromboembolic event (TE) according to the CHA2DS2-VASc definition.
	Note(s): A thromboembolic event is defined as a thrombus formed in a blood vessel that breaks loose and travels to occlude another vessel.
Target Value:	Any occurrence between birth and the procedure
Supporting Definition:	Thromboembolic Events (peripheral)
	Peripheral embolism is defined as a thromboembolic event (TE) outside the brain, heart, eyes, and lungs. Pulmonary embolism is defined by the responsible physician.
	TE is defined as either an ischemic stroke, peripheral embolism, or pulmonary embolism.
	Source: Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation. Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest. 2010;137(2):263-272.
Element: 4045	CHA2DS2-VASc Vascular Disease
Coding Instruction:	Indicate if the patient has been diagnosed with vascular disease according to the CHA2DS2-VASc definition.
	Note(s): CHA2DS2-VASc Score Vascular disease (defined as prior MI, PAD, or aortic plaque) if Yes = + 1; If the clinician has utilized the presence of CAD, PCI, CABG, or carotid disease in the patient's history as determining factors for selecting the CHA2DS2-VASc Vascular Disease element when considering the patient's risk score, please note CAD, PCI, CABG, and carotid disease were not part of the original validated vascular disease criterion for the CHA2DS2-VASc score.
Target Value:	Any occurrence between birth and the procedure





## Section: CHA2DS2-VASc Risk Scores

Parent: History and Risk Factors

Coding Instruction: Indicate if the patient has a history of a prior myocardial infarction (MI), peripheral artery disease (PAD) or a known aortic plaque. If the patient has multiple vascular diseases, select all relevant disease types.

Note(s):

The following conditions are not part of the original definition of CHA2DS2-VASc Vascular Disease type: CAD, PCI, CABG, Carotid Disease, Carotid Stent, or Carotid Endarterectomy. Any finding of these conditions in the patient's medical history does not automatically allow coding of yes. Please code only if the physician utilized any of these conditions as part of the assessment when documenting or determining the patient's CHA2DS2-VASc risk score.

Target Value: Any occurrence between birth and the procedure

#### Vascular Disease Type - 1.3.6.1.4.1.19376.1.4.1.6.5.221

Selection	Definition	Source	Code	Code System
Prior Myocardial Infarction (MI)			399211009	SNOMED CT
Peripheral Arterial Occlusive Disease (PAD)	Current or previous history of peripheral arterial disease (includes subclavian, iliac, femoral, and upper - and lower-extremity vessels; excludes renal, coronary, cerebral, and mesenteric vessels and aneurysms). This can include: * Claudication on exertion * Amputation for arterial vascular insufficiency * Vascular reconstruction, bypass surgery, or percutaneous revascularization in the arteries of the extremities * Positive noninvasive test (e.g., ankle brachial index <= 0.9, ultrasound, MR or CT imaging of >50% diameter stenosis in any peripheral artery (i.e., subclavian, femoral, iliac) or angiographic imaging)	ACCF/AHA 2011 Key Data Elements and Definitions of r a Base Cardiovascular Vocabulary for Electronic Health Records (JACC 2011;58;202-222)	399957001	SNOMED CT
Known Aortic Plaque	Discovery of a complex aortic plaque (> 4 mm thick, or mobile, ulcerated, or pedunculated) may occur when TEE is performed as part of the evaluation for an acute stroke or peripheral embolism. Imaging techniques used for detection of aortic plaques have included transesophageal echocardiogram (TEE), computed tomography (CT), magnetic resonance imaging (MRI), and transthoracic echocardiogram (TTE).	r Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the Euro Heart Survey on atrial fibrillation. Lip GY, Nieuwlaat R, Pisters R, et al. Chest. 2010;137:263-72.	1522000 15825003	SNOMED CT
Coronary Artery Disease (CAD)*	Current or previous history of any of the following: * Coronary artery stenosis >=50% (by cardiac catheterization or other modality or of direct imaging of the coronary arteries) * Previous CABG surgery * Previous PCI * Previous MI	ACCF/AHA 2011 Key Data Elements and Definitions of a Base Cardiovascular Vocabulary for Electronic Health Records (JACC 2011;58;202-222)	53741008	SNOMED CT
Percutaneous Coronary Intervention (PCI)*	Current or previous history of percutaneous coronary artery, coronary valvular or coronary structural intervention.	,	415070008	SNOMED CT
Coronary Artery Bypass Graft (CABG)*	Current or previous history of coronary artery bypass graft.	3	232717009	SNOMED CT
Carotid Artery Disease*	Current or previous history of carotid disease.		371160000	SNOMED CT





	BLED Risk Scores	Parent: History and Risk Factors	
Element: 4055		HAS-BLED Hypertension (Uncontrolled)	
	Coding Instruction:	Indicate if the patient has been diagnosed with uncontrolled hypertension as defined HAS- BLED Risk Model.	
	Target Value:	Any occurrence between 30 days prior to the procedure and the procedure	
	Supporting Definition:	HAS-BLED Hypertension (Uncontrolled)	
		Uncontrolled Hypertension is defined as a systolic blood pressure >160 mmHg despite medical therapy to lower the patient's blood pressure. This may also be documented as Hypertension resistant to medical therapy within the medical record.	
		Source: A novel user-friendly score (HAS-BLED) to assess 1-year risk of major bleeding in patients with atrial fibrillation: the Euro Heart Survey. Pisters R, Lane DA, Nieuwlaat R, et al. Chest. 2010;138(5):1093-1100	С
<b>lement:</b> 4060		HAS-BLED Abnormal Renal Function	
	Coding Instruction:	Indicate if the patient has been diagnosed with abnormal renal function as defined by the HAS-BLED Risk Model.	
	Target Value:	Any occurrence between 30 days prior to the procedure and the procedure	
	Supporting Definition:	HAS-BLED Abnormal Renal Function	
		Abnormal Renal Function is defined by the HAS-BLED Risk Model by any one of the following variables: a history of being the recipi at least one kidney transplant or chronic dialysis in the past or a dialysis treatment in the week prior to admission or serum creatining 200 micromole/L (≥2.6 mg/dL). Chronic is defined as three months or greater.	
		Dialysis treatment includes hemodialysis and peritoneal dialysis.	
		Source: A novel user-friendly score (HAS-BLED) to assess 1-year risk of major bleeding in patients with atrial fibrillation: the Euro Heart Survey. Pisters R, Lane DA, Nieuwlaat R, et al. Chest. 2010;138(5):1093-1100	C
Element: 4065		HAS-BLED Abnormal Liver Function	
	Coding Instruction:	Indicate if the patient has been diagnosed with abnormal liver function as defined by the HAS-BLED Risk Model.	
	Target Value:	Any occurrence between 30 days prior to the procedure and the procedure	
	Supporting Definition:	HAS-BLED Abnormal Liver Function	
		Abnormal liver function is defined by the HAS-BLED Risk Model as chronic hepatic disease (eg, cirrhosis) or biochemical evidence of significant hepatic derangement (eg, bilirubin more than two times the upper limit of normal, in association with aspartate transaminase/alanine transaminase/alkaline phosphatase more than three times the upper limit normal). Chronic is defined as three months or greater.	of
		Source: A novel user-friendly score (HAS-BLED) to assess 1-year risk of major bleeding in patients with atrial fibrillation: the European	С
Element: 4070		HAS-BLED Stroke	
	Coding Instruction:	Indicate if the patient has experienced a stroke in the past as defined by the HAS-BLED Risk Model.	
	Target Value:	Any occurrence between birth and the procedure	
	Supporting Definition:	HAS-BLED Stroke	
		A stroke is defined by the HASBLED Risk Model as an acute episode of focal or global neurological dysfunction caused by brain, sp cord, or retinal vascular injury as a result of hemorrhage or infarction.	inal
		Source: A novel user-friendly score (HAS-BLED) to assess 1-year risk of major bleeding in patients with atrial fibrillation: the Euro Heart Survey. Pisters R, Lane DA, Nieuwlaat R, et al. Chest. 2010;138(5):1093-1100Lip GY. Implications of the CHA(2)DS(2)-VASC HAS-BLED Scores for thromboprophylaxis in atrial fibrillation. Am J Med. 2011 Feb;124(2):111-4.	
Element: 14792		HAS-BLED Stroke Type	
	Coding Instruction:	Indicate what type of stroke the patient has experienced in the past as defined by the HAS-BLED Risk Model.	
	Target Value:	Any occurrence between birth and the procedure	
	Supporting Definition:	HAS-BLED Stroke	
		A stroke is defined by the HASBLED Risk Model as an acute episode of focal or global neurological dysfunction caused by brain, sp cord, or retinal vascular injury as a result of hemorrhage or infarction.	ina
		<b>Source:</b> A novel user-friendly score (HAS-BLED) to assess 1-year risk of major bleeding in patients with atrial fibrillation: the Euro Heart Survey. Pisters R, Lane DA, Nieuwlaat R, et al. Chest. 2010;138(5):1093-1100Lip GY. Implications of the CHA(2)DS(2)-VASC HAS-BLED Scores for thromboprophylaxis in atrial fibrillation. Am J Med. 2011 Feb;124(2):111-4.	
IAS-BLED Stroke	Гуре - 1.3.6.1.4.1.19376.1	.4.1.6.5.773	
election	Definition	Source Code Code S	-
lemorrhagic Stroke	stroke. In this s	ay be a consequence of ischemic 230706003 SNON situation, the stroke is an ischemic stroke jic transformation and not a hemorrhagic	ЛЕD

with hemorrhagic transformation and not a hemorrhagic





Section: HAS-E	BLED Risk Scores	Parent: History and Risk	Factors
	stroke.		
	Hemorrhagic st	oke is defined as an acute episode of	
	•	erebral or spinal dysfunction caused /mal, intraventricular, or subarachnoid	
	hemorrhage.		
	Note: Subdural events and not	nematomas are intracranial hemorrhagic strokes.	
chemic Stroke	An ischemic str	oke is an acute episode of focal or	422504002 SNOME
	cord, or retinal	cal dysfunction caused by brain, spinal ascular injury as a result of infarction us system tissue.	
ndetermined Stroke	A stroke of und	termined origin is defined as an acute	230713003 SNOME
		or global neurological dysfunction Imed brain, spinal cord, or retinal	
		is a result of hemorrhage or infarction	
	as ischemic or l	ent information to allow categorization emorrhagic.	
Element: 4095		HAS-BLED Bleeding	
	Coding Instruction:	Indicate if the patient has a history of a major bleeding event or predisposition	o bleeding (eg, bleeding diathesis, anemia) as defined b
		the HAS-BLED Risk Model.	
		Note(s): Major bleeding defined as any bleeding requiring hospitalization, and/ requiring blood transfusion that was not hemorrhagic stroke.	or causing a decrease in hemoglobin level > 2 g/dL, and/
	Target Value:	Any occurrence between birth and the procedure	
	Supporting Definition:	HAS-BLED Bleeding	
		Bleeding is defined by the HAS-BLED Risk Model as a history of a major bleed diathesis, anemia).	ng event or predisposition to bleeding (eg, bleeding
		<b>Source:</b> A novel user-friendly score (HAS-BLED) to assess 1-year risk of m Heart Survey. Pisters R, Lane DA, Nieuwlaat R, et al. Chest. 2010;138(5):1093	
Element: 4100		HAS-BLED Labile INR	
	Coding Instruction:	Indicate if the patient has experienced a labile international normalized ratios ( BLED Risk Model.	NR) while on Warfarin therapy as defined by the HAS-
	Target Value:	Any occurrence between 30 days prior to the procedure and the procedure	
	Supporting Definition:	HAS-BLED Labile INR	
		Labile INR is defined by the HAS-BLED Risk Model as unstable/high internation therapeutic range. Therapeutic range is defined as 2 - 3 inclusive.	al normalized ratios (INR) or <60 percent of INR values in
		Source: A novel user-friendly score (HAS-BLED) to assess 1-year risk of m Heart Survey. Pisters R, Lane DA, Nieuwlaat R, et al. Chest. 2010;138(5):1093	
Element: 4105		HAS-BLED Alcohol	
	Coding Instruction:	Indicate if the patient uses alcohol in excess as defined by the HAS-BLED Risl	Score.
	Target Value:	Any occurrence between 30 days prior to the procedure and the procedure	
	Supporting Definition:		
	cupperting bernition.	Alcohol excess is defined by the HAS-BLED Risk Model as consuming >=8 un	ts/week.
		<b>Source:</b> A novel user-friendly score (HAS-BLED) to assess 1-year risk of m Heart Survey. Pisters R, Lane DA, Nieuwlaat R, et al. Chest. 2010;138(5):109	ajor bleeding in patients with atrial fibrillation: the Euro
Element: 4110		HAS-BLED Drugs - Antiplatelet	
	Coding Instruction:	Indicate if the patient is taking antiplatelet medications.	
		Note(s): If the patient is taking any dosage of aspirin code as "Yes".	
	Target Value:	Any occurrence between 30 days prior to the procedure and the procedure	
		HAS-BLED Drugs - Antiplatelets	
		Concomitant use of ASA/NSAIDS or antiplatelet medication with alcohol may p	edisposed the patient to bleeding per the HAS-BLED Ris
		Model. Source: A novel user-friendly score (HAS-BLED) to assess 1-year risk of m Heart Survey. Pisters R, Lane DA, Nieuwlaat R, et al. Chest. 2010;138(5):109	
Element: 4115		HAS-BLED Drugs - NSAIDS	





## Section: HAS-BLED Risk Scores

## Parent: History and Risk Factors

Coding Instruction: Indicate if the patient is taking a non-steroidal anti-inflammatory drug (NSAID).

Target Value: Any occurrence between 30 days prior to the procedure and the procedure

## Supporting Definition: HAS-BLED Drugs - NSAIDS

Concomitant use of ASA/NSAIDS or antiplatelet medication with alcohol may predisposed the patient to bleeding per the HAS-BLED Risk Model.

Source: A novel user-friendly score (HAS-BLED) to assess 1-year risk of major bleeding in patients with atrial fibrillation: the Euro Heart Survey. Pisters R, Lane DA, Nieuwlaat R, et al. Chest. 2010;138(5):1093-1100





	nal Stroke and Ble		
Element: 14793		Increased Fall Risk	
	Coding Instruction:	Indicate if the patient has an increased susceptibility to falling that may cause physical harm as defined by the Ame Society.	erican Geriatrics
	Target Value:	Any occurrence between 12 months prior to the procedure and start of the procedure	
s	Supporting Definition:	Increased Fall Risk	
		A patient is at increased risk for falls if they have experienced any of the following: two or more falls in the prior 1: with an acute fall for this episode of care; or experiences difficultly walking or balancing.	2 months; presents
		<b>Source:</b> American Geriatrics Society/British Geriatrics Society Clinical Practice Guideline for Prevention of Falls in Geriatr Soc. 2010.	n Older Persons. J Am
Element: 14794		Clinically Relevant Bleeding Event	
	Coding Instruction:	Indicate if the patient had any of the following associated with a Clinically Relevant Bleeding Event.	
	Target Value:	Any occurrence between birth and the procedure	
S	Supporting Definition:	Clinically Relevant Bleeding Event	
		<ul> <li>A clinically relevant bleeding event is defined as any one of the following:</li> <li>1. Hemoglobin drop of &gt;=3 g/dL;</li> <li>2. Transfusion of packed red blood cells;</li> <li>3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding</li> <li>4. Hospital admission with primary discharge diagnosis related to a bleeding event.</li> <li>Source: NCDR</li> </ul>	
Element: 14796		Bleeding Event Type	
	Coding Instruction:		
	Target Value:	Any occurrence between birth and the procedure	
S	Supporting Definition:	Bleeding Event	
		A bleeding event observed and documented in the medical record that was associated with a hematocrit drop of $\geq$ hemoglobin drop of $\geq$ 3 g/dL or that required transfusion or surgical intervention.	10% and/or a
		<b>Source:</b> Cannon CP, Brindis RG, Chaitman BR, et al. 2013 ACCF>AHA Key Date Elements and Definitions for Me Management and Outcomes of Patients with Acute Coronary Syndromes and Coronary Artery Disease. Circulation	
Bleeding Event Type	- 1.3.6.1.4.1.19376.1.4.	1.6.5.774	
Selection	Definition	Source Code	Code Syster
ntracranial Bleed		1386000	SNOMED C
Epistaxis Gastrointestinal Bleed		249366005 74474003	SNOMED C SNOMED C
Other		1000142371	ACC NCD
Element: 14797		Genetic Coadulopatiny	
	Coding Instruction:	Genetic Coagulopathy Indicate if the patient has been diagnosed with a genetic coagulopathy.	

Element: 14798

Coding Instruction: Indicate if the patient was using any anticoagulant medication at the time of the clinically relevant bleeding event.

Target Value: Any occurrence between birth and the procedure

Concurrent Anticoagulant Therapy





Section: Rhythm History	Parent: History and Risk Factors
Element: 13709	Atrial Fibrillation
Coding Instruction:	Indicate if the patient has a history of atrial fibrillation.
Target Value:	Any occurrence between birth and current procedure
Element: 4400	Atrial Fibrillation Classification
Coding Instruction:	Indicate the type of atrial fibrillation experienced by the patient.
Target Value:	Any occurrence between birth and the first procedure in this admission
Supporting Definition:	Atrial Fibrillation Classification
	Atrial Fibrillation is a supraventricular tachyarrhythmia with uncoordinated atrial activation and consequently ineffective atrial contraction.
	Electrocardiogram (ECG) characteristics include: 1) irregular R-R intervals (when atrioventricular [AV] conduction is present), 2) absence of distinct repeating P waves, and 3) irregular atrial activity.
	Atrial Fibrillation can be further characterized as:
	<ul> <li>Paroxysmal AF is defined as AF that terminates spontaneously or with intervention within seven days of onset. Episodes may recur with variable frequency.</li> <li>Persistent AF is defined as AF that fails to self-terminate within seven days. Episodes often require pharmacologic or electrical cardioversion to restore sinus rhythm.</li> <li>Long-standing persistent AF is defined as AF that has lasted for more than 12 month</li> <li>Permanent AF is defined as when the patient and clinician make a joint decision to stop further attempts to restore and/or maintain sinus rhythm. Acceptance of AF represents a therapeutic attitude on the part of the patient and clinician rather than an inherent pathophysiological attribute of AF. Acceptance of AF may change as symptoms, efficacy of therapeutic interventions, and patient and clinician preferences evolve.</li> <li>Source: January CT, Wann LS, Alpert JS, et al. 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol 2014. DOI: 10.1016/j.jacc.2014.03.022</li> </ul>

#### Atrial Fibrillation Classification - 1.3.6.1.4.1.19376.1.4.1.6.5.17

Selection	Definition	Source	Code	Code System
Paroxysmal (terminating spontaneously within 7 days	s) within 7 days o	AF that terminates spontaneously or with intervention within 7 days of onset. Episodes may recur with variable frequency.		SNOMED CT
Persistent (greater than 7 days)		that is sustained >7 days or with rmacological termination.	62459000	SNOMED CT
Long-standing persistent (greater than 1 year)	Continuous AF	of >12 months duration.	100001029	ACC NCDR
Permanent	clinician make a	anent AF" is used when the patient and joint decision to stop further attempts to a naintain sinus rhythm.	6934004	SNOMED CT
	on the part of th	- Acceptance of AF represents a therapeutic attitude on the part of the patient and clinician rather than an inherent pathophysiological attribute of the AF.		
		AF may change as symptoms, the peutic interventions, and patient and nces evolve.		
Element: 4380		Valvular Atrial Fibrillation		
Coo	ding Instruction:	Indicate if the patient has atrial fibrillation occurring in the setting of valvular ha attributable to valvular heart disease (especially mitral valvular disease).	eart disease and believed to be, at least	in part, directly
	Target Value:	Any occurrence between birth and the procedure		
Element: 14799		History of Rheumatic Valve Disease		
Cod	ding Instruction:	Indicate if the patient has a history of rheumatic valve disease.		
	Target Value:	Any occurrence between birth and the procedure		
Element: 4385		History of Mitral Valve Replacement		
Cod	ding Instruction:	Indicate if the patient has a history of mitral valve replacement either via open	surgical or a percutaneous transcathete	er intervention.
	Target Value:	Any occurrence between birth and the procedure		



Coder's Data Dictionary v1.4



ocotion. Knyth	m History	Parent: History and Risk Factors
Element: 4390		Mechanical Valve in Mitral Position
	Coding Instruction:	Indicate if the patient has a mechanical valve placed in the mitral position.
	-	Any occurrence between birth and the procedure
Element: 4395		History of Mitral Valve Repair
	Coding Instruction:	Indicate if the patient has a history of mitral valve repair, specifically via the surgical route. Either a surgical repair of a mitral valve leaflet or mitral annuloplasty qualifies as repair.
	Target Value:	Any occurrence between birth and the procedure
Element: 4410		Attempt at Atrial Fibrillation Termination
	Coding Instruction:	Indicate if the patient has had previous attempts to terminate the atrial fibrillation.
	Target Value:	Any occurrence between birth and the procedure
	Supporting Definition:	Previous Attempt at Atrial Fibrillation Termination
		Therapeutic options for conversion of AF to sinus rhythm includes: antiarrhythmic drugs, direct current cardioversion, catheter ablation and surgical ablation.
		<b>Source:</b> McNamara RL, Brass LM, Drozda JP, Jr, et al. ACC/AHA key data elements and definitions for measuring the clinical management and outcomes of patients with atrial fibrillation: A report of the American College of Cardiology/American Heart Association Task Force on clinical data standards (writing committee to develop data standards on atrial fibrillation). J Am Coll Cardiol. 2004;44(2):475 -495
Element: 4415		Atrial Fibrillation Termination - Pharmacologic Cardioversion
	Coding Instruction:	Indicate if the patient has a history of pharmacological cardioversion.
	Target Value:	Any occurrence between birth and the procedure
	Supporting Definition:	Pharmacologic Cardioversion
		Antiarrhythmic drugs can be administered for attempted conversion of AF to sinus rhythm or to facilitate electrical cardioversion.
		Source: January CT, Wann LS, Alpert JS, et al. 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol 2014. DOI: 10.1016/j.jacc.2014.03.022
Element: 4420		Atrial Fibrillation Termination - DC Cardioversion
	Coding Instruction:	Indicate if the patient has a history of direct current (DC) cardioversion.
	Target Value:	Any occurrence between birth and the procedure
	Supporting Definition:	DC Cardioversion
		Direct-current cardioversion involves the delivery of an electrical shock synchronized with the QRS complex to avoid inducing ventricular fibrillation as can occur by a shock applied during ventricular repolarization on the T wave.
		Source: January CT, Wann LS, Alpert JS, et al. 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol 2014. DOI: 10.1016/j.jacc.2014.03.022
Element: 4425		Atrial Fibrillation Termination - Catheter Ablation
	Coding Instruction:	Indicate if the patient has a history of catheter ablation for termination of atrial fibrillation.
	Target Value:	Any occurrence between birth and the procedure
	Supporting Definition:	Catheter Ablation
		Various methods of catheter ablation are used. Currently most techniques focus on isolating the triggers in the pulmonary veins (PVs) from the vulnerable substrate in the left atrium. The majority of ablations performed use radiofrequency energy or cryothermy (cryoballoon ablation). Source: January CT, Wann L, Alpert JS, et al. 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol. 2014;64(21):e1-e76.
Element: 4430		Atrial Fibrillation Most Recent Catheter Ablation Date
	Coding Instruction:	Indicate the date of the most recent attempt to terminate the atrial fibrillation via catheter ablation.
		Note(s): If the month or day is unknown, please code 01/01/YYYY. If the specific year is unknown in the current record, the year may be estimated based on timeframes found in prior medical record documentation (Example: If the patient had "most recent ablation" documented in a record from 2011, then the year 2011 can be utilized and coded as 01/01/2011).





## Section: Rhythm History

Parent: History and Risk Factors

Target Value: Any occurrence between birth and the procedure

Vendor Instruction: Atrial Fibrillation Most Recent Catheter Ablation Date

Element: 4435

Prior Catheter Ablation Strategy

Coding Instruction: Indicate the previously attempted catheter ablation strategy/strategies used to treat the atrial fibrillation.

Note(s):

The strategies that should be collected in your application are controlled by Ablation Strategy Master file. This file is maintained by the NCDR and will be made available on the internet for downloading and importing/updating into your application.

Target Value: Any occurrence between birth and the procedure

#### Ablation Strategy - 1.3.6.1.4.1.19376.1.4.1.6.5.211

Selection	Definition	Source	Code	Code System
Complex Fractionated Atrial Electrogram		tegy targeting areas of continuous high nplex fractionated) atrial electrograms.	100000910	ACC NCDR
Convergent Procedure	followed by end ablation in patie	procedure consists of epicardial (Epi) ocardial (Endo) radio-frequency nts (pts) with atrial fibrillation (AF), risk of recurrence with endo ablation	100000911	ACC NCDR
Cryoablation		freezing technology, involves a coolant nto the catheter's balloon to freeze and a.	233161001	SNOMED CT
Empiric LA Linear Lesions	lesions (such a may accompan	tegy that can include adjunctive linear s a roof line or mitral annular line) that / WACA, PVI, or other approaches, eventing development of subsequent	100000912	ACC NCDR
Focal Ablation An ablation stra putative trigger a trigger of AF accompanies A		tegy targeting one or more foci of of atrial fibrillation. Ablation may be of or just of a focal atrial tachycardia that F or emerges following previous AF a stand-alone rhythm).	100000913	ACC NCDR
Ganglion Plexus Ablation		tegy targeting one or more regions of e plexi around the left atrium.	100000914	ACC NCDR
Pulmonary Vein Isolation		tegy defined as electrical disconnection dium extending into the pulmonary veins f the left atrium.	100000915	ACC NCDR
Segmental PV Ablation	An ablation stra of pulmonary v the body of the	tegy with the goal of electrical isolation nous atrial tachycardia triggers from eft atrium by ablating segmentally rentially within a vein or near the	100000916	ACC NCDR
Rotor Based Mapping		tegy guided by mapping software loyed to identify specific atrial fibrillation	100000917	ACC NCDR
Wide Area Circumferential Ablation	circumferential and left venous modification, is This approach	tegy that includes placement of large ablation lesion sets encircling the right antra with the goal of either substrate lation of the pulmonary veins, or both. generally implies that formal testing for and/or exit block is NOT performed.	100000918	ACC NCDR
Element: 4440		Atrial Fibrillation Termination - Surgical Ablation		
Cod	ing Instruction:	Indicate if the patient has a history of surgical ablation.		
	Target Value:	Any occurrence between birth and the procedure		
Suppo	rting Definition:	Surgical Ablation		
		The Maze operation is one surgical ablation option treat patients with both p therapy.	paroxysmal and chronic AF refractory to a	ntiarrhythmic
		Source: The surgical treatment of atrial fibrillation. IV. Surgical technique.	Cox JL . J Thorac Cardiovasc Surg. 1991	;101(4):584.
Element: 4445		Atrial Fibrillation, Most Recent Surgical Ablation Date		
Cod	ing Instruction:	Indicate the date of the most recent attempt to terminate the atrial fibrillation	via surgical ablation.	
		Note(s): If the month or day is unknown, please code 01/01/YYYY. If the specific ye estimated based on timeframes found in prior medical record documentation		

documented in a record from 2011, then the year 2011 can be utilized and coded as 01/01/2011).



Section: Rhythm History

Parent: History and Risk Factors



Section: Rhyth	m History	Parent: History and Risk Factors				
Target Value:		Any occurrence between birth and the procedure				
	Supporting Definition:	Surgical Ablation				
		The Maze operation is one surgical ablation option treat patients with both paroxysmal and otherapy.	chronic AF refractory to a	ntiarrhythmic		
		Source: The surgical treatment of atrial fibrillation. IV. Surgical technique. Cox JL . J Thor	ac Cardiovasc Surg. 1991	1;101(4):584.		
	Vendor Instruction:	n: Atrial Fibrillation Most Recent Surgical Ablation Date (4445) must be Less than or Equal to the Procedure Start Date and Time (7000)				
Element: 4450		Atrial Flutter				
	Coding Instruction:	Indicate if the patient has a history of atrial flutter.				
	Target Value:	Any occurrence between birth and the procedure				
Supporting Definition		Atrial Flutter				
		Atrial flutter is defined as a cardiac arrhythmia arising in the atrium which has a regular rate length 240-170 ms) in the absence of antiarrhythmic drugs.	typically between 250 ar	id 350 bpm (cycle		
		<b>Source:</b> January CT, Wann LS, Alpert JS, Calkins H, Cleveland Jr JC, Cigarroa JE, Conti JB KT, Sacco RL, Stevenson WG, Tchou PJ, Tracy CM, Yancy CW, 2014 AHA/ACC/HRS Guidel Atrial Fibrillation, Journal of the American College of Cardiology (2014), doi: 10.1016/j.jacc.20	line for the Management of			
Element: 4455		Atrial Flutter Classification				
	Coding Instruction:	Indicate the predominate type of atrial flutter experienced by the patient.				
	Target Value:	Any occurrence between birth and the procedure				
	Supporting Definition:	Atrial Flutter Type				
		Atrial flutter is further classified into typical or atypical dependent on whether or not re-entry cavotricuspid isthmus.	is dependent upon cond	uction through the		
		<b>Source:</b> January CT, Wann LS, Alpert JS, Calkins H, Cleveland Jr JC, Cigarroa JE, Conti JB KT, Sacco RL, Stevenson WG, Tchou PJ, Tracy CM, Yancy CW, 2014 AHA/ACC/HRS Guidel Atrial Fibrillation, Journal of the American College of Cardiology (2014), doi: 10.1016/j.jacc.20	line for the Management of			
Atrial Flutter Classi	fication - 1.3.6.1.4.1.193	76.1.4.1.6.5.191				
Selection	Definition	Source	Code	Code Syster		
Гурісаl/Cavotricuspid CTI) Dependent	tachycardia tha down the latera cavotricuspid (s tricuspid valve	tter is a macro-re-entrant atrial t usually proceeds up the atrial septum, I atrial wall, and through the subeustachian) isthmus between the annulus and inferior vena cava, where argeted for ablation.	100000982	ACC NCD		
Atypical	dependent mac describes macr	acro-re-entrant atrial tachycardia", acro-re-entrant atrial tachycardias that are e typical forms of atrial flutter that use the		SNOMED C		
Element: 4460		Attempt at Atrial Flutter Termination				
	Coding Instruction:	Indicate if the patient has had previous attempts to terminate the atrial flutter.				
	Target Value:	Any occurrence between birth and the procedure				
	Supporting Definition:	Previous Attempt at Atrial Flutter Termination				
		Therapeutic options for conversion of atrial flutter to sinus rhythm includes: antiarrhythmic d catheter ablation.	drugs, direct current card	ioversion, and		
		<b>Source:</b> McNamara RL, Brass LM, Drozda JP, Jr, et al. ACC/AHA key data elements and c management and outcomes of patients with atrial fibrillation: A report of the American Colleg Task Force on clinical data standards (writing committee to develop data standards on atrial -495.	ge of Cardiology/Americar	Heart Association		
Element: 4465		Atrial Flutter Termination - Pharmacologic Cardioversion				
		Indicate if the patient has a history of pharmacologic cardioversion to terminate the atrial flut	ter.			
	Coding Instruction:					
	-	Any occurrence between birth and the procedure				
	Target Value:					
	Target Value:	Any occurrence between birth and the procedure	r to facilitate electrical ca	rdioversion.		





Section: Rhythm History		Parent: History and Risk Factors		
Element: 4470		Atrial Flutter Termination - DC Cardioversion		
	Coding Instruction:	Indicate if the patient has a history of DC cardioversion to terminate the atrial flutter.		
	Target Value:	Any occurrence between birth and the procedure		
	Supporting Definition:	DC Cardioversion		
		Direct-current cardioversion involves the delivery of an electrical shock synchronized with the QRS complex to avoid inducing ventricular fibrillation as can occur by a shock applied during ventricular repolarization on the T wave.		
		Source: January CT, Wann LS, Alpert JS, et al. 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol 2014. DOI: 10.1016/j.jacc.2014.03.022		
Element: 4475		Atrial Flutter Termination - Catheter Ablation		
	Coding Instruction:	Indicate if the patient has a history of catheter ablation to terminate the atrial flutter.		
	Target Value:	Any occurrence between birth and the procedure		
Element: 4480		Atrial Flutter Most Recent Catheter Ablation Date		
	Coding Instruction:	Indicate the date of the most recent catheter ablation.		
		Note(s): If the month or day is unknown, please code 01/01/YYYY. If the specific year is unknown in the current record, the year may be estimated based on timeframes found in prior medical record documentation (Example: If the patient had "most recent ablation" documented in a record from 2011, then the year 2011 can be utilized and coded as 01/01/2011).		
	Target Value:	Any occurrence between birth and the procedure		

Vendor Instruction: Atrial Flutter Most Recent Catheter Ablation Date (4480) must be Less than or Equal to the Procedure Start Date and Time (7000)





Section: Interventions	Parent: History and Risk Factors	
Element: 14802	Cardiac Structural Intervention	
Coding Instruction	n: Indicate if the patient has a history of cardiac structural interventions (percutaneously or surgically).	
Target Valu	e: Any occurrence between birth and the procedure	
Element: 14803	Cardiac Structural Intervention Type	
Coding Instruction	n: Indicate the type of prior cardiac structural intervention.	
Target Valu	e: Any occurrence between birth and the procedure	

Selection	Definition	Source	Code	Code System
Aortic Balloon Valvulo	plasty		77166000	SNOMED CT
Transcatheter Aortic N Replacement (TAVR)	/alve		41873006	SNOMED CT
AV Replacement - Sur	gical		725351001	SNOMED CT
AV Repair - Surgical			112816004	SNOMED CT
Mitral Balloon Valvulop	lasty		112000001951	ACC NCDR
Transcatheter Mitral V Repair (TMVR)	alve		112000001801	ACC NCDR
MV Replacement - Sur	gical		53059001	SNOMED CT
MV Repair - Surgical			384641003	SNOMED CT
Mitral Annuloplasty Rir Surgical	ng -		232744004	SNOMED CT
Mitral Transcatheter - valve	Valve-in-		112000002069	ACC NCDR
ASD Closure			112811009	SNOMED CT
PFO Closure			41817002	SNOMED CT
Pulmonic Replacement			88045004	SNOMED CT
Pulmonic Repair			386749005	SNOMED CT
Tricuspid Replacement	t		25236004	SNOMED CT
Tricuspid Repair			384643000	SNOMED CT

#### Element: 14804

Left Atrial Appendage Occlusion Intervention

Coding Instruction: Indicate if the patient has a history of a left atrial appendage occlusion intervention.

Note(s): Previously "Aborted" LAA interventions should be captured in this element.

Target Value: Any occurrence between birth and the procedure

#### Element: 14806

Left Atrial Appendage Intervention Type

Coding Instruction: Indicate the type of prior left atrial appendage occlusion intervention.

Target Value: Any occurrence between birth and the procedure

#### Left Atrial Appendage Intervention Type - 1.3.6.1.4.1.19376.1.4.1.6.5.776

Selection	Definition	Source	Code	Code System
Epicardial Ligation	Ligation via an epicardial approach, isolating the left atrial appendage (LAA) from circulation via inside the pericardial space.		11200002072	ACC NCDR
Surgical Amputation	Amputation and complete excision of the left atrial appendage (LAA) until no trabeculated portion remains and the neck of the LAA is sewn closed. Another term for this technique is left atrial appendectomy.		112000002073	ACC NCDR
Surgical Ligation	Ligation via surgical approach where the left atrial appendage (LAA) is permanently sealed off from the rest of the heart preventing blood from circulating and pooling in the appendage.		112000002074	ACC NCDR
Percutaneous Occlusion	Occlusion of the left atrial appendage (LAA) using solely a percutaneous, catheter-based method.		112000002076	ACC NCDR
Surgical Closure Device	Left atrial appendage (LAA) surgical closure device was used.		112000002077	ACC NCDR
Surgical Stapling	Excision or exclusion technique of the left atrial appendage (LAA) via surgical approach using pericardial buttressing of the LAA staple line.		11200002075	ACC NCDR





Section: Addit	ional History and Ris	k Factors Parent: History and Risk Factors	S	
Element: 4565		Cardiomyopathy (CM)		
	Coding Instruction:	Indicate if the patient has a history of cardiomyopathy.		
	Target Value:	Any occurrence between birth and the procedure		
Element: 4570		Cardiomyopathy Type		
	Coding Instruction:	Indicate the type of cardiomyopathy experienced by the patient.		
		Note(s): If the patient has had multiple cardiomyopathies, select all applicable types.		
	Target Value:	Any occurrence between birth and the procedure		
	Supporting Definition:	Cardiomyopathy Type		
		Hypertrophic: Characterized morphologically and defined by a hypertrophied, nondilated LV in the ab is capable of producing the magnitude of wall thickening evident (eg, systemic hyperter customarily made with 2-dimensional echocardiography (or alternatively with cardiac m otherwise unexplained LV wall thickening, usually in the presence of a small LV cavity, as part of family screening. [1]	nsion, aortic valve stenosis). Cl nagnetic resonance imaging) by	inical diagnosis is / detection of
		Restrictive: Non Hypertrophied, Non Dilated: A rare form of heart muscle disease and a cause of hi decreased volume of both ventricles associated with biatrial enlargement, normal LV w filling with restrictive physiology, and normal (or near normal) systolic function. [1]		
		Non ischemic: Includes cardiomyopathies resulting from volume or pressure overload, such as hypert	ension or valvular heart diseas	e. [2]
		Ischemic: Considered to be present in patients with HF who have had a myocardial infarction (MI) myocardium or, on angiography, severe coronary disease.	) or have evidence of viable hit	pernating
		The term ischemic cardiomyopathy has been used to describe significantly impaired lef fraction ≤35 to 40 percent) that results from coronary artery disease. Despite the comm cardiomyopathy, ventricular dysfunction caused by coronary disease is not a cardiomy Association and 2008 European Society of Cardiology statements. [2]	non clinical use of the term isch	emic
		Other cardiomyopathy type: The term "unclassified cardiomyopathy" was included in the 2008 ESC classification st into any of the above phenotypic categories [3]. Examples cited include LV noncompact cardiomyopathy. [3]	-	
		Source: [1] Barry J. Maron, MD, Chair; Jeffrey A. Towbin, MD, FAHA; Gaetano Thiene, MD; Charles Antzelevitch, PhD, FAHA; Domenico Corrado, MD, PhD; Donna Arnett, PhD, FAHA; Arthur J. Moss, MD, FAHA; Christine E. Seidman, MD, FAHA; James B. Young, MD, FAHA; Christine E. Seidman, MD, FAHA; James B. Young, MD, FAHA. Contemporary definitions and classification of the cardior Scientific Statement from the Council on Clinical Cardiology, Heart Failure and Transplan Research and Functional Genomics and Translational Biology Interdisciplinary Working O Prevention. Circulation. 2006;113(14):1807.	tation Committee; Quality of Ca	ire and Outcomes
		[2] Yancy CW, Jessup M, Bozkurt B, et al. 2013 ACCF/AHA Guideline for the Managem College of Cardiology Foundation/American Heart Association Task Force on Practice G e239. doi:10.1016/j.jacc.2013.05.019.	•	
		[3] Richardson P, McKenna W, Bristow M, Maisch B, Mautner B, O'Connell J, Olsen E, T Report of the 1995 World Health Organization/International Society and Federation of Ca Classification of cardiomyopathies. Circulation. 1996;93(5):841		
ardiomyopathy T	ype - 1.3.6.1.4.1.19376.1.	1.1.6.5.193		
election	Definition	Source	Code	Code Syste

	pressure overload, such as hypertension or valvular heart disease.		
Ischemic cardiomyopathy	Considered to be present in patients with HF who have had a myocardial infarction (MI) or have evidence of viable hibernating myocardium or, on angiography, severe coronary disease.	426856002	SNOMED CT

The term ischemic cardiomyopathy has been used to



# Coder's Data Dictionary v1.4



Section: Additional His	tory and Ris	k Factors Parent: History and Ris	sk Factors	
		cantly impaired left ventricular function		
		ejection fraction =35 to 40 percent) that		
		onary artery disease. Despite the use of the term ischemic		
		, ventricular dysfunction caused by		
		se is not a cardiomyopathy as defined		
	•	erican Heart Association and 2008		
		ty of Cardiology statements. [2]		
	21 1	ied, Non Dilated: A rare form of heart	415295002	SNOMED C
		and a cause of heart failure that is y normal or decreased volume of both		
		siated with biatrial enlargement, normal		
	LV wall thickne	ss and AV valves, impaired ventricular		
	-	ctive physiology, and normal (or near		
	normal) systolic		000070004	
		norphologically and defined by a nondilated LV in the absence of another	233873004	SNOMED C
		diac disease that is capable of		
	producing the m	nagnitude of wall thickening evident (eg,		
		rension, aortic valve stenosis). Clinical		
	-	tomarily made with 2-dimensional hy (or alternatively with cardiac		
		ance imaging) by detection of		
		plained LV wall thickening, usually in		
		a small LV cavity, after suspicion is		
	screening.	inical profile or as part of family		
	•	ssified cardiomyopathy" was included	100001065	ACC NCD
, i , ii		C classification system to describe		
		o not readily fit into any of the above		
		gories [3]. Examples cited include LV		
	cardiomyopathy	and stress-induced (takotsubo)		
Element: 4575		Chronic Lung Disease		
Codin	g Instruction:	Indicate if the patient has a history of chronic lung disease.		
Codin	g Instruction:	Indicate if the patient has a history of chronic lung disease.		
Codin	g Instruction:	Note(s):		
Codin	g Instruction:	Note(s): A history of chronic inhalation reactive disease (asbestosis, mesothelioma,	· · ·	
Codin	g Instruction:	Note(s): A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis a	<b>.</b>	
	-	Note(s): A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis a a transient condition and does not qualify.	<b>.</b>	
	-	Note(s): A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis a	<b>.</b>	
	Target Value:	Note(s): A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis a a transient condition and does not qualify.	<b>.</b>	
	Target Value:	Note(s): A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis al a transient condition and does not qualify. Any occurrence between birth and the procedure <b>Chronic Lung Disease</b> Chronic lung disease can include patients with chronic obstructive pulmona include a patient who is currently being chronically treated with inhaled or anti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patien	Iso qualifies as chronic lung disease. A history ary disease, chronic bronchitis, or emphysema oral pharmacological therapy (e.g., beta-adren	, of atelectasis is a. It can also lergic agonist,
	Target Value:	Note(s): A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis al a transient condition and does not qualify. Any occurrence between birth and the procedure <b>Chronic Lung Disease</b> Chronic lung disease can include patients with chronic obstructive pulmona include a patient who is currently being chronically treated with inhaled or of	Iso qualifies as chronic lung disease. A history ary disease, chronic bronchitis, or emphysema oral pharmacological therapy (e.g., beta-adren ts with asthma or seasonal allergies are not co	y of atelectasis is a. It can also lergic agonist, onsidered to
Supporti	Target Value:	Note(s): A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis al a transient condition and does not qualify. Any occurrence between birth and the procedure <b>Chronic Lung Disease</b> Chronic lung disease can include patients with chronic obstructive pulmona include a patient who is currently being chronically treated with inhaled or canti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patien have chronic lung disease. <b>Source:</b> ACC/AHA Key Data Elements and Definitions for Measuring the C Heart Failure Circulation. 2005;112:1888-1916	Iso qualifies as chronic lung disease. A history ary disease, chronic bronchitis, or emphysema oral pharmacological therapy (e.g., beta-adren ts with asthma or seasonal allergies are not co	y of atelectasis is a. It can also lergic agonist, onsidered to
Supporti Element: 4285	Target Value:	Note(s): A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis al a transient condition and does not qualify. Any occurrence between birth and the procedure <b>Chronic Lung Disease</b> Chronic lung disease can include patients with chronic obstructive pulmona include a patient who is currently being chronically treated with inhaled or c anti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patien have chronic lung disease. <b>Source:</b> ACC/AHA Key Data Elements and Definitions for Measuring the C Heart Failure Circulation. 2005;112:1888-1916 <b>Coronary Artery Disease</b>	Iso qualifies as chronic lung disease. A history ary disease, chronic bronchitis, or emphysema oral pharmacological therapy (e.g., beta-adren ts with asthma or seasonal allergies are not co	y of atelectasis is a. It can also lergic agonist, onsidered to
Supporti Element: 4285 Codin	Target Value: ing Definition: g Instruction:	Note(s): A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis al a transient condition and does not qualify. Any occurrence between birth and the procedure <b>Chronic Lung Disease</b> Chronic lung disease can include patients with chronic obstructive pulmona include a patient who is currently being chronically treated with inhaled or canti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patient have chronic lung disease. <b>Source:</b> ACC/AHA Key Data Elements and Definitions for Measuring the Ca Heart Failure Circulation. 2005;112:1888-1916 <b>Coronary Artery Disease</b> Indicate if the patient has a history of coronary artery disease (CAD).	Iso qualifies as chronic lung disease. A history ary disease, chronic bronchitis, or emphysema oral pharmacological therapy (e.g., beta-adren ts with asthma or seasonal allergies are not co	y of atelectasis is a. It can also lergic agonist, onsidered to
Supporti Element: 4285 Codin	Target Value: ing Definition: g Instruction: Target Value:	Note(s): A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis at a transient condition and does not qualify. Any occurrence between birth and the procedure <b>Chronic Lung Disease</b> Chronic lung disease can include patients with chronic obstructive pulmona include a patient who is currently being chronically treated with inhaled or of anti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patien have chronic lung disease. <b>Source:</b> ACC/AHA Key Data Elements and Definitions for Measuring the O Heart Failure Circulation. 2005;112:1888-1916 <b>Coronary Artery Disease</b> Indicate if the patient has a history of coronary artery disease (CAD). Any occurrence between birth and the procedure	Iso qualifies as chronic lung disease. A history ary disease, chronic bronchitis, or emphysema oral pharmacological therapy (e.g., beta-adren ts with asthma or seasonal allergies are not co	y of atelectasis is a. It can also lergic agonist, onsidered to
Supporti Element: 4285 Codin	Target Value: ing Definition: g Instruction: Target Value:	Note(s): A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis at a transient condition and does not qualify. Any occurrence between birth and the procedure <b>Chronic Lung Disease</b> Chronic lung disease can include patients with chronic obstructive pulmona include a patient who is currently being chronically treated with inhaled or of anti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patien have chronic lung disease. <b>Source:</b> ACC/AHA Key Data Elements and Definitions for Measuring the O Heart Failure Circulation. 2005;112:1888-1916 <b>Coronary Artery Disease</b> Indicate if the patient has a history of coronary artery disease (CAD). Any occurrence between birth and the procedure <b>Coronary Artery Disease</b>	Iso qualifies as chronic lung disease. A history ary disease, chronic bronchitis, or emphysema oral pharmacological therapy (e.g., beta-adren ts with asthma or seasonal allergies are not co	y of atelectasis is a. It can also lergic agonist, onsidered to
Supporti Element: 4285 Codin	Target Value: ing Definition: g Instruction: Target Value:	Note(s): A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis al a transient condition and does not qualify. Any occurrence between birth and the procedure <b>Chronic Lung Disease</b> Chronic lung disease can include patients with chronic obstructive pulmona include a patient who is currently being chronically treated with inhaled or canti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patien have chronic lung disease. <b>Source:</b> ACC/AHA Key Data Elements and Definitions for Measuring the C Heart Failure Circulation. 2005;112:1888-1916 <b>Coronary Artery Disease</b> Indicate if the patient has a history of coronary artery disease (CAD). Any occurrence between birth and the procedure <b>Coronary Artery Disease</b> A history of any of the following:	Iso qualifies as chronic lung disease. A history ary disease, chronic bronchitis, or emphysema oral pharmacological therapy (e.g., beta-adren ts with asthma or seasonal allergies are not co Clinical Management and Outcomes of Patients	y of atelectasis is a. It can also hergic agonist, onsidered to s With Chronic
Supporti Element: 4285 Codin	Target Value: ing Definition: g Instruction: Target Value:	Note(s): A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis at a transient condition and does not qualify. Any occurrence between birth and the procedure <b>Chronic Lung Disease</b> Chronic lung disease can include patients with chronic obstructive pulmona include a patient who is currently being chronically treated with inhaled or canti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patien have chronic lung disease. <b>Source:</b> ACC/AHA Key Data Elements and Definitions for Measuring the Cart Heart Failure Circulation. 2005;112:1888-1916 <b>Coronary Artery Disease</b> Indicate if the patient has a history of coronary artery disease (CAD). Any occurrence between birth and the procedure <b>Coronary Artery Disease</b> A history of any of the following: - Coronary artery stenosis >=50% (by cardiac catheterization or other model)	Iso qualifies as chronic lung disease. A history ary disease, chronic bronchitis, or emphysema oral pharmacological therapy (e.g., beta-adren ts with asthma or seasonal allergies are not co Clinical Management and Outcomes of Patients	y of atelectasis i a. It can also hergic agonist, onsidered to s With Chronic
Supporti Element: 4285 Codin	Target Value: ing Definition: g Instruction: Target Value:	Note(s): A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis al a transient condition and does not qualify. Any occurrence between birth and the procedure <b>Chronic Lung Disease</b> Chronic lung disease can include patients with chronic obstructive pulmona include a patient who is currently being chronically treated with inhaled or canti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patien have chronic lung disease. <b>Source:</b> ACC/AHA Key Data Elements and Definitions for Measuring the C Heart Failure Circulation. 2005;112:1888-1916 <b>Coronary Artery Disease</b> Indicate if the patient has a history of coronary artery disease (CAD). Any occurrence between birth and the procedure <b>Coronary Artery Disease</b> A history of any of the following:	Iso qualifies as chronic lung disease. A history ary disease, chronic bronchitis, or emphysema oral pharmacological therapy (e.g., beta-adren ts with asthma or seasonal allergies are not co Clinical Management and Outcomes of Patients	y of atelectasis is a. It can also hergic agonist, onsidered to s With Chronic
Supporti Element: 4285 Codin	Target Value: ing Definition: g Instruction: Target Value:	Note(s):         A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis at a transient condition and does not qualify.         Any occurrence between birth and the procedure         Chronic Lung Disease         Chronic lung disease can include patients with chronic obstructive pulmona include a patient who is currently being chronically treated with inhaled or canti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patien have chronic lung disease.         Source:       ACC/AHA Key Data Elements and Definitions for Measuring the CHeart Failure Circulation. 2005;112:1888-1916         Coronary Artery Disease       Indicate if the patient has a history of coronary artery disease (CAD).         Any occurrence between birth and the procedure       Coronary Artery Disease         A history of any of the following:       - Coronary artery stenosis >=50% (by cardiac catheterization or other mod - Previous CABG surgery	Iso qualifies as chronic lung disease. A history ary disease, chronic bronchitis, or emphysema oral pharmacological therapy (e.g., beta-adren ts with asthma or seasonal allergies are not co Clinical Management and Outcomes of Patients	y of atelectasis is a. It can also hergic agonist, onsidered to s With Chronic
Supporti Element: 4285 Codin	Target Value: ing Definition: g Instruction: Target Value:	Note(s): A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis al a transient condition and does not qualify. Any occurrence between birth and the procedure <b>Chronic Lung Disease</b> Chronic lung disease can include patients with chronic obstructive pulmona include a patient who is currently being chronically treated with inhaled or c anti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patien have chronic lung disease. <b>Source:</b> ACC/AHA Key Data Elements and Definitions for Measuring the C Heart Failure Circulation. 2005;112:1888-1916 <b>Coronary Artery Disease</b> Indicate if the patient has a history of coronary artery disease (CAD). Any occurrence between birth and the procedure <b>Coronary Artery Disease</b> A history of any of the following: - Coronary artery stenosis >=50% (by cardiac catheterization or other mod - Previous CABG surgery - Previous PCI	Iso qualifies as chronic lung disease. A history ary disease, chronic bronchitis, or emphysema oral pharmacological therapy (e.g., beta-adren ts with asthma or seasonal allergies are not c Clinical Management and Outcomes of Patients	, of atelectasis is a. It can also lergic agonist, onsidered to s With Chronic
Supporti Element: 4285 Codin	Target Value: ing Definition: g Instruction: Target Value:	Note(s):         A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis at a transient condition and does not qualify.         Any occurrence between birth and the procedure         Chronic Lung Disease         Chronic lung disease can include patients with chronic obstructive pulmona include a patient who is currently being chronically treated with inhaled or canti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patien have chronic lung disease.         Source:       ACC/AHA Key Data Elements and Definitions for Measuring the CHeart Failure Circulation. 2005;112:1888-1916         Coronary Artery Disease         Indicate if the patient has a history of coronary artery disease (CAD).         Any occurrence between birth and the procedure         Coronary Artery Disease         A history of any of the following:         - Coronary artery stenosis >=50% (by cardiac catheterization or other model a Previous CABG surgery         - Previous MI	Iso qualifies as chronic lung disease. A history ary disease, chronic bronchitis, or emphysema oral pharmacological therapy (e.g., beta-adren ts with asthma or seasonal allergies are not c Clinical Management and Outcomes of Patients	, of atelectasis is a. It can also lergic agonist, onsidered to s With Chronic
Element: 4285 Codin Supporti	Target Value: ing Definition: g Instruction: Target Value:	Note(s): A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis at a transient condition and does not qualify. Any occurrence between birth and the procedure <b>Chronic Lung Disease</b> Chronic lung disease can include patients with chronic obstructive pulmona include a patient who is currently being chronically treated with inhaled or canti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patien have chronic lung disease. <b>Source:</b> ACC/AHA Key Data Elements and Definitions for Measuring the C Heart Failure Circulation. 2005;112:1888-1916 <b>Coronary Artery Disease</b> Indicate if the patient has a history of coronary artery disease (CAD). Any occurrence between birth and the procedure <b>Coronary Artery Disease</b> A history of any of the following: - Coronary artery stenosis >=50% (by cardiac catheterization or other mod - Previous CABG surgery - Previous PCI - Previous PCI - Previous MI <b>Source:</b> ACCF/AHA 2011 Key Data Elements and Definitions of a Base O (JACC 2011;58;202-222).	Iso qualifies as chronic lung disease. A history ary disease, chronic bronchitis, or emphysema oral pharmacological therapy (e.g., beta-adren ts with asthma or seasonal allergies are not c Clinical Management and Outcomes of Patients	, of atelectasis i a. It can also lergic agonist, onsidered to s With Chronic
Element: 4285 Codin Supporti	Target Value: ing Definition: g Instruction: Target Value: ing Definition:	Note(s):         A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis at a transient condition and does not qualify.         Any occurrence between birth and the procedure         Chronic Lung Disease         Chronic lung disease can include patients with chronic obstructive pulmona include a patient who is currently being chronically treated with inhaled or canti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patien have chronic lung disease.         Source:       ACC/AHA Key Data Elements and Definitions for Measuring the CHeart Failure Circulation. 2005;112:1888-1916         Coronary Artery Disease       Indicate if the patient has a history of coronary artery disease (CAD).         Any occurrence between birth and the procedure       Coronary Artery Disease         A history of any of the following:       Coronary artery stenosis >=50% (by cardiac catheterization or other mod - Previous CABG surgery - Previous PCI - Previous PCI - Previous PCI         Previous MI       Source: ACCF/AHA 2011 Key Data Elements and Definitions of a Base C (JACC 2011;58;202-222).         Sleep Apnea       Sleep Apnea	Iso qualifies as chronic lung disease. A history ary disease, chronic bronchitis, or emphysema oral pharmacological therapy (e.g., beta-adren ts with asthma or seasonal allergies are not c Clinical Management and Outcomes of Patients Clinical Management and Outcomes of Patients Clinical Management and Outcomes of Patients Clinical Management and Outcomes of Patients	, of atelectasis i a. It can also lergic agonist, onsidered to s With Chronic
Element: 4285 Codin Supporti	Target Value: ing Definition: g Instruction: Target Value: ing Definition:	Note(s): A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis at a transient condition and does not qualify. Any occurrence between birth and the procedure <b>Chronic Lung Disease</b> Chronic lung disease can include patients with chronic obstructive pulmona include a patient who is currently being chronically treated with inhaled or of anti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patien have chronic lung disease. <b>Source:</b> ACC/AHA Key Data Elements and Definitions for Measuring the O Heart Failure Circulation. 2005;112:1888-1916 <b>Coronary Artery Disease</b> Indicate if the patient has a history of coronary artery disease (CAD). Any occurrence between birth and the procedure <b>Coronary Artery Disease</b> A history of any of the following: - Coronary artery stenosis >=50% (by cardiac catheterization or other mod - Previous CABG surgery - Previous CABG surgery - Previous MI <b>Source:</b> ACCF/AHA 2011 Key Data Elements and Definitions of a Base O (JACC 2011;58;202-222). <b>Sleep Apnea</b> Indicate if the patient has a history of sleep apnea that has been diagnosed	Iso qualifies as chronic lung disease. A history ary disease, chronic bronchitis, or emphysema oral pharmacological therapy (e.g., beta-adren ts with asthma or seasonal allergies are not c Clinical Management and Outcomes of Patients Clinical Management and Outcomes of Patients Clinical Management and Outcomes of Patients Clinical Management and Outcomes of Patients	y of atelectasis is a. It can also lergic agonist, onsidered to s With Chronic
Element: 4285 Codin Supporti	Target Value: ing Definition: g Instruction: Target Value: ing Definition:	Note(s):         A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis at a transient condition and does not qualify.         Any occurrence between birth and the procedure         Chronic Lung Disease         Chronic lung disease can include patients with chronic obstructive pulmona include a patient who is currently being chronically treated with inhaled or canti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patien have chronic lung disease.         Source:       ACC/AHA Key Data Elements and Definitions for Measuring the CHeart Failure Circulation. 2005;112:1888-1916         Coronary Artery Disease       Indicate if the patient has a history of coronary artery disease (CAD).         Any occurrence between birth and the procedure       Coronary Artery Disease         A history of any of the following:       Coronary artery stenosis >=50% (by cardiac catheterization or other mod - Previous CABG surgery - Previous PCI - Previous PCI - Previous PCI         Previous MI       Source: ACCF/AHA 2011 Key Data Elements and Definitions of a Base C (JACC 2011;58;202-222).         Sleep Apnea       Sleep Apnea	Iso qualifies as chronic lung disease. A history ary disease, chronic bronchitis, or emphysema oral pharmacological therapy (e.g., beta-adren ts with asthma or seasonal allergies are not c Clinical Management and Outcomes of Patients Clinical Management and Outcomes of Patients Clinical Management and Outcomes of Patients Clinical Management and Outcomes of Patients	, of atelectasis is a. It can also lergic agonist, onsidered to s With Chronic
Element: 4285 Codin Supporti	Target Value: ing Definition: g Instruction: Target Value: ing Definition:	Note(s): A history of chronic inhalation reactive disease (asbestosis, mesothelioma, chronic lung disease. Radiation induced pneumonitis or radiation fibrosis at a transient condition and does not qualify. Any occurrence between birth and the procedure <b>Chronic Lung Disease</b> Chronic lung disease can include patients with chronic obstructive pulmona include a patient who is currently being chronically treated with inhaled or canti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patient have chronic lung disease. <b>Source:</b> ACC/AHA Key Data Elements and Definitions for Measuring the C Heart Failure Circulation. 2005;112:1888-1916 <b>Coronary Artery Disease</b> Indicate if the patient has a history of coronary artery disease (CAD). Any occurrence between birth and the procedure <b>Coronary Artery Disease</b> A history of any of the following: - Coronary artery stenosis >=50% (by cardiac catheterization or other mod - Previous CABG surgery - Previous PCI - Previous MI <b>Source:</b> ACCF/AHA 2011 Key Data Elements and Definitions of a Base O (JACC 2011;58;202-222). <b>Sleep Apnea</b> Indicate if the patient has a history of sleep apnea that has been diagnosed Note(s):	Iso qualifies as chronic lung disease. A history ary disease, chronic bronchitis, or emphysema oral pharmacological therapy (e.g., beta-adren ts with asthma or seasonal allergies are not of Clinical Management and Outcomes of Patients Clinical Management and Outcomes of Patients claity or of direct imaging of the coronary arter Cardiovascular Vocabulary for Electronic Healt d by a sleep study.	, of atelectasis i a. It can also lergic agonist, onsidered to s With Chronic





## Section: Additional History and Risk Factors

Parent: History and Risk Factors

Both Obstructive Sleep Apnea (recurrent collapse of the pharynx during sleep) and Central Sleep apnea: (transient cessation of neural drive to respiratory muscles) should be considered. Capture patients with prescribed home therapy despite frequency of use. Do not capture suspected sleep apnea or that reported by family members as sleep apnea. Sleep apnea must be diagnosed by a physician.

Target Value: Any occurrence between birth and the procedure

Element: 4585

Sleep Apnea Recommended Treatment Followed

**Coding Instruction:** Indicate if the patient followed the sleep apnea treatment plan recommended.

Note(s):

CPAP or BiPAP therapy is not a requirement to code 'Yes' for sleep apnea.

Both Obstructive Sleep Apnea (recurrent collapse of the pharynx during sleep) and Central Sleep Apnea (transient cessation of neural drive to respiratory muscles) should be considered.

Capture patients with prescribed home therapy despite frequency of use.

Code 'No' if sleep apnea has been surgically corrected.

Target Value: Any occurrence between birth and the procedure





Section: Epicardia	I Access Assess	nent	Parent: History and Risk Factors		
Element: 14824		Epicardial Approach Considered			
	Coding Instruction:	Indicate if an epicardial approach to th	e left atrial appendage intervention was considered for	or this episode of care.	
	Target Value:	Any occurrence between birth and the	e procedure		
Element: 14823		Medical Conditions			
	Coding Instruction:	Indicate if any of the following medical	conditions were present.		
	Target Value:	Any occurrence between birth and the	e procedure		
	-	·			
Medical Conditions - 1. Selection	3.6.1.4.1.19376.1.4.1 Definition	.6.5.781	Source	Code	Code System
Cardiac Surgery	Any surgery in	volving the coronary arteries, valves, on pair of the heart.		64915003	SNOMED C1
Pericarditis	characterized b changes and o	by chest pain, electrocardiographic ften pericardial effusion. It is often the ectious or a noninfectious process but	Chiabrando JG, Bonaventure A, Vecchie A, et al. Management of acute and recurrent pericarditis. J A Coll Cardiol 2020;75:76-92.	3238004 m	SNOMED CT
Epicardial Access				11200002078	ACC NCDF
Thoracic Radiation Thera	ру			112000002090	ACC NCDF
Pectus Excavatum				391987005	SNOMED CT
Epigastric Surgery	<b>U</b> 1	dure in the epigastric region of the en, including epigastric hernia repair.		112000002091	ACC NCDF
Autoimmune Disease				85828009	SNOMED CT
Hepatomegaly				80515008	SNOMED CT
Hiatal Hernia		hiatus hernia is an abnormal bulging of stomach through the diaphragm	https://www.merckmanuals.com/home/digestive- disorders/esophageal-and-swallowing- disorders/hiatus-hernia	84089009	SNOMED C
Element: 14825		Lupus Erythematosus			
	Coding Instruction:	Indicate if an Lupus Erythematosus was considered for this episode of care.	as the condition for which an epicardial approach to the	ne left atrial appendage i	ntervention was

Target Value: Any occurrence between birth and the procedure



Section: Diagnostic Studies

Parent: Root



Element: 5100		Atrial Rhythm		
	Coding Instruction:	Indicate the patient's atrial rhythm at the start of the procedure.		
	Target Value:	The last value within 30 days prior to the first procedure in this admission		
Atrial Rhythm - 1.3.6	6.1.4.1.19376.1.4.1.6.5.18	7		
Selection	Definition	Source	Code	Code Syster
Sinus node rhythm			106067008	SNOMED C
Atrial fibrillation			49436004 276796006	SNOMED C SNOMED C
Atrial tachycardia			5370000	SNOMED C
Sinus arrest			5609005	SNOMED C
Atrial paced			251268003	SNOMED C
Not Documented			100001116	ACC NCD
Element: 5110		LVEF Assessed		
	Coding Instruction:	Indicate if a left ejection fraction percentage has been assessed.		
	Target Value:	The last value between 90 days prior to the start of the current procedure and the start of p	rocedure	
Element: 5115		Most Recent LVEF %		
	Coding Instruction:	Indicate the most recent left ventricular ejection fraction.		
	Target Value:	The last value between 90 days prior to the start of the current procedure and the start of p	rocedure	
	Supporting Definition:	Most Recent LVEF %		
	5	The left ventricular ejection fraction is the percentage of blood emptied from the left ventricle	at the end of contraction.	
		Source: ACC Clinical Data Standards, Society for Thoracic Surgeons Adult Cardiac Surge	ry Database (STS)	
Element: 5120		Transthoracic Echo (TTE) Performed		
	Coding Instruction:	Indicate if a transthoracic echocardiogram (TTE) was performed prior to the procedure.		
	Target Value:	The last value between 90 days prior to the start of the current procedure and the start of p	rocedure	
Element: 5125		Most Recent TTE Date		
	Coding Instruction:	Indicate the date of the most recent transthoracic echocardiogram (TTE) performed and used	d to evaluate the patient fo	r this intervention.
	Target Value:	The last value between 90 days prior to the start of the current procedure and the start of p	rocedure	
	Vendor Instruction:	Most Recent TTE Date (5125) must be Less than or Equal to the Procedure Start Date and Tir	me (7000)	
Element: 5170		Baseline Imaging Performed		
Element. 5170	Coding Instruction.			
	-	Indicate if pre-procedure imaging was performed.		
	Target Value:	The last value between 90 days prior to the start of the current procedure and the start of p	rocedure	
Element: 5175		Baseline CT Performed		
	Coding Instruction:	Indicate if pre-procedure imaging was performed via CT.		
	-		rocoduro	
	Target value:	The last value between 90 days prior to the start of the current procedure and the start of p	locedure	
Element: 5180		Most Recent CT Date		
	Coding Instruction:	Indicate the date of the most recent CT imaging.		
	-			
	-	The last value between 90 days prior to the start of the current procedure and the start of p		
	Vendor Instruction:	Most Recent CT Date (5180) must be Less than or Equal to the Procedure Start Date and Tim	ne (7000)	
Element: 5185		Baseline MRI Performed		
	Coding Instruction:	Indicate if pre-procedure imaging was performed via MRI.		
	Target Value:	The last value between 90 days prior to the start of the current procedure and the start of p	rocedure	
	larget value.			





Section: Diagnostic Studies	Parent: Root
Coding Instruction:	Indicate the date of the most recent MRI imaging.
Target Value:	The last value between 90 days prior to the start of the current procedure and the start of procedure
Vendor Instruction:	Most Recent MRI Date (5190) must be Less than or Equal to the Procedure Start Date and Time (7000)
Element: 14826	Intracardiac Echo Performed
Coding Instruction:	Indicate if pre-procedure imaging was performed via intracardiac echo (ICE).
Target Value:	The last value between 90 days prior to the start of the current procedure and the start of procedure
Supporting Definition:	Intracardiac three dimensional echocardiography
	Intracardiac echocardiography (ICE) is an imaging technique that is increasingly available as an alternative to transoesophageal echocardiography to guide percutaneous interventional procedures.
	<b>Source:</b> Mitchell ARJ, Puwanarajah P, Timperley J, Becher H, Wilson N, Ormero OJ. The Emerging Role of Intracardiac Echocardiography Into the ICE Age. Br J Cardiol. 2007;14(1):31-36.
Element: 14827	Date of Intracardiac Echo
Coding Instruction:	Indicate the date of the most recent intracardiac echo (ICE).
Target Value:	The last value between 90 days prior to the start of the current procedure and the start of procedure
Supporting Definition:	Intracardiac three dimensional echocardiography
	Intracardiac echocardiography (ICE) is an imaging technique that is increasingly available as an alternative to transoesophageal echocardiography to guide percutaneous interventional procedures.
	<b>Source:</b> Mitchell ARJ, Puwanarajah P, Timperley J, Becher H, Wilson N, Ormero OJ. The Emerging Role of Intracardiac Echocardiography Into the ICE Age. Br J Cardiol. 2007;14(1):31-36.





Section: Physical Exam and Labs	Parent: Root
Element: 6000	Height
_	Indicate the patient's height in centimeters.     The last value prior to the start of the first precedure.
Target Value	: The last value prior to the start of the first procedure
Element: 6005	Weight
Coding Instruction	: Indicate the patient's weight in kilograms.
Target Value	: The last value prior to the start of the first procedure
Element: 6010	Pulse
Coding Instruction	: Indicate the patient's heart rate (beats per minute).
Target Value	: The last value prior to the start of the first procedure
Element: 6015	Systolic BP
Coding Instruction	: Indicate the patient's systolic blood pressure in mmHg.
Target Value	: The last value prior to the start of the first procedure
Element: 6020	Diastolic BP
Coding Instruction	Indicate the patient's diastolic blood pressure in mmHg.
Target Value	: The last value prior to the start of the first procedure
Element: 6030	Homoglobin
	Hemoglobin
·····	Note(s):
	This may include POC (Point of Care) testing results or results obtained prior to arrival at this facility.
Target Value	: The last value within 30 days prior to the first procedure in this admission
Supporting Definition	-
	Hemoglobin (Hb or Hgb) is the iron-containing oxygen-transport metalloprotein in the red blood cells. It carries oxygen from the lungs to the rest of the body (i.e. the tissues) where it releases the oxygen to burn nutrients and provide energy. Hemoglobin concentration measurement is among the most commonly performed blood tests, usually as part of a complete blood cells. If the concentration is below normal, this is called anemia. Anemias are classified by the size of red blood cells: "microcytic" if red cells are small, "macrocytic" if they are large, and "normocytic" if otherwise. Dehydration or hyperhydration can greatly influence measured hemoglobin levels. <b>Source:</b> http://s.details.loinc.org/LOINC/718-7.html?sections=Simple
Element: 6031	Hemoglobin Not Drawn
-	: Indicate if the hemoglobin was not drawn.
-	: The last value within 30 days prior to the first procedure in this admission
Supporting Definition	: Hemoglobin Hemoglobin (Hb or Hgb) is the iron-containing oxygen-transport metalloprotein in the red blood cells. It carries oxygen from the lungs to the rest of the body (i.e. the tissues) where it releases the oxygen to burn nutrients and provide energy. Hemoglobin concentration measurement is among the most commonly performed blood tests, usually as part of a complete blood count. If the concentration is below normal, this is called anemia. Anemias are classified by the size of red blood cells: "nicrocytic" if red cells are small, "macrocytic" if they are large, and "normocytic" if otherwise. Dehydration or hyperhydration can greatly influence measured hemoglobin levels. Source: http://s.details.loinc.org/LOINC/718-7.html?sections=Simple
Element: 6040	Prothrombin Time (PT)
Coding Instruction	: Indicate the last prothrombin time (PT) in seconds.
	Note(s): This may include POC (Point of Care) testing results.
	Most recent values prior to the start of the procedure.
Target Value	: The last value between 1 day prior to the procedure and the current procedure
Supporting Definition	: Prothrombin Time (PT)
	The prothrombin time (PT) and its derived measures of prothrombin ratio (PR) and international normalized ratio (INR) are measures of the extrinsic pathway of coagulation. They are used to determine the clotting tendency of blood, in the measure of warfarin dosage, liver Effective for Patient Discharged October
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Section: Phys	ical Exam and Labs	Parent: Root
		damage and vitamin K status. The reference range for prothrombin time is usually around 12-15 seconds; the normal range for the INR is 0.8-1.2. It is used in conjunction with the activated partial thromboplastin time (aPTT) which measures the intrinsic pathway. PT is sometimes used as the third screening test in the lupus anticoagulant testing algorithm and is included in the LOINC LA aPTT & dRVVT & PT panel.
		Source: http://s.details.loinc.org/LOINC/5902-2.html?sections=Simple
Element: 6041		Prothrombin Not Drawn
	Coding Instruction:	Indicate if prothrombin (PT) was not drawn.
	Target Value:	N/A
	Supporting Definition:	<ul> <li>Prothrombin Time (PT)</li> <li>The prothrombin time (PT) and its derived measures of prothrombin ratio (PR) and international normalized ratio (INR) are measures of the extrinsic pathway of coagulation. They are used to determine the clotting tendency of blood, in the measure of warfarin dosage, liver damage and vitamin K status. The reference range for prothrombin time is usually around 12-15 seconds; the normal range for the INR is 0.8-1.2. It is used in conjunction with the activated partial thromboplastin time (aPTT) which measures the intrinsic pathway. PT is sometimes used as the third screening test in the lupus anticoagulant testing algorithm and is included in the LOINC LA aPTT &amp; dRVVT &amp; PT panel.</li> <li>Source: http://s.details.loinc.org/LOINC/5902-2.html?sections=Simple</li> </ul>
Element: 6045		International Normalized Ratio (INR)
	Coding Instruction:	Indicate the international normalized ratio (INR) if the patient was on routine Warfarin/Coumadin therapy.
		Note(s): This may include POC (Point of Care) testing results.
		Most recent values prior to the start of the procedure.
	_	The last value between 1 day prior to the procedure and the current procedure International Normalized Ratio (INR)
		The INR is specifically intented for evaluating protime results on patients stabilized on long term oral anticoagulant therapy. The INR is not appropriate to evaluate hemostatic function in patients with liver disease, for screening for hereditary factor deficiencies or acquired vitamin K deficiencies, or for routine preoperative screening; this should be evaluated on the normal range in seconds. INR is calculated by the equation, INR = (PTR) raised to the power of ISI, where ISI = International Sensitivity Index (assigned to each reagent thromboplastin). PTR = prothrombin time ratio (pat PT/pop mean PT). Computation of the INR of specific thromboplastin reagent should allow for uniformity in prothrombin time testing regardless of the reagent system or instrumentation used. <b>Source:</b> http://s.details.loinc.org/LOINC/6301-6.html?sections=Simple
Element: 6046		International Normalized Ratio Not Drawn
	Coding Instruction:	Indicate if INR was not drawn.
	Target Value:	N/A
	Supporting Definition:	International Normalized Ratio (INR) The INR is specifically intented for evaluating protime results on patients stabilized on long term oral anticoagulant therapy. The INR is not appropriate to evaluate hemostatic function in patients with liver disease, for screening for hereditary factor deficiencies or acquired vitamin K deficiencies, or for routine preoperative screening; this should be evaluated on the normal range in seconds. INR is calculated by the equation, INR = (PTR) raised to the power of ISI, where ISI = International Sensitivity Index (assigned to each reagent thromboplastin). PTR = prothrombin time ratio (pat PT/pop mean PT). Computation of the INR of specific thromboplastin reagent should allow for uniformity in prothrombin time testing regardless of the reagent system or instrumentation used. <b>Source:</b> http://s.details.loinc.org/LOINC/6301-6.html?sections=Simple
Element: 6050		Creatinine
	Coding Instruction:	Indicate the creatinine (Cr) level mg/dL. Note(s): This may include POC (Point of Care) testing results or results obtained prior to arrival at this facility.
	Target Value:	The last value between 30 days prior to the procedure and the current procedure
	Supporting Definition:	Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine results in the formation of creatinine. It is transferred to the kidneys by blood plasma, whereupon it is eliminated by glomerular filtration and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A rise in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver and pancreas. Source: http://s.details.loinc.org/LOINC/2160-0.html?sections=Simple
Element: 6051		Creatinine Not Drawn
		Effective for Patient Discharged October 0





Section: Physical Exam	and Labs	Parent: Root		
Coding	Instruction:	Indicate if a creatinine level was not drawn.		
Та	arget Value:	N/A		
Supporting	g Definition:	Creatinine		
		Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. results in the formation of creatinine. It is transferred to the kidneys by blood plasma, where and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and me in blood creatinine levels is observed only with marked damage to functioning nephrons; th early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver a <b>Source:</b> http://s.details.loinc.org/LOINC/2160-0.html?sections=Simple	upon it is eliminated by glo asuring its serum level is a erefore this test is not suita	merular filtration simple test. A rise
Element: 14210		Albumin		
Coding	Instruction:	Indicate the total albumin (in g/dL).		
-		The last value between 30 days prior to the procedure and the current procedure		
Element: 14211		Albumin Not Drawn		
Coding	Instruction:	Indicate true if the total albumin was not drawn		
Та	arget Value:	N/A		
Element: 13213		Platelet Count		
Coding	Instruction:	Indicate the pre-procedure platelet count in platelets per microliter.		
Ta	arget Value:	The last value between 30 days prior to the procedure and the current procedure		
Element: 13214		Platelet Count Not Drawn		
Coding	Instruction:	Indicate if a platelet count was not drawn prior to the procedure.		
Та	arget Value:	N/A		
Element: 14805		Modified Rankin Scale		
Coding	Instruction:	Indicate the patient's functional ability according to the modified Rankin Scale (mRS) admini	stered pre-procedure.	
Та	arget Value:	The last value between 30 days prior to the procedure and the current procedure		
Supporting	Definition:	Modified Rankin Scale		
		The Modified Rankin Scale is a standardized neurological examination of patients with disal		of global disability.
		Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med	J. 1957; 2:200-15.	
		Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stro	ke. Stroke. 1988;19(12):14	97-1500.
Rankin Scale Assessment Find				
Selection D 0: No symptoms at all	efinition	Source	LA6111-4	Code System
	ble to carry ou	t all usual duties and activities.	LA6112-2	LOINC
0 ,	,	out all previous activities, but able to affairs without assistance.	LA6113-0	LOINC
3: Moderate disability R		help, but able to walk without	LA6114-8	LOINC
		without assistance and unable to attend eeds without assistance.	LA6115-5	LOINC
5: Severe disability B	-	ntinent and requiring constant nursing	LA10137-0	LOINC
6: Death			419620001	SNOMED CT
Element: 9130		Modified Rankin Scale Not Administered		
Coding	Instruction:	Indicate if the Modified Rankin Scale was not administered after the current procedure.		
Та	arget Value:	N/A		
Supporting	g Definition:	Modified Rankin Scale		
		The Modified Rankin Scale is a standardized neurological examination of patients with disal	pility that provides a scale of	of global disability.
		Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med	1 1057: 2:200 15	
			J. 1957, 2.200-15.	





## Section: Pre-Procedure Medications

Parent: Root

## Element: 6985

Pre-procedure Medication Code

Coding Instruction: Indicate the NCDR-assigned IDs for the medications prescribed within 24 hours prior to and during the procedure.

 Target Value:
 Any occurrence within 24 hours prior to start of current procedure

## Pre-Procedure Medication - 1.3.6.1.4.1.19376.1.4.1.6.5.216

Selection	Definition	Source	Code	Code System
Fondaparinux			321208	RxNorm
Heparin Derivative			100000921	ACC NCDR
Low Molecular Weight	t Heparin		373294004	SNOMED CT
Unfractionated Hepari	n		96382006	SNOMED CT
Warfarin			11289	RxNorm
Aspirin 81 to 100 mg			11200002080	ACC NCDR
Aspirin 101 to 324 mg			11200002081	ACC NCDR
Aspirin 325 mg			317300	RxNorm
Aspirin/Dipyridamole			226716	RxNorm
Vorapaxar			1537034	RxNorm
Apixaban			1364430	RxNorm
Dabigatran			1546356	RxNorm
Edoxaban			1599538	RxNorm
Rivaroxaban			1114195	RxNorm
Cangrelor			1656052	RxNorm
Clopidogrel			32968	RxNorm
Other P2Y12			112000001003	ACC NCDR
Prasugrel			613391	RxNorm
Ticagrelor			1116632	RxNorm
Ticlopidine			10594	RxNorm

Element: 14883

#### Medication Administered

Coding Instruction: Indicate the prescribing history and administration status (past, current, held, never) of each medication.

Target Value: Any occurrence within 24 hours prior to start of current procedure

Vendor Instruction: When a Pre-procedure Medication Code (6985) is selected, Medication Administered (14883) cannot be Null

#### Pre-procedure Medication Administration - 1.3.6.1.4.1.19376.1.4.1.6.5.44

Selection	Definition	Source	Code	Code System
Past			100001070	ACC NCDR
Current			100000987	ACC NCDR
Held			100001010	ACC NCDR
Never			100001046	ACC NCDR





Section: Pre-Procedure Diagnostic	s Parent: Procedure Information
Element: 14828	Transesophageal Echocardiogram (TEE) Performed
Coding Instruction:	Indicate if transesophageal echocardiogram (TEE) was performed prior to the device insertion or attempted device insertion during the current procedure.
	Note: Prior to current procedure refers to prior to start of current procedure.
Target Value:	The last value between 1 week prior to current procedure and current procedure
Element: 14829	Most Recent TEE Date
Coding Instruction:	Indicate the date of the most recent transesophageal echocardiogram (TEE) performed prior to the device insertion or attempted device insertion during the current procedure.
Target Value:	The last value between 1 week prior to current procedure and current procedure
Vendor Instruction:	Most Recent TEE Date (14829) must be Less than or Equal to the Procedure Start Date and Time (7000)
Element: 14838	Atrial Thrombus Detected
Coding Instruction:	Indicate if an atrial thrombus was detected or suspected.
Target Value:	The last value between 1 week prior to current procedure and current procedure
Supporting Definition:	Atrial Thrombus Detected
	Presence of thrombus is considered to be definite if 3 of the following 5 criteria are present: Clear borders, echogenicity from the surrounding structures, independent mobility, longest diameter > 15mm, seen in more than one echocardiographic plane.
	<b>Source:</b> Buxton AE, Calkins H, Callans DJ, et al. ACC/AHA/HRS 2006 Key Data Elements and Definitions for Electrophysiological Studies and Procedures: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Data Standards (ACC/AHA/HRS Writing Committee to Develop Data Standards on Electrophysiology). J Am Coll Cardiol. 2006;48(11):2360-2396.
Element: 14830	Left Atrial Appendage Occlusion Orifice width
Coding Instruction:	Indicate the maximal orifice width of the left atrial appendage (LAA) in mm.

Target Value: The last value between 1 week prior to current procedure and current procedure





Section: Procedu		Parent: Procedure Information		
Element: 7000		Procedure Start Date and Time		
	Coding Instruction:	Indicate the date and time the procedure started.		
		Note(s): Indicate the date/time (mm/dd/yyyy hours:minutes) using the military 24-hour clock, begin procedure started is defined as the time at which local anesthetic was first administered attempt at vascular access for the cardiac catheterization (use whichever is earlier).		
	Target Value:	Any occurrence on current procedure		
Su	pporting Definition:	Procedure Start Date Time		
		The time the procedure started is defined as the time at which local anesthetic was first the first attempt at vascular access for the interventional procedure (use whichever is ex <b>Source:</b> NCDR		cess, or the time c
	Vendor Instruction:	Procedure Start Date and Time (7000) must be Greater than or Equal to Arrival Date (300	0)	
		Procedure Start Date and Time (7000) must be Less than or Equal to Procedure End Date	and Time (7005)	
		Procedure Start Date and Time (7000) must be Less than or Equal to Discharge Date (10)	100)	
Element: 7005		Procedure End Date and Time		
	Coding Instruction:	Indicate the ending date and time at which the operator completes the procedure and bre	eaks scrub at the end of the p	procedure.
		Note(s): If more than one operator is involved in the case then use the date and time the last oper	ator breaks scrub for the last	time.
	Target Value:	The value on current procedure		
	Vendor Instruction:	Procedure End Date and Time (7005) must be Less than or Equal to Discharge Date (101	00)	
		Procedure End Date and Time (7005) and Procedure Start Date and Time (7000) must no	t overlap on multiple procedu	res
Element: 14732		Shared Decision Making		
	Coding Instruction:	Indicate if shared decision making was performed for the procedure.		
	Target Value:	The value on current procedure		
Element: 14733		Shared Decision Making Tool Used		
	Coding Instruction:	Indicate if a shared decision making tool was used.		
	Target Value:	The value on current procedure		
Element: 14734		Shared Decision Making Tool Name		
	Coding Instruction:	Indicate what tool was used. If the tool used is not in the drop-down list, please contact NCDR@acc.org to have a sele	ection added.	
	Target Value:	The value on current procedure		
Shared Decision Makir	-			• • •
Selection Other Shared Decision M	Definition	Source	Code 100000351	Code Syste
Tool			10000001	
Element: 12871		Procedure Location		
	Coding Instruction:	Indicate the location where the procedure was performed.		
	-	The value on current procedure		
Procedure Location - 1 Selection	.3.6.1.4.1.19376.1.4.1 Definition	.6.5.327 Source	Code	Code Syste
Operating Room	Deninition	Goulde	225738002	SNOMED
Hybrid Operating Room S	Suite		112000001265	ACC NC
Cardiac Catheterization _aboratory			11200000616	ACC NC
Hybrid Catheterization _aboratory Suite			112000001266	ACC NC
= D L ab			11200002100	

EP Lab

112000002109

ACC NCDR





## Section: Procedure

Parent: Procedure Information

#### Element: 7130

Coding Instruction: Indicate the type of sedation used for the intervention.

Target Value: The value on current procedure

Sedation

#### Sedation Method - 1.3.6.1.4.1.19376.1.4.1.6.5.199

Selection	Definition	Source	Code	Code System
Minimal Sedation/Anxi	olysis		427255001	SNOMED CT
Moderate Sedation/Analgesia (Conscious Sedation)			314271007	SNOMED CT
Deep sedation/Analgesia			426155000	SNOMED CT
General Anesthesia			420653000	SNOMED CT

#### Element: 14837

LAA Occlusion Indication

Coding Instruction: Provide the documented indication for the left atrial appendage (LAA) occlusion procedure.

Target Value: The value on current procedure

Supporting Definition: Procedure Indication

The primary reason the procedure is being performed

Source:

#### LAAO Indications - 1.3.6.1.4.1.19376.1.4.1.6.5.784

Selection	Definition	Source	Code	Code System
High fall risk			11200000398	ACC NCDR
History of major bleed			112000002105	ACC NCDR
Clinically significant bleeding risk (Other than those listed here)			711536002	SNOMED CT
Increased thromboembolic stroke risk			112000002106	ACC NCDR
Labile INR			100001024	ACC NCDR
Non-compliance with anticoagulation therapy			112000002108	ACC NCDR
Patient preference			112000002107	ACC NCDR

Element: 14834

Procedure Canceled

Coding Instruction: Indicate if the procedure was canceled after the patient had entered the procedure room AND before venous or epicardial access was obtained.

Target Value: The value on current procedure

Element: 14833

#### Procedure Canceled Reason

Coding Instruction: Indicate the reason(s) why the procedure was canceled.

Target Value: The value on current procedure

#### Procedure Canceled Reasons - 1.3.6.1.4.1.19376.1.4.1.6.5.783

Selection	Definition	Source	Code	Code System
Anatomy not conducive for implant			112000002093	ACC NCDR
Appendage too large (for device implant)			112000002096	ACC NCDR
Appendage too small (for device implant)			112000002097	ACC NCDR
Catherization challenge			11200002094	ACC NCDR
Decompensation in patient condition			112000002098	ACC NCDR
Epicardial access issue			11200002100	ACC NCDR
Thrombus detected			11200002095	ACC NCDR
Unanticipated patient condition	ı		11200002099	ACC NCDR
Patient/Family choice			112000002101	ACC NCDR

#### Element: 14831

Coding Instruction: Indicate if the LAAO intervention was aborted at any time after venous or epicardial access was obtained.

**Procedure Aborted** 





#### Section: Procedure

Parent: Procedure Information

Vendor Instruction: If Device Successfully Deployed (14968) is 'Yes' for at least one device under the procedure, then Procedure Aborted (14831) must be 'No'.

If Device Successfully Deployed (14968) is 'No' for all the devices under the procedure, then Procedure Aborted (14831) must be 'Yes'.

Element: 14832

Procedure Aborted Reason

Coding Instruction: Indicate the reason(s) why the procedure was aborted.

Target Value: The value on current procedure

#### Procedure Aborted Reasons - 1.3.6.1.4.1.19376.1.4.1.6.5.782

Selection	Definition	Source	Code	Code System
Anatomy not conducive for implant			112000002093	ACC NCDR
Appendage too large (for device implant)			112000002096	ACC NCDR
Appendage too small (for device implant)			112000002097	ACC NCDR
Catherization challenge			11200002094	ACC NCDR
Decompensation in patient condition			112000002098	ACC NCDR
Device related			112000001828	ACC NCDR
Transcatheter device retrieval			112000002124	ACC NCDR
Device release criteria not met			112000002104	ACC NCDR
Epicardial access issue			112000002100	ACC NCDR
Surgical device retrieval			112000001838	ACC NCDR
Device associated thrombus developed during procedure			112000002103	ACC NCDR
Unanticipated patient condition			112000002099	ACC NCDR
Patient/Family choice			11200002101	ACC NCDR

Element: 14848	Device Margin Residual Leak	
Coding Instruction:	Indicate the size (in mm) of the residual leak noted at the device margin.	
Target Value:	The value on current procedure	
<b>Element:</b> 14849	Device Margin Residual Leak Not Assessed	
Coding Instruction:	Indicate if the device margin was not assessed for any potential residual leak.	
Target Value:	The value on current procedure	
Element: 7200	Guidance Method	
Coding Instruction:	Indicate the assigned identification number associated with the guidance method used for this procedure.	
	Note(s): The method(s) that should be collected in your application are controlled by a Guidance Method Master file. This fil NCDR and will be made available on the internet for downloading and importing/updating into your application.	e is maintained by the
Target Value:	The value on current procedure	
Guidance Method - 1.3.6.1.4.1.19376.1.4.1.6.	5.212	
Selection Definition	Source Code	Code System
Intracardiac three dimensional echocardiography	448761005	SNOMED CT
Electro Anatomic Mapping	10000908	ACC NCDR
Fluoroscopy	44491008	SNOMED CT

Transesophageal Echocardiogram (TEE)

Element: 14846

Conversion to Open Heart Surgery

Coding Instruction: Indicate if this procedure converted to open heart surgery.

Target Value: The value on current procedure

Element: 14847

Conversion to Open Heart Surgery Reason

Coding Instruction: Indicate the reason why the procedure converted to open heart surgical access.

SNOMED CT

105376000



Parent: Procedure Information



## Section: Procedure

Target Value: The value on current procedure

## Conversion to Open Heart Surgery Reasons - 1.3.6.1.4.1.19376.1.4.1.6.5.787

Complication       88797001         Device Retrieval       112000001838         Unfavorable Anatomy       112000002114         Medical decision for open       112000002115         ligation of appendage       112000002115         Element: 14855       Concomitant Procedures Performed         Coding Instruction:       Indicate if other procedures (Afib Ablation, ICD, PCI, TAVR or TMVR) were performed during the same lab visit as thi         Target Value:       The value on current procedure         Element: 14857       Concomitant Procedures         Coding Instruction:       Indicate which specific other procedures were performed during the same lab visit.         Target Value:       The value on current procedure         Concomitant Procedures       Indicate which specific other procedures were performed during the same lab visit.         Target Value:       The value on current procedure         Concomitant Procedures       The value on current procedure         Concomitant Procedures       The value on current procedure         Concomitant Procedures       The value on current procedure         Concomitant Procedures Type - 2.16.840.1.113883.3.3478.6.4.10       Device	Code System	Code	Source	Definition	Selection
Unfavorable Anatomy       112000002114         Medical decision for open       112000002115         ligation of appendage       112000002115         Element: 14855       Concomitant Procedures Performed         Coding Instruction:       Indicate if other procedures (Afib Ablation, ICD, PCI, TAVR or TMVR) were performed during the same lab visit as thi         Target Value:       The value on current procedure         Element: 14857       Concomitant Procedures         Coding Instruction:       Indicate which specific other procedures were performed during the same lab visit.         Target Value:       The value on current procedures         Concomitant Procedures       Indicate which specific other procedures were performed during the same lab visit.         Target Value:       The value on current procedure         Concomitant Procedures       The value on current procedure	SNOMED C	88797001			Complication
Medical decision for open       11200002115         ligation of appendage       Concomitant Procedures Performed         Element: 14855       Concomitant Procedures Performed         Coding Instruction:       Indicate if other procedures (Afib Ablation, ICD, PCI, TAVR or TMVR) were performed during the same lab visit as thi         Target Value:       The value on current procedure         Element: 14857       Concomitant Procedures         Coding Instruction:       Indicate which specific other procedures were performed during the same lab visit.         Target Value:       The value on current procedures         Coding Instruction:       Indicate which specific other procedures were performed during the same lab visit.         Target Value:       The value on current procedure         Concomitant Procedures       The value on current procedure         Concomitant Procedures       The value on current procedure         Concomitant Procedures       The value on current procedure	ACC NCDF	112000001838			Device Retrieval
Itigation of appendage         Element: 14855       Concomitant Procedures Performed         Coding Instruction:       Indicate if other procedures (Afib Ablation, ICD, PCI, TAVR or TMVR) were performed during the same lab visit as thi         Target Value:       The value on current procedure         Element: 14857       Concomitant Procedures         Coding Instruction:       Indicate which specific other procedures were performed during the same lab visit.         Target Value:       The value on current procedures         Coding Instruction:       Indicate which specific other procedures were performed during the same lab visit.         Target Value:       The value on current procedure         Concomitant Procedures       The value on current procedure         Concomitant Procedures       The value on current procedure         Concomitant Procedures       The value on current procedure	ACC NCDF	112000002114			Unfavorable Anatomy
Coding Instruction:       Indicate if other procedures (Afib Ablation, ICD, PCI, TAVR or TMVR) were performed during the same lab visit as this         Target Value:       The value on current procedure         Element:       14857       Concomitant Procedures         Coding Instruction:       Indicate which specific other procedures were performed during the same lab visit.         Target Value:       The value on current procedures         Concomitant Procedures       The value on current procedure         Concomitant Procedures       The value on current procedure         Concomitant Procedures       The value on current procedure	ACC NCDF	112000002115		•	
Target Value:       The value on current procedure         Element:       14857       Concomitant Procedures         Coding Instruction:       Indicate which specific other procedures were performed during the same lab visit.         Target Value:       The value on current procedure         Concomitant Procedures Type - 2.16.840.1.113883.3.3478.6.4.10			Concomitant Procedures Performed		Element: 14855
Element: 14857       Concomitant Procedures         Coding Instruction:       Indicate which specific other procedures were performed during the same lab visit.         Target Value:       The value on current procedure         Concomitant Procedures Type - 2.16.840.1.113883.3.3478.6.4.10	s procedure.	performed during the same lab visit as this p	Indicate if other procedures (Afib Ablation, ICD, PCI, TAVR or TMVR) were	Coding Instruction:	
Coding Instruction: Indicate which specific other procedures were performed during the same lab visit. Target Value: The value on current procedure Concomitant Procedures Type - 2.16.840.1.113883.3.3478.6.4.10			The value on current procedure	Target Value:	
Target Value: The value on current procedure         Concomitant Procedures Type - 2.16.840.1.113883.3.3478.6.4.10			Concomitant Procedures		Element: 14857
Concomitant Procedures Type - 2.16.840.1.113883.3.3478.6.4.10		ab visit.	Indicate which specific other procedures were performed during the same	Coding Instruction:	
			The value on current procedure	Target Value:	
			.113883.3.3478.6.4.10	dures Type - 2.16.840.1.	Concomitant Procedur
Selection Definition Source Code	Code System	Code	Source	Definition	Selection

Selection	Definition	Source	Code	Code System
AFib Ablation			18286008:363702006=49436004	SNOMED CT
ICD			ACC-NCDR-ICD	ACC NCDR
PCI			415070008	SNOMED CT
TAVR			441873006	SNOMED CT
TMVR			112000001801	ACC NCDR
ASD Closure Congenital			112811009	SNOMED CT
ASD Closure latrogenic			112000001885	ACC NCDR
PFO Closure Congenital			41817002	SNOMED CT





Section: Operator Information	Parent: Procedure
Element: 14861	Operator Leat Name
	Operator Last Name
Coding Instruction:	Indicate the last name of operator.
	Note(s):
	If the name exceeds 50 characters, enter the first 50 characters only.
Target Value:	The value on current procedure
Element: 14860	Operator First Name
Coding Instruction:	Indicate the first name of operator.
	Note(s):
	If the name exceeds 50 characters, enter the first 50 characters only.
Target Value:	The value on current procedure
Vendor Instruction:	Operator First Name (14860) cannot be Null
Element: 14862	Operator Middle Name
Coding Instruction:	Indicate the middle name of operator.
	Note(s):
	If the name exceeds 50 characters, enter the first 50 characters only.
Target Value:	The value on current procedure
Element: 14863	LAAO Operator NPI
Coding Instruction:	Indicate the National Provider Identifier (NPI) of the operator who is performing the procedure. NPI's, assigned by the Centers for Medicare and Medicaid Services (CMS), are used to uniquely identify physicians for Medicare billing purposes.
Target Value:	The value on current procedure
Vendor Instruction:	LAAO Operator NPI (14863) cannot be Null
	LAAO Operator NPI (14863) may only be entered/selected once.





Section: Fellow Information	Parent: Procedure
Element: 15433	Fellow Last Name
Coding Instruction:	Indicate the last name of the Fellow-in-Training operator.
	Note(s): If the name exceeds 50 characters, enter the first 50 characters only.
Target Value:	The value on current procedure
Element: 15434	Fellow First Name
Coding Instruction:	Indicate the first name of the Fellow-in-Training operator.
	Note(s): If the name exceeds 50 characters, enter the first 50 characters only.
Target Value:	The value on current procedure
Element: 15435	Fellow Middle Name
Coding Instruction:	Indicate the middle name of the Fellow-in-Training operator.
	Note(s): If the name exceeds 50 characters, enter the first 50 characters only.
Target Value:	The value on current procedure
Element: 15436	Fellow NPI
Coding Instruction:	Indicate the National Provider Identifier (NPI) of the Fellow-in-Training operator who is performing the procedure. NPI's, assigned by the Centers for Medicare and Medicaid Services (CMS), are used to uniquely identify physicians for Medicare billing purposes.
Target Value:	The value on current procedure
Vendor Instruction:	Fellow NPI (15436) may only be entered/selected once.
Element: 15431	Fellowship Program Identification Number
Coding Instruction:	Indicate the institution's Accreditation Council for Graduate Medical Education (ACGME) number for the program in which the Fellow is participating.
Target Value:	The value on current procedure
Supporting Definition:	Fellowship Program Identification Number
	The institution's Accreditation Council for Graduate Medical Education (ACGME) number for the program in which the Fellow is participating.
	ACGME oversees the accreditation of fellowship programs in the US. Each accredited training program is assigned a program ID. <b>Source:</b> A list of programs by specialty can be found here: ACGME - Accreditation Data System (ADS): https://apps.acgme.org/ads/Public/Reports/Report/1.





Section: Access	Systems	Parent: Procedure Information
Element: 14840		Access System Counter
	Coding Instruction:	The access system counter distinguishes an individual access system when multiple are used during one procedure.
	Target Value:	The value on current procedure
Element: 14839		Access System ID
	Coding Instruction:	Indicate the access system(s) utilized during the current procedure.
	Target Value:	The value on current procedure
	Vendor Instruction:	Access System ID (14839) cannot be Null when Procedure Canceled (14834) is No





Section: Device	S	Parent: Access Systems		
Element: 14842		Device Counter		
	Coding Instruction:	The device counter distinguishes individual devices when multiple are used during one pr	ocedure.	
	Target Value:	The value on current procedure		
Element: 14841		Device ID		
	Coding Instruction:	Indicate the device(s) utilized during the current procedure.		
	Target Value:	The value on current procedure		
Element: 14843		Device UDI Direct Identifier		
	Coding Instruction:	[Reserved for Future Use] Indicate the direct identifier portion of the Unique Device Identif ID is provided by the device manufacturer, and is either a GTIN or HIBBC number.	fier (UDI) associated with th	e device used. This
	Target Value:	The value on current procedure		
:	Supporting Definition:	Unique Device Identifier (UDI)		
		An identifier that is the main (primary) lookup for a medical device product and meets the through its distribution and use. This value is supplied to the FDA by the manufacturer.	requirements to uniquely ide	entify a device
		Source: US FDA		
Element: 14844		LAA Isolation Approach		
	Coding Instruction:	Indicate which approach was used to deliver the closure device.		
	Target Value:	The value on current procedure		
	s - 1.3.6.1.4.1.19376.1.4			
Selection	Definition	Source	Code 11200002078	Code Syste ACC NCE
Epicardial Percutaneous			103388001	SNOMED (
Element: 14968		Device Successfully Deployed		
	Coding Instruction:	Indicate whether the device was successfully deployed.		
	Target Value:	The value on current procedure		
	Vendor Instruction:	When Device ID (14841) is provided then Device Successfully Deployed (14968) cannot be	be Null.	
		If more than one Device Counter (14842) within the Procedure/Lab Visit have identical LA one Device Counter (14842) can have a Device Successfully Deployed (14968) = 'Yes'.	A Isolation Approach (1484	4) values, then only
Element: 14845		Reason Device Not Deployed Successfully		
	Coding Instruction:	Indicate the outcome listed for the device unsuccessfully deployed.		
	Target Value:	The value on current procedure		
	Vendor Instruction:	When Device Successfully Deployed (14968) is No then Outcome of Device Unsuccessful	Illy Deployed (14845) canno	ot be Null
Intervention Device	Outcomes - 1.3.6.1.4.1.	19376.1.4.1.6.5.786		
Selection	Definition	Source	Code	Code Syster
Deployed, not released	d		112000002112	ACC NCE

Not Deployed

Device retrieved

ACC NCDR

ACC NCDR

112000002113

112000001838





Section: Radiation Exposure	Parent: Procedure Information
Element: 7210	Cumulative Air Kerma
Coding Instruction:	Indicate the total radiation dose (Cumulative Air Kerma, or Reference Air Kerma) recorded to the nearest milligray (mGy) or gray (Gy). The value recorded should include the total dose for the lab visit. Cumulative air kerma is the total air kerma accrued from the beginning of an examination or procedure and includes all contributions from fluoroscopic and radiographic irradiation.
Target Value:	The total between start of current procedure and end of current procedure
Supporting Definition:	Cumulative (Reference) Air kerma
	Cumulative air kerma (also known as reference, reference dose, cumulative dose, or cumulative dose at a reference point) is the air kerma accumulated at a specific point in space (the patient entrance reference point) relative to the gantry of the fluoroscopy system.
	The quantity, kerma, originated from the acronym, KERMA, for Kinetic Energy Released per unit Mass (of air).
	Source: Miller DL, et al. Radiation doses in interventional radiology procedures. (J Vasc Interv Radiol 2003;14:711-727.)
Element: 7215	Contrast Volume
Coding Instruction:	Indicate the volume of contrast (ionic and non-ionic) used in milliliters (ml). The volume recorded should be the total volume for the lab visit.
Target Value:	The total between start of current procedure and end of current procedure
Element: 14278	Dose Area Product
Coding Instruction:	Indicate the total fluoroscopy dose to the nearest integer. The value recorded should include the total dose for the lab visit.
Target Value:	The total between start of current procedure and end of current procedure
Supporting Definition:	Dose Area Product
	Dose Area Product is the integral of air kerma (the energy extracted from an x-ray beam per unit mass of air in a small irradiated air volume; for diagnostic x-rays, the dose delivered to that volume of air) across the entire x-ray beam emitted from the x-ray tube. It is a surrogate measure of the amount of energy delivered to the patient.
	Also known as KAP (Kerma Area Product).

Source: Miller DL, et al. Radiation doses in interventional radiology procedures. (J Vasc Interv Radiol 2003; 14:711-727.)



# Coder's Data Dictionary v1.4



Section: Intrapr	ocedure Anticoagu	lation Strategy Parent: Procedure Information	
Element: 7225		Intraprocedure Anticoagulation	
	Coding Instruction:	Indicate if intraprocedure anticoagulation therapy was provided.	
	-	The value on current procedure	
	Taiget value.	The value on current procedure	
Element: 7230		Uninterrupted Warfarin Therapy	
	Coding Instruction:	Indicate if the patient continued on warfarin therapy and it was not held for the procedure.	
	Target Value:	The value on current procedure	
Element: 15139		Heparin Administered During Procedure	
	Coding Instruction:	Indicate if heparin was administered during the procedure.	
	Target Value:	The value on current procedure	
	-		
Inticoagulation Admiselection	ninistration - 1.3.6.1.4.1 Definition	.19376.1.4.1.6.5.819 Source Code	Codo Svetor
lo - Not Prescribed	Definition	11200000168	Code Syster ACC NCD
es - Prescribed		100001247	ACC NCD
Element: 14852		Heparin Initial Administration Timing	
		Indicate the timing of initial administration of heparin.	
	Coding Instruction:		
	-	Any occurrence on current procedure	
Andioation Adminic	Target Value:	Any occurrence on current procedure	
	Target Value: tration Timing - 1.3.6.1.	Any occurrence on current procedure 4.1.19376.1.4.1.6.5.169	Code System
Selection	Target Value: tration Timing - 1.3.6.1. Definition	Any occurrence on current procedure 4.1.19376.1.4.1.6.5.169 Source Code	
Selection Pre-transseptal Punct	Target Value: tration Timing - 1.3.6.1. Definition ure	Any occurrence on current procedure 4.1.19376.1.4.1.6.5.169	ACC NCD
election Pre-transseptal Puncto Post-transseptal Punc	Target Value: tration Timing - 1.3.6.1. Definition ure	Source         Code           100001082         100001081	ACC NCD
Selection Pre-transseptal Puncto Post-transseptal Punc	Target Value: tration Timing - 1.3.6.1. Definition ure ture	Source         Code           100001082         100001082           100001081         Bivalirudin	ACC NCD
Selection Pre-transseptal Puncto Post-transseptal Punc	Target Value: tration Timing - 1.3.6.1. Definition ure ture	Source         Code           100001082         100001081	ACC NCD
Selection Pre-transseptal Puncto Post-transseptal Punc	Target Value: tration Timing - 1.3.6.1. Definition ure ture Coding Instruction:	Source         Code           100001082         100001082           100001081         Bivalirudin	ACC NCD
election Pre-transseptal Punct Post-transseptal Punc Element: 15140	Target Value: tration Timing - 1.3.6.1. Definition ure ture Coding Instruction:	Any occurrence on current procedure 4.1.19376.1.4.1.6.5.169   Source Code 100001082 100001082 100001081  Bivalirudin  Indicate if bivalirudin was administered during the procedure. The value on current procedure	ACC NCD
Selection Pre-transseptal Punct Post-transseptal Punct Element: 15140 Anticoagulation Adr	Target Value: tration Timing - 1.3.6.1. Definition ure ture Coding Instruction: Target Value:	Any occurrence on current procedure 4.1.19376.1.4.1.6.5.169   Source Code 100001082 100001082 100001081  Bivalirudin  Indicate if bivalirudin was administered during the procedure. The value on current procedure	ACC NCD
Selection Pre-transseptal Punct Post-transseptal Punct Element: 15140 Element: Administration Administration	Target Value: tration Timing - 1.3.6.1. Definition Jure ture Coding Instruction: Target Value: ninistration - 1.3.6.1.4.1	Any occurrence on current procedure 4.1.19376.1.4.1.6.5.169    Source Code 100001082 100001082 100001081  Bivalirudin  Indicate if bivalirudin was administered during the procedure. The value on current procedure .19376.1.4.1.6.5.819	ACC NCD ACC NCD ACC NCD
Selection Pre-transseptal Punct Post-transseptal Punct Element: 15140 Selection Selection Io - Not Prescribed	Target Value: tration Timing - 1.3.6.1. Definition Jure ture Coding Instruction: Target Value: ninistration - 1.3.6.1.4.1	Any occurrence on current procedure 4.1.19376.1.4.1.6.5.169  Source Code 100001082 100001082 100001081 Bivalirudin Bivalirudin Indicate if bivalirudin was administered during the procedure. The value on current procedure .19376.1.4.1.6.5.819  Code	ACC NCD ACC NCD Code System ACC NCD
Selection Pre-transseptal Punct Post-transseptal Punct Element: 15140 Election No - Not Prescribed Yes - Prescribed	Target Value: tration Timing - 1.3.6.1. Definition Jure ture Coding Instruction: Target Value: ninistration - 1.3.6.1.4.1	Any occurrence on current procedure 4.1.19376.1.4.1.6.5.169  Source Code 100001082 100001082 100001081 Bivalirudin Bivalirudin Indicate if bivalirudin was administered during the procedure. The value on current procedure .19376.1.4.1.6.5.819  Code 11200000168	ACC NCD ACC NCD Code System ACC NCD
Selection Pre-transseptal Punct Post-transseptal Punct Element: 15140 Election No - Not Prescribed Yes - Prescribed	Target Value: tration Timing - 1.3.6.1. Definition ure ture Coding Instruction: Target Value: ninistration - 1.3.6.1.4.1 Definition	Any occurrence on current procedure 4.1.19376.1.4.1.6.5.169    Source Code 100001082 100001081  Bivalirudin Indicate if bivalirudin was administered during the procedure. The value on current procedure .19376.1.4.1.6.5.819   Source Code 11200000168 100001247	ACC NCD ACC NCD Code System ACC NCD
Selection Pre-transseptal Punct Post-transseptal Punct Element: 15140 Election No - Not Prescribed Yes - Prescribed	Target Value: tration Timing - 1.3.6.1. Definition ure ture Coding Instruction: Target Value: ninistration - 1.3.6.1.4.1 Definition Coding Instruction:	Any occurrence on current procedure 4.1.19376.1.4.1.6.5.169   Source Code 100001082 100001081 Bivalirudin Indicate if bivalirudin was administered during the procedure. The value on current procedure .19376.1.4.1.6.5.819  Source Code 11200000168 100001247 Other Anticoagulant	ACC NCD ACC NCD Code System ACC NCD
Selection Pre-transseptal Punct Post-transseptal Punc Element: 15140 Anticoagulation Adr Selection No - Not Prescribed (es - Prescribed Element: 15138	Target Value: tration Timing - 1.3.6.1. Definition ure ture Coding Instruction: Target Value: ninistration - 1.3.6.1.4.1 Definition Coding Instruction:	Any occurrence on current procedure  4.1.19376.1.4.1.6.5.169	ACC NCDI ACC NCDI Code System ACC NCDI
Selection Pre-transseptal Punct Post-transseptal Punc Element: 15140 Anticoagulation Adr Selection No - Not Prescribed Yes - Prescribed Element: 15138	Target Value: tration Timing - 1.3.6.1. Definition ure ture Coding Instruction: Target Value: ninistration - 1.3.6.1.4.1 Definition Coding Instruction: Target Value:	Any occurrence on current procedure  4.1.19376.1.4.1.6.5.169   Code  100001082  100001081  Bivalirudin  Indicate if bivalirudin was administered during the procedure. The value on current procedure  .19376.1.4.1.6.5.819  Code  11200000168  100001247  Other Anticoagulant Indicate if any other anticoagulation medical therapy, not listed above, was used during the procedure. The value on current procedure .19376.1.4.1.6.5.819  Other Anticoagulant Indicate if any other anticoagulation medical therapy, not listed above, was used during the procedure. The value on current procedure .19376.1.4.1.6.5.819  Other Anticoagulant Indicate if any other anticoagulation medical therapy, not listed above, was used during the procedure. The value on current procedure .19376.1.4.1.6.5.819	Code System ACC NCDF ACC NCDF ACC NCDF Code System ACC NCDF ACC NCDF
Selection Pre-transseptal Punct Post-transseptal Punc Element: 15140 Anticoagulation Adr Selection No - Not Prescribed Yes - Prescribed Element: 15138	Target Value: tration Timing - 1.3.6.1. Definition ure ture Coding Instruction: Target Value: ninistration - 1.3.6.1.4.1 Definition Coding Instruction: Target Value: ninistration - 1.3.6.1.4.1	Any occurrence on current procedure  4.1.19376.1.4.1.6.5.169	ACC NCDF ACC NCDF Code System ACC NCDF ACC NCDF

#### Element: 14853

Anticoagulation Reversal

Coding Instruction: Indicate if there was a reversal of the anticoagulation at the end of the LAA occlusion procedure.

Target Value: Any occurrence on current procedure





## Section: Intra or Post-Procedure Events

Element: 12153

Intra or Post Procedure Events

Coding Instruction: Indicate if the specific intra or post procedure event(s) occurred.

Target Value: Any occurrence between start of procedure and until next procedure or discharge

Vendor Instruction: An Intra or Post Procedure - combination of Events (12153), Occurred (9002) and Event Date (14275) - may only be entered/selected once

Parent: Procedure Information

#### Intra or Post Procedure Events - 1.3.6.1.4.1.19376.1.4.1.6.5.706

Selection	efinition	Source Code	Code System
Air Embolism		271376002	SNOMED CT
Cardiac Arrest		410429000	SNOMED CT
Heart Failure		84114007	SNOMED CT
Heart Valve Damage		368009	SNOMED CT
Left Atrial Thrombus		473360003	SNOMED CT
Myocardial Infarction		22298006	SNOMED CT
Pericardial Effusion (no intervention required)		11200002125	ACC NCDR
Pericarditis		3238004	SNOMED CT
Anaphylaxis		39579001	SNOMED CT
Arterial Thrombosis		65198009	SNOMED CT
Deep Vein Thrombosis		128053003	SNOMED CT
Systemic Thromboembolism (other than stroke) (Complete Adjudication)		11200002126	ACC NCDR
Esophageal Injury (resulting from TEE probe)		11200002127	ACC NCDR
Hepatic Injury		112000002128	ACC NCDR
New Requirement for Dialysis		100014076	ACC NCDR
Device Explant		100001141	ACC NCDR
Device Infection		11200002137	ACC NCDR
Device Migration		370512004	SNOMED CT
Device Thrombus		112000001839	ACC NCDR
Device Systemic Embolization (catheter retrieval)		112000002138	ACC NCDR
Device Systemic Embolization (surgical retrieval)		112000002139	ACC NCDR
AV Fistula (no intervention required)		112000002140	ACC NCDR
AV Fistula (requiring surgical repair) (Complete Adjudication)		112000002141	ACC NCDR
Pseudoaneurysm (no intervention required)		11200002143	ACC NCDR
Pseudoaneurysm (requiring endovascular repair) (Complete Adjudication)		11200002144	ACC NCDR
Pseudoaneurysm (requiring surgical repair) (Complete Adjudication)		112000002145	ACC NCDR
Pseudoaneurysm (requiring thrombin injection only) (Complete Adjudication)		112000002146	ACC NCDR
Hemorrhagic Stroke (Complete Adjudication)		230706003	SNOMED CT
Intracranial Hemorrhage (other than hemorrhagic stroke) (Complete Adjudication)		1386000	SNOMED CT
Ischemic Stroke (Complete Adjudication)		422504002	SNOMED CT
TIA (Complete Adjudication)		266257000	SNOMED CT
Undetermined Stroke (Complete Adjudication)		230713003	SNOMED CT
Access Site Bleeding (Complete Adjudication)		1000142440	ACC NCDR
GI Bleeding (Complete Adjudication)		74474003	SNOMED CT
Hematoma (Complete Adjudication)		385494008	SNOMED CT
Hemothorax (not requiring		11200002147	ACC NCDR





Section: Intra or Post-Procedure E	vents Parent: Procedure Information	
drainage) (Complete Adjudication)		
Hemothorax (requiring drainage) (Complete Adjudication)	100001011	ACC NCD
Other Hemorrhage (non- intracranial) (Complete Adjudication)	50960005	SNOMED C
Pericardial Effusion (requiring open heart surgery) (Complete Adjudication)	112000002148	ACC NCD
Pericardial Effusion with tamponade (requiring percutaneous drainage) (Complete Adjudication)	11200002149	ACC NCD
Pericardial Effusion without tamponade (requiring percutaneous drainage) (Complete Adjudication)	11200002150	ACC NCD
Retroperitoneal Bleeding (Complete Adjudication)	95549001	SNOMED C
Vascular Complications (Complete Adjudication)	213217008	SNOMED C
Pleural Effusion	60046008	SNOMED C
Pneumonia	233604007	SNOMED C
Pneumothorax (no intervention required)	11200002153	ACC NCD
Pneumothorax (requiring intervention)	11200002152	ACC NCD
Pulmonary Embolism	59282003	SNOMED C
Respiratory Failure	409622000	SNOMED C
Element: 9002	Intra/Post-Procedure Events Occurred	
Coding Instruction:	Indicate if the specific intra or post procedure event(s) occurred.	
Target Value:	Any occurrence between start of procedure and until next procedure or discharge	
Vendor Instruction:	When an Intra or Post-Procedure Event (12153) selection/code is provided more than once in a single Lab Visit, th Procedure Events Occurred (9002) value cannot have conflicting responses or be duplicate negatives.	nen its Intra/Post-
	When an Intra or Post Procedure Events (12153) is selected then Intra/Post-Procedure Events Occurred (9002) m	nust not be Null
	later and Dept Drage dury Friend Deta	

 Element: 14275
 Intra and Post Procedure Event Date

 Coding Instruction
 Indicate all dates of intra or post procedure events that occurred.

 Target Value
 Any occurrence between start of procedure and until next procedure or discharge

 Vendor Instruction
 Intra and Post Procedure Event Date (14275) must be Greater than or Equal to Procedure Start Date and Time (7000)

Intra and Post Procedure Event Date (14275) must be Less than or Equal to Discharge Date (10100)





### Section: In-Hospital Adjudication

#### Parent: Procedure Information

#### Element: 14312 Adjudication Event

Coding Instruction: Indicate the event being adjudicated.

Target Value: N/A

Vendor Instruction: An Adjudication - combination of Event (14312) and Date (14313) - may only be entered/selected once

Adjudication Event (14312) cannot be Null if Intra or Post Procedure Events (12153) is Equal to (Hemorrhagic Stroke, Intracranial Hemorrhage (other than hemorrhagic stroke), Ischemic Stroke, TIA, Undetermined Stroke, Access Site Bleeding, GI Bleeding, Hematoma, Hemothorax (not requiring drainage), Hemothorax (requiring drainage), Other Hemorrhage (non-intracranial), Pericardial Effusion (requiring open heart surgery), Pericardial Effusion with tamponade (requiring percutaneous drainage), Pericardial Effusion without tamponade (requiring percutaneous drainage), Retroperitoneal Bleeding, Vascular Complications, Systemic Thromboembolism (other than stroke), AV Fistula (requiring surgical repair), Pseudoaneurysm (requiring endovascular repair), Pseudoaneurysm (requiring surgical repair), Pseudoaneurysm (requiring events Occurred (9002) is Yes. Every Intra or Post Procedure Event (combination of Event (12153), Occurred (9002) and Event Date (14275)) that requires adjudication must have a corresponding adjudication record (combination of Event (14312) and Event Date (14213).

#### Intra or Post Procedure Events - 1.3.6.1.4.1.19376.1.4.1.6.5.706

Selection	Definition	Source	Code	Code System
Air Embolism			271376002	SNOMED CT
Cardiac Arrest			410429000	SNOMED CT
Heart Failure			84114007	SNOMED CT
Heart Valve Damage			368009	SNOMED CT
Left Atrial Thrombus			473360003	SNOMED CT
Myocardial Infarction			22298006	SNOMED CT
Pericardial Effusion (no intervention required)			112000002125	ACC NCDR
Pericarditis			3238004	SNOMED CT
Anaphylaxis			39579001	SNOMED CT
Arterial Thrombosis			65198009	SNOMED CT
Deep Vein Thrombosis			128053003	SNOMED CT
Systemic Thromboembolisr (other than stroke) (Comple Adjudication)			112000002126	ACC NCDR
Esophageal Injury (resultin from TEE probe)	ng		112000002127	ACC NCDR
Hepatic Injury			112000002128	ACC NCDR
New Requirement for Dialy	ysis		100014076	ACC NCDR
Device Explant			100001141	ACC NCDR
Device Infection			112000002137	ACC NCDR
Device Migration			370512004	SNOMED CT
Device Thrombus			112000001839	ACC NCDR
Device Systemic Embolizat (catheter retrieval)	tion		112000002138	ACC NCDR
Device Systemic Embolizat (surgical retrieval)	tion		112000002139	ACC NCDR
AV Fistula (no intervention required)	1		112000002140	ACC NCDR
AV Fistula (requiring surgirepair) (Complete Adjudica			112000002141	ACC NCDR
Pseudoaneurysm (no intervention required)			112000002143	ACC NCDR
Pseudoaneurysm (requirin endovascular repair) (Complete Adjudication)	ıg		112000002144	ACC NCDR
Pseudoaneurysm (requirin surgical repair) (Complete Adjudication)			112000002145	ACC NCDR
Pseudoaneurysm (requirin thrombin injection only) (Complete Adjudication)	ığ		112000002146	ACC NCDR
Hemorrhagic Stroke (Comp Adjudication)	blete		230706003	SNOMED CT
Intracranial Hemorrhage (c than hemorrhagic stroke) (Complete Adjudication)	other		1386000	SNOMED CT
Ischemic Stroke (Complete			422504002	SNOMED CT
Adjudication)				





Section: In-Hospital Adjudication	Parent: Procedure Information	
Undetermined Stroke (Complete Adjudication)	230713003	SNOMED CT
Access Site Bleeding (Complete Adjudication)	1000142440	ACC NCDR
GI Bleeding (Complete Adjudication)	74474003	SNOMED CT
Hematoma (Complete Adjudication)	385494008	SNOMED CT
Hemothorax (not requiring drainage) (Complete Adjudication)	11200002147	ACC NCDR
Hemothorax (requiring drainage) (Complete Adjudication)	100001011	ACC NCDR
Other Hemorrhage (non- intracranial) (Complete Adjudication)	50960005	SNOMED CT
Pericardial Effusion (requiring open heart surgery) (Complete Adjudication)	11200002148	ACC NCDR
Pericardial Effusion with tamponade (requiring percutaneous drainage) (Complete Adjudication)	11200002149	ACC NCDR
Pericardial Effusion without tamponade (requiring percutaneous drainage) (Complete Adjudication)	11200002150	ACC NCDR
Retroperitoneal Bleeding (Complete Adjudication)	95549001	SNOMED CT
Vascular Complications (Complete Adjudication)	213217008	SNOMED CT
Pleural Effusion	60046008	SNOMED CT
Pneumonia	233604007	SNOMED CT
Pneumothorax (no intervention required)	11200002153	ACC NCDR
Pneumothorax (requiring intervention)	11200002152	ACC NCDR
Pulmonary Embolism	59282003	SNOMED CT
Respiratory Failure	409622000	SNOMED CT

Element: 14313

Adjudication Event Date

Coding Instruction: Indicate the date the clinical event being adjudicated occurred.

Target Value: N/A

Vendor Instruction: When Adjudication Event (14312) is selected, Adjudication Event Date (14313) cannot be Null

The Adjudication Event Date (14313) / Adjudication Event Code (14312) must match with Intra or Post-Procedure Event Date (14275) / Intra or Post Procedure Event Code (12153)





Section: Neurologic		Parent: In-Hospital Adjudication	
Element: 14902		Adjudication Status	
	Coding Instruction:	Indicate whether the patient was alive or deceased on the date the adjudication was performed.	
	-	Any value between start of current procedure and discharge	
	-	Adjudication Status (14902) cannot be Null if Adjudication Event (14312) is Equal to (Hemorrhagic Stroke, Intracranial Hem	orrhage.
		Ischemic Stroke, TIA, Undetermined Stroke)	
Adjudication Life Stat	tus - 1.3.6.1.4.1.19376.	1.4.1.6.5.726	
Selection Alive	Definition	Source         Code           438949009	Code Syste
Deceased			harge dispositio
Element: 14903		Adjudication Date of Death	
	Coding Instruction:	Indicate the date the patient was declared deceased.	
	-	Any value between start of current procedure and discharge	
	-	Adjudication Date of Death (14903) must be Greater than or Equal to Procedure Start Date and Time (7000)	
		Adjudication Date of Death (14903) must be Greater than or Equal to Adjudication Event Date (14313)	
		Adjudication Date of Death (14903) must be Greater than or Equal to Symptom Onset Date (14904)	
Element: 14904		Symptom Onset Date	
	Coding Instruction:	Indicate the date of symptom onset associated with this event.	
	-	Any value between start of current procedure and discharge	
Element: 14905		Neurologic Deficit with Rapid Onset	
	Coding Instruction:	Indicate if the patient had a sudden onset of a focal or global neurologic deficit regardless of the duration of symptoms.	
		Rapid onset means sudden or maximal within minutes.	
	Target Value:	Any value between start of current procedure and discharge	
Element: 14906		Neurologic Deficit Clinical Presentation	
	Coding Instruction:	Indicate the clinical presentation of the neurologic deficit.	
	Target Value:	Any value between start of current procedure and discharge	
Neurologic Deficit Cli	nical Presentation - 1.	3.6.1.4.1.19376.1.4.1.6.5.716	
Selection	Definition	Source Code	Code Syste
Stroke-related		100014109	ACC NCE
Non-Stroke-related		112000001860	ACC NCE
Element: 14907		Diagnosis Confirmation by Neurology	
	Coding Instruction:	Indicate if the diagnosis was confirmed by a neurologist or a neurosurgeon.	
	Target Value:	Any value between start of current procedure and discharge	
Element: 14908		Brain Imaging Performed	
	Coding Instruction:	Indicate if neuro imaging (such as CT, MRI, cerebral angiography) was performed in an attempt to confirm the diagnosis.	
	-	All values between start of current procedure and discharge	
	-		
Element: 14909		Brain Imaging Type	
	Coding Instruction:	Indicate the type of neurologic imaging which was performed.	
	Target Value:	All values between start of procedure and end of procedure	
	1.3.6.1.4.1.19376.1.4.1.		
Selection Cerebral Angiography	Definition	Source         Code           3258003         3258003	Code Syste SNOMED (
Cerebral Anglography Computed Tomography		77477000	SNOMED C





Element:     14910     Deficit Type       Coding Instruction:     indicate tay per didarit distribute by the neuropraging study.       Target Value:     All values between start of procedure and end of procedure       stain imaging Finding - 1.53.1.11.9377.1.4.1.6.1.5377       Selection     Definition       Source     Code       Source     Code       Coding Instruction:     For palering presenting with all intracrantal herroritage, indicate the herroritage location.       Target Value:     All values between start of current procedure and discharge       Coding Instruction:     For palering presenting with all intracrantal herroritage, indicate the herroritage location.       Target Value:     All values between start of current procedure and discharge       Element:     14910     Memorrhage: Stocke Type       Element:     Definition     Source       Coding Instruction:     For palering presenting value and discharge       Element:     14912     Subsequent Intravenous Recombinant tasue Plasminogen Activator Administered       Coding Instruction:     Indicate if intravenous Recombinant tasue plasminogen Activator Administered       Element:     14913     Subsequent Endowscular Therrophale Intrave presentione as treatment option related to this event.       Target Value:     An value between start of current procedure and discharge       Element:     14914     Neurologic Symptoms    <	Section: Neurolog		Parent: In-Hospital Adjudication		
Coding Instruction:       Indicate the type of dollard domthed by the naturalinging study;         Target Value:       All values between start of procedure and end of procedure         Start Innaging Finding - 1.53.1.4.1.397.1.4.1.6.5717       Source       Code System         Selection       Definition       Source       Code System         Selection       Definition       Source       Code System         Selection       Definition       Source       Code System         Coding Instructions:       For patients presenting with an instructural hereartmaps, indicate the hereartmaps backton.       Source         Element:       11200002004       Socree       Code System         Reterring:       Structure Type       Code System       Structure Type         Reterring:       Structure Type       Code Code System       Structure Type         Reterring:       Structure Type       Structure Type       Structure Type         Reterring:       All values between start of current procedure and discharge       Structure Type         Element:       14912       Structure Type       Structure Type         Laburant       Structure Type       Structure Type       Structure Type         Laburant       Structure Type       Structure Type       Structure Type         Laburant	Other			112000001862	ACC NCD
	Element: 14910		Deficit Type		
		Coding Instruction:	Indicate the type of deficit identified by the neuroimaging study.		
Stain Imaging Finding - 1.3.6.1.4.1.19276.1.4.1.6.5.717 Selection Definition Source Code Code Syst Solution Sol		-			
Definition         Source         Code         Code         Source           isolated         00001231         ACCNO         Source         Source <td></td> <td>-</td> <td></td> <td></td> <td></td>		-			
la defini la defini definition				Codo	Codo Sveto
Interction	No deficit	Demition	Jource		ACC NCE
both         11200002004         ACC NC           Element: 14911         Hemorrhagic Stroke Type         Coding instruction:         For patients persenting with an instruction is the the themorrhage, backton.         Target Value:         Automate Stroke Type - 1.3.6.1.4.119376-1.4.1.6.5.794           Element: 14912         Definition         Source         Code         Code         Source           Instruction:         Definition         Source         Code         Source         Source <td>nfarction</td> <td></td> <td></td> <td>55641003</td> <td>SNOMED (</td>	nfarction			55641003	SNOMED (
Element: 14911       Hemorrhagic Stroke Type         Coding Instruction:       For patients presenting with an intracranial hemorrhage, indicate the hemorrhage location. Target Value: Al values between start of current procedure and discharge         Reserving (S stroke Type - 1.3.6.1.4.119376.1.4.1.6.5.79         Selection       Definition         Subsequent Intracembrail       274100004         Subsequent Intravenous Recombinant Tissue Plasminogen Activator Administered       Subsequent Intravenous Recombinant Tissue Plasminogen Activator Administered         Coding Instruction:       Indicate if intravenous Recombinant Tissue Plasminogen Activator (PR) was used as a treatment option related to this event.         Target Value:       Any value between start of current procedure and discharge         Element: 14913       Subsequent Endovascular Intervention         Coding Instruction:       Indicate if an endovascular interventional therapy was performed as a treatment option related to this event.         Target Value:       Any value between start of current procedure and discharge         Element: 14914       Neurologic Symptoms         Coding Instruction:       Indicate the duration (in housy) of the neurologic symptoms.         Target Value:       Any value between start of current procedure and discharge         Coding Instruction:       Indicate the patient experienced a physicial trauma within 24 hours         Coding Instruction:       Indicate the patient	Hemorrhage				SNOMED (
Coding Instruction:       For patients presenting with an intractanial hemorrhage, indicate the hemorrhage location.         Target Value:       All values between start of current procedure and discharge         Hemorrhagic Stroke Type 1.1.6.1.1.119376.1.1.6.5.794         Betection       Code       Code       Stortee         All values       Stortee       Code       Stortee         Subsequent Intraceneeball       274100000       Stortee         Subsequent Intravescular (V) recombinant tissue Plasminogen activator (MPA) was used as a treatment option related to this event.       Target Value:       Any value between start of current procedure and discharge         Element:       14913       Subsequent Intravencular Therapeutic Intervention       Subsequent Endovascular Therapeutic Intervention         Coding Instruction:       Indicate the duration (in hours) of the neurologic symptoms.       Target Value:       Any value between start of current procedure and discharge         Element:       14913       Neurologic Symptoms Duration       Coding Instruction:       Indicate the duration (in hours) of the neurologic symptoms.         Target Value:       All values between start of current procedure and discharge       12000002131       Accc No         Element:       14915       Target Value:       Acc No       Acc No         Statts the barlient experienced a physical trauma within 24 hours prior to the neurologic event.<	Both			112000002004	ACC NCE
Target Value: All values between start of current procedure and discharge         Element: 14912       Code Code Syrat         Coding Instruction:       Indicate if intravenous Recombinant Tissue Plasminogen Activator Administered       Section 2         Element: 14912       Subsequent Intravenous Recombinant Tissue Plasminogen Activator Administered       Section 2         Coding Instruction:       Indicate if intravenous Recombinant tissue plasminogen activator (HPA) was used as a treatment option related to this event. Target Value:       Any value between start of current procedure and discharge         Element: 14913       Subsequent Endovascular Interapeutic Intervention       Section 2         Coding Instruction:       Indicate if interaction of normal torrent procedure and discharge         Element: 14913       Subsequent Endovascular Interventional therapy was performed as a treatment option related to this event. Target Value:         Any value between start of procedure and end of procedure       Indicate if intervencion of the reurologic symptoms. Target Value:         Element: 14914       Neurologic Symptoms Duration       Coding Instruction:         Coding Instruction:       Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event. Target Value:       Acc No         Coding Instruction:       Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event. Target Value:       Acc No <td< td=""><td>Element: 14911</td><td></td><td>Hemorrhagic Stroke Type</td><td></td><td></td></td<>	Element: 14911		Hemorrhagic Stroke Type		
temorrhagic Stroke Type - 1.3.6.1.4.1.1937c.1.4.1.6.5.794 Selection Definition Source Code Code Systeminogen Activator Administered Subarachnoid 3446000 SNOMED Subarachnoid 35466000 SNOMED Subarachnoid 35466000 SNOMED Element: 14912 Subsequent Intravenous Recombinant Tissue Plasminogen Activator Administered Coding Instruction: Indicate if Intravascular (IV) recombinant tissue plasminogen Activator Administered Coding Instruction: Indicate if Intravascular (IV) recombinant tissue plasminogen Activator Administered Element: 14913 Subsequent Endovascular Therapeutic Intervention Coding Instruction: Indicate if an endovascular Therapeutic Intervention Coding Instruction: Indicate if an endovascular Therapeutic Intervention Coding Instruction: Indicate if an endovascular Intervention Identity as used as a treatment option related to this event. Target Value: Any value between start of current procedure and discharge Element: 14914 Neurologic Symptoms Duration Coding Instruction: Indicate tif an endovascular Intervention Identity as used as a treatment option related to this event. Target Value: All values between start of procedure and discharge Element: 14914 Neurologic Symptoms Duration Coding Instruction: Indicate tif an endovascular Intervention Intervention Intervention Intervention: Indicate tif an endovascular Intervention Intervention: Target Value: All values between start of procedure and discharge Ises than 1Hour - 14100002130 ACC NO - 244 fours 11200002130 ACC NO - 244 fours 1120000213		Coding Instruction:	For patients presenting with an intracranial hemorrhage, indicate the hemorrhage location	۱.	
temorrhagic Stroke Type - 1.3.6.1.4.1.1937c.1.4.1.6.5.794 Selection Definition Source Code Code Systeminogen Activator Administered Subarachnoid 3446000 SNOMED Subarachnoid 35466000 SNOMED Subarachnoid 35466000 SNOMED Element: 14912 Subsequent Intravenous Recombinant Tissue Plasminogen Activator Administered Coding Instruction: Indicate if Intravascular (IV) recombinant tissue plasminogen Activator Administered Coding Instruction: Indicate if Intravascular (IV) recombinant tissue plasminogen Activator Administered Element: 14913 Subsequent Endovascular Therapeutic Intervention Coding Instruction: Indicate if an endovascular Therapeutic Intervention Coding Instruction: Indicate if an endovascular Therapeutic Intervention Coding Instruction: Indicate if an endovascular Intervention Identity as used as a treatment option related to this event. Target Value: Any value between start of current procedure and discharge Element: 14914 Neurologic Symptoms Duration Coding Instruction: Indicate tif an endovascular Intervention Identity as used as a treatment option related to this event. Target Value: All values between start of procedure and discharge Element: 14914 Neurologic Symptoms Duration Coding Instruction: Indicate tif an endovascular Intervention Intervention Intervention Intervention: Indicate tif an endovascular Intervention Intervention: Target Value: All values between start of procedure and discharge Ises than 1Hour - 14100002130 ACC NO - 244 fours 11200002130 ACC NO - 244 fours 1120000213		Target Value:	All values between start of current procedure and discharge		
Section Definition Source Code Systematesetal Definition Source 2014 Code Systematesetal 21449007 SNOMED Subarchold 21449007 SNOMED Subarchold 21449007 SNOMED Subarchold 35488000 SNOMED Subarchold 35488000 SNOMED Statut 214912 Subsequent Intravenous Recombinant Tissue Plasminogen Activator Administered Coding Instruction: Indicate if intravascular (IV) recombinant tissue plasminogen Activator Administered Element: 14912 Subsequent Intravenous Recombinant Tissue Plasminogen Activator Administered Coding Instruction: Indicate if intravascular (IV) recombinant tissue plasminogen Activator (ItPA) was used as a treatment option related to this event. Target Value: Any value between stant of current procedure and discharge Element: 14913 Subsequent Endovascular Therapeutic Intervention Coding Instruction: Indicate if an endovascular Therapeutic Intervention Coding Instruction: Indicate if an endovascular interventional therapy was performed as a treatment option related to this event. Target Value: Any value between stant of current procedure and discharge Element: 14914 Neurologic Symptoms Duration Coding Instruction: Indicate the duration (in hours) of the neurologic symptoms. Target Value: All values between stant of procedure and end of procedure and the ass than 1 Hour 112000002130 ACC NO 112000002130 ACC NO 112000002131 ACC NO 112000002130 ACC NO 112000002130 ACC NO 112000002130 ACC NO 112000002131 ACC NO 112000002130 ACC NO 112000002130 ACC NO 112000002130 ACC NO 112000002131 ACC NO 112000002131 ACC NO 112000002130 ACC NO 1120000021	lleweende vie Oreche T	-			
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Element: 14912       Subsequent Intravenous Recombinant Tissue Plasminogen Activator Administered         Coding Instruction:       Indicate if Intravascular (IV) recombinant tissue plasminogen activator (IPA) was used as a treatment option related to this event. Target Value:         Any value between start of current procedure and discharge         Element: 14913       Subsequent Endovascular Therapeutic Intervention         Coding Instruction:       Indicate if an endovascular Interventional therapy was performed as a treatment option related to this event. Target Value:         Any value between start of current procedure and discharge       Neurologic Symptoms Duration         Coding Instruction:       Indicate the duration (in hours) of the neurologic symptoms. Target Value:       All values between start of procedure and end of procedure         Duration 1.3.6.1.4.1.1.9376.1.4.1.6.5.795       Subsequent Intravence and discharge       Code Code Systo         Substart that 24 Hours       112000002130       ACC NO         L: 24 Hours       112000002132       ACC NO         Element: 14915       Trauma       112000002132       ACC NO         Element: 14916       Modified Rankin Scale       No value between start of current procedure and discharge       Indicate if the patient sfunctional ability according to the modified Rankin Scale (mRS) administered following the event. Target Value:       Any value between start of current procedure and discharge         Element: 14916       Modified	Subarachnoid			21454007	SNOMED C
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Element: 14915       Trauma         Coding Instruction:       Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event.         Target Value:       Any value between start of current procedure and discharge         Element: 14916       Modified Rankin Scale         Coding Instruction:       Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the event.         Target Value:       Any value between start of current procedure and discharge         Supporting Definition:       Modified Rankin Scale         The Modified Rankin Scale       The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.         Source:       Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.         Source:       Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.         Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.         Rankin Scale Assessment Finding - 1.3.6.1.4.1.19376.1.4.1.6.5.139         Selection       Definition:         Source       Source         No significant disability       Able to carry out all usual duties and activities.	1 - 24 Hours				ACC NCD
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Element: 14916       Modified Rankin Scale         Coding Instruction:       Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the event.         Target Value:       Any value between start of current procedure and discharge         Supporting Definition:       Modified Rankin Scale         The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.         Source:       Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.         Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.         Rankin Scale Assessment Finding - 1.3.6.1.4.1.19376.1.4.1.6.5.139         Selection       Definition         Source       Source         No symptoms at all       LA6111-4         No significant disability       Able to carry out all usual duties and activities.		Target Value:	Any value between start of current procedure and discharge		
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Supporting Definition:       Modified Rankin Scale         The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.         Source:       Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.         Source:       Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.         Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. 1988;19(12):1497-1500.         Rankin Scale Assessment Finding - 1.3.6.1.4.1.19376.1.4.1.6.5.139         Selection       Definition         Source:       Source         No symptoms at all       LA6111-4         I: No significant disability       Able to carry out all usual duties and activities.		Coding Instruction:	Indicate the patient's functional ability according to the modified Rankin Scale (mRS) adm	inistered following the event	
Supporting Definition:       Modified Rankin Scale         The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.         Source:       Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.         Source:       Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.         Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. 1988;19(12):1497-1500.         Rankin Scale Assessment Finding - 1.3.6.1.4.1.19376.1.4.1.6.5.139         Selection       Definition         Source:       Source         No symptoms at all       LA6111-4         I: No significant disability       Able to carry out all usual duties and activities.		Target Value:	Any value between start of current procedure and discharge		
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Selection         Definition         Source         Code         Code System           D: No symptoms at all         LA6111-4         LA6111-4         LA0111-4           D: No significant disability         Able to carry out all usual duties and activities.         LA6112-2         LA0112-2			Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after st	roke. Stroke. 1988;19(12):14	497-1500.
b: No symptoms at all     LA6111-4     LOI       b: No significant disability     Able to carry out all usual duties and activities.     LA6112-2     LOI	Rankin Scale Assessm	ent Finding - 1.3.6.1	.4.1.19376.1.4.1.6.5.139		
: No significant disability Able to carry out all usual duties and activities. LA6112-2 LO	Selection	Definition	Source		Code System
		Able to carry or	It all usual duties and activities		LOIN
	despite symptoms	. 1510 10 04119 01			LOIN

2: Slight disability	Unable to carry out all previous activities, but able to

LA6113-0 LOINC





Section: Neurologic		Parent: In-Hospital Adjudication	
	look after own	affairs without assistance.	
3: Moderate disability	Requiring some assistance.	e help, but able to walk without LA6114-8	LOING
4: Moderately severe disabilit		without assistance and unable to attend LA6115-5 leeds without assistance.	LOING
5: Severe disability	Bedridden, inco care and attenti	ontinent and requiring constant nursing LA10137-0 ion.	LOING
6: Death		419620001	SNOMED C
Element: 14917		Adjudication Modified Rankin Scale Not Administered	
Cod	ling Instruction:	Indicate if the modified Rankin Scale (mRS) was not administered following the event.	
Target Va			
	Target Value:	Any value between start of current procedure and discharge	
Suppo	-	Any value between start of current procedure and discharge Modified Rankin Scale	
Suppo	-		ale of global disability.
Suppo	-	Modified Rankin Scale	ale of global disability.
Suppo	-	Modified Rankin Scale The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sc	
Suppo Element: 14918	-	Modified Rankin Scale The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sc Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.	
Element: 14918	rting Definition:	Modified Rankin Scale The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sc Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15. Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12)	2):1497-1500.
Element: 14918	rting Definition:	Modified Rankin Scale         The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sc         Source:       Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.         Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12)         Procedure Related Neurologic Event         Indicate using the following selections the likelihood in which this event is related to the LAAO procedure based of the stroke.	2):1497-1500.
Element: 14918	rting Definition: ling Instruction: Target Value:	Modified Rankin Scale         The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sc         Source:       Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.         Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12)         Procedure Related Neurologic Event         Indicate using the following selections the likelihood in which this event is related to the LAAO procedure based uclinical judgement.         Any value between start of current procedure and discharge	2):1497-1500.
Element: 14918 Cod	rting Definition: ling Instruction: Target Value:	Modified Rankin Scale         The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sc         Source:       Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.         Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12)         Procedure Related Neurologic Event         Indicate using the following selections the likelihood in which this event is related to the LAAO procedure based uclinical judgement.         Any value between start of current procedure and discharge	pon the clinician's best
Element: 14918 Cod Qualifier Value - 1.3.6.1.4.1	rting Definition: ling Instruction: Target Value: .19376.1.4.1.6.5.7 Definition The clinical adv	Modified Rankin Scale         The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sc         Source:       Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.         Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12)         Procedure Related Neurologic Event         Indicate using the following selections the likelihood in which this event is related to the LAAO procedure based u clinical judgement.         Any value between start of current procedure and discharge	2):1497-1500.

Centain	relationship to the procedure and cannot be explained by concurrent disease or other drugs or devices.	17102000	SNOWED CT
Probable	The clinical adverse event occurs within a reasonable time sequence to the procedure and it is unlikely to be attributed to concurrent disease or other drugs or devices.	11200002134	ACC NCDR
Possible	The clinical adverse event occurs within a reasonable time sequence to the procedure, but the event could also be explained by concurrent disease or other drugs or devices.	371930009	SNOMED CT
Unlikely	The clinical adverse event, based upon its temporal relationship to the procedure, makes a causal relationship improbable. Additionally, other drugs, devices or underlying disease provide plausible explanations.	112000002135	ACC NCDR
Unclassifiable	The clinical adverse event is reported yet more data is essential for a proper assessment OR the clinical adverse event is reported yet the causality cannot be judged because information is insufficient or contradictory, and cannot be supplemented or verified.	112000002136	ACC NCDR





# Section: Neurologic

Element: 14931

Device Related Neurologic Event

Coding Instruction: Indicate using the following selections the likelihood in which this event is related to the LAAO device based upon the clinician's best clinical judgement.

Parent: Neurologic

Target Value: Any value between start of current procedure and discharge

Selection	Definition	Source Code	Code System
Certain	The clinical adverse event occurs in a plausible time relationship to the procedure and cannot be explaine by concurrent disease or other drugs or devices.	d 17162000	SNOMED CT
Probable	The clinical adverse event occurs within a reasonab time sequence to the procedure and it is unlikely to b attributed to concurrent disease or other drugs or devices.		ACC NCDR
Possible	The clinical adverse event occurs within a reasonab time sequence to the procedure, but the event could also be explained by concurrent disease or other drugs or devices.	le 371930009	SNOMED CT
Unlikely	The clinical adverse event, based upon its temporal relationship to the procedure, makes a causal relationship improbable. Additionally, other drugs, devices or underlying disease provide plausible explanations.	112000002135	ACC NCDR
Unclassifiable	The clinical adverse event is reported yet more data essential for a proper assessment OR the clinical adverse event is reported yet the causality cannot b judged because information is insufficient or contradictory, and cannot be supplemented or verifie	9	ACC NCDR





Section: Bleeding		Parent: In-Hospital Adjudication	
		Adjudication Status	
Element: 14924	adina Instruction.	Adjudication Status	
	-	Indicate whether the patient was alive or deceased on the date the adjudication was performed.	
Ve	-	Any value between start of current procedure and discharge	loading Homotomo
		Adjudication Status (14924) cannot be Null if Adjudication Event (14312) is Equal to (Access Site Bleeding, GI B Hemothorax (not requiring drainage), Hemothorax (requiring drainage), Other Hemorrhage, Pericardial Effusion surgery), Pericardial Effusion with tamponade (requiring percutaneous drainage), Pericardial Effusion without t percutaneous drainage), Retroperitoneal Bleeding, Vascular Complications, AV Fistula (requiring surgical repair (requiring endovascular repair), Pseudoaneurysm (requiring surgical repair), Pseudoaneurysm (requiring throm 1444.05.700	(requiring open cardiac amponade (requiring r), Pseudoaneurysm
Adjudication Life Status Selection	- 1.3.6.1.4.1.19376. Definition	I.4.1.6.5.726 Source Code	Code Systen
Alive		438949009	SNOMED C
Deceased		20	HL7 Discharge disposition
Element: 14930		Adjudication Date of Death	
C	oding Instruction:	Indicate the date the patient was declared deceased.	
	Target Value:	Any value between start of current procedure and discharge	
Ve	endor Instruction:	Adjudication Date of Death (14930) must be Greater than or Equal to Procedure Start Date and Time (7000)	
		Adjudication Date of Death (14930) must be Greater than or Equal to Adjudication Event Date (14313)	
Element: 14929		Invasive Intervention Required	
C	oding Instruction:	Indicate if there was a surgical or percutaneous intervention required to treat the patient for this bleeding even	t.
	Target Value:	Any value between start of current procedure and discharge	
Element: 14919		RBC Transfusion	
Co	oding Instruction:	Indicate if there was at least one transfusion of PRBCs given to treat the patient for this bleeding event.	
	Target Value:	All values between start of current procedure and discharge	
-			
Element: 14920		Number of RBC Units Transfused	
C	-	Indicate the number of PRBC units transfused for treatment of this bleeding event.	
	Target Value:	All values between start of current procedure and discharge	
Element: 14921		Hemoglobin Pre-Transfusion	
C	oding Instruction:	Indicate the lowest hemoglobin (Hgb) value (g/dL), obtained via lab assay or point of care assay, between the	intra or post procedure
	C C	bleeding event and prior to the transfusion.	
	Target Value:	All values between start of current procedure and discharge	
<b>-</b>			
Element: 14922		Diagnostic Imaging Performed	
C	-	Indicate if imaging (such as CT, MRI) was performed in an attempt to confirm the diagnosis.	
	larget Value:	All values between start of current procedure and discharge	
Element: 14923		End Organ Damage	
	oding Instruction:	Indicate if the patient was diagnosed with end organ damage after this bleeding event.	
	-	All values between start of procedure and end of procedure	
	ranget value.		
Element: 14927		Major Surgery	
C	oding Instruction:	Indicate if the patient underwent surgery within 30 days prior to this bleeding event.	
	Target Value:	Any value between start of current procedure and discharge	
Element: 14928		Percutaneous Coronary Intervention	
C	oding Instruction:	Indicate if the patient had a percutaneous coronary artery or percutaneous valvular intervention within 30 days	prior to this bleeding
		event.	





#### Section: Bleeding

#### Parent: In-Hospital Adjudication

#### Target Value: Any value between start of current procedure and discharge

# Element: 14925 Procedure Related Bleeding Event Coding Instruction: Indicate using the following selections the likelihood in which this event is related to the LAAO procedure based upon the clinician's best clinical judgement. Target Value: Any value between start of current procedure and discharge Supporting Definition: Bleeding Event A bleeding event observed and documented in the medical record that was associated with a hematocrit drop of ≥10% and/or a hemoglobin drop of ≥3 g/dL or that required transfusion or surgical intervention.

Source: Cannon CP, Brindis RG, Chaitman BR, et al. 2013 ACCF>AHA Key Date Elements and Definitions for Measuring the Clinical Management and Outcomes of Patients with Acute Coronary Syndromes and Coronary Artery Disease. Circulation. 2013;127;1052-1089.

#### Qualifier Value - 1.3.6.1.4.1.19376.1.4.1.6.5.796

Selection	Definition	Source	Code	Code System
Certain	The clinical adverse event occurs in a plausible time relationship to the procedure and cannot be explaine by concurrent disease or other drugs or devices.	1	17162000	SNOMED CT
Probable	The clinical adverse event occurs within a reasonabl time sequence to the procedure and it is unlikely to be attributed to concurrent disease or other drugs or devices.	-	112000002134	ACC NCDR
Possible	The clinical adverse event occurs within a reasonabl time sequence to the procedure, but the event could also be explained by concurrent disease or other drugs or devices.	e	371930009	SNOMED CT
Unlikely	The clinical adverse event, based upon its temporal relationship to the procedure, makes a causal relationship improbable. Additionally, other drugs, devices or underlying disease provide plausible explanations.		112000002135	ACC NCDR
Unclassifiable	The clinical adverse event is reported yet more data essential for a proper assessment OR the clinical adverse event is reported yet the causality cannot be judged because information is insufficient or contradictory, and cannot be supplemented or verifie	9	112000002136	ACC NCDR





Section: Bleeding	Parent: Bleeding	
Element: 14926	Device Related Bleeding Event	
Coding Instruction:	Indicate using the following selections the likelihood in which this event is related to the LAAO device based upon the clinician's best clinical judgement.	
Target Value:	Any value between start of current procedure and discharge	

Supporting Definition: Bleeding Event

A bleeding event observed and documented in the medical record that was associated with a hematocrit drop of  $\geq$ 10% and/or a hemoglobin drop of  $\geq$ 3 g/dL or that required transfusion or surgical intervention.

Source: Cannon CP, Brindis RG, Chaitman BR, et al. 2013 ACCF>AHA Key Date Elements and Definitions for Measuring the Clinical Management and Outcomes of Patients with Acute Coronary Syndromes and Coronary Artery Disease. Circulation. 2013;127;1052-1089.

#### Qualifier Value - 1.3.6.1.4.1.19376.1.4.1.6.5.796

Selection	Definition	Source	Code	Code System
Certain	The clinical adverse event occurs in a plausible time relationship to the procedure and cannot be explained by concurrent disease or other drugs or devices.	1	17162000	SNOMED CT
Probable	The clinical adverse event occurs within a reasonabl time sequence to the procedure and it is unlikely to be attributed to concurrent disease or other drugs or devices.		112000002134	ACC NCDR
Possible	The clinical adverse event occurs within a reasonabl time sequence to the procedure, but the event could also be explained by concurrent disease or other drugs or devices.	9	371930009	SNOMED CT
Unlikely	The clinical adverse event, based upon its temporal relationship to the procedure, makes a causal relationship improbable. Additionally, other drugs, devices or underlying disease provide plausible explanations.		112000002135	ACC NCDR
Unclassifiable	The clinical adverse event is reported yet more data i essential for a proper assessment OR the clinical adverse event is reported yet the causality cannot be judged because information is insufficient or contradictory, and cannot be supplemented or verifie		112000002136	ACC NCDR





Element: 14932		Adjudication Status	
	Coding Instruction:	Indicate whether the patient was alive or deceased on the date the adjudication was performed.	
	Target Value:	Any value between start of current procedure and discharge	
	-	Adjudication Status (14932) cannot be Null if Adjudication Event (14312) is Equal to (Systemic Thromboemboli	ism (other than stroke))
Adjudication Life Sta Selection	atus - 1.3.6.1.4.1.19376. Definition		Codo Svot
Alive	Deminion	Source Code 43894900	,
Deceased			0 HL7 Discharge disposit
Element: 14933		Adjudication Date of Death	
	Coding Instruction:	Indicate the date the patient was declared deceased.	
	Target Value:	Any value between start of current procedure and discharge	
	Vendor Instruction:	Adjudication Date of Death (14933) must be Greater than or Equal to Procedure Start Date and Time (7000)	
		Adjudication Date of Death (14933) must be Greater than or Equal to Adjudication Event Date (14313)	
Element: 14934		Cause of Death	
	Coding Instruction:	If deceased, indicate if the patient's death cause was due to systemic thromboembolization, or focal end-orga from systemic thromboembolism, or therapeutic intervention to treat systemic thromboembolism.	an hypoperfusion resulting
	Target Value:	Any value between start of current procedure and discharge	
Element: 14935		Focal End-Organ Hypoperfusion Present	
	Coding Instruction:	Indicate if focal end-organ hypoperfusion resulted from the systemic thromboembolism event.	
	Target Value:	Any value between start of current procedure and discharge	
Element: 14939		Systemic Thromboembolization Imaging Evidence	
	Coding Instruction:	Indicate if imaging evidence indicated systemic thromboembolism.	
	Target Value:	All values between start of procedure and end of procedure	
Element: 14936		Imaging Method	
	Coding Instruction:	Indicate the imaging method to identify systemic thromboembolism.	
	Target Value:	All values between start of current procedure and discharge	
	.1.4.1.19376.1.4.1.6.5.41		
Selection Angiography	Definition	Source Cod 7734300	
	V	7747700	
		11309100	
Computed Tomograph	maying	11000100	0 SNOMED
Computed Tomograph Magnetic Resonance I	maging	1120000104	
Computed Tomograph Magnetic Resonance In Jltrasound	maying		2 ACC NC
Computed Tomograph Magnetic Resonance In JItrasound Dther Imaging	maying	1120000104	2 ACC NC
Computed Tomograph Magnetic Resonance In JItrasound Dther Imaging		1120000104 1120000186	2 ACC NO 2 ACC NO
Computed Tomograph Magnetic Resonance In JItrasound Other Imaging	Coding Instruction:	1120000104         1120000186         Therapeutic Intervention Performed         Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was performed to treat the	2 ACC NC 2 ACC NC
Computed Tomograph Magnetic Resonance In Jitrasound Other Imaging Element: 14937	Coding Instruction: Target Value:	1120000104         1120000186         Therapeutic Intervention Performed         Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was performed to treat the thromboembolism.         All values between start of procedure and end of procedure         Intervention Type	2 ACC NC 2 ACC NC
Computed Tomograph Magnetic Resonance In Jitrasound Other Imaging Element: 14937	Coding Instruction: Target Value:	1120000104         1120000186         Therapeutic Intervention Performed         Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was performed to treat the thromboembolism.         All values between start of procedure and end of procedure	2 ACC NC 2 ACC NC
Computed Tomograph Magnetic Resonance In Jitrasound Other Imaging Element: 14937	Coding Instruction: Target Value: Coding Instruction: Target Value:	1120000104         1120000186         Therapeutic Intervention Performed         Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was performed to treat the thromboembolism.         All values between start of procedure and end of procedure         Intervention Type         Indicate the intervention type.         All values between start of procedure and end of procedure	2 ACC NO 2 ACC NO
Computed Tomograph Magnetic Resonance In Ultrasound Other Imaging Element: 14937 Element: 14938	Coding Instruction: Target Value: Coding Instruction: Target Value: 1.3.6.1.4.1.19376.1.4.1.6	1120000104         1120000186         Therapeutic Intervention Performed         Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was performed to treat the thromboembolism.         All values between start of procedure and end of procedure         Intervention Type         Indicate the intervention type.         All values between start of procedure and end of procedure <b>5.797</b>	2 ACC NC 2 ACC NC
Computed Tomograph Magnetic Resonance In Ultrasound Other Imaging Element: 14937 Element: 14938	Coding Instruction: Target Value: Coding Instruction: Target Value:	1120000104         1120000186         Therapeutic Intervention Performed         Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was performed to treat the thromboembolism.         All values between start of procedure and end of procedure         Intervention Type         Indicate the intervention type.         All values between start of procedure and end of procedure         .5.797         Source       Cod	2 ACC NC 2 ACC NC e systemic e Code Syste
Computed Tomograph Magnetic Resonance In Ultrasound Other Imaging Element: 14937 Element: 14938 Intervention Type - 1 Selection Catheter	Coding Instruction: Target Value: Coding Instruction: Target Value: 1.3.6.1.4.1.19376.1.4.1.6	1120000104         1120000186         Therapeutic Intervention Performed         Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was performed to treat the thromboembolism.         All values between start of procedure and end of procedure         Intervention Type         Indicate the intervention type.         All values between start of procedure and end of procedure <b>5.797</b> Source       Cod         27627200	2 ACC NC 2 ACC NC e systemic e Code Syste 2 SNOMED
Computed Tomograph Magnetic Resonance In Ultrasound Other Imaging Element: 14937 Element: 14938	Coding Instruction: Target Value: Coding Instruction: Target Value: 1.3.6.1.4.1.19376.1.4.1.6	1120000104         1120000186         Therapeutic Intervention Performed         Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was performed to treat the thromboembolism.         All values between start of procedure and end of procedure         Intervention Type         Indicate the intervention type.         All values between start of procedure and end of procedure         .5.797         Source       Cod	2 ACC NC 2 ACC NC e systemic e <u>Code Syste</u> 2 SNOMED 7 SNOMED





Section: Systemic Thromboembolism

Parent: In-Hospital Adjudication





# Section: In-Hospital Adjudication Medications

Element: 14940

Coding Instruction: Indicate the NCDR assigned identification number for the medications the patient was taking or administered at the time of the event.

Parent: In-Hospital Adjudication

#### 0

Adjudication Medication Code

Target Value: All values between start of current procedure and discharge

Selection	Definition	Source	Code	Code System
Fondaparinux			321208	RxNorm
Heparin Derivative			100000921	ACC NCDR
Low Molecular Weigh	nt Heparin		373294004	SNOMED CT
Unfractionated Hepai	rin		96382006	SNOMED CT
Warfarin			11289	RxNorm
Aspirin 81 to 100 mg			11200002080	ACC NCDR
Aspirin 101 to 324 m	g		11200002081	ACC NCDR
Aspirin 325 mg			317300	RxNorm
Aspirin/Dipyridamole			226716	RxNorm
Vorapaxar			1537034	RxNorm
Apixaban			1364430	RxNorm
Dabigatran			1546356	RxNorm
Edoxaban			1599538	RxNorm
Rivaroxaban			1114195	RxNorm
Cangrelor			1656052	RxNorm
Clopidogrel			32968	RxNorm
Other P2Y12			112000001003	ACC NCDR
Prasugrel			613391	RxNorm
Ticagrelor			1116632	RxNorm
Ticlopidine			10594	RxNorm

Element: 14941

#### Medication Administered

Coding Instruction: Indicate if the patient was taking or being administered the medication at the time of the event.

Target Value: All values between start of procedure and end of procedure

Vendor Instruction: When an Adjudication Medication Code (14940) is selected, Medication Administered (14941) cannot be Null

Drug Administered - 1.3.6.1.4.1.19376.1.4.1.6.5.711

Selection	Definition	Source Code	Code System
Yes		112000001851	ACC NCDR
No		100014173	ACC NCDR





Section: Post Procedure Labs	Parent: Procedure Information
Element: 14868	Post Procedure Peak Creatinine
Coding Instruction:	Indicate the post-procedure peak creatinine (Cr) level (mg/dL).
Target Value:	The highest value between end of current procedure and discharge
Supporting Definition:	Creatinine
	Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine results in the formation of creatinine. It is transferred to the kidneys by blood plasma, whereupon it is eliminated by glomerular filtration and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A rise in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver and pancreas.
	Source: http://s.details.loinc.org/LOINC/2160-0.html?sections=Simple
Element: 14870	Post Procedure Peak Creatinine Not Drawn
Coding Instruction:	Indicate if post-procedure peak creatinine level could not be assessed as either only one level or no creatinine labs were drawn.
Target Value:	N/A
Supporting Definition:	
	Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine results in the formation of creatinine. It is transferred to the kidneys by blood plasma, whereupon it is eliminated by glomerular filtration and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A rise in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver and pancreas.
	Source: http://s.details.loinc.org/LOINC/2160-0.html?sections=Simple
Element: 14871	Post Procedure Hemoglobin
Coding Instruction:	: Indicate the lowest hemoglobin (Hgb) value (g/dL), obtained via lab assay or point of care assay, between the end of the procedure and the time of discharge.
Target Value:	The lowest value between end of current procedure and discharge
Supporting Definition:	Hemoglobin
	Hemoglobin (Hb or Hgb) is the iron-containing oxygen-transport metalloprotein in the red blood cells. It carries oxygen from the lungs to the rest of the body (i.e. the tissues) where it releases the oxygen to burn nutrients and provide energy. Hemoglobin concentration measurement is among the most commonly performed blood tests, usually as part of a complete blood count. If the concentration is below normal, this is called anemia. Anemias are classified by the size of red blood cells: "microcytic" if red cells are small, "macrocytic" if they are large, and "normocytic" if otherwise. Dehydration or hyperhydration can greatly influence measured hemoglobin levels.
	Source: http://s.details.loinc.org/LOINC/718-7.html?sections=Simple
Element: 14872	Post Procedure Hemoglobin Not Drawn
Coding Instruction:	Indicate if the post-procedure hemoglobin was not drawn.
Target Value:	N/A
Target Value: Supporting Definition:	
-	





Section: Post Procedure Creatining	e Parent: Post Procedure Labs
Element: 14869	Post Procedure Creatinine
Coding Instruction:	Indicate the post-procedure creatinine (Cr) level (mg/dL).
Target Value:	The last value between end of last procedure and discharge
Supporting Definition:	Creatinine
	Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine results in the formation of creatinine. It is transferred to the kidneys by blood plasma, whereupon it is eliminated by glomerular filtration and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A rise in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver and pancreas. Source: http://s.details.loinc.org/LOINC/2160-0.html?sections=Simple
Element: 14867	Post Procedure Creatinine Not Drawn
Coding Instruction:	Indicate if the post-procedure creatinine level was not drawn.
Target Value:	N/A
Supporting Definition:	Creatinine
	Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine results in the formation of creatinine. It is transferred to the kidneys by blood plasma, whereupon it is eliminated by glomerular filtration and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A rise in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver and pancreas.

Source: http://s.details.loinc.org/LOINC/2160-0.html?sections=Simple





Section: Discha	rge	Parent: Root	
Element: 14835		Surgery	
Liement. 14033			
	-	Indicate if the patient had an inpatient operation during this episode of care.	
	Target Value:	The value on discharge	
Element: 14836		Percutaneous Coronary Intervention	
	Coding Instruction:	Indicate if the patient had any other percutaneous coronary artery, coronary valvular or coronary structural interpisode of care.	erventions during this
	Target Value:	The value on discharge	
s	Supporting Definition:	Percutaneous Coronary Intervention	
		A percutaneous coronary intervention (PCI) is the placement of an angioplasty guide wire, balloon, or other development of a statement of an angioplasty guide wire, balloon, or other development of a statement of an angioplasty guide wire, balloon, or other development of a statement of an angioplasty guide wire, balloon, or other development of a statement of an angioplasty guide wire, balloon, or other development of a statement of an angioplasty guide wire, balloon, or other development of a statement of an angioplasty guide wire, balloon, or other development of a statement of a statement of an angioplasty guide wire, balloon, or other development of a statement of a s	
Element: 10100		Discharge Date	
	Coding Instruction:	Indicate the date on which the patient was discharged from your facility.	
	-		
	-	The value on discharge	
	Vendor Instruction:	Discharge Date (10100) and Arrival Date (3000) must not overlap on multiple episodes	
		Discharge Date (10100) must be Greater than or Equal to 10/01/2022	
Element: 10105		Discharge Status	
	Coding Instruction:	Indicate whether the patient was alive or deceased at discharge.	
	Target Value	The value on discharge	
Discharge Life Status Selection	s - 1.3.6.1.4.1.19376.1.4 Definition	.1.6.5.42 Source Code	Codo Svoto
Alive	Definition	438949009	Code Syste SNOMED
Deceased			HL7 Discharge dispositi
Element: 10110		Discharge Location	
	Coding Instruction:	Indicate the location to which the patient was discharged.	
	-		
	Target value:	The value on discharge	
Discharge Location -	1.3.6.1.4.1.19376.1.4.1	.6.5.41	
Selection	Definition	Source Code	Code Syste
Home			HL7 Discharge dispositi
Extended Care/TCU/Re			HL7 Discharge dispositi
Other acute care hospi	Ital		HL7 Discharge dispositi
Skilled Nursing facility			HL7 Discharge dispositi
Other		100001249	ACC NC
Left against medical ac AMA)	lvice	07	HL7 Discharge disposit
Element: 10115		Hospice Care	
	Coding Instruction:	Indicate if the patient was discharged to hospice care.	
	Target Value:	The value on discharge	
Element: 10120		Death During the Procedure	
	Coding Instruction:	Indicate if the patient expired during the procedure.	
		Note(s): Make sure to only capture 'death during the procedure' in the procedure appropriate registry.	
		For example, if the patient had a CathPCI procedure and a TVT procedure in the same episode of care (hospita	lization) but different cath
		lab visits and the death occurred during the TVT procedure, code 'Yes' only in the TVT Registry and not the Catt CathPCI procedure and TVT procedure occurred during the same cath lab visit then code 'Yes' in both registries	

Target Value: Any occurrence on discharge





Section: Dischar	ge	Parent: Root
Element: 10125		Cause of Death
	Coding Instruction:	Indicate the primary cause of death, i.e. the first significant abnormal event which ultimately led to death.
	Target Value:	The value on time of death
	Vendor Instruction:	When Cause of Death (10125) is Equal to Stroke, at least one of the following Adjudication Events (14312) must be selected: Hemorrhagic Stroke, Intracranial Hemorrhage, Ischemic Stroke, TIA, Undetermined Stroke
		When Cause of Death (10125) is Equal to (Cardiovascular hemorrhage, Hemorrhage), at least one of the following Adjudication Events (14312) must be selected: Access Site Bleeding, GI Bleeding, Hematoma, Hemothorax (not requiring drainage), Hemothorax (requiring drainage), Other Hemorrhage, Pericardial Effusion (requiring open cardiac surgery), Pericardial Effusion with tamponade (requiring percutaneous drainage), Pericardial Effusion without tamponade (requiring percutaneous drainage), Retroperitoneal Bleeding, Vascular Complications, AV Fistula (requiring surgical repair), Pseudoaneurysm (requiring endovascular endovascular endovascular endovascular endovascular endovascular endovascular endov

surgical repair), Pseudoaneurysm (requiring thrombin injection only)

## Cause of Death Clinical Finding - 1.3.6.1.4.1.19376.1.4.1.6.5.88

Selection	Definition	Source	Code	Code System
Acute myocardial infa	rction		100000960	ACC NCDR
Sudden cardiac death	l		100000978	ACC NCDR
Heart failure			100000964	ACC NCDR
Stroke			100000977	ACC NCDR
Cardiovascular proce	dure		100000962	ACC NCDR
Cardiovascular hemor	rrhage		100000961	ACC NCDR
Other cardiovascular	reason		100000972	ACC NCDR
Pulmonary			100000975	ACC NCDR
Renal			100000976	ACC NCDR
Gastrointestinal			100000963	ACC NCDR
Hepatobiliary			10000966	ACC NCDR
Pancreatic			100000974	ACC NCDR
Infection			100000967	ACC NCDR
Inflammatory/Immunol	ogic		100000968	ACC NCDR
Hemorrhage			100000965	ACC NCDR
Non-cardiovascular p	rocedure		100000971	ACC NCDR
or surgery				
Trauma			100000980	ACC NCDR
Suicide			100000979	ACC NCDR
Neurological			100000970	ACC NCDR
Malignancy			100000969	ACC NCDR
Other non-cardiovasc	cular		100000973	ACC NCDR
reason				





Section: Dischar	rge Medications	Parent: Discharge
Element: 10200		Discharge Medication Code
	Coding Instruction:	Indicate the assigned identification number associated with the medications the patient was prescribed upon discharge.
		Note(s):

Discharge medications not required for patients who expired, discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care.

The medication(s) collected in this field are controlled by the Medication Master file. This file is maintained by the NCDR and will be made available on the internet for downloading and importing/updating into your application. Each medication in the Medication Master file is assigned to a value set. The value set is used to separate procedural medications from medications prescribed at discharge. The separation of these medications is depicted on the data collection form.

Target Value: N/A

#### Discharge Medication - 1.3.6.1.4.1.19376.1.4.1.6.5.165

Selection	Definition	Source	Code	Code System
Fondaparinux			321208	RxNorm
Heparin Derivative			100000921	ACC NCDR
Low Molecular Weigh	t Heparin		373294004	SNOMED CT
Unfractionated Hepar	in		96382006	SNOMED CT
Warfarin			11289	RxNorm
Aspirin			1191	RxNorm
Aspirin/Dipyridamole			226716	RxNorm
Vorapaxar			1537034	RxNorm
Apixaban			1364430	RxNorm
Dabigatran			1546356	RxNorm
Edoxaban			1599538	RxNorm
Rivaroxaban			1114195	RxNorm
Cangrelor			1656052	RxNorm
Clopidogrel			32968	RxNorm
Other P2Y12			11200001003	ACC NCDR
Prasugrel			613391	RxNorm
Ticagrelor			1116632	RxNorm
Ticlopidine			10594	RxNorm

Element: 10205

Discharge Medication Prescribed

Coding Instruction: Indicate if the medication was prescribed, not prescribed, or was not prescribed for either a medical or patient reason.

Target Value: The value on discharge

#### Discharge Medication Administration - 1.3.6.1.4.1.19376.1.4.1.6.5.86

Selection	Definition	Source	Code	Code System
Yes			100001247	ACC NCDR
No - No Reason			100001048	ACC NCDR
No - Medical Reason			100001034	ACC NCDR
No - Patient Reason			100001071	ACC NCDR

Element: 10207

Discharge Medication Dose

Coding Instruction: Indicate the category of the medication dose prescribed.

Target Value: The value on discharge

Medication	Dose - 1	136141	19376 1	4165321
weuteation	DUSE -	1.3.0.1.4.1	. 1 3 3 7 0. 1.	4.1.0.3.321

Selection	Definition	Source	Code	Code System
Aspirin 81 to 100 mg			112000002080	ACC NCDR
Aspirin 101 to 324 mg			112000002081	ACC NCDR
Aspirin 325 mg			317300	RxNorm





	-Up	Parent: Root		
Element: 10999		Follow-Up Unique Key		
<b>Liement.</b> 10999	Coding Instruction			application
	-	Indicate the unique key associated with each patient follow-up record as assigned by the EMR	PERK OF YOUR SORWARE	application.
	Target Value:	IV/A		
Element: 11000		Follow-Up Assessment Date		
	Coding Instruction:	Indicate the date of the follow-up assessment was performed.		
	Target Value:	The value on Follow-up		
	Vendor Instruction:	Follow-Up Assessment Date (11000) must be Greater than the Follow-Up Reference Procedure	e Start Date and Time	(11001)
		Follow-Up Assessment Date (11000) must be Greater than or Equal to 10/01/2022		
Element: 14851		Follow Up Interval		
	Coding Instruction:	Indicate the interval of follow-up: 45 days, 6 months, 1 year or 2 years.		
	Target Value:	The value on Follow-up		
	Vendor Instruction:	A Follow Up - combination of Follow Up Interval (14851), Follow-Up Assessment Date (11000)	and Follow-Up Refere	ence Procedure Sta
		Date and Time (11001) - may only be entered/selected once		
		The date difference between Follow-up Assessment Date (11000) and Follow-up Reference P must fall within the valid range for the Follow Up Interval (14851). The valid ranges for the Follo follows:		
		45 day: 1-91 days 6 month: 92-256 days 1 year: 257-548 days 2 year: 549-913 days		
Follow Up Interval - 1	.3.6.1.4.1.19376.1.4.1.6	.5.806		
Selection	Definition	Source	Code	Code Syste
Selection 45 day	Definition	Source	112000002119	Code Syste
45 day 6 month	Definition	Source	112000002119 300042001	ACC NCE SNOMED (
45 day 6 month 1 year	Definition	Source	112000002119	ACC NCI SNOMED SNOMED
45 day 6 month 1 year 2 year	Definition		112000002119 300042001 183627004	ACC NCE SNOMED SNOMED
45 day 6 month 1 year 2 year		Reference Episode Arrival Date	11200002119 300042001 183627004 112000002118	ACC NCE SNOMED SNOMED
45 day 6 month 1 year 2 year	Coding Instruction:		11200002119 300042001 183627004 112000002118	ACC NCE SNOMED SNOMED
45 day 6 month 1 year 2 year	Coding Instruction:	Reference Episode Arrival Date Indicate the date and time of arrival for the episode of care that included the reference procedu	11200002119 300042001 183627004 112000002118	ACC NCI SNOMED SNOMED
45 day 5 month 1 year 2 year <b>Element:</b> 14946	Coding Instruction:	Reference Episode Arrival Date Indicate the date and time of arrival for the episode of care that included the reference procedu	11200002119 300042001 183627004 112000002118	ACC NCE SNOMED SNOMED
45 day 6 month 1 year 2 year <b>Element:</b> 14946	Coding Instruction: Target Value:	Reference Episode Arrival Date Indicate the date and time of arrival for the episode of care that included the reference procedu The value on Follow-up	11200002119 300042001 183627004 112000002118	ACC NCE SNOMED SNOMED
45 day 6 month 1 year 2 year <b>Element:</b> 14946	Coding Instruction: Target Value: Coding Instruction:	Reference Episode Arrival Date Indicate the date and time of arrival for the episode of care that included the reference procedu The value on Follow-up Follow-Up Reference Discharge Date	11200002119 300042001 183627004 112000002118	ACC NCE SNOMED ( SNOMED (
45 day 6 month 1 year 2 year <b>Element:</b> 14946	Coding Instruction: Target Value: Coding Instruction: Target Value:	Reference Episode Arrival Date Indicate the date and time of arrival for the episode of care that included the reference procedu The value on Follow-up Follow-Up Reference Discharge Date Indicate the date of discharge for the episode of care that included the reference procedure.	11200002119 300042001 183627004 112000002118	ACC NCE SNOMED ( SNOMED (
45 day 5 month 1 year 2 year Element: 14946	Coding Instruction: Target Value: Coding Instruction: Target Value:	Reference Episode Arrival Date Indicate the date and time of arrival for the episode of care that included the reference procedu The value on Follow-up Follow-Up Reference Discharge Date Indicate the date of discharge for the episode of care that included the reference procedure. The value on Follow-up	11200002119 300042001 183627004 112000002118	ACC NCE SNOMED SNOMED
45 day 6 month 1 year 2 year Element: 14946	Coding Instruction: Target Value: Coding Instruction: Target Value: Vendor Instruction:	Reference Episode Arrival Date Indicate the date and time of arrival for the episode of care that included the reference procedu The value on Follow-up Follow-Up Reference Discharge Date Indicate the date of discharge for the episode of care that included the reference procedure. The value on Follow-up Follow-up Reference Discharge Date (14338) must not be Null	11200002119 300042001 183627004 112000002118	ACC NCE SNOMED SNOMED
45 day 6 month 1 year 2 year Element: 14946	Coding Instruction: Target Value: Coding Instruction: Target Value: Vendor Instruction: Coding Instruction:	Reference Episode Arrival Date         Indicate the date and time of arrival for the episode of care that included the reference procedu         The value on Follow-up         Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-Up Reference Discharge Date (14338) must not be Null         Follow-Up Reference Procedure Start Date and Time         Indicate the reference procedure start date and time on the follow-up assessment date.	11200002119 300042001 183627004 112000002118	ACC NCI SNOMED SNOMED
45 day 5 month 1 year 2 year Element: 14946	Coding Instruction: Target Value: Coding Instruction: Target Value: Vendor Instruction: Coding Instruction:	Reference Episode Arrival Date         Indicate the date and time of arrival for the episode of care that included the reference procedu         The value on Follow-up         Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-Up Reference Discharge Date (14338) must not be Null         Follow-Up Reference Procedure Start Date and Time	11200002119 300042001 183627004 112000002118	ACC NCI SNOMED SNOMED
45 day 6 month 1 year 2 year Element: 14946 Element: 14338	Coding Instruction: Target Value: Coding Instruction: Target Value: Vendor Instruction: Coding Instruction:	Reference Episode Arrival Date         Indicate the date and time of arrival for the episode of care that included the reference procedu         The value on Follow-up         Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-Up Reference Discharge Date (14338) must not be Null         Follow-Up Reference Procedure Start Date and Time         Indicate the reference procedure start date and time on the follow-up assessment date.	11200002119 300042001 183627004 112000002118	ACC NCE SNOMED SNOMED
45 day 6 month 1 year 2 year Element: 14946 Element: 14338	Coding Instruction: Target Value: Coding Instruction: Target Value: Vendor Instruction: Coding Instruction: Target Value:	Reference Episode Arrival Date         Indicate the date and time of arrival for the episode of care that included the reference procedu         The value on Follow-up         Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-up Reference Discharge Date (14338) must not be Null         Follow-Up Reference Procedure Start Date and Time         Indicate the reference procedure start date and time on the follow-up assessment date.         The value on Follow-up	11200002119 300042001 183627004 112000002118	ACC NCE SNOMED ( SNOMED (
45 day 6 month 1 year 2 year Element: 14946 Element: 14338	Coding Instruction: Target Value: Coding Instruction: Target Value: Vendor Instruction: Coding Instruction: Target Value: Coding Instruction:	Reference Episode Arrival Date         Indicate the date and time of arrival for the episode of care that included the reference procedu         The value on Follow-up         Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-Up Reference Discharge Date (14338) must not be Null         Follow-Up Reference Procedure Start Date and Time         Indicate the reference procedure start date and time on the follow-up assessment date.         The value on Follow-up	11200002119 300042001 183627004 112000002118	ACC NCE SNOMED ( SNOMED (
45 day 6 month 1 year 2 year Element: 14946 Element: 14338 Element: 11001 Element: 11003	Coding Instruction: Target Value: Coding Instruction: Target Value: Vendor Instruction: Coding Instruction: Target Value: Coding Instruction: Target Value: e Follow-up status - 1.3	Reference Episode Arrival Date         Indicate the date and time of arrival for the episode of care that included the reference procedu         The value on Follow-up         Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-Up Reference Discharge Date (14338) must not be Null         Follow-Up Reference Procedure Start Date and Time         Indicate the reference procedure start date and time on the follow-up assessment date.         The value on Follow-up         Method to Determine Follow-Up Status         Indicate the method(s) used to determine the patient's vital status for follow up.         The value on Follow-up         8.6.1.4.1.19376.1.4.1.6.5.370	11200002119 300042001 183627004 112000002118	ACC NCE SNOMED ( SNOMED ( ACC NCE
45 day 6 month 1 year 2 year Element: 14946 Element: 14338 Element: 11001 Element: 11003 Method to Determine Selection	Coding Instruction: Target Value: Coding Instruction: Target Value: Vendor Instruction: Coding Instruction: Target Value: Coding Instruction: Target Value:	Reference Episode Arrival Date         Indicate the date and time of arrival for the episode of care that included the reference procedu         The value on Follow-up         Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-Up Reference Discharge Date (14338) must not be Null         Follow-Up Reference Procedure Start Date and Time         Indicate the reference procedure start date and time on the follow-up assessment date.         The value on Follow-up         Method to Determine Follow-Up Status         Indicate the method(s) used to determine the patient's vital status for follow up.         The value on Follow-up	11200002119 300042001 183627004 112000002118 ure.	ACC NCE SNOMED ( SNOMED ( ACC NCE
45 day 6 month 1 year 2 year Element: 14946 Element: 14338 Element: 11001 Element: 11003 Method to Determine Selection Office Visit	Coding Instruction: Target Value: Coding Instruction: Target Value: Vendor Instruction: Coding Instruction: Target Value: Coding Instruction: Target Value: e Follow-up status - 1.3	Reference Episode Arrival Date         Indicate the date and time of arrival for the episode of care that included the reference procedu         The value on Follow-up         Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-Up Reference Discharge Date (14338) must not be Null         Follow-Up Reference Procedure Start Date and Time         Indicate the reference procedure start date and time on the follow-up assessment date.         The value on Follow-up         Method to Determine Follow-Up Status         Indicate the method(s) used to determine the patient's vital status for follow up.         The value on Follow-up         8.6.1.4.1.19376.1.4.1.6.5.370	11200002119 300042001 183627004 112000002118 ure. Code 183654001	ACC NCE SNOMED ( SNOMED ( ACC NCE ACC NCE
45 day 6 month 1 year 2 year Element: 14946 Element: 14338 Element: 11001 Element: 11003 Method to Determine Selection Office Visit Medical Records	Coding Instruction: Target Value: Coding Instruction: Target Value: Vendor Instruction: Coding Instruction: Target Value: Coding Instruction: Target Value: e Follow-up status - 1.3 Definition	Reference Episode Arrival Date         Indicate the date and time of arrival for the episode of care that included the reference procedu         The value on Follow-up         Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-Up Reference Discharge Date (14338) must not be Null         Follow-Up Reference Procedure Start Date and Time         Indicate the reference procedure start date and time on the follow-up assessment date.         The value on Follow-up         Method to Determine Follow-Up Status         Indicate the method(s) used to determine the patient's vital status for follow up.         The value on Follow-up         8.6.1.4.1.19376.1.4.1.6.5.370	11200002119 300042001 183627004 112000002118 ure.	ACC NCE SNOMED ( SNOMED ( ACC NCE ACC NCE SNOMED ( ACC NCE
45 day 6 month 1 year 2 year Element: 14946 Element: 14338 Element: 11001	Coding Instruction: Target Value: Coding Instruction: Target Value: Vendor Instruction: Coding Instruction: Target Value: Coding Instruction: Target Value: e Follow-up status - 1.3 Definition	Reference Episode Arrival Date         Indicate the date and time of arrival for the episode of care that included the reference procedu         The value on Follow-up         Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-Up Reference Discharge Date (14338) must not be Null         Follow-Up Reference Procedure Start Date and Time         Indicate the reference procedure start date and time on the follow-up assessment date.         The value on Follow-up         Method to Determine Follow-Up Status         Indicate the method(s) used to determine the patient's vital status for follow up.         The value on Follow-up         8.6.1.4.1.19376.1.4.1.6.5.370	11200002119 300042001 183627004 112000002118 ure. Code 183654001	ACC NCE SNOMED ( SNOMED ( ACC NCE ACC NCE

File



# Coder's Data Dictionary v1.4



Section: Follow-U	٩L	Parent: Root	
Hospitalized		1000142363	ACC NCDF
Other		100000351	ACC NCDI
Element: 11004		Follow-Up Status	
	Coding Instruction:	Indicate whether the patient is alive or deceased.	
	Target Value:	The value on Follow-up	
	.6.1.4.1.19376.1.4.1.6.		
Selection	Definition	Source Code	Code System
Alive		438949009	SNOMED C
Deceased			J
ost to follow-up		399307001	SNOMED C
Element: 11006		Follow-Up Date of Death	
	Coding Instruction:	Indicate the date of death.	
	Target Value:	The value on Follow-up	
	Vendor Instruction:	Follow-Up Date of Death (11006) must be Greater than the Follow-Up Reference Procedure Start Date and Time	e (11001)
		Follow-Up Date of Death (11006) must be Greater than or Equal to the Follow-Up Event Date (14277)	
Element: 11007		Cause of Death	
	Coding Instruction:	Indicate the primary cause of death, i.e. the first significant abnormal event which ultimately led to death.	
	Target Value:	The value on Follow-up	
	Vendor Instruction:	When Cause of Death (11007) is Equal to Stroke, at least one of the following Adjudication Events (14967) must Hemorrhagic Stroke, Intracranial Hemorrhage, Ischemic Stroke, TIA, Undetermined Stroke	t be selected:
		When Cause of Death (11007) is Equal to (Cardiovascular hemorrhage, Hemorrhage), at least one of the follow (14967) must be selected: Access Site Bleeding, GI Bleeding, Hematoma, Hemothorax (not requiring drainage), drainage), Other Hemorrhage, Pericardial Effusion (requiring open cardiac surgery), Pericardial Effusion without tamponade (requiring percutaneous drainage), Retroperito Complications, AV Fistula (requiring surgical repair), Pseudoaneurysm (requiring endovascular repair), Pseudoaneurysm (requiring endovascular repair), Pseudoaneurysm (requiring endovascular repair), Pseudoaneurysm (requiring hrombin injection only)	Hemothorax (requiring mponade (requiring meal Bleeding, Vascular

Selection	Definition	Source	Code	Code System
Acute myocardial infa	arction		10000960	ACC NCDR
Sudden cardiac death	ı		100000978	ACC NCDR
Heart failure			100000964	ACC NCDR
Stroke			100000977	ACC NCDR
Cardiovascular proce	dure		100000962	ACC NCDR
Cardiovascular hemo	rrhage		100000961	ACC NCDR
Other cardiovascular	reason		100000972	ACC NCDR
Pulmonary			100000975	ACC NCDR
Renal			100000976	ACC NCDR
Gastrointestinal			100000963	ACC NCDR
Hepatobiliary			10000966	ACC NCDR
Pancreatic			100000974	ACC NCDR
Infection			100000967	ACC NCDR
Inflammatory/Immunol	ogic		100000968	ACC NCDR
Hemorrhage			100000965	ACC NCDR
Non-cardiovascular p or surgery	procedure		100000971	ACC NCDR
Trauma			100000980	ACC NCDR
Suicide			100000979	ACC NCDR
Neurological			100000970	ACC NCDR
Malignancy			10000969	ACC NCDR
Other non-cardiovaso reason	cular		100000973	ACC NCDR

Element: 14858

Left Ventricular Ejection Fraction Assessed

Coding Instruction: Indicate if a left ventricular ejection fraction (LVEF) has been assessed.

Target Value: The value on Follow-up





Section: Follow-Up	Parent: Root
Element: 13690	Left Ventricular Ejection Fraction
Coding Instruction:	Indicate the left ventricular ejection fraction.
Target Value:	The value on Follow-up
Supporting Definition:	Most Recent LVEF %
	The left ventricular ejection fraction is the percentage of blood emptied from the left ventricle at the end of contraction.
	Source: ACC Clinical Data Standards, Society for Thoracic Surgeons Adult Cardiac Surgery Database (STS)
Element: 14859	Transthoracic Echo Performed
	Indicate if a transthoracic echocardiogram (TTE) was performed.
-	The value on Follow-up
Target Value.	
Element: 14873	TTE Date
Coding Instruction:	Indicate the date of the most recent transthoracic echo study performed.
Target Value:	The value on Follow-up
Vendor Instruction:	TTE Date (14873) must be Greater than the Follow-Up Reference Procedure Start Date and Time (11001)
Element: 14874	Transesophageal Echocardiogram (TEE) Performed
Coding Instruction:	Indicate if transesophageal echocardiogram (TEE) was performed.
Target Value:	The value on Follow-up
Element: 14875	TEE Date
Coding Instruction:	Indicate the date of the most recent transesophageal echocardiogram (TEE).
Target Value:	The value on Follow-up
Vendor Instruction:	TEE Date (14875) must be Greater than the Follow-Up Reference Procedure Start Date and Time (11001)
Element: 14876	Cardiac CT Performed
	Indicate if cardiac computed tomography (CT) was performed.
Target value.	The value on Follow-up
Element: 14877	Cardiac CT Date
Coding Instruction:	Indicate the date of the most recent cardiac computed tomography (CT).
Target Value:	The value on Follow-up
Vendor Instruction:	Cardiac CT Date (14877) must be Greater than the Follow-Up Reference Procedure Start Date and Time (11001)
Element: 14878	Cardiac MRI Performed
Coding Instruction:	Indicate if cardiac magnetic resonance imaging (MRI) was performed.
Target Value:	The value on Follow-up
-	
Element: 14879	Cardiac MRI Date
	Indicate the date of the most recent cardiac magnetic resonance imaging (MRI).
-	The value on Follow-up
Vendor Instruction:	Cardiac MRI Date (14879) must be Greater than the Follow-Up Reference Procedure Start Date and Time (11001)
Element: 14880	Intracardiac Echo Performed
	Indicate if intracardiac echo (ICE) was performed.
Coding Instruction:	
Coding Instruction: Target Value:	The value on Follow-up
Coding Instruction: Target Value:	
Coding Instruction: Target Value:	The value on Follow-up Intracardiac three dimensional echocardiography





Element: 14831     Date of Intracactica Echo       Element: 14831     Value of Intracactica Echo       Supporting Definition:     Induste of Intracactica Echo       Supporting Definition:     Intracactica Echo (DE):       Coding Instruction:     Intracactica Echo (DE):       Supporting Definition:     Intracactica Echo (DE):       Substant All Promoting Definition:     Intracactica Echo (DE):       Supporting Definition:     Intracactica Echo (DE):       Substant All Promoting Definit	Section: Follow-Up	Parent: Root
Coding Instruction:       Indicate the date of the most record instruction instruction (DE):         Target Value:       The value on Follow-up         Supporting Definition:       Instruction is interaction of the date of the most record instruction of the instruction.         Supporting Definition:       Instruction:       Supporting Definition:         Element:       14882       Atrial Thrombus Detected         Coding Instruction:       Index in 5 and failed thrombus was detected.         Supporting Definition:       Index in 5 and failed thrombus was detected.         Supporting Definition:       Index in 5 and failed thrombus was detected.         Supporting Definition:       Index in 5 and failed thrombus was detected.         Supporting Definition:       Index in 5 and failed thrombus was detected.         Supporting Definition:       Index in 5 and failed thrombus was detected.         Supporting Definition:       Index in 5 and failed thrombus was detected.         Supporting Definition:       Index in 5 and failed thrombus was detected.         Supporting Definition:       Index in 5 and failed thrombus was detected.         Supporting Definition:       Index in 5 and failed thrombus was detected.         Supporting Definition:       Index in 5 and failed thrombus was detected.         Supporting Definition:       Index in 5 and failed thrombus was detected.         Sup		Echocardiography Into the ICE Age. Br J Cardiol. 2007;14(1):31-36.
Traget Value     The value on Follow-up       Supporting Dirithic     Intracadice chread display(VGE) is in insign exclusingly whilebe as an alternative to transcessphageal exclusion/graphy (VGE) is in insign exclusing processes.       Element: 1482     Atrial Thrombus Detected       Coding Instruction     Intracadice chread processes.       Supporting Dirithic     Intracadice chread processes.       Coding Instruction     Intracadice chread processes.       Coding Instruction     Intracadit lock at the dorice negring vase not assessed. <t< td=""><td>Element: 14881</td><td>Date of Intracardiac Echo</td></t<>	Element: 14881	Date of Intracardiac Echo
Traget Value     The value on Polices-up       Supporting Definition     Intracadice chreading apply (E.) is an ranging technical path and increasing) we allable as an alternative to transcessphageal encoundingapply to guide pinceture. Without Discussion       Element:     14882       Coding Instruction     Indicate if is all marging technical pinceture. We show the test is increasingly we allable as an alternative to transcessphageal encoundingaphly - Inno the ICE App. 5t J Cardiol. 2007(14)(1):1-35.       Element:     14882       Coding Instruction     Indicate if is all marging technical pinceture. We show the detecture surgesphageal pinceture. The value on Follow up       Supporting Definition     Artial Thrombus Detected       Surger:     Surger:       Coding Instruction     Indicate th a stallaul lask the device margin in milinteles (mn).       Target Value:     The value on Foliow-up       Element:     14885     Device Margin Residual Leak Not Assessed       Coding Instruction     Indicate th a stallaul lask the device margin in milinteles (mn).       Target Value:     The value on Foliow-up <td>Coding Instruction:</td> <td>Indicate the date of the most recent intracardiac echo (ICE).</td>	Coding Instruction:	Indicate the date of the most recent intracardiac echo (ICE).
Supporting Definition       Intracactical carbon discussional a chocardiography         Intracactical carbon discussional carbon discusional carbon discusin discussional discussional carbon discussion	-	
Interaction of the probability (CG) is an imaging unclosure to its increasingly would be as an adversative to insuccessphagead echacaciong apply to galar percultaments interventional proceedures.           Secure:::::::::::::::::::::::::::::::::::	-	
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Coding Instruction:       Indicate it a left atrial thrombus was detected.         Target Value:       The value on Follow-up         Supporting Definition:       Atrial Thrombus a considered to be definite if 3 of the following 5 criteria are present: Clear borders, achogenicity from the summaring simulane, independent mobily, Orgest demeter > 150m, seen in one Ethor and comprision of the thrombus a considered to be definite if 3 of the following 5 criteria are present: Clear borders, achogenicity from the summaring simulane, independent mobily, Orgest demeter > 150m, seen in anote throm etholocation of the cline of the Atria Atria at the device margin in millimeters (mm).         Element:       Coding Instruction:       Indicate the residual leak at the device margin in millimeters (mm).         Target Value:       The value on Follow-up         Element:       14886       Device Margin Residual Leak Not Assessed         Coding Instruction:       Indicate if the residual leak at the device margin was not assessed.         Target Value:       The value on Follow-up         Element:       14886       Creatinine         Coding Instruction:       Indicate the most recent creation in the kinety blood plasma, whereagon is a similared by glomerular filtration on a partial thubar exection. Cleatinine is a similared by glomerular filtration on an partial thubar exection. Cleatine is a most of creatine photophate in muscle. The loss of water modeule from creatine results in the value on Follow-up         Element:       14887       Creatinine       Creatinine is a most of creatine in thubar exe		Source: Mitchell ARJ, Puwanarajah P, Timperley J, Becher H, Wilson N, Ormero OJ. The Emerging Role of Intracardiac
Target Yeau       The value on Follow up         Supporting Definition       All TarGmbus Descence1         Surget Yeau       Presence of thermulas is constrained to a definite 13 of the following 5 criteria are present: Clear borders, edrogencier) from the sinumators (ACMH4HRS 2008 CACHAH4HRS 2008 CACHAHAHRS 2008 CACHAHRS 2008 CACHAHAHRS 2008 CACHAHRS 2008 CACH	Element: 14882	Atrial Thrombus Detected
Supporting Definition       Arial Trombus Detected         Supporting Definition       Support Definition       Suppor	Coding Instruction:	Indicate if a left atrial thrombus was detected.
Rement:     Presence of thrombus is considered to be definite if 3 of the following 5 oftenia may more han one obconding/applicipance.       Source:     Boorted, Calkins H, Callins DJ, et al. ACC/AHAHRS 2006 Key Data Benerss and Definitions for Electraphysiological Studies and Procodures. A Physiol of the Amrifeston Calling of Carlind Studies and Definitions for Electraphysiology). J Am Coll Carliol. 2005;48(11):2300-2386.       Element:     14884     Device Margin Residual Leak       Coding Instruction:     Indicate the readual leak at the device margin in millimeters (nm).       Target Value:     The value on Follow-up       Element:     14885     Device Margin Residual Leak Not Assessed       Coding Instruction:     Indicate the readual leak at the device margin was not assessed.       Target Value:     The value on Follow-up       Supporting Definition:     Creatinine       Coding Instruction:     Indicate the readual leak the device margin was not assessed.       Target Value:     The value on Follow-up       Supporting Definition:     Creatinine       Coding Instruction:     Indicate the most recent creatine (C) (level (mg/dL).       Target Value:     The value on Follow-up       Supporting Definition:     Creatinine or creatine antrydrifie, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine environment. Herefore and creatine and measure in the source margin is some Nove ID as simple text. And in the formation of creatine in therefolatin in the kindows, muscle, liver and pancees. <td>Target Value:</td> <td>The value on Follow-up</td>	Target Value:	The value on Follow-up
surounding structures, independent mobiley, longest diameter - tiorin, seen in more achocardiographic planel. Suroures: Waton AE. Cakins I, Calans D, et al. ACC/MAH-MES 2005 Key Data Elements and Definitors for Electrophysiology). J Am Coll Cardol. 2006;48(11):2360- 2396. Element: 14884 Device Margin Residual Leak Coding Instruction: Indicate the residual leak at the device margin in millimeters (nm). Target Value: The value on Fallow-up Coding Instruction: Indicate the residual leak Not Assessed Coding Instruction: Indicate the residual leak Not Assessed Coding Instruction: Indicate the residual leak Not Assessed Coding Instruction: Indicate the residual leak the device margin vas not assessed. Target Value: The value on Follow-up Element: 14886 Cereatinne Coding Instruction: Indicate if the residual leak at the device margin was not assessed. Target Value: The value on Follow-up Element: 14886 Cereatinne Coding Instruction: Indicate if the residual leak at the device margin vas not assessed. Target Value: The value on Follow-up Supporting Definition: Creatinine Creatinine Creatinine Creatinine Creatinine (Cr) level (mglcL). Target Value: The value on Follow-up Supporting Definition: Indicate if the creatinine (Cr) level (mglcL). Target Value: The value on Follow-up Supporting Definition: Indicate if the creatinine Lis tradedmin product of create phosphate in muscle. The loss of water molecule from ereatine results in the formation d'argeneration in the formation device in the value on Follow-up Element: 14887 Creatinine Not Drawn Element: 14887 Creatinine Not Drawn Element: 14887 Creatinine Creatine levels is and ordawn. Target Value: A value on Follow-up Supporting Definition: Is transchore to	Supporting Definition:	Atrial Thrombus Detected
Buildeis and Procedures: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Data Buildeis (CCC)HA/HRS Writing Committee to Develop Data Standards on Electrophysiology). J Am Coll Cardiol. 2006;48(11):2360- 2396.       Element: 14884     Device Margin Residual Leak       Coding Instruction:     Indicate the residual leak at the device margin in millimeters (nm).       Target Value:     The value on Follow-up       Element: 14885     Device Margin Residual Leak Not Assessed       Coding Instruction:     Indicate if the residual leak at the device margin was not assessed.       Target Value:     The value on Follow-up       Element: 14886     Creatinine       Coding Instruction:     Indicate if the residual leak at the device margin was not assessed.       Target Value:     The value on Follow-up       Element: 14886     Creatinine       Coding Instruction:     Indicate the most necent creatinine (Cr) level (mg/dL).       Target Value:     The value on Follow-up       Supporting Definition:     Creatinine       Coding Instruction:     Indicate the most necent creatinine (Cr) level (mg/dL).       Target Value:     The value on Follow-up       Supporting Definition:     Creatinine       Coding Instruction:     Indicate if the creatinine (Cr) level (mg/dL).       Target Value:     The value on Follow-up       Supporting Definition:     Creatinine       Cod		
Coding Instruction       Indicate the residual leak at the device margin in millimeters (mm).         Target Value       The value on Follow-up         Element:       14885       Device Margin Residual Leak Not Assessed         Coding Instruction       Indicate the residual leak at the device margin was not assessed.         Target Value       The value on Follow-up         Element:       14886       Creatinine         Coding Instruction       Indicate the most recent creatinine (Cr) level (mg/dL).         Target Value       The value on Follow-up         Supporting Definition       Creatinine         Creatinine       Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine require is observed only with marked damage to functioning methors. therefore this test is not suitable for detecting early kidney disease. Creatinine are metabolized in the kidneys, muscle, liver and pancreas.         Source:       Intp://s.details.loinc.org/L.OINC/2160-0.htm?sections=Simple         Element:       14887       Creatinine or creatine enhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine and restinine are metabolized in the kidneys, muscle, liver and pancreas.         Source:       Intp://s.details.loinc.org/L.OINC/2160-0.htm?sections=Simple         Element:       14887       Creatinine or creatine enhydride, is a breakdown product of creatine phosphate in muscle. The loss of wate		Studies and Procedures: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Data Standards (ACC/AHA/HRS Writing Committee to Develop Data Standards on Electrophysiology). J Am Coll Cardiol. 2006;48(11):2360-
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Element: 14885       Device Margin Residual Leak Not Assessed         Coding Instruction:       Indicate if the residual leak at the device margin was not assessed.         Target Value:       The value on Follow-up         Element: 14886       Creatinine         Coding Instruction:       Indicate the most recent creation (Cr) level (mg/dL).         Target Value:       The value on Follow-up         Supporting Definition:       Creatinine         Creatinine or creatine antydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine and partial tubular exercisito. Creatinine is usually produced at a fainty constant rate and measuring its serum level is a simple test. A ris in blood creatine levels is observed only with marked damage to functioning rate and measuring its serum level is a simple test. A ris in blood creatine levels is observed only with marked damage to functioning rate and measuring its serum level is a simple test. A ris in blood creatine level is a some only with marked damage to functioning rate and measuring its serum level is a simple test. A ris in blood creatine level is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine and results in the formation of creatinine and creatine and results in the kineys, muscle, liver and parcteas.         Source:       http://s.details.loin.or.org/LOINC/2160-0.html?section=Simple         Element: 14887       Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine results in the formation of creatinine is usually produced at a fainy constant rate and measuring	Coding Instruction:	Indicate the residual leak at the device margin in millimeters (mm).
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Element: 14887       Creatinine Not Drawn         Coding Instruction:       Indicate if the creatinine level was not drawn.         Target Value:       The value on Follow-up         Supporting Definition:       Creatinine         Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine results in the formation of creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A ris in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver and pancreas.         Source:       http://s.details.loinc.org/LOINC/2160-0.html?sections=Simple         Element: 14888       Lowest Hemoglobin Value         Coding Instruction:       Indicate the lowest hemoglobin (Hgb) value (g/dL), obtained via lab assay or point of care assay, after discharge if 45 day follow up; or the lowest value between the prior follow up visit and current follow up visit for any follow up after the 45 day follow up.		results in the formation of creatinine. It is transferred to the kidneys by blood plasma, whereupon it is eliminated by glomerular filtration and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A ris in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting
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Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine results in the formation of creatinine. It is transferred to the kidneys by blood plasma, whereupon it is eliminated by glomerular filtration and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A rise in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver and pancreas.         Source:       http://s.details.loinc.org/LOINC/2160-0.html?sections=Simple         Element: 14888       Lowest Hemoglobin Value         Red the lowest hemoglobin (Hgb) value (g/dL), obtained via lab assay or point of care assay, after discharge if 45 day follow up; or the lowest value between the prior follow up visit and current follow up visit for any follow up after the 45 day follow up.	Target Value:	The value on Follow-up
results in the formation of creatinine. It is transferred to the kidneys by blood plasma, whereupon it is eliminated by glomerular filtration and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A rise in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver and pancreas.         Source:       http://s.details.loinc.org/LOINC/2160-0.html?sections=Simple         Element: 14888       Lowest Hemoglobin Value         Indicate the lowest hemoglobin (Hgb) value (g/dL), obtained via lab assay or point of care assay, after discharge if 45 day follow up; or the lowest value between the prior follow up visit and current follow up visit for any follow up after the 45 day follow up.	Supporting Definition:	Creatinine
Coding Instruction: Indicate the lowest hemoglobin (Hgb) value (g/dL), obtained via lab assay or point of care assay, after discharge if 45 day follow up; o the lowest value between the prior follow up visit and current follow up visit for any follow up after the 45 day follow up.		results in the formation of creatinine. It is transferred to the kidneys by blood plasma, whereupon it is eliminated by glomerular filtration and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A ris in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver and pancreas.
the lowest value between the prior follow up visit and current follow up visit for any follow up after the 45 day follow up.	Element: 14888	Lowest Hemoglobin Value
	Coding Instruction:	Indicate the lowest hemoglobin (Hgb) value (g/dL), obtained via lab assay or point of care assay, after discharge if 45 day follow up; or
	Target Value:	





Section: Follow-Up	Parent: Root
Supporting Definition:	Hemoglobin
	Hemoglobin (Hb or Hgb) is the iron-containing oxygen-transport metalloprotein in the red blood cells. It carries oxygen from the lungs to the rest of the body (i.e. the tissues) where it releases the oxygen to burn nutrients and provide energy. Hemoglobin concentration measurement is among the most commonly performed blood tests, usually as part of a complete blood count. If the concentration is below normal, this is called anemia. Anemias are classified by the size of red blood cells: "microcytic" if red cells are small, "macrocytic" if they are large, and "normocytic" if otherwise. Dehydration or hyperhydration can greatly influence measured hemoglobin levels.
	Source: http://s.details.loinc.org/LOINC/718-7.html?sections=Simple
Element: 14889	Hemoglobin Not Drawn
Coding Instruction:	Indicate if the hemoglobin was not drawn.
Target Value:	The value on Follow-up
Supporting Definition:	Hemoglobin
	Hemoglobin (Hb or Hgb) is the iron-containing oxygen-transport metalloprotein in the red blood cells. It carries oxygen from the lungs to the rest of the body (i.e. the tissues) where it releases the oxygen to burn nutrients and provide energy. Hemoglobin concentration measurement is among the most commonly performed blood tests, usually as part of a complete blood count. If the concentration is below normal, this is called anemia. Anemias are classified by the size of red blood cells: "microcytic" if red cells are small, "macrocytic" if they are large, and "normocytic" if otherwise. Dehydration or hyperhydration can greatly influence measured hemoglobin levels.
	Source: http://s.details.loinc.org/LOINC/718-7.html?sections=Simple
Element: 13148	Modified Rankin Scale Score
Coding Instruction:	Indicate the Modified Rankin Scale score.
Target Value:	The value on Follow-up
Supporting Definition:	Modified Rankin Scale
	The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability. <b>Source:</b> Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.
	Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.

#### Rankin Scale Assessment Finding - 1.3.6.1.4.1.19376.1.4.1.6.5.139

Selection	Definition	Source Code	Code System
0: No symptoms at all		LA6111-4	LOING
1: No significant disability despite symptoms	Able to carry ou	t all usual duties and activities. LA6112-2	LOING
2: Slight disability	,	out all previous activities, but able to LA6113-0	LOING
	look after own	affairs without assistance.	
3: Moderate disability	Requiring some assistance.	help, but able to walk without LA6114-8	LOINC
4: Moderately severe disability		without assistance and unable to attend LA6115-5 eeds without assistance.	LOINC
5: Severe disability	Bedridden, inco care and attenti	ntinent and requiring constant nursing LA10137-0 on.	LOINC
6: Death		419620001	SNOMED CT
Element: 14890		Modified Rankin Scale Not Administered	
Codir	ng Instruction:	Indicate if the Modified Rankin Scale was not administered at follow-up.	
	Target Value:	The value on Follow-up	
Support	-	The value on Follow-up Modified Rankin Scale	
Support	-		le of global disability.
Support	-	Modified Rankin Scale	ıle of global disability.
Support	-	Modified Rankin Scale The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sca	о́,
	-	Modified Rankin Scale The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sca Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.	о́,
<b>Element:</b> 14891	ting Definition:	Modified Rankin Scale The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sca Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15. Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12)	:1497-1500.
<b>Element:</b> 14891	ng Instruction:	Modified Rankin Scale The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sca Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15. Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12) Barthel Index Evaluation Performed Indicate if the Barthel Index Evaluation was performed. The Barthel Index (BI) or Barthel ADL index is a scale used	:1497-1500.
Element: 14891 Codir	ng Instruction:	Modified Rankin Scale The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sca Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15. Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12) Barthel Index Evaluation Performed Indicate if the Barthel Index Evaluation was performed. The Barthel Index (BI) or Barthel ADL index is a scale used performance in basic activities of daily living (ADL). The value on Follow-up	:1497-1500.
Element: 14891 Codir	ng Instruction: Target Value:	Modified Rankin Scale The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sca Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15. Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12) Barthel Index Evaluation Performed Indicate if the Barthel Index Evaluation was performed. The Barthel Index (BI) or Barthel ADL index is a scale used performance in basic activities of daily living (ADL). The value on Follow-up	:1497-1500.
Element: 14891 Codir	ng Instruction: Target Value:	Modified Rankin Scale The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sca Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15. Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12) Barthel Index Evaluation Performed Indicate if the Barthel Index Evaluation was performed. The Barthel Index (BI) or Barthel ADL index is a scale used performance in basic activities of daily living (ADL). The value on Follow-up Barthel Index	:1497-1500.





Section: Follow-Up			Parent: Root		
Element: 14892		Feeding			
Coding Instruction:		Choose the scoring point for the statement that most closely corresponds to the patient's current level of ability. Record actual, not potential, functioning. Information can be obtained from the patient's self-report, from a separate party who is familiar with the patient's abilities (such as a relative), or from observation.			
	Target Value:	The value on Follow-up			
Supporti	ing Definition:	Barthel Index Element			
		Copyright Notice: Used with permission	n.		
		Source: Mahonev FI, Barthel D, "Fur	nctional evaluation: the Barthel Index." Maryland State Med	Journal 1965:14:56-	61.
				,,	
Functional Ability - 1.3.6.1.4.1		5.801			
Selection	Definition		Source	Code	Code Systen
Unable	Complete assis	t for feeding required.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	289001005	SNOMED C
Needs Help		ecessary (with cutting up food, use salt read butter, etc).	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165223004	SNOMED C
Independent	table when som must be able to	neone puts the food within reach. They ocut up the food, use salt and pepper, etc. The patient must accomplish this in	Barthel Index." Maryland State Med Journal 1965;14:56-	165224005	SNOMED C
Dependent	Patient requires	s assistance for bathing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129043005	SNOMED C
Independent		e a bath tub, a shower, or take a ge bath. They must be able to do all the	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-	129041007	SNOMED C

	must be able to cut up the food, use salt and pepper, spread butter, etc. The patient must accomplish this in a reasonable time.			
Dependent	Patient requires assistance for bathing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129043005	SNOMED CT
Independent	Patient may use a bath tub, a shower, or take a complete sponge bath. They must be able to do all the steps involved in whichever method is employed without another person being present.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129041007	SNOMED CT
Needs Help	Patient needs assistance with any aspect of grooming	. Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704440004	SNOMED CT
Independent	Patient can wash hands and face, comb hair, clean teeth, and shave. They may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style hair.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704437004	SNOMED CT
Dependent	Patient is unable to assist with any dressing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129065005	SNOMED CT
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the work themselves. They must accomplish this in a reasonable time. Women need not be scored on use o a brassiere or girdle unless these are prescribed garments.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61. f	129039006	SNOMED CT
Independent	Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces wher these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	29035000	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	72042002	SNOMED CT
Inconsistent	Patient needs help in using a suppository or taking an enema or has occasional accidents.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165230005	SNOMED CT
Continent	Patient is able to control bowels and has no accidents. They can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).	Barthel Index." Maryland State Med Journal 1965;14:56-	24029004	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165232002	SNOMED CT
Inconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165233007	SNOMED CT
Continent	Patient is able to control his bladder day and night.	Mahoney FI, Barthel D. "Functional evaluation: the	165234001	SNOMED CT





Continue Collow			Devent: Deet		
Section: Follow			Parent: Root		
	device and leg l	rry patients who wear an external bag must put them on independently, y bag, and stay dry day and night.	Barthel Index." Maryland State Med Journal 1965;14:56- 61.		
Dependent		s full assistance.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129078005	SNOMED CT
Needs Help	Patient needs h clothes or in us		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165241007	SNOMED CT
Independent	unfasten clothe toilet paper with other stable obj necessary to us	o get on and off toilet, fasten and s, prevent soiling of clothes, and use nout help. They may use a wall bar or lect for support if needed. If it is se a bed pan instead of a toilet, they place it on a chair, empty it, and clean	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129062008	SNOMED CT
Unable		le to assist with any transfer.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	733744002	SNOMED CT
Major Assist Needed	a second perso		f Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002154	ACC NCDR
Minor Assist Needed	activity or the pa	nimal help is needed in some step of this atient needs to be reminded or safety of one or more parts of this	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002155	ACC NCDR
Independent	safely approact lift footrests, mo sitting position o position of the	all phases of this activity. Patient can h the bed in his wheelchair, lock brakes, ove safely to bed, lie down, come to a on the side of the bed, change the wheelchair, if necessary, to transfer ely, and return to the wheelchair.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	714915006	SNOMED CT
Immobile	Patient is immob	vile.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000001492	ACC NCDR
Wheelchair	wheelchair inde around corners table, bed, toile	t, etc. They must be able to push a chair s. Do not score this item if the patient	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165243005	SNOMED CT
One Person Assist	Patient needs h	least 50 yards with a little help.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	707739007	SNOMED CT
Independent	supervision. Th use crutches, c walker. They m used, assume t the necessary r and dispose of	k at least 50 yards without help or ey may wear braces or prostheses and anes, or a walkerette but not a rolling ust be able to lock and unlock braces if he standing position and sit down, get nechanical aides into position for use, them when he sits. (Putting on and s is scored under dressing.)	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	302042005	SNOMED CT
Unable	Patient is unabl		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	301589003	SNOMED CT
Needs Help	Patient needs h down stairs sa	elp with or supervision to go up or fely.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165248001	SNOMED CT
Independent	safely without h should use han needed. They r	o go up and down a flight of stairs lelp or supervision. They may and drails, canes, or crutches when nust be able to carry canes or crutches or descend stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165249009	SNOMED CT
Element: 14893		Bathing			
	Coding Instruction:		nent that most closely corresponds to the patient's current be obtained from the patient's self-report, from a separat oservation.		
	Target Value:	The value on Follow-up			
\$	Supporting Definition:	Barthel Index Element Copyright Notice: Used with permission			
		Source: Mahoney FI, Barthel D. "Fun	ctional evaluation: the Barthel Index." Maryland State Me	d Journal 1965;14:56-6	1.
				Effective for Patient	Discharged October 01





# Section: Follow-Up

# Parent: Root

Selection	Definition	Source	Code	Code System
Unable	Complete assist for feeding required.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	289001005	SNOMED CT
Needs Help	Some help is necessary (with cutting up food, use salt and pepper, spread butter, etc).	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165223004	SNOMED CT
Independent	The patient can feed themselves a meal from a tray or table when someone puts the food within reach. They must be able to cut up the food, use salt and pepper, spread butter, etc. The patient must accomplish this in a reasonable time.	Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165224005	SNOMED CT
Dependent	Patient requires assistance for bathing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129043005	SNOMED CT
Independent	Patient may use a bath tub, a shower, or take a complete sponge bath. They must be able to do all the steps involved in whichever method is employed without another person being present.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129041007	SNOMED CT
Needs Help	Patient needs assistance with any aspect of grooming	. Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704440004	SNOMED CT
Independent	Patient can wash hands and face, comb hair, clean teeth, and shave. They may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style hair.		704437004	SNOMED CT
Dependent	Patient is unable to assist with any dressing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129065005	SNOMED CT
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the work themselves. They must accomplish this in a reasonable time. Women need not be scored on use of a brassiere or girdle unless these are prescribed garments.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129039006	SNOMED CT
Independent	Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	29035000	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	72042002	SNOMED CT
Inconsistent	Patient needs help in using a suppository or taking an enema or has occasional accidents.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165230005	SNOMED CT
Continent	Patient is able to control bowels and has no accidents. They can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).	Barthel Index." Maryland State Med Journal 1965;14:56-	24029004	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165232002	SNOMED CT
Inconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165233007	SNOMED CT
Continent	Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165234001	SNOMED CT
Dependent	Patient requires full assistance.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129078005	SNOMED CT
Needs Help	Patient needs help because of imbalance or in handling clothes or in using toilet paper.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165241007	SNOMED CT
Independent	Patient is able to get on and off toilet, fasten and unfasten clothes, prevent soiling of clothes, and use toilet paper without help. They may use a wall bar or	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129062008	SNOMED CT





Section: Follow-Up			Parent: Root		
	other stable object for suppo necessary to use a bed pan i must be able to place it on a o it.	instead of a toilet, they			
Unable	Patient is unable to assist wi	th any transfer.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	733744002	SNOMED C
Major Assist Needed		o be lifted out of bed, or if	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-61.	112000002154	ACC NCDF
Minor Assist Needed		eeded in some step of this o be reminded or	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002155	ACC NCDF
Independent	Independent in all phases of safely approach the bed in h lift footrests, move safely to b sitting position on the side of position of the wheelchair, if back into it safely, and return	is wheelchair, lock brakes bed, lie down, come to a the bed, change the necessary, to transfer	Mahoney FI, Barthel D. "Functional evaluation: the , Barthel Index." Maryland State Med Journal 1965;14:56- 61.	714915006	SNOMED C
Immobile	Patient is immobile.		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000001492	ACC NCDF
Wheelchair	If a patient cannot ambulate b wheelchair independently. Th around corners, turn around, table, bed, toilet, etc. They m at least 50 yards. Do not scor gets score for walking	ney must be able to go maneuver the chair to a ust be able to push a chair	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165243005	SNOMED CT
One Person Assist	Patient needs help or superv but can walk at least 50 yard		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	707739007	SNOMED C
Independent	Patient can walk at least 50 y supervision. They may wear use crutches, canes, or a wa walker. They must be able to used, assume the standing p the necessary mechanical ai and dispose of them when he taking off braces is scored u	braces or prostheses and alkerette but not a rolling lock and unlock braces if position and sit down, get des into position for use, e sits. (Putting on and	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	302042005	SNOMED CT
Unable	Patient is unable to use stairs	5.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	301589003	SNOMED CT
Needs Help	Patient needs help with or su down stairs safely.	pervision to go up or	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165248001	SNOMED CT
Independent	Patient is able to go up and c safely without help or superv should use handrails, canes needed. They must be able t as they ascend or descend s	rision. They may and , or crutches when to carry canes or crutches	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165249009	SNOMED CT
Element: 14894	Grooming				
С	potential, fur		nent that most closely corresponds to the patient's curren be obtained from the patient's self-report, from a separate oservation.		
	Target Value: The value or	n Follow-up			
Sup	oorting Definition: Barthel Ind	ex Element			
	-	otice: Used with permission	n.		
	Source: M	lahoney FI, Barthel D. "Fur	nctional evaluation: the Barthel Index." Maryland State Med	l Journal 1965;14:56-61.	
Functional Ability - 1.3.6.	1.4.1.19376.1.4.1.6.5.801				
Selection	Definition		Source	Code	Code System
Unable	Complete assist for feeding r	equired.	Mahoney FI, Barthel D. "Functional evaluation: the	289001005	SNOMED CT

Unable	Complete assist for feeding required.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	289001005	SNOMED CT
Needs Help	Some help is necessary (with cutting up food, use sall and pepper, spread butter, etc).	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165223004	SNOMED CT
Independent	The patient can feed themselves a meal from a tray or table when someone puts the food within reach. They must be able to cut up the food, use salt and pepper,	Barthel Index." Maryland State Med Journal 1965;14:56-	165224005	SNOMED CT





Section: Follow-Up		Parent: Root		
	spread butter, etc. The patient must accomplish this in a reasonable time.			
Dependent	Patient requires assistance for bathing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129043005	SNOMED CT
Independent	Patient may use a bath tub, a shower, or take a complete sponge bath. They must be able to do all the steps involved in whichever method is employed without another person being present.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129041007	SNOMED CT
Needs Help	Patient needs assistance with any aspect of grooming.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704440004	SNOMED CT
Independent	Patient can wash hands and face, comb hair, clean teeth, and shave. They may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style hair.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704437004	SNOMED CT
Dependent	Patient is unable to assist with any dressing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129065005	SNOMED CT
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the work themselves. They must accomplish this in a reasonable time. Women need not be scored on use of a brassiere or girdle unless these are prescribed garments.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129039006	SNOMED CT
Independent	Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	29035000	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	72042002	SNOMED CT
Inconsistent	Patient needs help in using a suppository or taking an enema or has occasional accidents.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165230005	SNOMED CT
Continent	Patient is able to control bowels and has no accidents. They can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).	Barthel Index." Maryland State Med Journal 1965;14:56	24029004	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165232002	SNOMED CT
Inconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165233007	SNOMED CT
Continent	Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165234001	SNOMED CT
Dependent	Patient requires full assistance.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129078005	SNOMED CT
Needs Help	Patient needs help because of imbalance or in handling clothes or in using toilet paper.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165241007	SNOMED CT
Independent	Patient is able to get on and off toilet, fasten and unfasten clothes, prevent soiling of clothes, and use toilet paper without help. They may use a wall bar or other stable object for support if needed. If it is necessary to use a bed pan instead of a toilet, they must be able to place it on a chair, empty it, and clean it.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129062008	SNOMED CT
Unable	Patient is unable to assist with any transfer.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	733744002	SNOMED CT
Major Assist Needed	Patient can come to a sitting position without the help o a second person but needs to be lifted out of bed, or if they transfer with a great deal of help.		112000002154	ACC NCDR
Minor Assist Needed	Either some minimal help is needed in some step of this	Mahoney FI, Barthel D. "Functional evaluation: the	112000002155	ACC NCDR





Section: Follow-	Up		Parent: Root		
	•	atient needs to be reminded or safety of one or more parts of this	Barthel Index." Maryland State Med Journal 1965;14:56- 61.		
Independent	safely approach lift footrests, mo sitting position o position of the v	all phases of this activity. Patient can on the bed in his wheelchair, lock brakes have safely to bed, lie down, come to a son the side of the bed, change the wheelchair, if necessary, to transfer ally, and return to the wheelchair.	Mahoney FI, Barthel D. "Functional evaluation: the , Barthel Index." Maryland State Med Journal 1965;14:56- 61.	714915006	SNOMED CT
Immobile	Patient is immob	ile.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000001492	ACC NCDR
Wheelchair	wheelchair inde around corners table, bed, toilet	ot ambulate but can propel a pendently. They must be able to go turn around, maneuver the chair to a , etc. They must be able to push a chair s. Do not score this item if the patient valking		165243005	SNOMED CT
One Person Assist	Patient needs h	elp or supervision in any of the above least 50 yards with a little help.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	707739007	SNOMED CT
Independent	supervision. Th use crutches, c walker. They m used, assume t the necessary r and dispose of	k at least 50 yards without help or ey may wear braces or prostheses and anes, or a walkerette but not a rolling ust be able to lock and unlock braces if he standing position and sit down, get nechanical aides into position for use, hem when he sits. (Putting on and s is scored under dressing.)	Mahoney FI, Barthel D. "Functional evaluation: the d Barthel Index." Maryland State Med Journal 1965;14:56- 61	302042005	SNOMED CT
Unable	Patient is unable		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	301589003	SNOMED CT
Needs Help	Patient needs h down stairs saf	elp with or supervision to go up or ely.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165248001	SNOMED CT
Independent	safely without h should use han needed. They n	o go up and down a flight of stairs elp or supervision. They may and drails, canes, or crutches when nust be able to carry canes or crutches or descend stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165249009	SNOMED CT
Element: 14895		Dressing			
	Coding Instruction:		nent that most closely corresponds to the patient's curren be obtained from the patient's self-report, from a separate oservation.		
	Target Value:	The value on Follow-up			
S	upporting Definition:	Barthel Index Element			
		Copyright Notice: Used with permission	n.		
			nctional evaluation: the Barthel Index." Maryland State Mec	d Journal 1965;14:56-6	1.
	3.6.1.4.1.19376.1.4.1.6.5 Definition	5.801	Source	Code	Code Sustem
Selection Unable		t for feeding required.	Source Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	289001005	Code System SNOMED CT

		01.		
Needs Help	Some help is necessary (with cutting up food, use salt and pepper, spread butter, etc).	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165223004	SNOMED CT
Independent	The patient can feed themselves a meal from a tray or table when someone puts the food within reach. They must be able to cut up the food, use salt and pepper, spread butter, etc. The patient must accomplish this in a reasonable time.	Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165224005	SNOMED CT
Dependent	Patient requires assistance for bathing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129043005	SNOMED CT
Independent	Patient may use a bath tub, a shower, or take a complete sponge bath. They must be able to do all the steps involved in whichever method is employed without another person being present.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129041007	SNOMED CT
Needs Help	Patient needs assistance with any aspect of grooming	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-	704440004	SNOMED CT





Section: Follow-Up		Parent: Root		
Independent	Patient can wash hands and face, comb hair, clean teeth, and shave. They may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style hair.	61. Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704437004	SNOMED C
Dependent	Patient is unable to assist with any dressing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129065005	SNOMED CT
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the work themselves. They must accomplish this in a reasonable time. Women need not be scored on use of a brassiere or girdle unless these are prescribed garments.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129039006	SNOMED C1
Independent	Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	29035000	SNOMED C1
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	72042002	SNOMED CT
Inconsistent	Patient needs help in using a suppository or taking an enema or has occasional accidents.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165230005	SNOMED CT
Continent	Patient is able to control bowels and has no accidents. They can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).	Barthel Index." Maryland State Med Journal 1965;14:56-	24029004	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165232002	SNOMED CT
Inconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165233007	SNOMED CT
Continent	Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165234001	SNOMED CT
Dependent	Patient requires full assistance.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129078005	SNOMED CT
Needs Help	Patient needs help because of imbalance or in handling clothes or in using toilet paper.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165241007	SNOMED CT
Independent	Patient is able to get on and off toilet, fasten and unfasten clothes, prevent soiling of clothes, and use toilet paper without help. They may use a wall bar or other stable object for support if needed. If it is necessary to use a bed pan instead of a toilet, they must be able to place it on a chair, empty it, and clean it.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129062008	SNOMED CT
Unable	Patient is unable to assist with any transfer.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	733744002	SNOMED CT
Major Assist Needed	Patient can come to a sitting position without the help o a second person but needs to be lifted out of bed, or if they transfer with a great deal of help.	f Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002154	ACC NCDR
Minor Assist Needed	Either some minimal help is needed in some step of this activity or the patient needs to be reminded or supervised for safety of one or more parts of this activity.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002155	ACC NCDR
Independent	Independent in all phases of this activity. Patient can safely approach the bed in his wheelchair, lock brakes lift footrests, move safely to bed, lie down, come to a sitting position on the side of the bed, change the position of the wheelchair, if necessary, to transfer back into it safely, and return to the wheelchair.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	714915006	SNOMED CT
Immobile	Patient is immobile.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000001492	ACC NCDR





Section: Follow-Up		Parent: Root		
Wheelchair	If a patient cannot ambulate but can propel a wheelchair independently. They must be able to go around corners, turn around, maneuver the chair to a table, bed, toilet, etc. They must be able to push a chair at least 50 yards. Do not score this item if the patient gets score for walking		165243005	SNOMED CT
One Person Assist	Patient needs help or supervision in any of the above but can walk at least 50 yards with a little help.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	707739007	SNOMED CT
Independent	Patient can walk at least 50 yards without help or supervision. They may wear braces or prostheses and use crutches, canes, or a walkerette but not a rolling walker. They must be able to lock and unlock braces if used, assume the standing position and sit down, get the necessary mechanical aides into position for use, and dispose of them when he sits. (Putting on and taking off braces is scored under dressing.)	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	302042005	SNOMED CT
Unable	Patient is unable to use stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	301589003	SNOMED CT
Needs Help	Patient needs help with or supervision to go up or down stairs safely.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165248001	SNOMED CT
Independent	Patient is able to go up and down a flight of stairs safely without help or supervision. They may and should use handrails, canes, or crutches when needed. They must be able to carry canes or crutches as they ascend or descend stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165249009	SNOMED CT
Element: 14896	Bowels			

**Coding Instruction:** Choose the scoring point for the statement that most closely corresponds to the patient's current level of ability. Record actual, not potential, functioning. Information can be obtained from the patient's self-report, from a separate party who is familiar with the patient's abilities (such as a relative), or from observation.

Target Value: The value on Follow-up

### Supporting Definition: Barthel Index Element

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Source: Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-61.

Selection	Definition	Source	Code	Code System
Unable	Complete assist for feeding required.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	289001005	SNOMED CT
Needs Help	Some help is necessary (with cutting up food, use salt and pepper, spread butter, etc).	t Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165223004	SNOMED CT
Independent	The patient can feed themselves a meal from a tray or Mahoney FI, Barthel D. "Functional evaluation: the table when someone puts the food within reach. They Barthel Index." Maryland State Med Journal 1965;14:8 must be able to cut up the food, use salt and pepper, 61. spread butter, etc. The patient must accomplish this in a reasonable time.		165224005	SNOMED CT
Dependent	Patient requires assistance for bathing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129043005	SNOMED CT
Independent	Patient may use a bath tub, a shower, or take a complete sponge bath. They must be able to do all the steps involved in whichever method is employed without another person being present.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129041007	SNOMED CT
Needs Help	Patient needs assistance with any aspect of grooming	. Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704440004	SNOMED CT
Independent	Patient can wash hands and face, comb hair, clean teeth, and shave. They may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style hair.		704437004	SNOMED CT
Dependent	Patient is unable to assist with any dressing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129065005	SNOMED CT
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-	129039006	SNOMED CT
			Effective for Detion	Discharged October 01





Section: Follow-Up		Parent: Root		
	work themselves. They must accomplish this in a reasonable time. Women need not be scored on use of a brassiere or girdle unless these are prescribed garments.	61.		
ndependent	Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	29035000	SNOMED C
ncontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	72042002	SNOMED CT
nconsistent	Patient needs help in using a suppository or taking an enema or has occasional accidents.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165230005	SNOMED CT
Continent	Patient is able to control bowels and has no accidents. They can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-	24029004	SNOMED CT
ncontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165232002	SNOMED CT
Inconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165233007	SNOMED CT
Continent	Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165234001	SNOMED CT
Dependent	Patient requires full assistance.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-61.	129078005	SNOMED CT
Needs Help	Patient needs help because of imbalance or in handling clothes or in using toilet paper.		165241007	SNOMED CT
Independent	Patient is able to get on and off toilet, fasten and unfasten clothes, prevent soiling of clothes, and use toilet paper without help. They may use a wall bar or other stable object for support if needed. If it is necessary to use a bed pan instead of a toilet, they must be able to place it on a chair, empty it, and clean it.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129062008	SNOMED CT
Unable	Patient is unable to assist with any transfer.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	733744002	SNOMED CT
Major Assist Needed	Patient can come to a sitting position without the help of a second person but needs to be lifted out of bed, or if they transfer with a great deal of help.		112000002154	ACC NCDR
Minor Assist Needed	Either some minimal help is needed in some step of this activity or the patient needs to be reminded or supervised for safety of one or more parts of this activity.		112000002155	ACC NCDR
ndependent	Independent in all phases of this activity. Patient can safely approach the bed in his wheelchair, lock brakes, lift footrests, move safely to bed, lie down, come to a sitting position on the side of the bed, change the position of the wheelchair, if necessary, to transfer back into it safely, and return to the wheelchair.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	714915006	SNOMED CT
mmobile	Patient is immobile.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-61.	112000001492	ACC NCDR
Wheelchair	If a patient cannot ambulate but can propel a wheelchair independently. They must be able to go around corners, turn around, maneuver the chair to a table, bed, toilet, etc. They must be able to push a chair at least 50 yards. Do not score this item if the patient gets score for walking	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165243005	SNOMED CT
One Person Assist	Patient needs help or supervision in any of the above but can walk at least 50 yards with a little help.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	707739007	SNOMED CT
Independent	Patient can walk at least 50 yards without help or supervision. They may wear braces or prostheses and	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-	302042005	SNOMED CT





Section: Follow-Up		Parent: Root		
	use crutches, canes, or a walkerette but not a rolling walker. They must be able to lock and unlock braces if used, assume the standing position and sit down, get the necessary mechanical aides into position for use, and dispose of them when he sits. (Putting on and taking off braces is scored under dressing.)	61		
Unable	Patient is unable to use stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	301589003	SNOMED CT
Needs Help	Patient needs help with or supervision to go up or down stairs safely.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165248001	SNOMED CT
Independent	Patient is able to go up and down a flight of stairs safely without help or supervision. They may and should use handrails, canes, or crutches when needed. They must be able to carry canes or crutches as they ascend or descend stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165249009	SNOMED CT
Element: 14897	Bladder			

**Coding Instruction:** Choose the scoring point for the statement that most closely corresponds to the patient's current level of ability. Record actual, not potential, functioning. Information can be obtained from the patient's self-report, from a separate party who is familiar with the patient's abilities (such as a relative), or from observation.

Target Value: The value on Follow-up

Supporting Definition: Barthel Index Element

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Source: Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-61.

#### Functional Ability - 1.3.6.1.4.1.19376.1.4.1.6.5.801

Selection	Definition	Source	Code	Code System
Unable	Complete assist for feeding required.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	289001005	SNOMED CT
Needs Help	Some help is necessary (with cutting up food, use salt and pepper, spread butter, etc).	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165223004	SNOMED CT
Independent	The patient can feed themselves a meal from a tray or Mahoney FI, Barthel D. "Functional evaluation: the table when someone puts the food within reach. They Barthel Index." Maryland State Med Journal 1965;14:56- must be able to cut up the food, use salt and pepper, 61. spread butter, etc. The patient must accomplish this in a reasonable time.		165224005	SNOMED CT
Dependent	Patient requires assistance for bathing. Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.		129043005	SNOMED CT
Independent	Patient may use a bath tub, a shower, or take a complete sponge bath. They must be able to do all the steps involved in whichever method is employed without another person being present. Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14 61.		129041007	SNOMED CT
Needs Help	Patient needs assistance with any aspect of grooming	. Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704440004	SNOMED CT
Independent	Patient can wash hands and face, comb hair, clean teeth, and shave. They may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style hair.		704437004	SNOMED CT
Dependent	Patient is unable to assist with any dressing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129065005	SNOMED CT
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the work themselves. They must accomplish this in a reasonable time. Women need not be scored on use of a brassiere or girdle unless these are prescribed garments.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61. f	129039006	SNOMED CT
Independent	Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.		29035000	SNOMED CT





Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-61.	72042002	SNOMED CT
Inconsistent	Patient needs help in using a suppository or taking an enema or has occasional accidents.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165230005	SNOMED CT
Continent	Patient is able to control bowels and has no accidents. They can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).	Barthel Index." Maryland State Med Journal 1965;14:56-	24029004	SNOMED CT
ncontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165232002	SNOMED CT
nconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165233007	SNOMED CT
Continent	Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165234001	SNOMED CT
Dependent	Patient requires full assistance.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129078005	SNOMED CT
Needs Help	Patient needs help because of imbalance or in handling clothes or in using toilet paper.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165241007	SNOMED CT
Independent	Patient is able to get on and off toilet, fasten and unfasten clothes, prevent soiling of clothes, and use toilet paper without help. They may use a wall bar or other stable object for support if needed. If it is necessary to use a bed pan instead of a toilet, they must be able to place it on a chair, empty it, and clean it.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129062008	SNOMED CT
Unable	Patient is unable to assist with any transfer.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	733744002	SNOMED CT
Major Assist Needed	Patient can come to a sitting position without the help of a second person but needs to be lifted out of bed, or if they transfer with a great deal of help.	f Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002154	ACC NCDR
Minor Assist Needed	Either some minimal help is needed in some step of this activity or the patient needs to be reminded or supervised for safety of one or more parts of this activity.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002155	ACC NCDR
Independent	Independent in all phases of this activity. Patient can safely approach the bed in his wheelchair, lock brakes, lift footrests, move safely to bed, lie down, come to a sitting position on the side of the bed, change the position of the wheelchair, if necessary, to transfer back into it safely, and return to the wheelchair.	Mahoney FI, Barthel D. "Functional evaluation: the , Barthel Index." Maryland State Med Journal 1965;14:56- 61.	714915006	SNOMED CT
Immobile	Patient is immobile.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000001492	ACC NCDR
Wheelchair	If a patient cannot ambulate but can propel a wheelchair independently. They must be able to go around corners, turn around, maneuver the chair to a table, bed, toilet, etc. They must be able to push a chair at least 50 yards. Do not score this item if the patient gets score for walking		165243005	SNOMED CT
One Person Assist	Patient needs help or supervision in any of the above but can walk at least 50 yards with a little help.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	707739007	SNOMED CT
Independent	Patient can walk at least 50 yards without help or supervision. They may wear braces or prostheses and use crutches, canes, or a walkerette but not a rolling walker. They must be able to lock and unlock braces if used, assume the standing position and sit down, get the necessary mechanical aides into position for use, and dispose of them when he sits. (Putting on and taking off braces is scored under dressing.)	Mahoney FI, Barthel D. "Functional evaluation: the d Barthel Index." Maryland State Med Journal 1965;14:56- 61	302042005	SNOMED CT
Unable	Patient is unable to use stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-	301589003	SNOMED CT
		61.		





Section: Follow	w-op		Parent: Root		
Independent	safely without help or supervision. They may and		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165249009	SNOMED C
Element: 14898	т	oilet			
	p		ment that most closely corresponds to the patient's current be obtained from the patient's self-report, from a separate bservation.		
	Target Value: T	he value on Follow-up			
	Supporting Definition: B	arthel Index Element			
		opyright Notice: Used with permissio			
	S	ource: Mahoney FI, Barthel D. "Fu	nctional evaluation: the Barthel Index." Maryland State Med	Journal 1965;14:56-0	51.
Functional Ability -	1.3.6.1.4.1.19376.1.4.1.6.5.8	801			
Selection	Definition		Source	Code	Code Syster
Unable	Complete assist fo	or feeding required.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	289001005	SNOMED C
Needs Help	Some help is nece and pepper, sprea	,	t Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165223004	SNOMED C
Independent	table when someor must be able to cu	one puts the food within reach. They ut up the food, use salt and pepper, The patient must accomplish this in		165224005	SNOMED C
Dependent	Patient requires assistance for bathing.		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129043005	SNOMED (
Independent	Patient may use a bath tub, a shower, or take a complete sponge bath. They must be able to do all the steps involved in whichever method is employed without another person being present.		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129041007	SNOMED (
Needs Help	Patient needs assistance with any aspect of grooming.		. Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704440004	SNOMED (
Independent	Patient can wash hands and face, comb hair, clean teeth, and shave. They may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style		61.	704437004	SNOMED C
Dependent	hair. Patient is unable t	to assist with any dressing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129065005	SNOMED (
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the work themselves. They must accomplish this in a reasonable time. Women need not be scored on use of a brassiere or girdle unless these are prescribed		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129039006	SNOMED C
Independent	garments. Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	29035000	SNOMED C
Incontinent	Patient has routine	•	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	72042002	SNOMED C
Inconsistent	Patient needs help enema or has occ	o in using a suppository or taking an asional accidents.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165230005	SNOMED C
Continent	They can use a su	uppository or take an enema when spinal cord injury patients who have	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-	24029004	SNOMED (
Incontinent	Patient has routine		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-	165232002	SNOMED C
				Effective for Patient	Discharged October

Effective for Patient Discharged October 01, 2022 Page 77 of 104





Section: Follow-U	μ	Parent: Root		
		61.		
Inconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165233007	SNOMED C
Continent	Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165234001	SNOMED CT
Dependent	Patient requires full assistance.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129078005	SNOMED C
Needs Help	Patient needs help because of imbalance or in handling clothes or in using toilet paper.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165241007	SNOMED CT
Independent	Patient is able to get on and off toilet, fasten and unfasten clothes, prevent soiling of clothes, and use toilet paper without help. They may use a wall bar or other stable object for support if needed. If it is necessary to use a bed pan instead of a toilet, they must be able to place it on a chair, empty it, and clean it.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129062008	SNOMED CT
Unable	Patient is unable to assist with any transfer.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	733744002	SNOMED CT
Major Assist Needed	Patient can come to a sitting position without the help on a second person but needs to be lifted out of bed, or in they transfer with a great deal of help.	of Mahoney FI, Barthel D. "Functional evaluation: the f Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002154	ACC NCDF
Minor Assist Needed	Either some minimal help is needed in some step of this activity or the patient needs to be reminded or supervised for safety of one or more parts of this activity.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002155	ACC NCDR
Independent	Independent in all phases of this activity. Patient can safely approach the bed in his wheelchair, lock brakes lift footrests, move safely to bed, lie down, come to a sitting position on the side of the bed, change the position of the wheelchair, if necessary, to transfer back into it safely, and return to the wheelchair.	Mahoney FI, Barthel D. "Functional evaluation: the s, Barthel Index." Maryland State Med Journal 1965;14:56- 61.	714915006	SNOMED CT
Immobile	Patient is immobile.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000001492	ACC NCDR
Wheelchair	If a patient cannot ambulate but can propel a wheelchair independently. They must be able to go around corners, turn around, maneuver the chair to a table, bed, toilet, etc. They must be able to push a chai at least 50 yards. Do not score this item if the patient gets score for walking		165243005	SNOMED CT
One Person Assist	Patient needs help or supervision in any of the above but can walk at least 50 yards with a little help.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	707739007	SNOMED CT
Independent	Patient can walk at least 50 yards without help or supervision. They may wear braces or prostheses an use crutches, canes, or a walkerette but not a rolling walker. They must be able to lock and unlock braces ii used, assume the standing position and sit down, get the necessary mechanical aides into position for use, and dispose of them when he sits. (Putting on and taking off braces is scored under dressing.)	Mahoney FI, Barthel D. "Functional evaluation: the d Barthel Index." Maryland State Med Journal 1965;14:56- 61	302042005	SNOMED CT
Unable	Patient is unable to use stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	301589003	SNOMED CT
Needs Help	Patient needs help with or supervision to go up or down stairs safely.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165248001	SNOMED CT
Independent	Patient is able to go up and down a flight of stairs safely without help or supervision. They may and should use handrails, canes, or crutches when needed. They must be able to carry canes or crutches as they ascend or descend stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165249009	SNOMED CT
Element: 14899	Transfers			
<b>∟iement:</b> 14899	Coding Instruction: Choose the scoring point for the state	be obtained from the patient's self-report, from a separat		





## Section: Follow-Up

Target Value: The value on Follow-up

#### Supporting Definition: Barthel Index Element

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Source: Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-61.

Parent: Root

Selection	Definition	Source	Code	Code System
Unable	Complete assist for feeding required.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	289001005	SNOMED CT
Needs Help	Some help is necessary (with cutting up food, use salt and pepper, spread butter, etc).	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165223004	SNOMED CT
Independent	The patient can feed themselves a meal from a tray or table when someone puts the food within reach. They must be able to cut up the food, use salt and pepper, spread butter, etc. The patient must accomplish this in a reasonable time.	Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165224005	SNOMED CT
Dependent	Patient requires assistance for bathing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129043005	SNOMED CT
Independent	Patient may use a bath tub, a shower, or take a complete sponge bath. They must be able to do all the steps involved in whichever method is employed without another person being present.	Patient may use a bath tub, a shower, or take a complete sponge bath. They must be able to do all the steps involved in whichever method is employed       Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-61.		SNOMED CT
Needs Help	Patient needs assistance with any aspect of grooming.	. Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704440004	SNOMED CT
Independent	Patient can wash hands and face, comb hair, clean teeth, and shave. They may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style hair.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704437004	SNOMED CT
Dependent	Patient is unable to assist with any dressing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129065005	SNOMED CT
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the work themselves. They must accomplish this in a reasonable time. Women need not be scored on use of a brassiere or girdle unless these are prescribed garments.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129039006	SNOMED CT
Independent	Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	29035000	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	72042002	SNOMED CT
Inconsistent	Patient needs help in using a suppository or taking an enema or has occasional accidents.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165230005	SNOMED CT
Continent	Patient is able to control bowels and has no accidents. They can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).	Barthel Index." Maryland State Med Journal 1965;14:56-	24029004	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165232002	SNOMED CT
Inconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165233007	SNOMED CT
Continent	Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165234001	SNOMED CT
Dependent	Patient requires full assistance.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129078005	SNOMED CT





Section: Follow	w-0p		Parent: Root		
Needs Help	Patient needs h clothes or in usi		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165241007	SNOMED C
ndependent	unfasten clothe toilet paper with other stable obj necessary to us	o get on and off toilet, fasten and s, prevent soiling of clothes, and use nout help. They may use a wall bar or ect for support if needed. If it is se a bed pan instead of a toilet, they place it on a chair, empty it, and clean	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129062008	SNOMED (
Unable		e to assist with any transfer.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	733744002	SNOMED C
Major Assist Needed	a second perso		f Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002154	ACC NCD
Minor Assist Needed	activity or the pa	nimal help is needed in some step of this atient needs to be reminded or safety of one or more parts of this	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002155	ACC NCD
Independent	safely approach lift footrests, mo sitting position o position of the	all phases of this activity. Patient can in the bed in his wheelchair, lock brakes bye safely to bed, lie down, come to a on the side of the bed, change the wheelchair, if necessary, to transfer ely, and return to the wheelchair.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	714915006	SNOMED C
Immobile	Patient is immob	ile.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000001492	ACC NCD
Wheelchair	wheelchair inde around corners table, bed, toile	ot ambulate but can propel a pendently. They must be able to go , turn around, maneuver the chair to a t, etc. They must be able to push a chair s. Do not score this item if the patient valking		165243005	SNOMED C
One Person Assist		elp or supervision in any of the above least 50 yards with a little help.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	707739007	SNOMED C
Independent	supervision. Th use crutches, c walker. They m used, assume t the necessary r and dispose of	k at least 50 yards without help or ey may wear braces or prostheses and anes, or a walkerette but not a rolling ust be able to lock and unlock braces if he standing position and sit down, get nechanical aides into position for use, them when he sits. (Putting on and is is scored under dressing.)	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	302042005	SNOMED C
Unable	Patient is unabl	e to use stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	301589003	SNOMED C
Needs Help	Patient needs h down stairs sat	elp with or supervision to go up or iely.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165248001	SNOMED C
Independent	safely without h should use han needed. They n	o go up and down a flight of stairs elp or supervision. They may and drails, canes, or crutches when nust be able to carry canes or crutches or descend stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165249009	SNOMED C
Element: 14900		Mobility			
	-	Choose the scoring point for the stater potential, functioning. Information can abilities (such as a relative), or from ot	nent that most closely corresponds to the patient's currer be obtained from the patient's self-report, from a separat oservation.		
	Target Value:	The value on Follow-up			
	Supporting Definition:	Barthel Index Element			
		Copyright Notice: Used with permission	٦.		
		Source: Mahoney FI, Barthel D. "Fur	nctional evaluation: the Barthel Index." Maryland State Me	d Journal 1965;14:56-61.	
Functional Ability -	1.3.6.1.4.1.19376.1.4.1.6.	5.801			
Selection	Definition		Source	Code	Code Syster
Unable		t for feeding required.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	289001005	SNOMED C

61.





Section: Follow-Up		Parent: Root		
Needs Help	Some help is necessary (with cutting up food, use salt and pepper, spread butter, etc).	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165223004	SNOMED C
Independent	The patient can feed themselves a meal from a tray or table when someone puts the food within reach. They must be able to cut up the food, use salt and pepper, spread butter, etc. The patient must accomplish this in a reasonable time.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165224005	SNOMED CT
Dependent	Patient requires assistance for bathing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129043005	SNOMED CT
Independent	Patient may use a bath tub, a shower, or take a complete sponge bath. They must be able to do all the steps involved in whichever method is employed without another person being present.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129041007	SNOMED CT
Needs Help	Patient needs assistance with any aspect of grooming.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704440004	SNOMED CT
Independent	Patient can wash hands and face, comb hair, clean teeth, and shave. They may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style hair.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704437004	SNOMED CT
Dependent	Patient is unable to assist with any dressing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129065005	SNOMED CT
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the work themselves. They must accomplish this in a reasonable time. Women need not be scored on use of a brassiere or girdle unless these are prescribed garments.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129039006	SNOMED CT
Independent	Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	29035000	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	72042002	SNOMED CT
Inconsistent	Patient needs help in using a suppository or taking an enema or has occasional accidents.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165230005	SNOMED CT
Continent	Patient is able to control bowels and has no accidents. They can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).	Barthel Index." Maryland State Med Journal 1965;14:56-	24029004	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165232002	SNOMED CT
Inconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165233007	SNOMED CT
Continent	Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165234001	SNOMED CT
Dependent	Patient requires full assistance.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129078005	SNOMED CT
Needs Help	Patient needs help because of imbalance or in handling clothes or in using toilet paper.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165241007	SNOMED CT
Independent	Patient is able to get on and off toilet, fasten and unfasten clothes, prevent soiling of clothes, and use toilet paper without help. They may use a wall bar or other stable object for support if needed. If it is necessary to use a bed pan instead of a toilet, they must be able to place it on a chair, empty it, and clean it.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129062008	SNOMED CT





Section: Follow	/- <b>U</b> p		Parent: Root		
			61.		
Major Assist Needed	a second perso		f Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002154	ACC NCD
Minor Assist Needed	activity or the pa	nimal help is needed in some step of this atient needs to be reminded or safety of one or more parts of this	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002155	ACC NCD
Independent	Independent in all phases of this activity. Patient can a safely approach the bed in his wheelchair, lock brakes, E lift footrests, move safely to bed, lie down, come to a sitting position on the side of the bed, change the position of the wheelchair, if necessary, to transfer back into it safely, and return to the wheelchair.		· · · · · · · · · · · · · · · · · · ·	714915006	SNOMED C
Immobile	Patient is immob	bile.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000001492	ACC NCD
Wheelchair	If a patient cannot ambulate but can propel a wheelchair independently. They must be able to go		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165243005	SNOMED C
One Person Assist		elp or supervision in any of the above least 50 yards with a little help.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	707739007	SNOMED C
Independent	supervision. Th use crutches, c walker. They m used, assume t the necessary r and dispose of	k at least 50 yards without help or ney may wear braces or prostheses and anes, or a walkerette but not a rolling ust be able to lock and unlock braces if he standing position and sit down, get nechanical aides into position for use, them when he sits. (Putting on and as is scored under dressing.)	Mahoney FI, Barthel D. "Functional evaluation: the d Barthel Index." Maryland State Med Journal 1965;14:56- 61	302042005	SNOMED C
Unable	Patient is unabl	e to use stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	301589003	SNOMED C
Needs Help	Patient needs help with or supervision to go up or down stairs safely.		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165248001	SNOMED C
Independent	safely without h should use han needed. They n	to go up and down a flight of stairs help or supervision. They may and hdrails, canes, or crutches when must be able to carry canes or crutches I or descend stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165249009	SNOMED C
Element: 14901		Stairs			
	Coding Instruction:		nent that most closely corresponds to the patient's curre be obtained from the patient's self-report, from a separat oservation.		
	Target Value:	The value on Follow-up			
	Supporting Definition:	Barthel Index Element			
		Copyright Notice: Used with permission	n.		
Functional Ability -	1 2 6 1 4 1 10276 1 4 1 6 1	• · ·	nctional evaluation: the Barthel Index." Maryland State Me	d Journal 1965;14:56-6	1.
Selection	1.3.6.1.4.1.19376.1.4.1.6. Definition	5.001	Source	Code	Code System
Unable		t for feeding required.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	289001005	SNOMED C
Needs Help		ecessary (with cutting up food, use salt read butter, etc).	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165223004	SNOMED C
Independent	The patient can feed themselves a meal from a tray or table when someone puts the food within reach. The must be able to cut up the food, use salt and pepper, sorread butter, etc. The patient must accomplish this in		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165224005	SNOMED C

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Section: Follow-Up		Parent: Root		
	complete sponge bath. They must be able to do all the steps involved in whichever method is employed without another person being present.	Barthel Index." Maryland State Med Journal 1965;14:56- 61.		
Needs Help	Patient needs assistance with any aspect of grooming.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704440004	SNOMED CT
Independent	Patient can wash hands and face, comb hair, clean teeth, and shave. They may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style hair.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704437004	SNOMED CT
Dependent	Patient is unable to assist with any dressing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129065005	SNOMED CT
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the work themselves. They must accomplish this in a reasonable time. Women need not be scored on use of a brassiere or girdle unless these are prescribed garments.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129039006	SNOMED CT
Independent	Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	29035000	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	72042002	SNOMED CT
Inconsistent	Patient needs help in using a suppository or taking an enema or has occasional accidents.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165230005	SNOMED CT
Continent	Patient is able to control bowels and has no accidents. They can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).	Barthel Index." Maryland State Med Journal 1965;14:56-	24029004	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165232002	SNOMED CT
Inconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165233007	SNOMED CT
Continent	Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165234001	SNOMED CT
Dependent	Patient requires full assistance.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129078005	SNOMED CT
Needs Help	Patient needs help because of imbalance or in handling clothes or in using toilet paper.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165241007	SNOMED CT
Independent	Patient is able to get on and off toilet, fasten and unfasten clothes, prevent soiling of clothes, and use toilet paper without help. They may use a wall bar or other stable object for support if needed. If it is necessary to use a bed pan instead of a toilet, they must be able to place it on a chair, empty it, and clean it.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129062008	SNOMED CT
Unable	Patient is unable to assist with any transfer.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	733744002	SNOMED CT
Major Assist Needed	Patient can come to a sitting position without the help or a second person but needs to be lifted out of bed, or if they transfer with a great deal of help.		112000002154	ACC NCDR
Minor Assist Needed	Either some minimal help is needed in some step of this activity or the patient needs to be reminded or supervised for safety of one or more parts of this activity.		112000002155	ACC NCDR
Independent	Independent in all phases of this activity. Patient can safely approach the bed in his wheelchair, lock brakes lift footrests, move safely to bed, lie down, come to a	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	714915006	SNOMED CT





Barthel Index." Maryland State Med Journal 1965;14:56- 61.       Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.       165243005       SNOM         Wheelchair       If a patient cannot ambulate but can propel a wheelchair independently. They must be able to go around corners, turn around, maneuver the chair to a table, bed, toilet, etc. They must be able to push a chair at least 50 yards. Do not score this item if the patient gets score for walking       165243005       SNOM         One Person Assist       Patient needs help or supervision in any of the above but can walk at least 50 yards with a little help.       Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61       707739007       SNOM         Independent       Patient needs help or supervision in any of the above but can walk at least 50 yards without help or supervision. They may wear braces or prostheses and avalker: They must be able to lock and unlock braces if used, assume the standing position and sit down, get the necessary mechanical aides into position for use, and dispose of them when he sits. (Putting on and taking off braces is scored under dressing.)       Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.       301589003       SNOM         Needs Help       Patient needs help with or supervision to go up or down stairs safely.       Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.       165248001       SNOM         Needs Help       Patient needs help with or supervision to go up o	Section: Follow-Up		Parent: Root		
Barthel Index.* Maryland State Med Journal 1965;14:56- 61.       1         Wheelchair       If a patient cannot ambulate but can propel a wheelchair independently. They must be able to go around corners, turn around, maneuver the chair to a table, bed, toilet, etc. They must be able to push a chair at least 50 yards. Do not score this item if the patient gets score for walking       165243005       SNOM         One Person Assist       Patient needs help or supervision in any of the above but can walk at least 50 yards with a little help.       Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61       707739007       SNOM         Independent       Patient needs help or supervision in any of the above but can walk at least 50 yards without help or supervision. They may wear braces or prostheses and Barthel Index." Maryland State Med Journal 1965;14:56- 61       302042005       SNOM         Unable       Patient is unable to lock and unlock braces if used, assume the standing position and sit down, get the necessary mechanical ides into position for use, and dispose of them when he sits. (Putting on and taking off braces is scored under dressing.)       Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.       301589003       SNOM         Needs Help       Patient needs help with or supervision to go up or down stairs safely.       Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.       301589003       SNOM         Needs Help       Patient needs help with or supervision to go up or do		position of the wheelchair, if necessary, to transfer			
wheelchair independently. They must be able to go around corners, turn around, maneuver the chair to a table, bed, toilet, etc. They must be able to push a chair at least 50 yards. Do not score this item if the patient gets score for walkingBarthel Index." Maryland State Med Journal 1965;14:56- 61.707739007SNOMOne Person AssistPatient needs help or supervision in any of the above but can walk at least 50 yards with a little help. supervision. They may wear braces or prostheses and Barthel Index." Maryland State Med Journal 1965;14:56- 61707739007SNOMIndependentPatient can walk at least 50 yards with a little help. supervision. They may wear braces or prostheses and used, assume the standing position and sit down, get the necessary mechanical aides into position for use, and dispose of them when he sits. (Putting on and taking off braces is scored under dressing.)Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61301589003SNOMUnablePatient is unable to use stairs.Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.301589003SNOMNeeds HelpPatient is able to go up and down a flight of stairs safely.Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.165248001SNOMIndependentPatient is able to go up and down a flight of stairs safely without help or supervision. They may and should use handrails, canes, or crutches when needed. They must be able to cary canes or crutchesMahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:	Immobile	Patient is immobile.	Barthel Index." Maryland State Med Journal 1965;14:56-	112000001492	ACC NCDR
but can walk at least 50 yards with a little help.Barthel Index." Maryland State Med Journal 1965;14:56- 61302042005SNOMIndependentPatient can walk at least 50 yards without help or supervision. They may wear braces or prostheses and Barthel Index." Maryland State Med Journal 1965;14:56- 61302042005SNOMIndependentPatient can walk at least 50 yards without help or supervision. They may wear braces or prostheses and Barthel Index." Maryland State Med Journal 1965;14:56- 61302042005SNOMIndependentPatient can walk erette but not a rolling walker. They must be able to lock and unlock braces if used, assume the standing position and sit down, get the necessary mechanical aides into position for use, and dispose of them when he sits. (Putting on and taking off braces is scored under dressing.)Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.301589003SNOMUnablePatient needs help with or supervision to go up or down stairs safely.Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.165248001SNOMIndependentPatient is able to go up and down a flight of stairs safely without help or supervision. They may and should use handrails, canes, or crutches when needed. They must be able to carry canes or crutchesMahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.165249009SNOM	Wheelchair	wheelchair independently. They must be able to go around corners, turn around, maneuver the chair to a table, bed, toilet, etc. They must be able to push a chail at least 50 yards. Do not score this item if the patient	Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165243005	SNOMED CT
supervision. They may wear braces or prostheses and Barthel Index." Maryland State Med Journal 1965;14:56- use crutches, canes, or a walkerette but not a rolling walker. They must be able to lock and unlock braces if used, assume the standing position and sit down, get the necessary mechanical aides into position for use, and dispose of them when he sits. (Putting on and taking off braces is scored under dressing.)6161UnablePatient is unable to use stairs.Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.301589003SNOMNeeds HelpPatient needs help with or supervision to go up or down stairs safely.Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.165248001SNOMIndependentPatient is able to go up and down a flight of stairs safely without help or supervision. They may and 	One Person Assist		Barthel Index." Maryland State Med Journal 1965;14:56-	707739007	SNOMED CT
Barthel Index." Maryland State Med Journal 1965;14:56- 61.         Needs Help       Patient needs help with or supervision to go up or down stairs safely.       Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.       165248001       SNOM         Independent       Patient is able to go up and down a flight of stairs safely without help or supervision. They may and should use handrails, canes, or crutches when needed. They must be able to carry canes or crutches       Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.       165249009       SNOM	Independent	supervision. They may wear braces or prostheses and use crutches, canes, or a walkerette but not a rolling walker. They must be able to lock and unlock braces if used, assume the standing position and sit down, get the necessary mechanical aides into position for use, and dispose of them when he sits. (Putting on and	Barthel Index." Maryland State Med Journal 1965;14:56- 61	302042005	SNOMED CT
down stairs safely.     Barthel Index." Maryland State Med Journal 1965;14:56- 61.       Independent     Patient is able to go up and down a flight of stairs safely without help or supervision. They may and should use handrails, canes, or crutches when needed. They must be able to carry canes or crutches     Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.     165249009     SNOW	Unable	Patient is unable to use stairs.	Barthel Index." Maryland State Med Journal 1965;14:56-	301589003	SNOMED CT
safely without help or supervision. They may and should use handrails, canes, or crutches when needed. They must be able to carry canes or crutchesBarthel Index." Maryland State Med Journal 1965;14:56- 61.	Needs Help		Barthel Index." Maryland State Med Journal 1965;14:56-	165248001	SNOMED CT
	Independent	safely without help or supervision. They may and should use handrails, canes, or crutches when	Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165249009	SNOMED CT





Section: Follow-Up Medications		Parent: Follow-Up
Element: 11990	Follow-Up Medications Code	

Coding Instruction: Indicate the assigned identification number associated with the medications the patient was prescribed or received.

Note(s):

The medication(s) collected in this field are controlled by the Medication Master file. This file is maintained by the NCDR and will be made available on the internet for downloading and importing/updating into your application. Each medication in the Medication Master file is assigned to a value set. The value set is used to separate procedural medications from medications prescribed at discharge. The separation of these medications is depicted on the data collection form.

Target Value: N/A

### Follow-up Medication - 2.16.840.1.113883.3.3478.6.5.203

Selection	Definition	Source	Code	Code System
Fondaparinux			321208	RxNorm
Heparin Derivative			100000921	ACC NCDR
Low Molecular Weight	Heparin		373294004	SNOMED CT
Unfractionated Heparin	1		96382006	SNOMED CT
Warfarin			11289	RxNorm
Aspirin			1191	RxNorm
Aspirin/Dipyridamole			226716	RxNorm
Vorapaxar			1537034	RxNorm
Apixaban			1364430	RxNorm
Dabigatran			1546356	RxNorm
Edoxaban			1599538	RxNorm
Rivaroxaban			1114195	RxNorm
Cangrelor			1656052	RxNorm
Clopidogrel			32968	RxNorm
Other P2Y12			112000001003	ACC NCDR
Prasugrel			613391	RxNorm
Ticagrelor			1116632	RxNorm
Ticlopidine			10594	RxNorm

Element: 14949

Follow-up Current Medications at Time of Follow-up

Coding Instruction: Indicate if the patient was taking or being administered the medication at the time of follow-up, or was not taking or being administered the medication for an undocumented, a medical, or a patient reason.

Target Value: The value on Follow-up

Vendor Instruction: When a Follow-Up Medications Code (11990) is selected, Follow-up Current Medications at Time of Follow-up (14949) cannot be Null

#### Follow-Up Medication Administration - 1.3.6.1.4.1.19376.1.4.1.6.5.371

Selection	Definition	Source	Code	Code System
Yes			100001247	ACC NCDR
No - No Reason			100001048	ACC NCDR
No - Medical Reason			100001034	ACC NCDR
No - Patient Reason			100001071	ACC NCDR

Element: 14950

Follow-Up Medication Dose

Coding Instruction: Indicate the category of the medication dose.

Target Value: The value on Follow-up

#### Medication Dose - 1.3.6.1.4.1.19376.1.4.1.6.5.321

Selection	Definition	Source	Code	Code System
Aspirin 81 to 100 mg			112000002080	ACC NCDR
Aspirin 101 to 324 mg			112000002081	ACC NCDR
Aspirin 325 mg			317300	RxNorm





		n Therapy Parent: Follow-Up	
Element: 14951		Follow-up Warfarin Discontinued	
	Coding Instruction:	Indicate if the patient discontinued Warfarin at any time since the last follow-up (or since discharge if this is the 4	5-day follow-up).
	-	The value on Follow-up	
Anticopagulation Disc	-		
Selection	continuation - 1.3.6.1.4. Definition	Source Code	Code Syste
No - Not Discontinued		11200002220	ACC NCE
es - Discontinued		11200002221	ACC NCE
Element: 14952		Follow-up Warfarin Discontinued Date	
	Coding Instruction:	Indicate the date the Warfarin was discontinued.	
	Target Value:	The value on Follow-up	
	Vendor Instruction:	Follow-up Warfarin Discontinued Date (14952) must be Greater than the Follow-Up Reference Procedure Start Date	ate and Time (11001)
-			
Element: 14953		Follow-up Warfarin Resumed	
	Coding Instruction:	Indicate if the patient resumed Warfarin at any time since the last follow-up (or since discharge if this is the 45-d	ay follow-up).
	Target Value:	The value on Follow-up	
-	-	5.1.4.1.19376.1.4.1.6.5.803	
Selection	Definition	Source Code 11200000168	Code Syste
es (Thrombotic Even	t)	11200002181	ACC NCE
(Other)		100001247	ACC NCE
Element: 14954		Follow-up Warfarin Resumed Date	
	Coding Instruction:	Indicate the date the Warfarin was resumed.	
	-	The value on Follow-up	
	Target Value:	The value on Follow-up	and Time (11001)
	Target Value:		and Time (11001)
Element: 14955	Target Value:	The value on Follow-up	and Time (11001)
Element: 14955	Target Value: Vendor Instruction:	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date a	
Element: 14955	Target Value: Vendor Instruction: Coding Instruction:	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date a Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up	
	Target Value: Vendor Instruction: Coding Instruction:	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date a Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up this is the 45-day follow-up). The value on Follow-up	
Inticoagulation Disc	Target Value: Vendor Instruction: Coding Instruction: Target Value:	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date a Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.820 Code	(or since discharge if Code Syste
Anticoagulation Disc Selection Io - Not Discontinued	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4.	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date a Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.820 Code 11200002220	(or since discharge if Code Syste ACC NCE
Anticoagulation Disc Selection Io - Not Discontinued	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4.	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date a Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.820 Code	(or since discharge if Code Syste ACC NCE
Anticoagulation Disc Selection Io - Not Discontinued 'es - Discontinued	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4.	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date a Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.820 Code 11200002220	(or since discharge if Code Syste ACC NCE
Anticoagulation Disc Selection Io - Not Discontinued 'es - Discontinued	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date a Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.820 Code 11200002220 11200002221	(or since discharge if Code Syste ACC NCE
Anticoagulation Disc Selection No - Not Discontinued Yes - Discontinued	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date a Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.820 Code 112000002220 112000002221 Follow-up DOAC Therapy Discontinued Date	(or since discharge if Code System ACC NCE
Anticoagulation Disc Selection No - Not Discontinued Yes - Discontinued	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition Coding Instruction: Target Value:	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date a Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.820 Code 112000002220 112000002221 Follow-up DOAC Therapy Discontinued Date Indicate the date the DOAC was discontinued.	(or since discharge if Code Syste ACC NCE ACC NCE
Anticoagulation Disc Relection Io - Not Discontinued (es - Discontinued Element: 14956	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition Coding Instruction: Target Value:	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date a Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.820 Code 112000002220 112000002220 112000002221 Follow-up DOAC Therapy Discontinued Date Indicate the date the DOAC was discontinued. The value on Follow-up Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proceeding Code Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proceeding Code Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proceeding Code Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proceeding Code Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proceeding Code Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proceeding Code Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proceeding Code Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proceeding Code Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proceeding Code Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proceeding Code Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proceeding Code Follow-up NoAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proceeding Code Follow-up NoAC (DOAC) Therapy Discontinued Date Follow-up Follow-up Follow-up Follow-up Follow-up Follow-up Follow-up Follow-up Fol	(or since discharge if Code Syste ACC NCE ACC NCE
Anticoagulation Disc Selection No - Not Discontinued Yes - Discontinued Element: 14956	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition Coding Instruction: Target Value: Vendor Instruction:	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date a Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.820 Code 112000002220 112000002221 Follow-up DOAC Therapy Discontinued Date Indicate the date the DOAC was discontinued. The value on Follow-up Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proc Time (11001)	(or since discharge if Code Syste ACC NCE ACC NCE
Anticoagulation Disc Selection No - Not Discontinued 'es - Discontinued Element: 14956	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition Coding Instruction: Target Value: Vendor Instruction: Coding Instruction:	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date a Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.820 Code 112000002220 112000002221 Follow-up DOAC Therapy Discontinued Date Indicate the date the DOAC was discontinued. The value on Follow-up Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proc Time (11001) Follow-up DOAC Therapy Resumed Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (or	(or since discharge if Code Syste ACC NCE ACC NCE
Inticoagulation Disc ielection lo - Not Discontinued 'es - Discontinued Element: 14956 Element: 14957	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition Coding Instruction: Target Value: Vendor Instruction: Coding Instruction: Target Value: umption Reason - 1.3.6	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date i Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up this is the 45-day follow-up I.19376.1.4.1.6.5.803 Follow-up DOAC Therapy Discontinued Date Indicate the date the DOAC was discontinued Date (14956) must be Greater than the Follow-Up Reference Procedure	(or since discharge if Code Syste ACC NCE ACC NCE Cedure Start Date and since discharge if this is
Anticoagulation Disc Selection No - Not Discontinued Yes - Discontinued Element: 14956 Element: 14957	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition Coding Instruction: Target Value: Vendor Instruction: Coding Instruction: Target Value:	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date a Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up this is the 45-day follow-up 1.19376.1.4.1.6.5.80 Code Follow-up DOAC Therapy Discontinued Date Indicate the date the DOAC was discontinued Date Indicate if the patient POAC Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proceeding Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proceeding Follow-up DOAC Therapy Resumed Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (or the 45-day follow-up). The value on Follow-up <b>Follow-up</b> DOAC Therapy Resumed Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (or the 45-day follow-up). The value on Follow-up <b>Follow-up</b> DOAC Therapy Resumed Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (or the 45-day follow-up). The value on Follow-up <b>Follow-up</b> DOAC Therapy Resumed Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (or the 45-day follow-up). The value on Follow-up	(or since discharge if Code Syster ACC NCD ACC NCD Code Syster Code Syster
Anticoagulation Disc Selection No - Not Discontinued Yes - Discontinued Element: 14956 Element: 14957 Anticoagulation Res Selection No	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition Coding Instruction: Target Value: Vendor Instruction: Coding Instruction: Target Value: umption Reason - 1.3.6 Definition	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date a Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up this is the 45-day follow-up. The value on Follow-up 1.19376.1.4.1.6.5.803 Follow-up DOAC Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Procedure Procedure Start Date (14956) must be Greater than the Follow-Up Reference Procedure Start Date (14956) must be Greater than the Follow-Up Reference Procedure Start Date (14956) must be Greater than the Follow-Up Reference Procedure Start Date (14956) must be Greater than the Follow-Up Reference Procedure Start Date (14956) must be Greater than the Follow-Up Reference Procedure Start Date (14956) must be Greater than the Follow-Up Reference Procedure Start Date (14956) must be Greater than the Follow-Up Reference Procedure Start Date (14956) must be Greater than the Follow-Up Reference Procedure Start Date (14956) must be Greater than the Follow-Up Reference Procedure Start Date (14956) must be Greater than the Follow-Up Reference Procedure Start Date (14956) must be Greater than the Follow-Up Reference Procedure Start Date (14956) must be Greater than the Follow-Up Reference Procedure Start Date (14956) must be Greater than the Follow-Up Reference Procedure Start Date (14956) must be Greater than the Follow-Up (or the 45-day follow-up). Follow-up DOAC Therapy Resumed Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (or the 45-day follow-up). The value on Follow-up Start	(or since discharge if Code Syster ACC NCD ACC NCD Cedure Start Date and since discharge if this is Code Syster ACC NCD
Selection No - Not Discontinued Yes - Discontinued Element: 14956	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition Coding Instruction: Target Value: Vendor Instruction: Coding Instruction: Target Value: umption Reason - 1.3.6 Definition	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date a Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up this is the 45-day follow-up 1.19376.1.4.1.6.5.80 Code Follow-up DOAC Therapy Discontinued Date Indicate the date the DOAC was discontinued Date Indicate if the patient POAC Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proceeding Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proceeding Follow-up DOAC Therapy Resumed Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (or the 45-day follow-up). The value on Follow-up <b>Follow-up</b> DOAC Therapy Resumed Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (or the 45-day follow-up). The value on Follow-up <b>Follow-up</b> DOAC Therapy Resumed Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (or the 45-day follow-up). The value on Follow-up <b>Follow-up</b> DOAC Therapy Resumed Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (or the 45-day follow-up). The value on Follow-up	(or since discharge if Code Syster ACC NCD ACC NCD Cedure Start Date and since discharge if this is Code Syster

Coding Instruction: Indicate the date the DOAC was resumed.





Section: Follow-	Up Anticoagulation	n Therapy Parent: Follow-Up		
	Target Value:	The value on Follow-up		
	Vendor Instruction:	Follow-up NOAC (DOAC) Therapy Resumed Date (14958) must be Greater than the F (11001)	Follow-Up Reference Procedure S	Start Date and Time
<b>lement:</b> 14959		Follow-up Aspirin Therapy Discontinued		
	Coding Instruction:	Indicate if the patient discontinued Aspirin Therapy at any time since the last follow-u up).	up (or since discharge if this is th	e 45-day follow-
	Target Value:	The value on Follow-up		
nticoagulation Disc	ontinuation - 1.3.6.1.4.	1.19376.1.4.1.6.5.820		
election	Definition	Source	Code	Code Syster
o - Not Discontinued			112000002220	ACC NCD
es - Discontinued			112000002221	ACC NCD
lement: 14960		Follow-up Aspirin Therapy Discontinued Date		
	Coding Instruction:	Indicate the date the Aspirin was discontinued.		
	Target Value:	The value on Follow-up		
	Vendor Instruction:	Follow-up Aspirin Therapy Discontinued Date (14960) must be Greater than the Follow	w-Up Reference Procedure Start	Date and Time
		(11001)		
Element: 14961		Follow-up Aspirin Therapy Resumed		
	Coding Instruction:	Indicate if the patient resumed Aspirin Therapy at any time since the last follow-up (o	or since discharge if this is the 45	i-day follow-up).
	Target Value:	The value on Follow-up		
nticoagulation Res	umption Reason - 1.3.6	5.1.4.1.19376.1.4.1.6.5.803		
election	Definition	Source	Code	Code System
0 oo (Thromhotic Event	λ		112000000168	ACC NCD ACC NCD
es (Thrombotic Event	)		11200002101	ACC NCD
es (Other)			100001247	
res (Other)			100001247	ACC NCD
		Follow-up Aspirin Therapy Resumed Date	100001247	
	Coding Instruction:	Follow-up Aspirin Therapy Resumed Date Indicate the date the Aspirin was resumed.	100001247	
	-		100001247	
	Target Value:	Indicate the Aspirin was resumed.		ACC NCD
Element: 14962	Target Value:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up		ACC NCD
Element: 14962	Target Value: Vendor Instruction:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up (11001) Follow-up P2Y12 Therapy Discontinued	p Reference Procedure Start Da	ACC NCD
Element: 14962	Target Value: Vendor Instruction: Coding Instruction:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-up	p Reference Procedure Start Da	ACC NCD
Element: 14962 Element: 14963	Target Value: Vendor Instruction: Coding Instruction: Target Value:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-up The value on Follow-up	p Reference Procedure Start Da	ACC NCD
Element: 14962 Element: 14963 Inticoagulation Disc	Target Value: Vendor Instruction: Coding Instruction: Target Value: ontinuation - 1.3.6.1.4.	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-up The value on Follow-up 1.19376.1.4.1.6.5.820	p Reference Procedure Start Dat p (or since discharge if this is the	ACC NCD te and Time
Element: 14962 Element: 14963 nticoagulation Disc election	Target Value: Vendor Instruction: Coding Instruction: Target Value:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-up The value on Follow-up	p Reference Procedure Start Da	ACC NCD te and Time e 45-day follow-up). Code Syster
Element: 14962 Element: 14963 nticoagulation Disc election o - Not Discontinued	Target Value: Vendor Instruction: Coding Instruction: Target Value: ontinuation - 1.3.6.1.4.	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-up The value on Follow-up 1.19376.1.4.1.6.5.820	p Reference Procedure Start Dat p (or since discharge if this is the <b>Code</b>	ACC NCD te and Time e 45-day follow-up). Code System ACC NCD
Element: 14962 Element: 14963 Inticoagulation Disc Inticoagulation Disc	Target Value: Vendor Instruction: Coding Instruction: Target Value: ontinuation - 1.3.6.1.4.	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-up The value on Follow-up 1.19376.1.4.1.6.5.820	p Reference Procedure Start Dat p (or since discharge if this is the <u>Code</u> 112000002220	ACC NCD te and Time e 45-day follow-up). Code System ACC NCD
Element: 14962 Element: 14963 Inticoagulation Disc Inticoagulation Disc	Target Value: Vendor Instruction: Coding Instruction: Target Value: ontinuation - 1.3.6.1.4. Definition	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-U (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-u The value on Follow-up 1.19376.1.4.1.6.5.820 Follow-up P2Y12 Therapy Discontinued Date Follow-up P2Y12 Therapy Discontinued Date	p Reference Procedure Start Dat p (or since discharge if this is the <u>Code</u> 112000002220	ACC NCD te and Time e 45-day follow-up). Code System ACC NCD
Element: 14962 Element: 14963 Inticoagulation Disc Inticoagulation Disc	Target Value: Vendor Instruction: Coding Instruction: Target Value: ontinuation - 1.3.6.1.4. Definition	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-U (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-u The value on Follow-up 1.19376.1.4.1.6.5.820 Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued.	p Reference Procedure Start Dat p (or since discharge if this is the <u>Code</u> 112000002220	ACC NCD te and Time e 45-day follow-up). Code System ACC NCD
Element: 14962 Element: 14963 Inticoagulation Disc Inticoagulation Disc	Target Value: Vendor Instruction: Coding Instruction: Target Value: ontinuation - 1.3.6.1.4. Definition Coding Instruction: Target Value:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-U (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-u The value on Follow-up 1.19376.1.4.1.6.5.820 Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up	p Reference Procedure Start Dat p (or since discharge if this is the <u>Code</u> 112000002220 112000002221	ACC NCD te and Time e 45-day follow-up). Code System ACC NCD ACC NCD
Element: 14962 Element: 14963 Inticoagulation Disc Inticoagulation Disc	Target Value: Vendor Instruction: Coding Instruction: Target Value: ontinuation - 1.3.6.1.4. Definition Coding Instruction: Target Value:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-U (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-u The value on Follow-up 1.19376.1.4.1.6.5.820 Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued.	p Reference Procedure Start Dat p (or since discharge if this is the <u>Code</u> 112000002220 112000002221	ACC NCD te and Time e 45-day follow-up). Code System ACC NCD ACC NCD
Element: 14962 Element: 14963 Inticoagulation Disc ielection Io - Not Discontinued ies - Discontinued Element: 14964	Target Value: Vendor Instruction: Coding Instruction: Target Value: ontinuation - 1.3.6.1.4. Definition Coding Instruction: Target Value:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-U (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-u The value on Follow-up 1.19376.1.4.1.6.5.820 Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date (14964) must be Greater than the Follow-up Follow-up P2Y12 Therapy Discontinued Date (14964) must be Greater than the Follow-up	p Reference Procedure Start Dat p (or since discharge if this is the <u>Code</u> 112000002220 112000002221	ACC NCD te and Time e 45-day follow-up) Code System ACC NCD ACC NCD
Element: 14962 Element: 14963 Inticoagulation Disc ielection Io - Not Discontinued ies - Discontinued Element: 14964	Target Value: Vendor Instruction: Coding Instruction: Target Value: ontinuation - 1.3.6.1.4. Definition Coding Instruction: Target Value: Vendor Instruction:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-U (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-u The value on Follow-up 1.19376.1.4.1.6.5.820 Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date (14964) must be Greater than the Follow (11001)	p Reference Procedure Start Dar p (or since discharge if this is the <u>Code</u> 112000002220 112000002221	ACC NCD e and Time e 45-day follow-up). Code System ACC NCD ACC NCD Date and Time
Yes (Other) Element: 14962 Element: 14963 Anticoagulation Disc Selection Not Discontinued Yes - Discontinued Element: 14964 Element: 14965	Target Value: Vendor Instruction: Coding Instruction: Target Value: <u>ontinuation - 1.3.6.1.4.</u> Definition Coding Instruction: Target Value: Vendor Instruction:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-U (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-u The value on Follow-up 1.19376.1.4.1.6.5.820 Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date (14964) must be Greater than the Follow (11001) Follow-up P2Y12 Therapy Resumed	p Reference Procedure Start Dar p (or since discharge if this is the <u>Code</u> 112000002220 112000002221	ACC NCD e and Time e 45-day follow-up). Code System ACC NCD ACC NCD Date and Time
Element: 14962 Element: 14963 Element: 14963 Not Discontinued is - Discontinued Element: 14964 Element: 14965	Target Value: Vendor Instruction: Coding Instruction: Target Value: ontinuation - 1.3.6.1.4. Definition Coding Instruction: Target Value: Vendor Instruction: Coding Instruction: Target Value:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-U (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-u The value on Follow-up 1.19376.1.4.1.6.5.820 Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date (14964) must be Greater than the Follow (11001) Follow-up P2Y12 Therapy Resumed Indicate if the patient resumed P2Y12 Therapy at any time since the last follow-up (or The value on Follow-up	p Reference Procedure Start Dar p (or since discharge if this is the <u>Code</u> 112000002220 112000002221	ACC NCD e and Time e 45-day follow-up). Code System ACC NCD ACC NCD Date and Time
Element: 14962 Element: 14963 Element: 14963 o - Not Discontinued es - Discontinued Element: 14964 Element: 14965	Target Value: Vendor Instruction: Coding Instruction: Target Value: ontinuation - 1.3.6.1.4. Definition Coding Instruction: Target Value: Vendor Instruction: Coding Instruction: Target Value: umption Reason - 1.3.6	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-U (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-u The value on Follow-up 1.19376.1.4.1.6.5.820 Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date (14964) must be Greater than the Follow (11001) Follow-up P2Y12 Therapy Resumed Indicate if the patient resumed P2Y12 Therapy at any time since the last follow-up (or The value on Follow-up St.1.4.1.19376.1.4.1.6.5.803	p Reference Procedure Start Dat p (or since discharge if this is the <u>Code</u> 112000002220 112000002221 w-Up Reference Procedure Start r since discharge if this is the 45	ACC NCD e and Time e 45-day follow-up). Code Syster ACC NCD ACC NCD Date and Time -day follow-up).
Element: 14962 Element: 14963 Element: 14963 Not Discontinued is - Discontinued Element: 14964 Element: 14965	Target Value: Vendor Instruction: Coding Instruction: Target Value: ontinuation - 1.3.6.1.4. Definition Coding Instruction: Target Value: Vendor Instruction: Coding Instruction: Target Value:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-U (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-u The value on Follow-up 1.19376.1.4.1.6.5.820 Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date (14964) must be Greater than the Follow (11001) Follow-up P2Y12 Therapy Resumed Indicate if the patient resumed P2Y12 Therapy at any time since the last follow-up (or The value on Follow-up	p Reference Procedure Start Dar p (or since discharge if this is the <u>Code</u> 112000002220 112000002221	ACC NCD e and Time e 45-day follow-up). Code System ACC NCD ACC NCD Date and Time





Section: Follow-Up Anti	coagulation Therapy Pa	arent: Follow-Up	
Yes (Other)		100001247	ACC NCDR
Element: 14966	Follow-up P2Y12 Therapy Resumed Date	3	
Coding	Instruction: Indicate the date the P2Y12 was resumed.		

- ....

Target Value: The value on Follow-up

Vendor Instruction: Follow-up P2Y12 Therapy Resumed Date (14966) must be Greater than the Follow-Up Reference Procedure Start Date and Time (11001)





#### Section: Follow-Up Events Parent: Follow-Up Element: 14948 Follow-Up Event Coding Instruction: Indicate if any event from the NCDR-provided list had occurred between the time of the last follow-up (or discharge if this is the 45-day follow-up) and the current follow-up. Target Value: The value on Follow-up Vendor Instruction: A Follow-Up - combination of Event Name (14948), Occurred (14276) and Date (14277) - may only be entered/selected once Follow-up Events - 1.3.6.1.4.1.19376.1.4.1.6.5.802 Selection Definition Source Code Code System Endocarditis 56819008 SNOMED CT latrogenic ASD (requiring 112000002179 ACC NCDR

intervention)	11200002179	ACC NCDR
LAA Occlusion Reintervention	112000002200	ACC NCDR
Myocardial Infarction	22298006	SNOMED CT
PCI	415070008	SNOMED CT
Pericarditis	3238004	SNOMED CT
Unplanned Cardiac Surgery	112000001892	ACC NCDR
Unplanned Intervention	112000002180	ACC NCDR
Deep Vein Thrombosis	128053003	SNOMED CT
New Requirement for Dialysis	100014076	ACC NCDR
Non-Device Related	11200002177	ACC NCDR
Readmission	11200002111	ACC NODA
Systemic Thromboembolism (other than stroke) (Complete Adjudication)	112000002126	ACC NCDR
Device Explant	100001141	ACC NCDR
Device Fracture	112000001891	ACC NCDR
Device Migration	370512004	SNOMED CT
Device Related Readmission	112000002176	ACC NCDR
Device Systemic Embolism	112000002175	ACC NCDR
Device Thrombus	112000001839	ACC NCDR
Hemorrhagic Stroke (Complete Adjudication)	230706003	SNOMED CT
Intracranial Hemorrhage (other than hemorrhagic stroke) (Complete Adjudication)	1386000	SNOMED CT
Ischemic Stroke (Complete Adjudication)	422504002	SNOMED CT
TIA (Complete Adjudication)	266257000	SNOMED CT
Undetermined Stroke (Complete Adjudication)	230713003	SNOMED CT
Access Site Bleeding (Complete Adjudication)	1000142440	ACC NCDR
GI Bleeding (Complete Adjudication)	74474003	SNOMED CT
Hematoma (Complete Adjudication)	385494008	SNOMED CT
Hemothorax (not requiring drainage) (Complete Adjudication)	112000002147	ACC NCDR
Hemothorax (requiring drainage) (Complete Adjudication)	100001011	ACC NCDR
Other Hemorrhage (non- intracranial) (Complete Adjudication)	50960005	SNOMED CT
Pericardial Effusion (requiring open cardiac surgery) (Complete Adjudication)	112000002148	ACC NCDR
Pericardial Effusion with tamponade (requiring percutaneous drainage) (Complete Adjudication)	112000002149	ACC NCDR
Pericardial Effusion without tamponade (requiring percutaneous drainage) (Complete Adjudication)	112000002150	ACC NCDR
Retroperitoneal Bleeding	95549001	SNOMED CT
(Complete Adjudication)	20042001	





Section: Follow-Up Events		Parent: Follow-Up	
Vascular Complications (Complete Adjudication)		213217008	SNOMED CT
AV Fistula (requiring surgical repair) (Complete Adjudication)		11200002141	ACC NCDR
Pseudoaneurysm (requiring endovascular repair) (Complete Adjudication)		11200002144	ACC NCDR
Pseudoaneurysm (requiring surgical repair) (Complete Adjudication)		11200002145	ACC NCDR
Pseudoaneurysm (requiring thrombin injection only) (Complete Adjudication)		11200002146	ACC NCDR
Pulmonary Embolism		59282003	SNOMED CT
Element: 14276	Follow-Up Events Occurred		

Coding Instruction: Indicate if the event occurred.
Target Value: Any occurrence on follow-up

Vendor Instruction: When a Follow-Up Event (14948) is provided then Follow-Up Events Occurred (14276) cannot be Null

Element: 14277

Coding Instruction: Indicate the date the event occurred.

Follow-Up Event Date

Target Value: Any occurrence on follow-up

Vendor Instruction: Follow-Up Event Date (14277) must be Less than or Equal to the Follow-Up Assessment Date (11000)

Follow-Up Event Date (14277) must be Greater than the Follow-Up Reference Procedure Start Date and Time (11001)





Section: Follow-Up Adjudication

### Parent: Follow-Up

Element: 14967

Coding Instruction: Indicate the event being adjudicated.

Adjudication Event

Target Value: The value on Follow-up

Vendor Instruction: An Adjudication - combination of Event (14967) and Date (14386) - may only be entered/selected once

Adjudication Event (14967) cannot be Null if Follow-Up Event (14948) is Equal to (Hemorrhagic Stroke, Intracranial Hemorrhage (other than hemorrhagic stroke), Ischemic Stroke, TIA, Undetermined Stroke, Access Site Bleeding, GI Bleeding, Hematoma, Hemothorax (not requiring drainage), Hemothorax (requiring drainage), Other Hemorrhage (non-intracranial), Pericardial Effusion (requiring open heart surgery), Pericardial Effusion with tamponade (requiring percutaneous drainage), Pericardial Effusion without tamponade (requiring percutaneous drainage), Pericardial Effusion without tamponade (requiring percutaneous drainage), Pericardial Effusion (other than stroke), AV Fistula (requiring surgical repair), Pseudoaneurysm (requiring thrombin injection only)) and Follow-Up Events Occurred (14276) is Yes. Every Follow-up Event (combination of Event (14967) and Event Date (14277)) that requires adjudication must have a corresponding adjudication record (combination of Event (14967) and Event Date (14386).

#### Follow-up Events - 1.3.6.1.4.1.19376.1.4.1.6.5.802

Selection	Definition	Source	Code	Code System
Endocarditis			56819008	SNOMED CT
latrogenic ASD (requiring intervention)	]		112000002179	ACC NCDR
LAA Occlusion Reinterve	ention		112000002200	ACC NCDR
Myocardial Infarction			22298006	SNOMED CT
PCI			415070008	SNOMED CT
Pericarditis			3238004	SNOMED CT
Unplanned Cardiac Surge	ery		112000001892	ACC NCDR
Unplanned Intervention	•		112000002180	ACC NCDR
Deep Vein Thrombosis			128053003	SNOMED CT
New Requirement for Dia	alvsis		100014076	ACC NCDR
Non-Device Related			112000002177	ACC NCDR
Readmission				
Systemic Thromboemboli (other than stroke) (Comp Adjudication)			112000002126	ACC NCDR
Device Explant			100001141	ACC NCDR
Device Fracture			112000001891	ACC NCDR
Device Migration			370512004	SNOMED CT
Device Related Readmiss	sion		112000002176	ACC NCDR
Device Systemic Embolis			11200002175	ACC NCDR
Device Thrombus			112000001839	ACC NCDR
Hemorrhagic Stroke (Con Adjudication)	nplete		230706003	SNOMED CT
Intracranial Hemorrhage than hemorrhagic stroke) (Complete Adjudication)			1386000	SNOMED CT
Ischemic Stroke (Complet Adjudication)	te		422504002	SNOMED CT
TIA (Complete Adjudication	on)		266257000	SNOMED CT
Undetermined Stroke (Complete Adjudication)	,		230713003	SNOMED CT
Access Site Bleeding (Complete Adjudication)			1000142440	ACC NCDR
GI Bleeding (Complete Adjudication)			74474003	SNOMED CT
Hematoma (Complete Adjudication)			385494008	SNOMED CT
Hemothorax (not requirin drainage) (Complete Adjudication)	g		112000002147	ACC NCDR
Hemothorax (requiring drainage) (Complete Adjudication)			100001011	ACC NCDR
Other Hemorrhage (non- intracranial) (Complete Adjudication)			50960005	SNOMED CT
Pericardial Effusion (requ open cardiac surgery) (Complete Adjudication)	uiring		112000002148	ACC NCDR
Pericardial Effusion with			112000002149	ACC NCDR





Section: Follow-Up Adjudication	Parent: Follow-Up	
tamponade (requiring percutaneous drainage) (Complete Adjudication)		
Pericardial Effusion without tamponade (requiring percutaneous drainage) (Complete Adjudication)	11200002150	ACC NCDR
Retroperitoneal Bleeding (Complete Adjudication)	95549001	SNOMED CT
Vascular Complications (Complete Adjudication)	213217008	SNOMED CT
AV Fistula (requiring surgical repair) (Complete Adjudication)	11200002141	ACC NCDR
Pseudoaneurysm (requiring endovascular repair) (Complete Adjudication)	11200002144	ACC NCDR
Pseudoaneurysm (requiring surgical repair) (Complete Adjudication)	11200002145	ACC NCDR
Pseudoaneurysm (requiring thrombin injection only) (Complete Adjudication)	11200002146	ACC NCDR
Pulmonary Embolism	59282003	SNOMED CT

Element: 14386

Adjudication Event Date

Coding Instruction: Indicate the date the clinical event being adjudicated occurred.

Target Value: N/A

Vendor Instruction: When Adjudication Event (14967) is selected, Adjudication Event Date (14386) cannot be Null

The Adjudication Event Date (14386) / Adjudication Event (14967) must match with Follow-Up Event Date (14277) / Follow-Up Event (14948)





Section: Follow-	Up Neurologic	Parent: Follow-Up Adjudication	
Element: 14969		Adjudication Status	
	Coding Instruction:	Indicate whether the patient was alive or deceased on the date the adjudication was performed.	
	-	Any value between discharge or last follow up and the current follow up	
	-	Adjudication Status (14969) cannot be Null if Follow-Up Adjudication Event (14967) is Equal to (Hemorrhagic Stroke, Intra-	cranial
		Hemorrhage, Ischemic Stroke, TIA, Undetermined Stroke)	
	tus - 1.3.6.1.4.1.19376.		
Selection Alive	Definition	Source         Code           438949009         438949009	Code System SNOMED C
Deceased			charge disposition
Element: 14970		Adjudication Date of Death	
	Coding Instruction:	Indicate the date the patient was declared deceased.	
	Target Value:	Any value between discharge or last follow up and the current follow up	
	Vendor Instruction:	Adjudication Date of Death (14970) must be Greater than Follow-Up Reference Procedure Start Date and Time (11001)	
		Adjudication Date of Death (14970) must be Greater than or Equal to Follow-Up Adjudication Event Date (14386)	
		Adjudication Date of Death (14970) must be Greater than or Equal to Follow-Up Symptom Onset Date (14976)	
Element: 14976		Symptom Onset Date	
	Coding Instruction:	Indicate the date of symptom onset associated with this event.	
	Target Value:	Any value between discharge or last follow up and the current follow up	
	-		
Element: 14977		Neurologic Deficit with Rapid Onset	
	Coding Instruction:	Indicate if the patient had a sudden onset of a focal or global neurologic deficit regardless of the duration of symptoms.	
		Rapid onset means sudden or maximal within minutes.	
	Target Value:	Any value between discharge or last follow up and the current follow up	
Element: 14978		Neurologic Deficit Clinical Presentation	
	Coding Instruction:	Indicate the clinical presentation of the neurologic deficit.	
	-	Any value between discharge or last follow up and the current follow up	
Jaurologic Deficit Cl	-	3.6.1.4.1.19376.1.4.1.6.5.716	
Selection	Definition	Source Code	Code Syster
Stroke-related		100014109	ACC NCD
Ion-Stroke-related		11200001860	ACC NCD
Element: 14979		Diagnosis Confirmation by Neurology	
	Coding Instruction:	Indicate if the diagnosis was confirmed by a neurologist or a neurosurgeon.	
	Target Value:	Any value between discharge or last follow up and the current follow up	
Elementi 14090	Target Value:		
Element: 14980		Brain Imaging Performed	
Element: 14980	Coding Instruction:	Brain Imaging Performed Indicate if neuro imaging (such as CT, MRI, cerebral angiography) was performed in an attempt to confirm the diagnosis.	
Element: 14980	Coding Instruction:	Brain Imaging Performed	
	Coding Instruction:	Brain Imaging Performed Indicate if neuro imaging (such as CT, MRI, cerebral angiography) was performed in an attempt to confirm the diagnosis.	
	Coding Instruction: Target Value:	Brain Imaging Performed Indicate if neuro imaging (such as CT, MRI, cerebral angiography) was performed in an attempt to confirm the diagnosis. All values between discharge or last follow up and the current follow up	
	Coding Instruction: Target Value: Coding Instruction:	Brain Imaging Performed Indicate if neuro imaging (such as CT, MRI, cerebral angiography) was performed in an attempt to confirm the diagnosis. All values between discharge or last follow up and the current follow up Brain Imaging Type	
Element: 14981	Coding Instruction: Target Value: Coding Instruction:	Brain Imaging Performed         Indicate if neuro imaging (such as CT, MRI, cerebral angiography) was performed in an attempt to confirm the diagnosis.         All values between discharge or last follow up and the current follow up         Brain Imaging Type         Indicate the type of neurologic imaging which was performed.         All values between discharge or last follow up and the current follow up	
Element: 14981 Brain Imaging Type -	Coding Instruction: Target Value: Coding Instruction: Target Value:	Brain Imaging Performed         Indicate if neuro imaging (such as CT, MRI, cerebral angiography) was performed in an attempt to confirm the diagnosis.         All values between discharge or last follow up and the current follow up         Brain Imaging Type         Indicate the type of neurologic imaging which was performed.         All values between discharge or last follow up and the current follow up	Code System
Element: 14980 Element: 14981 Brain Imaging Type - Selection Cerebral Angiography Computed Tomography	Coding Instruction: Target Value: Coding Instruction: Target Value: 1.3.6.1.4.1.19376.1.4.1. Definition	Brain Imaging Performed Indicate if neuro imaging (such as CT, MRI, cerebral angiography) was performed in an attempt to confirm the diagnosis. All values between discharge or last follow up and the current follow up Brain Imaging Type Indicate the type of neurologic imaging which was performed. All values between discharge or last follow up and the current follow up 6.5.808	Code System SNOMED C SNOMED C





Section: Follow	-op Meurologic	Parent: Follow-Up Adjudicatio		
Other			112000001862	ACC NCD
Element: 14982		Deficit Type		
	Coding Instruction:	Indicate the type of deficit identified by the neuroimaging study.		
	Target Value:	All values between discharge or last follow up and the current follow up		
Brain Imaging Findin	ıg - 1.3.6.1.4.1.19376.1.4	1 1 6 5 717		
election	Definition	Source	Code	Code Syste
lo deficit			100001231	ACC NCE
nfarction			55641003	SNOMED (
lemorrhage			50960005	SNOMED (
Both			11200002004	ACC NCE
Element: 14983		Hemorrhagic Stroke Type		
	Coding Instruction:	For patients presenting with an intracranial hemorrhage, indicate the hemorrhage local	ition.	
	Target Value:	All values between discharge or last follow up and the current follow up		
Hemorrhagic Stroke	Type - 1.3.6.1.4.1.1937	6.1.4.1.6.5.794		
Selection	Definition	Source	Code	Code Syste
ntracerebral			274100004	SNOMED (
Subarachnoid			21454007	SNOMED (
Subdural			35486000	SNOMED
Element: 14984		Subsequent Intravenous Recombinant Tissue Plasminogen Activator Activator	dministered	
	Coding Instruction:	Indicate if intravascular (IV) recombinant tissue plasminogen activator (rtPA) was use	d as a treatment option related	to this event.
	Target Value:	Any value between discharge or last follow up and the current follow up		
Element: 14985		Subsequent Endovascular Therapeutic Intervention		
	Coding Instruction:	Indicate if an endovascular interventional therapy was performed as a treatment optic	on related to this event	
	-	Any value between discharge or last follow up and the current follow up		
	Target Value.	Any value between discharge of last follow up and the current follow up		
Element: 14986		Neurologic Symptoms Duration		
	Coding Instruction:	Indicate the duration (in hours) of the neurologic symptoms.		
	-	All values between discharge or last follow up and the current follow up		
	Target value.	All values between discharge of last follow up and the current follow up		
Duration - 1.3.6.1.4.1. Selection	19376.1.4.1.6.5.795 Definition	Cauraa	Codo	Cada Suata
Less than 1 Hour	Definition	Source	11200002130	Code Syster ACC NCD
1 - 24 Hours			112000002132	ACC NCD
Greater than 24 Hours			112000002131	ACC NCD
<b>Element</b> : 14097		Trauma		
Element: 14987		Trauma		
	Coding Instruction:	Indicate if the patient experienced a physical trauma within 24 hours prior to the neuro	ologic event.	
	Target Value:	Any value between discharge or last follow up and the current follow up		
Element: 14988		Modified Rankin Scale		
	Coding Instruction:	Indicate the patient's functional ability according to the modified Rankin Scale (mRS) a	dministered following the event.	
	Target Value:	Any value between discharge or last follow up and the current follow up		
5	Supporting Definition:	Modified Rankin Scale		
		The Modified Rankin Scale is a standardized neurological examination of patients with	disability that provides a scale	of global disability.
		Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott	Med J. 1957; 2:200-15.	
		Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after	er stroke. Stroke. 1988;19(12):14	197-1500.
Rankin Scale Assoc	ment Finding - 1 3 6 1	.4.1.19376.1.4.1.6.5.139	/	
Selection	Definition	.4.1.19376.1.4.1.6.5.139 Source	Code	Code Syster
D: No symptoms at all			LA6111-4	LOIN
1: No significant disabi	lity Able to carry ou	ut all usual duties and activities.	LA6112-2	LOIN





Section: Follow-Up Ne	eurologic	Parent: Follow-Up Adjudicat	ion	
	look after own	affairs without assistance.		
3: Moderate disability	Requiring some assistance.	help, but able to walk without	LA6114-8	LOINC
4: Moderately severe disability		without assistance and unable to attend eeds without assistance.	LA6115-5	LOINC
5: Severe disability	Bedridden, inco care and attenti	ntinent and requiring constant nursing on.	LA10137-0	LOINC
6: Death			419620001	SNOMED CT
Element: 14989		Adjudication Modified Rankin Scale Not Administered		
Codi	ng Instruction:	Indicate if the modified Rankin Scale (mRS) was not administered following the even	nt.	
	Target Value:	Any value between discharge or last follow up and the current follow up		
Support	ting Definition:	Modified Rankin Scale		
		The Modified Rankin Scale is a standardized neurological examination of patients w	ith disability that provides a scale of	global disability.
		Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Sco	ott Med J. 1957; 2:200-15.	
		Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function a	fter stroke. Stroke. 1988;19(12):149	7-1500.
Element: 14990		Procedure Related Neurologic Event		
Codi	ng Instruction:	Indicate using the following selections the likelihood in which this event is related to clinical judgement.	the LAAO procedure based upon the	ne clinician's best
	Target Value:	All values between discharge or last follow up and the current follow up		

### Qualifier Value - 1.3.6.1.4.1.19376.1.4.1.6.5.796

Selection	Definition	Source Code	Code System
Certain	The clinical adverse event occurs in a plausible time relationship to the procedure and cannot be explained by concurrent disease or other drugs or devices.	17162000	SNOMED CT
Probable	The clinical adverse event occurs within a reasonable time sequence to the procedure and it is unlikely to be attributed to concurrent disease or other drugs or devices.		ACC NCDR
Possible	The clinical adverse event occurs within a reasonable time sequence to the procedure, but the event could also be explained by concurrent disease or other drugs or devices.	e 371930009	SNOMED CT
Unlikely	The clinical adverse event, based upon its temporal relationship to the procedure, makes a causal relationship improbable. Additionally, other drugs, devices or underlying disease provide plausible explanations.	11200002135	ACC NCDR
Unclassifiable	The clinical adverse event is reported yet more data i essential for a proper assessment OR the clinical adverse event is reported yet the causality cannot be judged because information is insufficient or contradictory, and cannot be supplemented or verifier		ACC NCDR





## Section: Follow-Up Neurologic

## Parent: Follow-Up Neurologic

Element: 15015

Follow-up Device Related Neurologic Event

Coding Instruction: Indicate using the following selections the likelihood in which this event is related to the LAAO device based upon the clinician's best clinical judgement.

Target Value: Any value between discharge or last follow up and the current follow up

<b>Qualifier Value - 1</b>	.3.6.1.4.1.19376.1.4.1.6.5.796
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Selection	Definition	Source Code	Code System
Certain	The clinical adverse event occurs in a plausible time relationship to the procedure and cannot be explained by concurrent disease or other drugs or devices.	17162000 I	SNOMED CT
Probable	The clinical adverse event occurs within a reasonable time sequence to the procedure and it is unlikely to be attributed to concurrent disease or other drugs or devices.		ACC NCDR
Possible	The clinical adverse event occurs within a reasonable time sequence to the procedure, but the event could also be explained by concurrent disease or other drugs or devices.	e 371930009	SNOMED CT
Unlikely	The clinical adverse event, based upon its temporal relationship to the procedure, makes a causal relationship improbable. Additionally, other drugs, devices or underlying disease provide plausible explanations.	112000002135	ACC NCDR
Unclassifiable	The clinical adverse event is reported yet more data i essential for a proper assessment OR the clinical adverse event is reported yet the causality cannot be judged because information is insufficient or contradictory, and cannot be supplemented or verifier		ACC NCDR





Section: Follow-Up Bleeding		Parent: Follow-Up Adjudication		
Element: 14971		Adjudication Status		
	Coding Instruction:	Indicate whether the patient was alive or deceased on the date the adjudication was perform	ned	
	-	Any value between discharge or last follow up and the current follow up	iou.	
	-	Adjudication Status (14971) cannot be Null if Adjudication Event (14967) is Equal to (Access s	Sito Ploading, CI Ploading	Homotomo
Adjudication Life St	atus - 1.3.6.1.4.1.19376.	Hemothorax (not requiring drainage), Hemothorax (requiring drainage), Other Hemorrhage, F surgery), Pericardial Effusion with tamponade (requiring percutaneous drainage), Pericardia percutaneous drainage), Retroperitoneal Bleeding, Vascular Complications), AV Fistula (requiring endovascular repair), Pseudoaneurysm (requiring surgical repair), Pseudoaneurysm	Pericardial Effusion (requir Effusion without tampon uiring surgical repair), Pse	ring open cardiac ade (requiring eudoaneurysm
Selection	Definition	Source	Code	Code Syster
Alive			438949009	SNOMED C
Deceased			20 HL7	Discharge dispositio
Element: 14972		Adjudication Date of Death		
	Coding Instruction:	Indicate the date the patient was declared deceased.		
	Target Value:	Any value between discharge or last follow up and the current follow up		
	Vendor Instruction:	Adjudication Date of Death (14972) must be Greater than the Follow-Up Reference Procedur	e Start Date and Time (1	1001)
		Adjudication Date of Death (14972) must be Greater than or Equal to Follow-Up Adjudication	Event Date (14386)	
Element: 14991		Invasive Intervention Required		
	Coding Instruction:	Indicate if there was a surgical or percutaneous intervention required to treat the patient for	this bleeding event.	
	Target Value:	Any value between discharge or last follow up and the current follow up		
Element: 14992		RBC Transfusion		
	Coding Instruction:	Indicate if there was at least one transfusion of PRBCs given to treat the patient for this blee	ding event.	
	Target Value:	All values between discharge or last follow up and the current follow up		
Element: 14993		Follow-up number of RBC Units Transfused		
	-	Indicate the number of PRBC units transfused for treatment of this bleeding event.		
	Target Value:	All values between discharge or last follow up and the current follow up		
Element: 14994		Hemoglobin Pre-Transfusion		
	Coding Instruction:	Indicate the lowest hemoglobin (Hgb) value (g/dL), obtained via lab assay or point of care as	ssav, between the intra o	r post procedure
	·····j	bleeding event and prior to the transfusion.	,	
	Target Value:	All values between discharge or last follow up and the current follow up		
Element: 14995		Diagnostic Imaging Performed		
	Coding Instruction:	Indicate if imaging (such as CT, MRI) was performed in an attempt to confirm the diagnosis.		
	Target Value:	All values between discharge or last follow up and the current follow up		
Element: 14996		End Organ Damage		
Liement. 14990	Coding Instruction			
	-	Indicate if the patient was diagnosed with end organ damage after this bleeding event.		
	rarget value:	All values between discharge or last follow up and the current follow up		
Element: 14975		Bleeding Event Readmission		
	Coding Instruction:	Indicate if a readmission was associated with a bleeding related diagnosis.		
	-	Any value between discharge or last follow up and the current follow up		
		,		
Element: 14997		Major Surgery		
	Coding Instruction:	Indicate if the patient underwent surgery within 30 days prior to this bleeding event.		
	Target Value:	Any value between discharge or last follow up and the current follow up		



Parent: Follow-Up Adjudication



### Section: Follow-Up Bleeding

## Element: 14998 Percutaneous Coronary Intervention Coding Instruction: Indicate if the patient had a percutaneous coronary artery or percutaneous valvular intervention within 30 days prior to this bleeding event. Target Value: Any value between discharge or last follow up and the current follow up Supporting Definition: Percutaneous Coronary Intervention A percutaneous coronary intervention (PCI) is the placement of an angioplasty guide wire, balloon, or other device (e.g. stent, atherectomy, brachytherapy, or thrombectomy catheter) into a native coronary artery or coronary artery bypass graft for the purpose of mechanical coronary revascularization. Source: Medline Plus, 2017 by Merriam-Webster, Incorporated Element: 14999 Procedure Related Bleeding Event Coding Instruction: Indicate using the following selections the likelihood in which this event is related to the LAAO procedure based upon the clinician's best clinical judgement. Target Value: Any value between discharge or last follow up and the current follow up Supporting Definition: Bleeding Event A bleeding event observed and documented in the medical record that was associated with a hematocrit drop of ≥10% and/or a hemoglobin drop of ≥3 g/dL or that required transfusion or surgical intervention. Source: Cannon CP, Brindis RG, Chaitman BR, et al. 2013 ACCF>AHA Key Date Elements and Definitions for Measuring the Clinical Management and Outcomes of Patients with Acute Coronary Syndromes and Coronary Artery Disease. Circulation. 2013;127;1052-1089.

#### Qualifier Value - 1.3.6.1.4.1.19376.1.4.1.6.5.796

Selection	Definition	Source	Code	Code System
Certain	The clinical adverse event occurs in a plausible tir relationship to the procedure and cannot be expla by concurrent disease or other drugs or devices.		17162000	SNOMED CT
Probable	The clinical adverse event occurs within a reason time sequence to the procedure and it is unlikely tr attributed to concurrent disease or other drugs or devices.	be	112000002134	ACC NCDR
Possible	The clinical adverse event occurs within a reason time sequence to the procedure, but the event cou also be explained by concurrent disease or other drugs or devices.		371930009	SNOMED CT
Unlikely	The clinical adverse event, based upon its tempor relationship to the procedure, makes a causal relationship improbable. Additionally, other drugs, devices or underlying disease provide plausible explanations.	al	112000002135	ACC NCDR
Unclassifiable	The clinical adverse event is reported yet more da essential for a proper assessment OR the clinical adverse event is reported yet the causality canno judged because information is insufficient or contradictory, and cannot be supplemented or ver	t be	112000002136	ACC NCDR





# Section: Follow-Up Bleeding

Element: 15000	Device Related Bleeding Event
Coding Instruction:	Indicate using the following selections the likelihood in which this event is related to the LAAO device based upon the clinician's best clinical judgement.
Target Value:	Any value between discharge or last follow up and the current follow up
Supporting Definition:	Bleeding Event
	A bleeding event observed and documented in the medical record that was associated with a hematocrit drop of $\geq 10\%$ and/or a hemoglobin drop of $\geq 3$ g/dL or that required transfusion or surgical intervention.

Source: Cannon CP, Brindis RG, Chaitman BR, et al. 2013 ACCF>AHA Key Date Elements and Definitions for Measuring the Clinical Management and Outcomes of Patients with Acute Coronary Syndromes and Coronary Artery Disease. Circulation. 2013;127;1052-1089.

Parent: Follow-Up Bleeding

## Qualifier Value - 1.3.6.1.4.1.19376.1.4.1.6.5.796

Selection	Definition	Source	Code	Code System
Certain	The clinical adverse event occurs in a plausible time relationship to the procedure and cannot be explained by concurrent disease or other drugs or devices.	1	17162000	SNOMED CT
Probable	The clinical adverse event occurs within a reasonabl time sequence to the procedure and it is unlikely to be attributed to concurrent disease or other drugs or devices.		112000002134	ACC NCDR
Possible	The clinical adverse event occurs within a reasonabl time sequence to the procedure, but the event could also be explained by concurrent disease or other drugs or devices.	e	371930009	SNOMED CT
Unlikely	The clinical adverse event, based upon its temporal relationship to the procedure, makes a causal relationship improbable. Additionally, other drugs, devices or underlying disease provide plausible explanations.		112000002135	ACC NCDR
Unclassifiable	The clinical adverse event is reported yet more data essential for a proper assessment OR the clinical adverse event is reported yet the causality cannot be judged because information is insufficient or contradictory, and cannot be supplemented or verifie	9	112000002136	ACC NCDR





Coding Instruction: indicate whether the patient was alle or deceased on the data the adjutchalon was performed. Target Value: Any value between discharge or lask (files up and the current follow up or the order function or the order functio	Section: Follow-	-Up Systemic Thro	nboembolism Parent: Follow-Up Adjudication		
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Vender Instruction:       Middation Data Diams (14073) cannot be Mail Adjuication Event (14077) is Equal to (Systemic Thromboembolice) (14078)		-		ponomodi	
signification Life Status - 1.3.0.1.4.1.19370-1.4.1.0.5.720 effection Dofinition Source Code Code System were set to Dofinition Date of Death - 4308.4000 Source Code System C		-		Systemic Thromboombolism (othe	or than atraka))
siereiten Definition Source Code Sys live					
ine discrete				Codo	Codo Svet
Idence it 14974         Adjudication Date of Death           Coding instruction:         Indicate the date the patient was declared deceased.           Target Value:         Any value between discharge or last follow up and the current follow up           Vendor Instruction:         Adjudication Date of Death (1497-) must be Greater than the Follow-Up Reference Procedure Stat Date and Time (11001)           Adjudication Date of Death (1497-) must be Greater than or Equat to the Follow-Up Adjudication Found to 1497-)         Adjudication Date of Death (1497-)           Element: 15016         Death Cause (End-Organ Hypoperfusion OR Systemic Thromboembolization or Instruction: from systemic thromboembolization or tensing systemic thromboembolization or focal end-organ hypoperfusion results from systemic thromboembolization are used in the systemic thromboembolization or focal end-organ hypoperfusion results from systemic thromboembolization are used into the used the current follow up           Element: 15001         Focal End-Organ Hypoperfusion Present           Target Value:         Any value between discharge or last follow up and the current follow up           Target Value:         Al values between discharge or last follow up and the current follow up           Target Value:         Al values between discharge or last follow up and the current follow up           Target Value:         Al values between discharge or last follow up and the current follow up           Target Value:         Al values between discharge or last follow up and the current follow up           Targe	Alive	Deminion	Source		SNOMED
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Target Value       Any value between discharge or last follow up and the current follow up         Vendor Instruction       Adjuication Date of Death (14974) must be Greater than on Equal to the Follow-Up Adjuication Event Date (14374)         Element: 15016       Death Cause (End-Organ Hypoperfusion OR Systemic thromboembolization OR Intervention for systemic thromboembolization, or focal and organ hypoperfusion results from systemic thromboembolization, or focal and organ hypoperfusion results from systemic thromboembolization.         Target Value       Any value between discharge or last follow up and the current follow up         Element: 15001       Focal End-Organ Hypoperfusion Resulted from the systemic thromboembolization or for an indrogen hypoperfusion resulted from the systemic thromboembolization.         Target Value       Indicate if focal end-organ hypoperfusion resulted from the systemic thromboembolization.         Target Value       Indicate if focal end-organ hypoperfusion resulted from the systemic thromboembolization.         Target Value       Haviaus between discharge or last follow up and the current follow up         Element: 15002       Soloneuro         Coding Instruction       Indicate in inging method to identify systemic thromboembolization.         Target Value       Al values between discharge or last follow up and the current follow up         Element: 15003       Follow-up Imaging Method         Element: 15004       Definition         Soloneuro       Target Value		Coding Instruction:	Indicate the date the patient was declared deceased.		
Vendor Instruction:       Adjudication Date of Death (14974) must be Greater than the Follow-Up Adjudication Event Date (14908)         Element:       15016       Death Cause (End-Organ Hypoperfusion OR Systemic Thromboembolization OR Intervention to treat systemic thromboembolization ar tocal end-organ hypoperfusion results for interpretion to treat systemic thromboembolization ar tocal end-organ hypoperfusion Present         Element:       15001       Focal End-Organ Hypoperfusion Present         Target Value       Any value between discharge or last follow up and the current follow up         Element:       15002       Systemic Thromboembolization Imaging Evidence         Target Value       Any value between discharge or last follow up and the current follow up         Element:       15002       Systemic Thromboembolization Imaging Evidence         Target Value       All values between discharge or last follow up and the current follow up         Element:       15002       Systemic Thromboembolization Imaging Evidence         Target Value       All values between discharge or last follow up and the current follow up         Element:       15002       Systemic Thromboembolization Imaging Evidence         Target Value       All values between discharge or last follow up and the current follow up         Element:       15003       Follow-up Imaging Method         Element:       15004       Target Value       SNOKE <t< td=""><td></td><td>-</td><td></td><td></td><td></td></t<>		-			
Adjudication Date of Death (14974) must be Greater than or Equal to the Follow-Up Adjudication Event Date (14386)  Element: 15016 Death Cause (End-Organ Hypoperfusion OR Systemic Thromboembolization, or focal end-organ hypoperfusion resulting from systemic thromboembolization, or therapeutic intervention between bolization, or focal end-organ hypoperfusion resulting from systemic thromboembolization, or therapeutic intervention between bolization, or focal end-organ hypoperfusion resulting from systemic thromboembolization, or therapeutic intervention between bolization, or focal end-organ hypoperfusion resulting from systemic thromboembolization, or therapeutic intervention bolization, or focal end-organ hypoperfusion resulting from systemic thromboembolization resulting from systemic thromboembolization resulting from systemic thromboembolization resulting from systemic thromboembolization from the systemic thromboembolization array Value between discharge or last follow up and the current follow up  Element: 15002 Systemic Thromboembolization fraging Evidence Coding Instruction Indicate firmaging evidence indicated systemic thromboembolism. Target Value Al values between discharge or last follow up and the current follow up  Element: 15003 Follow-up Imaging Method Coding Instruction Indicate the imaging method to identify systemic thromboembolism. Target Value Al values between discharge or last follow up and the current follow up  Element: 15004 Frianget Thromboembolized, catheter, surgical, or other therapeutic intervention was performed to treat the systemic thromboembolism Target Value Al values between discharge or last follow up and the current follow up  Element: 15004 Thranpeutic Intervention Performed  Element: 15005 Intervention Type Al values between discharge or last follow up and the current follow up  Element: 15004 Thranpeutic Intervention Performed Intervention Type In		-		Procedure Start Date and Time (11	001)
Ceding Instruction:       If deceased, indicate if the patient's death cause was due to systemic thromboembolism.         Target Value:       Any value between discharge or last follow up and the current follow up         Element:       15001       Focal End-Organ Hypoperfusion Present         Coding Instruction:       Indicate if focal end-organ hypoperfusion resulted from the systemic thromboembolism event.         Target Value:       Any value between discharge or last follow up and the current follow up         Element:       15002       Systemic Thromboembolization Imaging Evidence         Coding Instruction:       Indicate if focal end-organ hypoperfusion resulted from the systemic thromboembolism.         Target Value:       All values between discharge or last follow up and the current follow up         Element:       15003       Follow-up Imaging Method         Coding Instruction:       Indicate if maging method to identify systemic thromboembolism.         Target Value:       All values between discharge or last follow up and the current follow up         region Type - 1.3.6.1.4.1.9376.1.4.1.6.5.47       Solow-up Imaging Method         Coding Instruction:       Indicate if any pharmacological, catheler, surgical, or other therapeutic intervention was performed to treat the systemic thromboembolism.         Target Value:       All values between discharge or last follow up and the current follow up         Regineit: Resonand: Imagin       Therapeutic Inter					001)
tom systemic thromboenbolism, or therapeutic intervention to ireat systemic thromboenbolism. Target Value Any value between discharge or last follow up and the current follow up  Element: 15001  Coding Instruction indicate if focal end-organ hypoperfusion resulted from the systemic thromboenbolism event. Target Value Any value between discharge or last follow up and the current follow up  Element: 15002  Systemic Thromboenbolization Imaging Evidence Coding Instruction indicate if imaging evidence indicated systemic thromboenbolism. Target Value All values between discharge or last follow up and the current follow up  Element: 15003 Follow-up Imaging Method Coding Instruction indicate if imaging method to identify systemic thromboenbolism. Target Value All values between discharge or last follow up and the current follow up  anging Type - 1.3.6.1.4.1.9.5717 Element: 15003 Follow-up Imaging Method Coding Instruction indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was performed to treat the systemic thromboenbolism. Target Value All values between discharge or last follow up and the current follow up  therapeutic intervention Performed Coding Instruction indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was performed to treat the systemic thromboenbolism. Target Value All values between discharge or last follow up and the current follow up  tervention Type Coding Instruction indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was performed to treat the systemic thromboenbolism. Target Value All values between discharge or last follow up and the current follow up  tervention Type Coding Instruction indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was performed to treat the systemic thromboenbolism. Target Value All values between discharge or last follow up and the current follow up  tervention Type Coding Instruction indicate intervention type. Target Value All values	Element: 15016		Death Cause (End-Organ Hypoperfusion OR Systemic Thromboemboli	zation OR Intervention)	
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Element: 15002       Systemic Thromboembolization Imaging Evidence         Coding Instruction:       Indicate if imaging evidence indicated systemic thromboembolism.         Target Value:       All values between discharge or last follow up and the current follow up         Element:       15003       Follow-up Imaging Method         Coding Instruction:       Indicate the imaging method to identify systemic thromboembolism.         Target Value:       All values between discharge or last follow up and the current follow up         maging Type - 1.3.6.1.4.1.19376.1.4.1.6.5.41         election       Definition       Source       Code Systemic Thromboembolism.         ranget Value:       All values between discharge or last follow up and the current follow up       SNOMET         ingiography       77434006       SNOMET         omputed Tomography       77447000       SNOMET         lagnetic Resonance Imaging       112000001642       ACC N         tarsound       112000001642       ACC N         tarsound       Therapeutic Intervention Performed       Element:         Coding Instruction:       Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was performed to treat the systemic thromboembolism.       Target Value:         tarset Value:       All values between discharge or last follow up and the current follow up       Target Value:		Coding Instruction:	Indicate if focal end-organ hypoperfusion resulted from the systemic thromboembolis	sm event.	
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election         Definition         Source         Code         Code Sys           ngiography         77343006         SNOMEI           omputed Tomography         77343006         SNOMEI           lagnetic Resonance Imaging         77477000         SNOMEI           lagnetic Resonance Imaging         11200001042         ACC N           titrasound         112000001042         ACC N           titrasound         112000001042         ACC N           Element: 15004         Therapeutic Intervention Performed         112000001042         ACC N           Element: 15005         Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was performed to treat the systemic thromboembolism.         Target Value:         All values between discharge or last follow up and the current follow up           Element: 15005         Intervention Type         Indicate the intervention type.         Target Value:         All values between discharge or last follow up and the current follow up           election         Definition         Source         Code         Code Sys           atheter         276272002         SNOMEI           harmacological         18282007         SNOMEI           urgical         387713003         SNOMEI		Target Value:	All values between discharge or last follow up and the current follow up		
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omputed Tomography       77477000       SNOMED         lagnetic Resonance Imaging       113091000       SNOMED         lagnetic Resonance Imaging       113000001042       ACC N         ltrasound       112000001042       ACC N         ther Imaging       112000001862       ACC N         Element: 15004       Therapeutic Intervention Performed       ACC N         Linervention Performed       Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was performed to treat the systemic thromboembolism.       Target Value:         Linervention Type       All values between discharge or last follow up and the current follow up       Intervention Type         Element: 15005       Intervention Type.       Target Value:       All values between discharge or last follow up and the current follow up         Element: 15005       Intervention Type.       Target Value:       All values between discharge or last follow up and the current follow up         Element: 15005       Intervention type.       Target Value:       All values between discharge or last follow up and the current follow up         Element: 15005       Element of the intervention type.       Source       Code Sys         Intervention Type - 1.3.6.1.4.1.19376.1.4.1.6.5.797       Election       Source       Source         election       Definition       Source       StooM		Deminion	Source		SNOMED
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the Imaging 1200001862 ACC M Element: 15004 The rapeutic Intervention Performed Coding Instruction: Indicate if any pharmacological, catheter, surgical, or other the rapeutic intervention was performed to treat the systemic thromboembolism. Target Value: All values between discharge or last follow up and the current follow up Element: 15005 Intervention Type Coding Instruction: Indicate the intervention type. Target Value: All values between discharge or last follow up and the current follow up tervention Type - 1.3.6.1.4.1.19376.1.4.1.6. Target Value: All values between discharge or last follow up and the current follow up tervention Type - 1.3.6.1.4.1.19376.1.4.1.6. Target Value: All values between discharge or last follow up and the current follow up tervention Type - 1.3.6.1.4.1.19376.1.4.1.6. Target Value: All values between discharge or last follow up and the current follow up tervention Type - 1.3.6.1.4.1.19376.1.4.1.6. Target Value: All values between discharge or last follow up and the current follow up tervention Type - 1.3.6.1.4.1.19376.1.4.1.6. Target Value: All values between discharge or last follow up and the current follow up tervention Type - 1.3.6.1.4.1.19376.1.4.1.6. Target Value: All values between discharge or last follow up and the current follow up tervention Type - 1.3.6.1.4.1.19376.1.4.1.6. Target Value: All values between discharge or last follow up and the current follow up tervention Type - 1.3.6.1.4.1.19376.1.4.1.6. Target Value: All values between discharge or last follow up and the current follow up tervention Type - 1.3.6.1.4.1.19376.1.4.1.6. Target Value: All values between discharge or last follow up and the current follow up tervention Type - 1.3.6.1.4.1.19376.1.4.1.6. Target Value: All values between discharge or last follow up and the current follow up tervention Type - 1.3.6.1.4.1.19376.1.4.1.6. Target Value: All values between discharge or last follow up and the current follow up tervention Type - 1.3.6.1.4.1.19376.1.4.1.6. Target Value: All v	Agnetic Resonance Ir	maging		113091000	SNOMED
Element: 15004       Therapeutic Intervention Performed         Coding Instruction:       Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was performed to treat the systemic thromboembolism.         Target Value:       All values between discharge or last follow up and the current follow up         Element: 15005       Intervention Type         Coding Instruction:       Indicate the intervention type.         Target Value:       All values between discharge or last follow up and the current follow up         Element: 15005       Intervention Type         Coding Instruction:       Indicate the intervention type.         Target Value:       All values between discharge or last follow up and the current follow up         tervention Type - 1.3.6.1.4.1.19376.1.4.1.6.5.797       Election         Definition       Source       Code System         atheter       276272002       SNOMED         harmacological       182832007       SNOMED         urgical       387713003       SNOMED	Jltrasound				ACC NCI
Coding Instruction:       Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was performed to treat the systemic thromboembolism.         Target Value:       All values between discharge or last follow up and the current follow up         Element:       15005       Intervention Type         Coding Instruction:       Indicate the intervention type.       Indicate the intervention type.         Target Value:       All values between discharge or last follow up and the current follow up       Vertex (Coding Instruction)         Intervention Type - 1.3.6.1.4.1.19376.1.4.1.6.5.797       All values between discharge or last follow up and the current follow up         Intervention Type - 1.3.6.1.4.1.19376.1.4.1.6.5.797       Source       Code       Code Systematication         Intervention Type - 1.3.6.1.4.1.19376.1.4.1.6.5.797       Source       Source       Source       Source         utervention Type - 1.3.6.1.4.1.19376.1.4.1.6.5.797       Source       Source </td <td>Other Imaging</td> <td></td> <td></td> <td>112000001862</td> <td>ACC NCI</td>	Other Imaging			112000001862	ACC NCI
thromboembolism.       Target Value:       All values between discharge or last follow up and the current follow up         Element:       15005       Intervention Type         Coding Instruction:       Indicate the intervention type.         Target Value:       All values between discharge or last follow up and the current follow up         ntervention Type - 1.3.6.1.4.1.19376.1.4.1.6.5.797       Code System         election       Definition       Source       Code System         atheter       276272002       SNOMED         harmacological       182832007       SNOMED         urgical       387713003       SNOMED	Element: 15004		· · · · · · · · · · · · · · · · · · ·		
Element: 15005       Intervention Type         Coding Instruction:       Indicate the intervention type.         Target Value:       All values between discharge or last follow up and the current follow up         ntervention Type - 1.3.6.1.4.1.19376.1.4.1.6.5.797       Code         election       Definition         satheter       276272002         harmacological       182832007         urgical       387713003		Coding Instruction:		was performed to treat the system	nic
Coding Instruction: Indicate the intervention type.         Target Value: All values between discharge or last follow up and the current follow up         Intervention Type - 1.3.6.1.4.1.19376.1.4.1.6.5.797         election       Code       Code System         atheter       276272002       SNOMED         harmacological       182832007       SNOMED         urgical       387713003       SNOMED		Target Value:	All values between discharge or last follow up and the current follow up		
Target Value: All values between discharge or last follow up and the current follow up         tervention Type - 1.3.6.1.4.1.9376.1.4.1.6.5.797         election       Definition       Source       Code       Code Syst         satheter       276272002       SNOMED         harmacological       182832007       SNOMED         urgical       387713003       SNOMED	Element: 15005		···		
Itervention Type - 1.3.6.1.4.1.19376.1.4.1.6.5.797         Source         Code         Source           election         Definition         Source         Code System         SNOMED           atheter         276272002         SNOMED         SNOMED           harmacological         182832007         SNOMED           urgical         387713003         SNOMED		-			
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urgical 387713003 SNOME					SNOMED
	Surgical				SNOMED (
	Dther				ACC NC





Section: Follow-Up Systemic Thromboembolism

Parent: Follow-Up Adjudication





## Section: Follow-Up Adjudication Medications

Element: 15006

Adjudication Medication Code

Coding Instruction: Indicate the NCDR assigned identification number for the medications the patient was taking or administered at the time of the event.

Parent: Follow-Up Adjudication

Target Value: All values between discharge or last follow up and the current follow up

## Pre-Procedure Medication - 1.3.6.1.4.1.19376.1.4.1.6.5.216

Code System	Code	Source	election Definition
RxNorm	321208		ondaparinux
ACC NCDR	100000921		eparin Derivative
SNOMED CT	373294004	Low Molecular Weight Heparin	
SNOMED CT	96382006		nfractionated Heparin
RxNorm	11289		/arfarin
ACC NCDR	112000002080		spirin 81 to 100 mg
ACC NCDR	11200002081		spirin 101 to 324 mg
RxNorm	317300		spirin 325 mg
RxNorm	226716		spirin/Dipyridamole
RxNorm	1537034		orapaxar
RxNorm	1364430		pixaban
RxNorm	1546356		abigatran
RxNorm	1599538		doxaban
RxNorm	1114195		ivaroxaban
RxNorm	1656052		angrelor
RxNorm	32968		lopidogrel
ACC NCDR	112000001003		ther P2Y12
RxNorm	613391		rasugrel
RxNorm	1116632		cagrelor
RxNorm	10594		clopidine

Element: 15007

### Medication Administered

Coding Instruction: Indicate if the patient was taking or being administered the medication at the time of the event.

Target Value: All values between discharge or last follow up and the current follow up

Vendor Instruction: When an Adjudication Medication Code (15006) is selected, Medication Administered (15007) cannot be Null

Drug Administered - 1.3.6.1.4.1.19376.1.4.1.6.5.711

Selection	Definition	Source	Code	Code System
Yes			112000001851	ACC NCDR
No			100014173	ACC NCDR





Section: Admin		Parent: Root
Element: 1000		Participant ID
	Coding Instruction:	Indicate the participant ID of the submitting facility.
	Target Value:	N/A
Element: 1010		Participant Name
	Coding Instruction:	Indicate the full name of the facility where the procedure was performed.
		Note(s): Values should be full, official hospital names with no abbreviations or variations in spelling.
	Target Value:	N/A
Element: 1020		Time Frame of Data Submission
	Coding Instruction: Target Value:	Indicate the time frame of data included in the data submission. Format: YYYYQQ. e.g.,2016Q1
	Taiget Value.	
Element: 1040		Transmission Number
	Coding Instruction:	This is a unique number created, and automatically inserted by the software into export file. It identifies the number of times the software has created a data submission file. The transmission number should be incremented by one every time the data submission files are
		exported. The transmission number should never be repeated.
	Target Value:	N/A
Element: 1050		Vendor Identifier
Element. 1050	Coding Instruction:	Vendor identification (agreed upon by mutual selection between the vendor and the NCDR) to identify software vendor. This is entered
	•••••••j	into the schema automatically by vendor software. Vendors must use consistent name identification across sites. Changes to vendor name identification must be approved by the NCDR.
	Target Value:	
	J. J	
Element: 1060		Vendor Software Version
	Coding Instruction:	Vendor's software product name and version number identifying the software which created this record (assigned by vendor). Vendor controls the value in this field. This is entered into the schema automatically by vendor software.
	Target Value:	
Element: 1070		Registry Identifier
	Coding Instruction:	The NCDR registry identifier describes the data registry to which these records apply. It is implemented in the software at the time the data is collected and records are created. This is entered into the schema automatically by software.
	Target Value:	N/A
Element: 1071		Registry Schema Version
	Coding Instruction:	Schema version describes the version number of the Registry Transmission Document (RTD) schema to which each record conforms. It is an attribute that includes a constant value indicating the version of schema file. This is entered into the schema automatically by
	Towned Volum	software.
	Target Value:	N/A
Element: 1085		Submission Type
	Coding Instruction:	Indicate if the data contained in the harvest/data file contains either standard patient episode of care records (arrival date to discharge only) or if it contains patient follow-up records.
		A transmission file with all episode of care records (from Arrival to Discharge only) is considered a 'Base Registry Record'.
		A file with patient follow-up records (any follow-up assessments performed during the quarter selected) is considered a 'Follow-Up Record'.
		Note(s): Selecting 'Follow-Up Records Only' will transmit all patient records with Follow-up Assessment Dates (Element Ref# 11000) contained in the selected timeframe, regardless of the procedure or discharge date. For example, if a patient has a procedure on 3/30/2017, is discharged on 3/31/2017, and has a follow-up assessment on 5/6/2017, the patient's episode of care data will be transmitted in the





Target Value: N/A

Parent: Root

Submission Type						
Selection	Definition	Source	Code	Code System		
Episode of Care Records Only			1000142424	ACC NCDR		
Follow-Up Records C	Only		1000142425	ACC NCDR		