Section: Demographics — Parent: Root

Element: 2000 — Last Name

Coding Instruction: Indicate the patient's last name. Hyphenated names should be recorded with a hyphen.

Target Value: 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.

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

Coding Instruction: 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

Vendor Instruction: SSN (2030) must be 9 numeric characters long

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: This number is automatically generated by the data collection software system used by your facility to abstract data

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 — Sex

Coding Instruction: Indicate the patient's sex at birth.

Target Value: The value on arrival at this facility

Person Sex - 1.3.6.1.4.1.19376.1.4.1.6.5.19

Selection	Definition	Source	Code	Code System
Male			M	HL7 Administrative Gender

Section: Demographics **Parent: Root**

Female F HL7 Administrative Gender

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

Vendor Instruction: Patient Zip Code (2065) must be 5 numeric characters long

Element: 2066 Zip Code N/A

Coding Instruction: Indicate if the patient does not have a United States Postal Service zip code.

Note(s):
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.

Target Value: The value on arrival at this facility

Supporting Definition: **White (race)**

Having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Source: 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.

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.

Target Value: The value on arrival at this facility

Supporting Definition: **American Indian or Alaskan Native (race)**

Having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Source: 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.

Target Value: The value on arrival at this facility

Supporting Definition: **Asian (race)**

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

Coding Instruction: Indicate if the patient is Native Hawaiian or Pacific Islander as determined by the patient/family.

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

Section: Demographics **Parent: Root**

Element: 2076 Hispanic or Latino Ethnicity

Coding Instruction: Indicate if the patient is of Hispanic or Latino ethnicity as determined by the patient/family.

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 Information **Parent: Episode of Care**

Element: 2999 Episode Unique Key

Coding Instruction: Indicate the unique key associated with each patient episode record as assigned by the EMR/EHR or your software application.

Target Value: N/A

Element: 3001 Arrival Date and Time

Coding Instruction: Indicate the date and time the patient arrived at this facility.

If the arrival date and time are not specified, code the earliest date and time found in the medical record indicating the patient was at this facility (i.e., ED triage, ECG, etc.).

Target Value: N/A

Vendor Instruction: Time between Arrival Date and Time (3001) and Arrival at Outside Facility Date and Time (12426) should be Less than or Equal to One Day

Patient must be at least 18 years old at time of Arrival Date and Time (3001)

Arrival Date and Time (3001) must be Less than Transferred out of Emergency Department Date and Time (12361)

Arrival Date and Time (3001) must be Greater than Arrival at Outside Facility Date and Time (12426)

Arrival Date and Time (3001) must be Less than Discharge Date and Time (10101)

Element: 12217 Admission Date and Time

Coding Instruction: Indicate the date and time the patient was admitted as an inpatient to your facility for the current episode of care.

Note(s):
Indicate the date and time that the inpatient admission order was written.

Indicate the date and time (mm/dd/yyyy hours:minutes) using the military 24-hour clock, beginning at midnight (0000 hours).

Target Value: N/A

Vendor Instruction: Admission Date and Time (12217) must be Less than Discharge Date and Time (10101)

Section: ED Professionals **Parent: Episode Information**

Element: 12202 Emergency Department Provider Last Name

Coding Instruction: Indicate the last name of the emergency department professional.

Note(s):
If the name exceeds 50 characters, enter the first 50 characters only.

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the professional level, which may assist professionals with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, Emergency and Discharging professionals' roles, as supported by the patient medical record.

Target Value: All values between arrival at this facility and discharge

Element: 12201 Emergency Department Provider First Name

Coding Instruction: Indicate the first name of the emergency department professional.

Note(s):
If the name exceeds 50 characters, enter the first 50 characters only.

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the professional level, which may assist professionals with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, Emergency and Discharging professionals' roles, as supported by the patient medical record.

Target Value: All values between arrival at this facility and discharge

Element: 12203 Emergency Department Provider Middle Name

Coding Instruction: Indicate the middle name of the emergency department professional.

Note(s):
If the name exceeds 50 characters, enter the first 50 characters only.

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the professional level, which may assist professionals with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, Emergency and Discharging professionals' roles, as supported by the patient medical record.

Target Value: All values between arrival at this facility and discharge

Element: 12204 Emergency Department Provider NPI

Coding Instruction: Indicate the National Provider Identifier (NPI) of the provider that will be listed as the physician of record during the Emergency Department visit. NPI's, assigned by the Centers for Medicare and Medicaid Services (CMS), are used to uniquely identify physicians for Medicare billing purposes.

Note(s):
The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the physician level, which may assist physicians with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, Emergency and Discharging Provider roles, as supported by the patient medical record.

Target Value: All values between arrival at this facility and discharge

Vendor Instruction: A partial response for Emergency Department Provider is not allowed. NPI (12204), First Name (12201), and Last Name (12202) must all be answered or left NULL

Section: Admitting Professional **Parent: Episode Information**

Element: 3050 Admitting Provider Last Name

Coding Instruction: Indicate the last name of the admitting professional.

Note(s):
If the name exceeds 50 characters, enter the first 50 characters only.

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the professional level, which may assist professionals with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging professionals' roles, as supported by the patient medical record.

Target Value: The value on arrival at this facility

Element: 3051 Admitting Provider First Name

Coding Instruction: Indicate the first name of the admitting professional.

Note(s):
If the name exceeds 50 characters, enter the first 50 characters only.

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the professional level, which may assist professionals with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging professionals' roles, as supported by the patient medical record.

Target Value: The value on arrival at this facility

Element: 3052 Admitting Provider Middle Name

Coding Instruction: Indicate the middle name of the admitting professional.

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.

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the professional level, which may assist professionals with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging professionals' roles, as supported by the patient medical record.

Target Value: The value on arrival at this facility

Element: 3053 Admitting Provider NPI

Coding Instruction: Indicate the National Provider Identifier (NPI) of the professional that admitted the patient.

National Provider Identifier (NPI) numbers, assigned by the Centers for Medicare and Medicaid Services (CMS), are used to uniquely identify professionals for Medicare billing purposes.

Note(s):
The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the professional level, which may assist professionals with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging professionals' roles, as supported by the patient medical record.

Target Value: The value on arrival at this facility

Vendor Instruction: A partial response for Admitting Provider is not allowed. NPI (3053), First Name (3051), and Last Name (3050) must all be answered or left NULL

Section: Attending Professionals **Parent: Episode Information**

Element: 3055 Attending Provider Last Name

Coding Instruction: Indicate the last name of the attending professional.

Note(s):
If the name exceeds 50 characters, enter the first 50 characters only.

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the professional level, which may assist professionals with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging professionals' roles, as supported by the patient medical record.

Target Value: All values between arrival at this facility and discharge

Element: 3056 Attending Provider First Name

Coding Instruction: Indicate the first name of the attending professional.

Note(s):
If the name exceeds 50 characters, enter the first 50 characters only.

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the professional level, which may assist professionals with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging professionals' roles, as supported by the patient medical record.

Target Value: All values between arrival at this facility and discharge

Element: 3057 Attending Provider Middle Name

Coding Instruction: Indicate the middle name of the attending professional.

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.

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the professional level, which may assist professionals with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging professionals' roles, as supported by the patient medical record.

Target Value: All values between arrival at this facility and discharge

Element: 3058 Attending Provider NPI

Coding Instruction: Indicate the National Provider Identifier (NPI) of the attending professional.

National Provider Identifier (NPI) numbers, assigned by the Centers for Medicare and Medicaid Services (CMS), are used to uniquely identify professionals for Medicare billing purposes.

Note(s):
The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the professional level, which may assist professionals with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging professionals' roles, as supported by the patient medical record.

Target Value: All values between arrival at this facility and discharge

Vendor Instruction: A partial response for Attending Provider is not allowed. NPI (3058), Last Name (3055), and First Name (3056) must all be answered or left NULL

Section: Health Insurance — Parent: Episode Information

Element: 3005 — Health Insurance

Coding Instruction: Indicate if the patient has health insurance.

Target Value: The value on arrival at this facility

Element: 3010 — Health Insurance Payment Source

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 discuss with your billing department to understand how it should be identified in the registry.

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	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
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
Medicare (Part A or B)	Medicare is a health insurance program for: people age 65 or older; people under age 65 with certain disabilities; and people of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant). Medicare Part A (Hospital Insurance) – Part A helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Medicare Part B (Medical Insurance) – Part B helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.	Medicare Program - General Information | CMS	1	PHDSC
Medicare Advantage (Part C)	Medicare Part C (Medicare Advantage) – Part C is an alternative way to get Medicare coverage through private insurance companies instead of the federal government. Part C provides the same benefits as Medicare Part A and Part B, and may include additional benefits such as dental, vision, prescription drug and wellness programs coverage.	Medicare Advantage Plans (Part C) | MedicareAdvantage.com	112000002025	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
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-IHS 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: Health Insurance **Parent: Episode Information**

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

Section: Diagnosis **Parent: Diagnosis and Intersystem Care Delivery**

Element: 12360 Patient Type

Coding Instruction: Indicate the (cardiac) patient type. See Inclusion Criteria document for coding selection definitions.

Target Value: The highest value between arrival at this facility and discharge

Vendor Instruction: When Patient Type (12360) is STEMI, then Percutaneous Coronary Intervention Indication (12326) must be in (STEMI - Immediate PCI for acute STEMI, STEMI - Other)

Patient Type - 1.3.6.1.4.1.19376.1.4.1.6.5.687

Selection	Definition	Source	Code	Code System
STEMI			401303003	SNOMED CT
NSTEMI			401314000	SNOMED CT
Unstable angina			4557003	SNOMED CT
Low-risk chest pain			112000000217	ACC NCDR

Element: 12447 STEMI Setting

Coding Instruction: Indicate the setting in which the STEMI occurred.

Target Value: The first value between first medical contact and discharge

STEMI Setting

Selection	Definition	Source	Code	Code System
Pre-Admit	Pre-Admit STEMI occurs pre-hospital or any time prior to order for admission. Orders for observation status (or like designation) do not qualify as admitting orders.		112000000300	ACC NCDR
In-Hospital	In-Hospital STEMI occurs after order for admission. The diagnostic ECG occurs after cardiac or non-cardiac admission order.		112000000216	ACC NCDR

Element: 15478 Admitting Diagnosis

Coding Instruction: Indicate the original admitting diagnosis documented prior to the in-hospital STEMI.

Target Value: The first value between arrival at first facility and discharge

Type of Admitting Diagnosis - 1.3.6.1.4.1.19376.1.4.1.6.5.910

Selection	Definition	Source	Code	Code System
Medical: Cardiac			56265001	SNOMED CT
Medical: Non-cardiac			8319008	SNOMED CT
Surgical: Cardiovascular			112802009	SNOMED CT
Surgical: Non-cardiovascular			387713003	SNOMED CT

Element: 15559 STEMI Type 2

Coding Instruction: Indicate if the STEMI is a Type 2 STEMI.

Note(s): To warrant coding 'Yes', documentation should list one of the following causes:
1. Coronary vasospasm
2. Embolism
3. Spontaneous coronary artery dissection (SCAD)
4. Other cause identified as a STEMI type 2

Target Value: The value on discharge

Supporting Definition: **Type 2**

Myocardial infarction caused by a mismatch between oxygen supply and demand. By definition, acute atherothrombotic plaque disruption is not a feature of type 2 myocardial infarctions.

Source: Thygesen K, Alpert J, Jaffe A, et al. Fourth Universal Definition of Myocardial Infarction (2018). J Am Coll Cardiol. 2018 Oct, 72 (18) 2231–2264.

Element: 15599 Type 2 Mechanism

Coding Instruction: Indicate the pathophysiological mechanism attributed to the type 2 STEMI.

Note(s):
Select 'Other' if SCAD, coronary embolism, or coronary vasospasm are not diagnosed as the mechanism of injury associated with the STEMI, and any of the following terms are documented in the medical record: 'Type 2 MI (STEMI)', 'Suspected type 2 MI (STEMI)', 'Probable type 2 MI (STEMI)', 'Supply/demand mismatch (STEMI)'.

Target Value: The value on discharge

MI Type 2 Mechanism - 1.3.6.1.4.1.19376.1.4.1.6.5.934

Section: Diagnosis	Parent: Diagnosis and Intersystem Care Delivery			
Selection	**Definition**	**Source**	**Code**	**Code System**
Spontaneous coronary artery dissection			197364005	SNOMED CT
Coronary embolism			264511000	SNOMED CT
Coronary vasospasm			263924000	SNOMED CT
Other			112000003583	ACC NCDR

Section: Intersystem Care Delivery **Parent: Diagnosis and Intersystem Care Delivery**

Element: 12188 Means of Transport to First Hospital

Coding Instruction: Indicate the means of transportation to the first acute care facility (hospital) where the patient first received treatment.

Note(s):
Patients that transport to hospital by medical personnel via wheelchair or stretcher are to be entered as “Self/Family” transport.

Target Value: N/A

Means of Transport to First Facility - 1.3.6.1.4.1.19376.1.4.1.6.5.905

Selection	Definition	Source	Code	Code System
Self/Family			112000000254	ACC NCDR
EMS - Ambulance			112000000255	ACC NCDR
EMS - Air			112000000256	ACC NCDR

Element: 15464 Call to 911 Date and Time

Coding Instruction: Indicate the date and time the call was placed to a 911 operator.

Note(s):
The completion of this data element is only required for facilities seeking Chest Pain Center (CPC) Accreditation or Chest Pain Center (CPC) Certification.

Target Value: N/A

Element: 12198 Emergency Medical Services Dispatch Date and Time

Coding Instruction: Indicate the date and time the responding unit was notified by dispatch.

Note(s):
Indicate the date/time (mm/dd/yyyy hours:minutes) using the military 24-hour clock, beginning at midnight (0000 hours).

Target Value: N/A

Vendor Instruction: Emergency Medical Services Dispatch Date and Time (12198) must be Less than the earliest of the following elements: Arrival at Outside Facility Date and Time (12426), Arrival Date and Time (3001), Emergency Medical Services First Medical Contact Date and Time (12197)

Element: 12197 Emergency Medical Services First Medical Contact Date and Time

Coding Instruction: Indicate the date and time when the patient was first evaluated by emergency medical services (EMS) prior to arrival at the first facility.

Note(s):
Code the earliest date/time indicating emergency medical services (EMS) was with the patient (i.e., arrival time, BP performed, ECG, etc.).

Emergency medical services (EMS) are pre-hospital healthcare providers (i.e., emergency medical technicians (EMT), paramedics, firefighters, etc.)

Target Value: N/A

Vendor Instruction: Emergency Medical Services First Medical Contact Date and Time (12197) must be Less than or Equal to Arrival at First Facility Date and Time (12612)

Element: 12199 Emergency Medical Services Leaving Scene Date and Time

Coding Instruction: Indicate the date and time the responding unit left the scene with a patient (started moving).

Note(s):
Indicate the date/time (mm/dd/yyyy hours:minutes) using the military 24-hour clock, beginning at midnight (0000 hours).

Target Value: N/A

Vendor Instruction: Emergency Medical Services Leaving Scene Date and Time (12199) must be Greater than Emergency Medical Services Dispatch Date and Time (12198)

Emergency Medical Services Leaving Scene Date and Time (12199) must be Greater than Emergency Medical Services First Medical Contact Date and Time (12197)

Emergency Medical Services Leaving Scene Date and Time (12199) must be Less than Arrival at First Facility Date and Time (12612)

Element: 12419 Emergency Medical Services First Medical Contact Non System Reason For Delay

Coding Instruction: Indicate if there was a patient-centered reason that delayed EMS from transporting the patient.

Note(s):
A patient-centered reason for delay is an issue/condition understood and documented to originate with the patient. It is not associated with the health care system (i.e. ambulance staff, equipment or processes, etc.).

Section: Intersystem Care Delivery | **Parent: Diagnosis and Intersystem Care Delivery**

To warrant coding 'Yes' the patient-centered reason(s) must be identified prior to EMS leaving the scene and be responsible for affecting EMS departure.

Examples: Patient delays transport until family member arrives, patient has cardiac arrest in the home.

Target Value: Any occurrence between first medical contact and EMS leaving scene

Element: 12200 Emergency Medical Services STEMI Alert

Coding Instruction: Indicate if the EMS notified the receiving hospital of a possible or positive ST Elevation Myocardial Infarction (STEMI).

Target Value: Any occurrence between first medical contact and arrival at this facility

Element: 15465 STEMI Alert Date and Time

Coding Instruction: Indicate the date and time the STEMI alert was activated.

Target Value: The value on arrival at this facility

Supporting Definition: **Destination Team Pre-Arrival Alert (or Activation)**

Indication that an alert (or activation) was called by EMS to the appropriate destination healthcare facility team. The alert (or activation) should occur prior to the EMS Unit arrival at the destination with the patient.

Source: http://nemsis.org/v3/downloads/datasetDictionaries.html

Element: 15593 Emergency Medical Services Agency NPI

Coding Instruction: Indicate the emergency medical services agency number.

Note(s): The EMS agency number is the National Provider Identifier (NPI). The NPI can be obtained from the National Plan and Provider Enumeration System (NPPES).
https://npiregistry.cms.hhs.gov/

Target Value: N/A

Supporting Definition: **EMS Agency Number**

The state-assigned provider number of the responding agency.

Source: http://nemsis.org/v3/downloads/datasetDictionaries.html

Element: 12190 Emergency Medical Services Run Number

Coding Instruction: Indicate the emergency medical services run number.

Target Value: N/A

Supporting Definition: **Incident Number**

The incident number assigned by the 911 Dispatch System.

Source: http://nemsis.org/v3/downloads/datasetDictionaries.html

Element: 12421 Transferred From Outside Facility

Coding Instruction: Indicate if the patient was transferred directly to your facility within 24 hours after initial presentation to an outside facility.

Target Value: N/A

Element: 12426 Arrival at Outside Facility Date and Time

Coding Instruction: Indicate the date and time the patient arrived at the outside facility.

Note(s):
Indicate the date/time (mm/dd/yyyy hours:minutes) using the military 24-hour clock, beginning at midnight (0000 hours).

Target Value: N/A

Vendor Instruction: Arrival at Outside Facility Date and Time (12426) must be Less than Transfer From Outside Facility Date and Time (12427)

Element: 12427 Transfer From Outside Facility Date and Time

Coding Instruction: Indicate the date and time the patient left the outside facility.

Note(s):
Indicate the date/time (mm/dd/yyyy hours:minutes) using the military 24-hour clock, beginning at midnight (0000 hours).

Target Value: N/A

Section: Intersystem Care Delivery **Parent: Diagnosis and Intersystem Care Delivery**

Vendor Instruction: Transfer From Outside Facility Date and Time (12427) must be Less than Arrival Date and Time (3001)

Element: 15468 Patient Centered Reason for Delay to Transfer

Coding Instruction: Indicate if there was a patient-centered reason that occurred at the transferring facility and impacted the patient's departure.

Note(s):
A patient-centered reason for delay is an issue/condition understood and documented to originate with the patient. It is not associated with the health care system (i.e. facility, staff or processes, etc.).

To warrant coding 'Yes' the patient-centered reason(s) must be identified within the first 30 minutes of the patient's arrival at the transferring facility or after the diagnosis of STEMI and be responsible for affecting the patient's departure time.

Examples: Patient delays in providing consent for transfer, patient has cardiac arrest and/or need for intubation before transfer, emergent CT scan for rule out CVA, is too unstable for transport (i.e., cardiovascular instability, acute heart failure, cardiogenic shock).

Target Value: Any occurrence in the first 30 minutes after arrival at the transferring facility (or within the first 30 minutes after STEMI diagnosis)

Element: 12402 Transferring Facility American Hospital Association Name

Coding Instruction: Indicate the name of the facility from which the patient was transferred.

Target Value: The value on arrival at this facility

Element: 12161 Transferring Facility American Hospital Association Number

Coding Instruction: Indicate the American Hospital Association number of the facility from which the patient was transferred.

Target Value: The value on arrival at this facility

Element: 15466 Same ID as Parent Facility

Coding Instruction: Indicate if the transferring facility's identification number is the same as their parent organization.

Target Value: N/A

Element: 12531 Number of Transferring Facility Unavailable

Coding Instruction: Indicate if the number of the facility from which the patient was transferred was not available.

Note(s):
This element should only be used for international sites or for when there is not an American Hospital Association Number available.

Target Value: The value on arrival at this facility

Section: Cardiac Arrest **Parent: Diagnosis and Intersystem Care Delivery**

Element: 4630 Cardiac Arrest Out of Healthcare Facility

Coding Instruction: Indicate if a cardiac arrest event occurred outside of any healthcare facility.

Cardiac arrest is defined as acute cardiac event documented by one of the following:
• Ventricular fibrillation
• Rapid ventricular tachycardia or bradycardia rhythms with hemodynamic compromise causing loss of consciousness
• Pulseless rhythms (PEA)
• Asystole

Requiring cardiopulmonary resuscitation (two or more chest compressions or open chest massage, emergency temporary pacing, pericardiocentesis, institution of ECMO, or defibrillation) and without these measures death would have almost certainly resulted.

Note: If an event occurs that meets the above definition of cardiac arrest, code “yes” regardless of a resuscitation status of DNR/hospice/comfort care.

Target Value: The value on arrival at this facility

Supporting Definition: **Cardiac Arrest**

"Sudden" Cardiac arrest is the sudden cessation of cardiac activity. The victim becomes unresponsive with no normal breathing and no signs of circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death. Cardiac arrest should be used to signify an event as described above that is reversed, usually by CPR and/or defibrillation or cardioversion or cardiac pacing.

Source: 2013 ACCF/AHA key data elements and definitions for measuring the clinical management and outcomes of patients with acute coronary syndromes and coronary artery disease.

Element: 4631 Cardiac Arrest Witnessed

Coding Instruction: Indicate if the out-of-hospital cardiac arrest was witnessed by another person.

Note(s):
The completion of this data element is only required for facilities seeking Chest Pain Center (CPC) Accreditation or Chest Pain Center (CPC) Certification.

Target Value: The value on arrival at this facility

Supporting Definition: **Cardiac Arrest Witnessed**

A witnessed arrest is one that is seen or heard by another person.

Source: Cardiac Arrest Registry to Enhand Survival - CARES Complete Data Set for EMS, Hospital and CAD participants and Instruction for Abstracting and Coding Data Elements

Element: 12283 Bystander Cardiopulmonary Resuscitation

Coding Instruction: Indicate if a bystander administered cardiopulmonary resuscitation (CPR) after cardiac arrest and prior to EMS arrival.

Note(s):
Code 'Yes' if an automated external defibrillator (AED) was used.

A healthcare professional is a bystander if they perform CPR and are not working a scheduled shift.

Target Value: The value on arrival at this facility

Element: 4632 Cardiac Arrest After Arrival of Emergency Medical Services

Coding Instruction: Indicate if the out-of-hospital cardiac arrest occurred after arrival of Emergency Medical Services (EMS).

Cardiac arrest is defined as acute cardiac event documented by one of the following:
• Ventricular fibrillation
• Rapid ventricular tachycardia or bradycardia rhythms with hemodynamic compromise causing loss of consciousness
• Pulseless rhythms (PEA)
• Asystole

Requiring cardiopulmonary resuscitation (two or more chest compressions or open chest massage, emergency temporary pacing, pericardiocentesis, institution of ECMO, or defibrillation) and without these measures death would have almost certainly resulted.

Note(s):
If an event occurs that meets the above definition of cardiac arrest, code “yes” regardless of a resuscitation status of DNR/hospice/comfort care.

The completion of this data element is only required for facilities seeking Chest Pain Center (CPC) Accreditation or Chest Pain Center (CPC) Certification.

Target Value: The value on arrival at this facility

Supporting Definition: **Cardiac Arrest After Arrival of EMS**

Patients who experience a cardiac arrest after the arrival of EMS personnel are in the best circumstances to be resuscitated by trained personnel with the equipment to provide immediate defibrillation.

Section: Cardiac Arrest **Parent: Diagnosis and Intersystem Care Delivery**

Source: Cardiac Arrest Registry to Enhand Survival - CARES Complete Data Set for EMS, Hospital and CAD participants and Instruction for Abstracting and Coding Data Elements

Element: 4633 First Cardiac Arrest Rhythm

Coding Instruction: Indicate if the initial out-of-hospital cardiac arrest rhythm was a shockable rhythm.

Target Value: The value on arrival at this facility

First Cardiac Arrest Rhythm

Selection	Definition	Source	Code	Code System
Shockable	Pulseless ventricular arrhythmias		100013034	ACC NCDR
Not shockable			100013035	ACC NCDR

Element: 4634 First Cardiac Arrest Rhythm Unknown

Coding Instruction: Indicate if the initial out-of-hospital cardiac arrest rhythm was unknown.

Target Value: The value on arrival at this facility

Element: 12285 Resuscitation Date and Time

Coding Instruction: Indicate the date and time of resuscitation (return of spontaneous circulation).

Target Value: The first value between first medical contact and discharge

Vendor Instruction: Resuscitation Date and Time (12285) must be Less than Discharge Date and Time (10101)

Element: 15513 Resuscitation Date and Time Unknown

Coding Instruction: Indicate if the date and time of resuscitation (return of spontaneous circulation) was unknown.

Target Value: N/A

Element: 4635 Cardiac Arrest at Transferring Healthcare Facility

Coding Instruction: Indicate if the patient had cardiac arrest at the transferring healthcare facility prior to arrival at the current facility.

Cardiac arrest is defined as acute cardiac event documented by one of the following:
- Ventricular fibrillation
- Rapid ventricular tachycardia or bradycardia rhythms with hemodynamic compromise causing loss of consciousness
- Pulseless rhythms (PEA)
- Asystole

Requiring cardiopulmonary resuscitation (two or more chest compressions or open chest massage, emergency temporary pacing, pericardiocentesis, institution of ECMO, or defibrillation) and without these measures death would have almost certainly resulted.

Note: If an event occurs that meets the above definition of cardiac arrest, code “yes” regardless of a resuscitation status of DNR/hospice/comfort care.

Target Value: The value on arrival at this facility

Supporting Definition: **Cardiac Arrest**

"Sudden" Cardiac arrest is the sudden cessation of cardiac activity. The victim becomes unresponsive with no normal breathing and no signs of circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death. Cardiac arrest should be used to signify an event as described above that is reversed, usually by CPR and/or defibrillation or cardioversion or cardiac pacing.

Source: 2013 ACCF/AHA key data elements and definitions for measuring the clinical management and outcomes of patients with acute coronary syndromes and coronary artery disease.

Element: 15595 Unconscious

Coding Instruction: Indicate if the patient remained unconscious post-resuscitation.

Target Value: The value on arrival at this facility

Section: History and Risk Factors **Parent: Root**

Element: 12242 Height

Coding Instruction: Indicate the patient's height in centimeters.

Note(s): If the patient's height is not measured at your facility, it is acceptable to code the height as reported by the patient/family.

Target Value: The first value between arrival at first facility and discharge

Element: 12243 Weight

Coding Instruction: Indicate the patient's weight in kilograms.

Note(s):
If the patient's weight is not measured at your facility, it is acceptable to code the weight as reported by the patient/family.

Target Value: The first value between arrival at first facility and discharge

Element: 4551 Cerebrovascular Disease

Coding Instruction: Indicate if the patient was diagnosed with cerebrovascular disease.

Target Value: Any occurrence between birth and arrival at this facility

Supporting Definition: **Cerebrovascular Disease**

Current or previous history of any of the following:
* Ischemic stroke: infarction of central nervous system tissue whether symptomatic or silent (asymptomatic).
* TIA: transient episode of neurological dysfunction caused by focal brain, spinal cord, or retinal ischemia without acute infarction. The symptoms typically last less than 24 hours.
* Noninvasive or invasive arterial imaging test demonstrating 50% stenosis of any of the major extracranial or intracranial vessels to the brain.
* Previous cervical or cerebral artery revascularization surgery or percutaneous intervention.

This does not include chronic (nonvascular) neurological diseases or other acute neurological insults such as metabolic and anoxic ischemic encephalopathy.

Source: Cannon CP, Brindis RG, Chaitman BR, et al. ACCF/AHA 2013 Key Data Elements and Definitions for Measuring the Clinical Management and Outcomes of Patients with Acute Coronary Syndromes and Coronary Artery Disease. J Am Coll Cardiol 2013;61:992-1025.

Element: 12248 Stroke

Coding Instruction: Indicate if the patient was diagnosed with a stroke.

Target Value: Any occurrence between birth and arrival at this facility

Supporting Definition: **Stroke (CVA)**

An ischemic stroke is an acute episode of focal or global neurological dysfunction caused by brain, spinal cord, or retinal vascular injury as a result of infarction of central nervous system tissue. Hemorrhage may be a consequence of ischemic stroke. In this situation, the stroke is an ischemic stroke with hemorrhagic transformation and not a hemorrhagic stroke. A hemorrhagic stroke is defined as an acute episode of focal or global cerebral or spinal dysfunction caused by intraparenchymal, intraventricular, or subarachnoid hemorrhage (note: subdural hematomas are intracranial hemorrhagic events and not strokes).

Source: Hicks KA, Tcheng JE, Bozkurt B, et al. 2014 ACC/AHA Key Data Elements and Definitions for Cardiovascular Endpoint Events in Clinical Trials: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Data Standards (Writing Committee to Develop Cardiovascular Endpoints Data Standards). J Am Coll Cardiol. 2015;():. Doi:10.1016/j.jacc.2014.12.018.

Element: 12249 Transient Ischemic Attack

Coding Instruction: Indicate if the patient was diagnosed with transient ischemic attack (TIA).

Target Value: Any occurrence between birth and arrival at this facility

Supporting Definition: **Transient Ischemic Attack (TIA)**

Transient episode of focal neurological dysfunction caused by brain, spinal cord, or retinal ischemia without acute infarction.

Source: Hicks KA, Tcheng JE, Bozkurt B, et al. 2014 ACC/AHA Key Data Elements and Definitions for Cardiovascular Endpoint Events in Clinical Trials: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Data Standards (Writing Committee to Develop Cardiovascular Endpoints Data Standards). J Am Coll Cardiol. 2015;():.Doi:10.1016/j.jacc.2014.12.018.

Element: 12245 Diabetes Mellitus

Coding Instruction: Indicate if the patient has a diagnosis of diabetes mellitus.

Note(s):
Code 'Yes' if the patient has a diagnosis of diabetes mellitus regardless of disease duration or need for diabetic medication.
Code 'No' if the only prior diagnosis was for gestational diabetes.

Target Value: Any occurrence between birth and arrival at this facility

Section: History and Risk Factors **Parent: Root**

Element: 12244 Currently on Dialysis

Coding Instruction: Indicate if the patient is currently undergoing either hemodialysis or peritoneal dialysis on an ongoing basis as a result of renal failure.

Target Value: The value on arrival at this facility

Element: 12253 Prior Heart Failure

Coding Instruction: Indicate if the patient has a diagnosis of heart failure.

Target Value: Any occurrence between birth and arrival at first facility.

Supporting Definition: **Heart Failure**

Heart failure is a complex clinical syndrome that results from any structural or functional impairment of ventricular filling or ejection of blood. The cardinal manifestations of HF are dyspnea and fatigue, which may limit exercise tolerance, and fluid retention, which may lead to pulmonary and/or splanchnic congestion and/or peripheral edema. Some patients have exercise intolerance but little evidence of fluid retention, whereas others complain primarily of edema, dyspnea, or fatigue. Because some patients present without signs or symptoms of volume overload, the term "heart failure" is preferred over "congestive heart failure." There is no single diagnostic test for HF because it is largely a clinical diagnosis based on a careful history and physical examination.

Source: 2013 ACCF/AHA Guideline for the Management of Heart Failure; J Am Coll Cardiol. 2013;62(16):e147-e239. doi:10.1016/j.jacc.2013.05.019

Element: 4615 Hypertension

Coding Instruction: Indicate if the patient has a current diagnosis of hypertension.

Target Value: Any occurrence between birth and arrival at this facility

Element: 4625 Tobacco Use

Coding Instruction: Indicate the frequency that the patient uses tobacco.

Note(s): Consider use of any tobacco product as equivalent to a cigarette for referenced definitions.

Target Value: The value on arrival at this facility

Tobacco Use - 1.3.6.1.4.1.19376.1.4.1.6.5.427

Selection	Definition	Source	Code	Code System
Never	A person who has not smoked 100 cigarettes (5 packs) in his or her lifetime.	The Office of the National Coordinator for Health Information Technology; 2015 Edition Smoking status criterion (§ 170.315(a)(11))	266919005	SNOMED CT
Former	A person who does not currently smoke tobacco but has smoked at least 100 cigarettes in his or her lifetime.	The Office of the National Coordinator for Health Information Technology; 2015 Edition Smoking status criterion (§ 170.315(a)(11))	8517006	SNOMED CT
Current	A person who reports currently smoking tobacco every day or on some days.	The Office of the National Coordinator for Health Information Technology; 2015 Edition Smoking status criterion (§170.315(a)(11))	112000003599	ACC NCDR
Unknown	A person whose current and prior smoking status is not known.	The Office of the National Coordinator for Health Information Technology; 2015 Edition Smoking status criterion (§ 170.315(a)(11))	266927001	SNOMED CT

Element: 15438 Electronic Cigarette Use

Coding Instruction: Indicate if the patient has used or is currently using electronic cigarettes.

Note
Code 'No' for electronic vaping devices that do not deliver a nicotine-containing substance.

Target Value: The value on arrival at this facility

Supporting Definition: **Electronic Cigarette (e-Cigarette)**

Battery-operated devices that heat a liquid containing nicotine, propylene glycol, and/or vegetable glycerin and flavorant chemicals to generate an aerosol that the user inhales. Because e-cigarettes do not burn tobacco, they do not produce tobacco smoke.

Source: Barua R, Rigotti N, Benowitz N, et al. 2018 ACC Expert Consensus Decision Pathway on Tobacco Cessation Treatment. J Am Coll Cardiol. 2018 Dec, 72 (25) 3332–3365. https://doi.org/10.1016/j.jacc.2018.10.027

Status - 1.3.6.1.4.1.19376.1.4.1.6.5.897

Selection	Definition	Source	Code	Code System
No			100013073	ACC NCDR
Yes			100013072	ACC NCDR

Section: History and Risk Factors		Parent: Root		
Unknown	An individual whose use of electronic cigarettes is not known.		261665006	SNOMED CT

Section: Condition History **Parent: History and Risk Factors**

Element: 12903 Condition History Name

Coding Instruction: The medical conditions listed in this field are controlled by the Condition History Master file. This file is maintained by the NCDR and will be made available for downloading and importing/updating into your application.

Target Value: N/A

Condition Histories - 1.3.6.1.4.1.19376.1.4.1.6.5.927

Selection	Definition	Source	Code	Code System
Atrial Fibrillation			49436004	SNOMED CT
Atrial Flutter			5370000	SNOMED CT
Cancer			363346000	SNOMED CT
Dyslipidemia			370992007	SNOMED CT
Myocardial Infarction			22298006	SNOMED CT
Peripheral Arterial Disease			399957001	SNOMED CT

Element: 15510 Condition History Occurrence

Coding Instruction: Indicate if the patient has or has not had a clinical diagnosis of the indicated medical condition.

Note(s):
Code 'Yes' to 'Cancer' only when the diagnosis of cancer included treatment with one or more of the following:
1. Chemotherapy
2. Hormone therapy
3. Immunotherapy
4. Radiation therapy

Target Value: Any occurrence between birth and arrival at this facility

Section: Condition History Details **Parent: History and Risk Factors**

Element: 15437 Cancer Treatment Type

Coding Instruction: Indicate if the patient has received chemotherapy, immunotherapy, hormone therapy or radiation therapy for cancer treatment.

Target Value: All values between 5 years prior to arrival and arrival at this facility

Treatment of Cancer - 1.3.6.1.4.1.19376.1.4.1.6.5.896

Selection	Definition	Source	Code	Code System
Chemotherapy	The treatment of disease using chemical agents or drugs that are selectively toxic to the causative agent of the disease, such as a virus, bacterium, or other microorganism.		367336001	SNOMED CT
Hormone therapy	Hormone therapy is used to prevent or delay recurrence of cancer after other modalities of treatment have removed the gross primary tumor and chemotherapy or radiation therapy have treated systemic and regional micrometastases.		243125009	SNOMED CT
Immunotherapy			76334006	SNOMED CT
Radiation	Radiation therapy uses x-rays, gamma rays and other sources of radiation to destroy cancer cells.		53438000	SNOMED CT

Section: Procedure History **Parent: History and Risk Factors**

Element: 12905 Procedure History Name

Coding Instruction: The procedures listed in this field are controlled by the Procedure History Master file. This file is maintained by the NCDR and will be made available for downloading and importing/updating into your application.

Target Value: N/A

Procedure History Names - 1.3.6.1.4.1.19376.1.4.1.6.5.928

Selection	Definition	Source	Code	Code System
Coronary Artery Bypass Graft	Coronary artery bypass graft surgery is when the native vessels of the heart are bypassed with other vessels (internal mammary artery, radial artery or saphenous vein) to restore normal blood flow to the obstructed coronary arteries.	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.	232717009	SNOMED CT
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.	Medline Plus, 2017 by Merriam-Webster, Incorporated	415070008	SNOMED CT

Element: 15511 Procedure History Occurrence

Coding Instruction: Indicate if the patient has or has not undergone the indicated medical procedure.

Target Value: Any occurrence between birth and arrival at this facility

Element: 15512 Procedure History Date

Coding Instruction: Indicate the date the procedure was performed.

Note(s):
If the month or day of the procedure 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 procedure" documented in a record from 2011, then the year 2011 can be utilized and coded as 01/01/2011).

Target Value: The last value between birth and arrival at this facility

Section: Patient Assessment On Arrival — Parent: Root

Element: 12218 Location of First Evaluation

Coding Instruction: Indicate the location where the patient was evaluated.

Target Value: The first value between arrival at this facility and discharge

Location of First Evaluation - 1.3.6.1.4.1.19376.1.4.1.6.5.929

Selection	Definition	Source	Code	Code System
Emergency department (ED)	The patient was first seen in the Emergency Department (ED) (e.g., traditional ED, ED-based chest pain unit, ED-observational unit, etc.).		112000000164	ACC NCDR
Cath lab	The patient was first seen in the Cath Lab (e.g., cath lab holding area, cath lab procedure room) AND did not have an assessment (e.g., BP, ECG, etc.) in another clinical unit prior to arrival in the cath lab.		112000000165	ACC NCDR
Observation unit	The patient was a direct admit to an observation unit AND did not have an assessment (e.g., BP, ECG, etc.) in another clinical area prior to arrival in the observation unit.		100013061	ACC NCDR
Inpatient	The patient was first evaluated in an inpatient unit (e.g., they are an in-house STEMI).		440654001	SNOMED CT
Other	None of the other coding options apply to the patient scenario.		100000351	ACC NCDR

Element: 12281 Heart Rate

Coding Instruction: Indicate the heart rate (beats per minute).

Note(s):
"Arrival" refers to either the time of arrival at the transferring facility or time of arrival at your facility.

Target Value: The first value between first medical contact and arrival at first facility

Element: 12282 Systolic Blood Pressure

Coding Instruction: Indicate the systolic blood pressure (mm Hg).

Note(s):
"Arrival" refers to either the time of arrival at the transferring facility or time of arrival at your facility.

Target Value: The first value between first medical contact and arrival at first facility

Element: 12280 Cardiogenic Shock at First Medical Contact

Coding Instruction: Indicate if the patient was in cardiogenic shock.

Note(s):
To code 'Yes' cardiogenic shock (stage C, D or E) has been diagnosed and/or the signs/symptoms/treatments (described below) are present and determined to be secondary to cardiac dysfunction:

Systolic blood pressure (SBP) less than 90 mmHg for more than 30 minutes and/or cardiac index less than 2.2 L/min per square meter for more than 30 minutes; and/or, requirement for parental inotropic or vasopressor agents or mechanical support (e.g., IABO, extracorporeal circulation, VADs, etc.) to maintain blood pressure and cardiac index above those specified levels.

Target Value: Any occurrence between first medical contact and arrival at this facility

Supporting Definition: **Cardiogenic Shock**

Source: Naidu SS, Baran DA, Jentzer JC, et al. SCAI Shock stage classification expert consensus update: A review and incorporation of validation studies. J Am Coll of Cardiol. 2022;79(9):933-946.

Source:

Element: 12279 Heart Failure

Coding Instruction: Indicate if there is physician diagnosis of new or acute exacerbation of heart failure.

Target Value: Any occurrence between first medical contact and arrival at this facility

Supporting Definition: **Heart Failure**

Heart failure is a complex clinical syndrome that results from any structural or functional impairment of ventricular filling or ejection of blood. The cardinal manifestations of HF are dyspnea and fatigue, which may limit exercise tolerance, and fluid retention, which may lead to pulmonary and/or splanchnic congestion and/or peripheral edema. Some patients have exercise intolerance but little evidence of fluid retention, whereas others complain primarily of edema, dyspnea, or fatigue. Because some patients present without signs or symptoms of volume overload, the term "heart failure" is preferred over "congestive heart failure." There is no single diagnostic test for HF because it is largely a clinical diagnosis based on a careful history and physical examination.

Source: 2013 ACCF/AHA Guideline for the Management of Heart Failure; J Am Coll Cardiol. 2013;62(16):e147-e239.

Section: Patient Assessment On Arrival **Parent: Root**

doi:10.1016/j.jacc.2013.05.019

Element: 15452 Canadian Study of Health and Aging (CSHA) Clinical Frailty Scale

Coding Instruction: Indicate the Canadian Study of Health and Aging (CSHA) Clinical Frailty Scale of the patient.

Target Value: The value on arrival at this facility

CSHA Clinical Frailty Score - 1.3.6.1.4.1.19376.1.4.1.6.5.338

Selection	Definition	Source	Code	Code System
1: Very fit	CHSA Clinical Frailty Scale 1: Very Fit - People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.		1000142382	ACC NCDR
2: Well	CHSA Clinical Frailty Scale 2: Well - People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.		1000142383	ACC NCDR
3: Managing well	CHSA Clinical Frailty Scale 3: Managing Well - People whose medical problems are well controlled, but are not regularly active beyond routine walking.		1000142384	ACC NCDR
4: Vulnerable	CHSA Clinical Frailty Scale 4: Vulnerable - While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.		1000142385	ACC NCDR
5: Mildly frail	CHSA Clinical Frailty Scale 5: Mildly Frail - These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.		1000142386	ACC NCDR
6: Moderately frail	CHSA Clinical Frailty Scale 6: Moderately Frail - People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.		1000142387	ACC NCDR
7: Severely frail	CHSA Clinical Frailty Scale 7: Severely Frail - Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).		1000142388	ACC NCDR
8: Very severely frail	CHSA Clinical Frailty Scale 8: Very Severely Frail - Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.		1000142389	ACC NCDR
9: Terminally ill	CHSA Clinical Frailty Scale 9: Terminally Ill - Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.		1000142390	ACC NCDR

Element: 15440 Chest Pain Symptoms

Coding Instruction: Indicate when the patient noted symptoms lasting greater than or equal to 10 minutes that prompted them to seek medical care.

Note(s):
Symptoms may be expressed not only as chest "pain" but also as burning, dull, heaviness, pressure, sharp, squeezing, stabbing, tearing, tightness.

Symptoms may include jaw pain, arm pain, shortness of breath, nausea, vomiting, fatigue/malaise, or other equivalent discomfort suggestive of a myocardial infarction and/or myocardial ischemia.

Target Value: The last value 24 hours prior to First Medical Contact and discharge

Chest Pain Symptoms - 1.3.6.1.4.1.19376.1.4.1.6.5.898

Selection	Definition	Source	Code	Code System
Prior to arrival			288556008	SNOMED CT
After arrival			255234002	SNOMED CT
No symptoms			LA6111-4	LOINC
Unknown			261665006	SNOMED CT

Element: 12277 Acute Coronary Syndrome Symptom Date

Coding Instruction: Indicate the date the patient noted symptoms lasting greater than or equal to 10 minutes.

Target Value: N/A

Section: Patient Assessment On Arrival **Parent: Root**

Vendor Instruction: ACS Symptom Date and Time (12277, 12276) must be Less than or Equal to Arrival Date and Time (3001)

Element: 12276 Acute Coronary Syndrome Symptom Time

Coding Instruction: Indicate the time the patient noted symptoms lasting greater than or equal to 10 minutes.

Note(s):
Indicate the time (hours:minutes) using the military 24-hour clock, beginning at midnight (00:00 hours).

If the symptom time is not specified in the medical record, it may be recorded as 0700 for morning; 1200 for lunchtime; 1500 for afternoon; 1800 for dinnertime; 2200 for evening and 0300 if awakened from sleep.

Target Value: N/A

Vendor Instruction: Time validation is included in the Vendor Instructions for Acute Coronary Syndrome Symptom Date (12277)

Element: 15441 Time of Symptoms Prior to Arrival Unknown

Coding Instruction: Indicate if the time that the patient experienced symptoms is unknown.

Target Value: N/A

Element: 15443 Chest Pain Symptoms Date (After Arrival)

Coding Instruction: Indicate the date the patient noted symptoms lasting greater than or equal to 10 minutes (for patients who have a STEMI setting of In-Hospital).

Note(s):
Symptoms may be expressed not only as chest "pain" but also as burning, dull, heaviness, pressure, sharp, squeezing, stabbing, tearing, tightness.

Symptoms may include jaw pain, arm pain, shortness of breath, nausea, vomiting, fatigue/malaise, or other equivalent discomfort suggestive of a myocardial infarction and/or myocardial ischemia.

Target Value: The first value between arrival at this facility and discharge

Element: 15505 Chest Pain Symptoms Time (After Arrival)

Coding Instruction: Indicate the time the patient noted symptoms lasting greater than or equal to 10 minutes.

Note(s):
Indicate the time (hours:minutes) using the military 24-hour clock, beginning at midnight (00:00 hours).

If the symptom time is not specified in the medical record, it may be recorded as 0700 for morning; 1200 for lunchtime; 1500 for afternoon; 1800 for dinnertime; 2200 for evening and 0300 if awakened from sleep.

Target Value: The first value between arrival at this facility and discharge

Element: 15442 Time of Symptoms After Arrival Unknown

Coding Instruction: Indicate if the time that the patient experienced symptoms is unknown.

Target Value: N/A

Section: Electrocardiogram **Parent: Patient Assessment On Arrival**

Element: 12286 Electrocardiogram Counter

Coding Instruction: The software assigned electrocardiogram (ECG) counter should start at 1 and be incremented by one for each ECG obtained between first medical contact and discharge.

Note(s):
The ECG counter number should be assigned sequentially in ascending order. Do not skip numbers.

Target Value: N/A

Vendor Instruction: Multiple ECG Counters (12286) must be in chronological order, earliest to latest, based on ECG Date and Time (12278)

Element: 12278 Electrocardiogram Date and Time

Coding Instruction: Indicate the date and time of the 12-lead electrocardiogram (ECG).

Note(s):
Enter the first 3 consecutive electrocardiograms (entered in chronological order), and the first STEMI positive ECG (if STEMI was not demonstrated on one of the first three ECGs).

Only values collected between first medical contact and discharge are accepted.

The date/time of the 12-lead ECG with a reading can be documented in the Emergency Medical Services (EMS) record, a physical copy of the 12-lead ECG is not required.

Indicate the date/time (mm/dd/yyyy hours:minutes) using the military 24-hour clock, beginning at midnight (0000 hours).

Target Value: N/A

Vendor Instruction: Electrocardiogram Date and Time (12278) must be Less than Discharge Date and Time (10101)

Electrocardiogram Date and Time (12278) should be Less than or Equal to Electrocardiogram Read Date and Time (15444)

Element: 15444 Electrocardiogram Read Date and Time

Coding Instruction: Indicate the date and time the ECG was read (interpreted) by a physician or an advanced practice provider.

Note(s):
This is the initial 'STEMI' vs. 'Not a STEMI' read (i.e., preliminary ED read), and used to determine if the encounter is an emergency or not. Cardiology over-read is not the focus of this data element.

Indicate the date/time (mm/dd/yyyy hours:minutes) using the military 24-hour clock, beginning at midnight (0000 hours).

Target Value: The first value between first medical contact and discharge

Element: 12300 STEMI or STEMI Equivalent First Noted

Coding Instruction: Indicate if a STEMI or STEMI equivalent was noted on the ECG.

Target Value: N/A

Section: Cardiac Troponin **Parent: Patient Assessment On Arrival**

Element: 15446 Troponin Not Drawn

Coding Instruction: Indicate if the troponin was not drawn.

Target Value: N/A

Element: 15456 Troponin Protocol

Coding Instruction: Indicate the troponin protocol utilized by your facility.

Note(s):
Select the hourly increment identified in the hospital's troponin protocol.
The hourly increment is not coded on when the troponin specimen was actually obtained and/or resulted.

Target Value: The first value between arrival at this facility and discharge

Troponin Protocol Used - 1.3.6.1.4.1.19376.1.4.1.6.5.902

Selection	Definition	Source	Code	Code System
STEMI	The patient has been diagnosed with STEMI by ECG, limited troponins drawn.		401303003	SNOMED CT
0-1 hour	The protocol specifies the second specimen be drawn 1 hour after the initial specimen.		112000003563	ACC NCDR
0-2 hours	The protocol specifies the second specimen be drawn 2 hours after the initial specimen.		112000003564	ACC NCDR
0-3 hours	The protocol specifies the second specimen be drawn 3 hours after the initial specimen.		112000003565	ACC NCDR
0-6 hours	The protocol specifies the second specimen be drawn 6 hours after the initial specimen.		112000003568	ACC NCDR
Not documented	A troponin protocol was not initiated and/or the use of one was not documented.		112000001830	ACC NCDR

Section: Troponin **Parent: Cardiac Troponin**

Element: 12255 Troponin Counter

Coding Instruction: The software assigned Troponin counter should start at 1 and be incremented by one for each Troponin Lab collected and resulted between first medical contact and discharge.

Note(s):
The Troponin counter number should be assigned sequentially in ascending order. Do not skip numbers.

Target Value: N/A

Vendor Instruction: Multiple Troponin Counters (12255) must be in chronological order, earliest to latest, based on Troponin Collected Date and Time (12405)

Element: 12405 Troponin Collected Date and Time

Coding Instruction: Indicate the date and time the troponin was collected.

Note(s):
The registry expectation is that each patient record will include the first 3 consecutive troponin results and the peak troponin (if not already provided).

Only values collected between first medical contact and discharge are accepted.

Indicate the date/time (mm/dd/yyyy hours:minutes) using the military 24-hour clock, beginning at midnight (0000 hours).

Target Value: N/A

Vendor Instruction: Troponin Collected Date and Time (12405) must be Less than Troponin Resulted Date and Time (12406)

Troponin Collected Date and Time (12405) must be Less than Discharge Date and Time (10101)

Troponin Collected Date and Time (12405) must be Greater than the earliest of the following elements: Arrival at Outside Facility Date and Time (12426), Arrival Date and Time (3001), Emergency Medical Services First Medical Contact Date and Time (12197)

Element: 12406 Troponin Resulted Date and Time

Coding Instruction: Indicate the date and time of the troponin value result.

Target Value: Any occurrence between first medical contact and discharge

Vendor Instruction: Troponin Resulted Date and Time (12406) must be Less than Discharge Date and Time (10101)

Troponin Resulted Date and Time (12406) must be Greater than the earliest of the following elements: Arrival at Outside Facility Date and Time (12426), Arrival Date and Time (3001), Emergency Medical Services First Medical Contact Date and Time (12197)

Element: 12544 Troponin Test Location

Coding Instruction: Indicate if the blood sample was run on a point of care (POC) troponin assay or on a central laboratory troponin assay.

Note(s):
The location of the machine is not captured, please indicate the troponin assay type.

Target Value: Any occurrence between first medical contact and discharge

Troponin Test Location

Selection	Definition	Source	Code	Code System
Lab			112000000387	ACC NCDR
POC			112000000388	ACC NCDR

Element: 12409 Lab Troponin Assay and URL

Coding Instruction: Indicate the troponin assay used for the troponin sample that was processed in the laboratory.

Target Value: Any occurrence between first medical contact and discharge

Element: 12543 Point of Care Troponin Assay and URL

Coding Instruction: Indicate the troponin assay used for the troponin sample that was processed at the point of care.

Target Value: Any occurrence between first medical contact and discharge

Element: 15558 Troponin Value

Coding Instruction: Indicate the troponin value with the appropriate unit of measure.

Target Value: Any occurrence between first medical contact and discharge

Section: Cath Lab Activation **Parent: Patient Assessment On Arrival**

Element: 12333 Catheterization Laboratory Activated

Coding Instruction: Indicate if the catheterization laboratory was activated due to a patient need for a primary PCI.

Target Value: The first value between first medical contact and current procedure

Element: 12334 Catheterization Laboratory Activated Date and Time

Coding Instruction: Indicate the date and time the catheterization laboratory was activated due to a patient need for a primary PCI.

Note(s): Indicate the date/time (mm/dd/yyyy hours:minutes) using the military 24-hour clock, beginning at midnight (0000 hours).

Target Value: The first value between first medical contact and current procedure

Vendor Instruction: Catheterization Laboratory Activated Date and Time (12334) must be Less than First Device Activation Date and Time (7845)

Element: 15447 Catheterization Laboratory Activation Initiated By

Coding Instruction: Indicate who activated the cath lab for a presumed STEMI case.

Note(s):
The completion of this data element is only required for facilities seeking Chest Pain Center (CPC) Accreditation or Chest Pain Center (CPC) Certification.

Target Value: The first value between first medical contact and current procedure

Specialty Responsible - 1.3.6.1.4.1.19376.1.4.1.6.5.899

Selection	Definition	Source	Code	Code System
Emergency medicine			773568002	SNOMED CT
Cardiology			394579002	SNOMED CT
Other			100000351	ACC NCDR

Element: 15448 PCI Operator Arrival Date and Time

Coding Instruction: Indicate the date and time the PCI operator arrived at the cath lab for a presumed STEMI case.

Note(s):
The completion of this data element is only required for facilities seeking Chest Pain Center (CPC) Accreditation or Chest Pain Center (CPC) Certification.

Target Value: The first value between first medical contact and current procedure

Element: 15449 Catheterization Laboratory Staff Arrival Date and Time

Coding Instruction: Indicate the date and time when the full complement of staff (as defined by the facility) were present in the cath lab.

Note(s):
The completion of this data element is only required for facilities seeking Chest Pain Center (CPC) Accreditation or Chest Pain Center (CPC) Certification.

Target Value: The first value between first medical contact and current procedure

Element: 12431 Catheterization Laboratory Activation Canceled

Coding Instruction: Indicate if the cath lab activation was canceled after being activated.

Target Value: The first value between first medical contact and discharge

Element: 15450 Catheterization Laboratory Activation Cancelled by

Coding Instruction: Indicate who cancelled the cath procedure previously activated for a presumed STEMI.

Note(s):
The completion of this data element is only required for facilities seeking Chest Pain Center (CPC) Accreditation or Chest Pain Center (CPC) Certification.

Target Value: The first value between first medical contact and discharge

Specialty Responsible - 1.3.6.1.4.1.19376.1.4.1.6.5.899

Selection	Definition	Source	Code	Code System
Emergency medicine			773568002	SNOMED CT
Cardiology			394579002	SNOMED CT
Other			100000351	ACC NCDR

Section: Risk Stratification **Parent: Patient Evaluation**

Element: 15453 Risk Stratification

Coding Instruction: Indicate the patient's risk documented according to the risk stratification tool utilized.

Note(s):
If a range is reported (i.e., intermediate-high or TIMI 2-3), code the highest value.

Target Value: The first value between arrival at this facility and discharge

Risk/Extent of Ischemia - 1.3.6.1.4.1.19376.1.4.1.6.5.901

Selection	Definition	Source	Code	Code System
Low	If the name of the risk score used is known and the value is provided, code low risk if the value is in the following range: TIMI: 0-2 GRACE: <=108 HEART: <3 Modified HEART 0-3 EDACS: <16		100013097	ACC NCDR
Intermediate	If the name of the risk score used is known and the value is provided, code intermediate risk if the value is in the following range: TIMI: 3-5 GRACE: 109-140 HEART: 4-6 Modified HEART: non-low risk >= 4, confirm with clinician EDACS: non-low risk >=16, confirm with clinician		100013098	ACC NCDR
High	If the name of the risk score used is known and the value is provided, code high risk if the value is in the following range: TIMI: >=6 GRACE: >140 HEART: 7-10 Modified HEART: non-low risk >= 4, confirm with clinician EDACS: non-low risk >=16, confirm with clinician		100000584	ACC NCDR

Element: 15454 Risk Stratification Not Documented

Coding Instruction: Indicate that a risk stratification was not documented.

Note: If the risk stratification was conducted and acted upon, yet not documented in the medical record, code Not Documented.

Target Value: N/A

Element: 15479 Risk Stratification Performed at Transferring Facility

Coding Instruction: Indicate if the risk stratification was performed at the transferring facility.

Target Value: The first value between arrival at this facility and discharge

Element: 15480 Risk Assessment Tool

Coding Instruction: Indicate the name or type of risk score documented.

Target Value: Any occurrence between arrival at this facility and discharge

Ischemia Scoring Method - 1.3.6.1.4.1.19376.1.4.1.6.5.913

Selection	Definition	Source	Code	Code System
TIMI risk score	The TIMI risk score is determined by the sum of the presence of 7 variables at admission; 1 point is given for each of the following variables: greater than or equal to 65 years of age; greater than or equal to 3 risk factors for CAD; prior coronary stenosis greater than or equal to 50%; ST deviation on ECG; greater than or equal to 2 anginal events in prior 24 hours; use of aspirin in prior 7 days; and elevated cardiac biomarkers. The TIMI risk index is useful in predicting 30 -day and 1-year mortality in patients with NSTE-ACS.	Antman EM, Cohen M, Bernink PJ, et al. The TIMI risk score for unstable angina/non-ST elevation MI: a method for prognostication and therapeutic decision making. JAMA. 2000;284:835-8	112000000191	ACC NCDR
GRACE risk score	The GRACE risk score predicts in-hospital and post discharge mortality or myocardial infarction. It derives data from age, development (or history) of heart failure, peripheral vascular disease, systolic blood pressure, Killip class, initial serum creatinine concentration, elevated initial cardiac biomarkers,	Fox KA, Dabbous OH, Goldberg RJ, et al. Prediction of risk of death and myocardial infarction in the six months after presentation with acute coronary syndrome: prospective multinational observational study (GRACE). BMJ. 2006;333:1091.10	112000000192	ACC NCDR

Section: Risk Stratification		Parent: Patient Evaluation		
	cardiac arrest on admission, and ST-segment deviation. The sum of scores is applied to a reference nomogram to determine all-cause mortality from hospital discharge to 6 months.			
HEART risk score	The HEART risk score is a clinical risk tool for rapid stratification of patients with chest pain. The score is composed of 5 components: history, ECG, age, risk factors and troponin. Each of these components may be scored with 0, 1, or 2 points with a maximum score of 10 points. Patients are categorized as: low risk (HEART less than or equal to 3), intermediate risk (HEART 4–6), and high risk (HEART greater than or equal to 7).	Six AJ, Backus BE, Kelder JC. Chest pain in the emergency room: value of the HEART score. Neth Heart J. 2008;16:191-196.12	112000000193	ACC NCDR
HEAR risk score	The HEAR risk score (without troponin) incorporates only the history, ECG, age, and risk factor aspects of the HEART Pathway assessment.	Smith LM, Ashburn NP, Snavely AC, et al. Identification of very low-risk acute chest pain patients without troponin testing. Emerg Med J. 2020;37:690-695.44	112000003554	ACC NCDR
EDACS risk score	The EDACS risk score predicts the short-term risk of major adverse cardiac event for adults presenting to the emergency department with possible cardiac chest pain. Points are allocated according to age, sex, known CAD, CAD risk factors, and symptoms.	Than M, Flaws D, Sanders S, et al. Development and validation of the Emergency Department Assessment of Chest pain Score and 2 h accelerated diagnostic protocol. Emerg Med Australas. 2014;26:34-44.	112000000232	ACC NCDR
NOTR Risk Score	The NOTR risk score identifies patients who are at low risk of ACS and could be discharged without further cardiac testing. The NOTR uses cardiac risk factors, history of MI or CAD, age, serial troponin measures, and a non-ischemic ECG (no ST depression or T-wave inversion in >1 contiguous lead).	Greenslade JH, Parsonage W, Than M, et al. A clinical decision rule to identify emergency department patients at low risk for acute coronary syndrome who do not need objective coronary artery disease testing: the no objective testing rule. Ann Emerg Med. 2016;67:478-489.e472.	112000003567	ACC NCDR

Element: 15516 Risk Assessment Tool Not Documented

Coding Instruction: Indicate if the risk stratification tool used was not documented.

Target Value: Any occurrence between arrival at this facility and discharge

Section: Prior Testing **Parent: Patient Evaluation**

Element: 15457 Functional Test Results

Coding Instruction: Indicate the results of the functional imaging and/or stress test.

Note(s): Functional imaging tests may include:
Exercise stress test
Echocardiogram
Nuclear - PET and/or SPECT
Cardiac magnetic resonance (CMR)

Target Value: Any occurrence between 1 year prior to arrival at this facility and arrival at this facility

Stress Test Result - 1.3.6.1.4.1.19376.1.4.1.6.5.714

Selection	Definition	Source	Code	Code System
Negative	Stress Test: Exercise Stress Test (w/o imaging) • A stress test is negative when the electrocardiogram (ECG) is normal or not suggestive of ischemia. ECGs are not suggestive of ischemia when < 1 mm of horizontal or downsloping ST-segment depression or elevation for >= 60-80 milliseconds after the end of the QRS complex, either during or after exercise. Stress Test: Stress Echocardiogram • The imaging study was normal. There was no change in wall motion during the procedure. Stress Test: Stress Nuclear • The results of the imaging study revealed no myocardial perfusion defects. Stress Test: Stress Imaging with CMR • The results of the imaging study revealed no myocardial perfusion defects.		100013083	ACC NCDR
Positive	Stress Test: Exercise Stress Test (w/o imaging) • A stress test is positive when the electrocardiogram (ECG) suggests ischemia. ECGs suggestive of ischemia can be described as having >= 1 mm of horizontal or downsloping ST-segment depression or elevation for >= 60-80 milliseconds after the end of the QRS complex, either during or after exercise. It is also be suggestive of ischemia if the patient had symptoms of ischemia (i.e.chest pain), arrhythmias, and/or a fall in blood pressure during or immediately after the procedure. Stress Test: Stress Echocardiogram • The imaging study was abnormal. There were changes that reflected wall motion abnormalities during the procedure. Stress Test: Stress Nuclear • The result of the imaging study revealed one or more stress-induced myocardial perfusion defects. Stress Test: Stress Imaging with CMR • The result of the imaging study revealed one or more stress-induced myocardial perfusion defects.		100013093	ACC NCDR
Indeterminate	The results of the study were uninterpretable. They cannot be considered to be positive or negative.		100013094	ACC NCDR
Unavailable	The results of the study were not available.		100000646	ACC NCDR
Not performed			112000001181	ACC NCDR

Element: 15458 Anatomical Imaging Results

Coding Instruction: Indicate the results of the anatomical imaging.

Note(s):
Anatomical imaging includes:
Cardiac CTA
Diagnostic Cath

Target Value: Last value between 2 years prior to arrival at this facility and arrival at this facility

Anatomical Imaging Result - 1.3.6.1.4.1.19376.1.4.1.6.5.903

Section: Prior Testing **Parent: Patient Evaluation**

Selection	Definition	Source	Code	Code System
No CAD	The prior anatomical test indicates the patient has clear coronary arteries, no disease identified in any >2mm native or graft vessel.		408573005	SNOMED CT
CAD	Coronary atherosclerotic disease was identified in at least one >2mm native or graft vessel.		53741008	SNOMED CT
Unavailable	A prior anatomical imaging test was performed, the test results are not available.		100000646	ACC NCDR
Not performed	Code 'Not Performed' if the only prior anatomical imaging was a coronary angiography at the transferring facility.		262008008	SNOMED CT

Element: 15459 Coronary Artery Disease Type

Coding Instruction: Indicate the type of coronary artery disease diagnosed by prior anatomical imaging.

Target Value: Last value between 2 years prior to arrival at this facility and arrival at this facility

Type of Coronary Artery Disease - 1.3.6.1.4.1.19376.1.4.1.6.5.904

Selection	Definition	Source	Code	Code System
Non-obstructive	Non-obstructive disease (disease <50% in all coronary vessels and left main disease <50%) Note: Only disease found in vessels >=2mm is captured unless a vessel <2mm is intended for PCI and/or the patient's overall coronary anatomy is <2mm		719678003	SNOMED CT
Moderate	Moderate disease (disease 50-69% in any coronary vessel defined as: LAD and any of its branches, LCX and any of its branches, RCA and any of its branches, a true RAMUS branch >2 mm, any bypass graft and left main disease <50%) Note: Only disease found in vessels >=2mm is captured unless a vessel <2mm is intended for PCI and/or the patient's overall coronary anatomy is <2mm		112000003539	ACC NCDR
Obstructive	Obstructive coronary atherosclerotic disease is disease >=70% in any coronary vessel defined as: LAD and any of its branches, LCX and any of its branches, RCA and any of its branches, a true RAMUS branch >2 mm, any bypass graft and/or left main disease >=50%. Note: Only disease found in vessels >=2mm is captured unless a vessel <2mm is intended for PCI and/or the patient's overall coronary anatomy is <2mm.		26036001	SNOMED CT
Unknown			261665006	SNOMED CT

Section: Non-Invasive Testing **Parent: Patient Evaluation**

Element: 15460 Shared Decision Making Tool

Coding Instruction: Indicated if the health care provider shared evidence-based information about the alternative treatment options available and considered the patient's values and preferences in the decision making process for this procedure.

Note(s): To code 'yes', the use of online modules, decision aids, or videos about treatment options must be used to support the patients understanding of the risks and benefits of various therapies and support their effective processing of health information so they were well equipped to participate in the treatment decision.

Target Value: The first value between arrival at this facility and discharge

Element: 15469 Ischemia Evaluation Performed

Coding Instruction: Indicate if testing with a stress component was performed.

Target Value: Any occurrence between arrival at this facility and discharge

Test Administration - 1.3.6.1.4.1.19376.1.4.1.6.5.925

Selection	Definition	Source	Code	Code System
Yes	The test was completed.		100013072	ACC NCDR
No - No reason	The test was not completed. There is neither a medical reason nor a patient reason documented explaining why it was not done.		112000000195	ACC NCDR
No - Medical reason	The test was not completed. There is clear documentation of a reason related to the patient's medical issue or concern explaining why it was not done.		112000000199	ACC NCDR
No - Patient reason	The test was not completed. There is clear documentation of a reason related to the patient's and/or family's preference explaining why it was not done.		112000000197	ACC NCDR

Element: 15470 Ischemia Evaluation Method

Coding Instruction: Indicate the stress method utilized for ischemia evaluation.

Target Value: The first value between arrival at this facility and discharge

Ischemia Assessment Method - 1.3.6.1.4.1.19376.1.4.1.6.5.911

Selection	Definition	Source	Code	Code System
Exercise Stress Test (w/o imaging)			165079009	SNOMED CT
Stress Echocardiogram			46136006	SNOMED CT
Stress Nuclear - SPECT			466414006	SNOMED CT
Stress Nuclear - PET			82918005	SNOMED CT
Stress CMR			58750-1	LOINC

Element: 15579 Ischemia Evaluation Ordered Date and Time

Coding Instruction: Indicate the date and time the imaging with stress was ordered.

Note: If more than one test was ordered at your hospital, note the date and time of the first imaging with stress.

Target Value: The first value between arrival at this facility and discharge

Element: 15471 Ischemia Evaluation Performed Date and Time

Coding Instruction: Indicate the date and time of the imaging with stress.

Note: If more than one test was performed at your hospital, note the date and time of the first imaging with stress performed.

Target Value: The first value between arrival at this facility and discharge

Element: 15472 Ischemia Assessment Results

Coding Instruction: Indicate the results of the stress component.

Target Value: The first value between arrival at this facility and discharge

Imaging with Stress Result - 1.3.6.1.4.1.19376.1.4.1.6.5.907

Selection	Definition	Source	Code	Code System
Negative	Stress Test: Exercise Stress Test (w/o imaging) • A stress test is negative when the electrocardiogram (ECG) is normal or not suggestive of ischemia. ECGs		100013083	ACC NCDR

Section: Non-Invasive Testing **Parent: Patient Evaluation**

	are not suggestive of ischemia when < 1 mm of horizontal or downsloping ST-segment depression or elevation for >= 60-80 milliseconds after the end of the QRS complex, either during or after exercise. Stress Test: Stress Echocardiogram • The imaging study was normal. There was no change in wall motion during the procedure. Stress Test: Stress Nuclear • The results of the imaging study revealed no myocardial perfusion defects. Stress Test: Stress Imaging with CMR • The results of the imaging study revealed no myocardial perfusion defects.		
Positive	Stress Test: Exercise Stress Test (w/o imaging) • A stress test is positive when the electrocardiogram (ECG) suggests ischemia. ECGs suggestive of ischemia can be described as having >= 1 mm of horizontal or downsloping ST-segment depression or elevation for >= 60-80 milliseconds after the end of the QRS complex, either during or after exercise. It is also be suggestive of ischemia if the patient had symptoms of ischemia (i.e.chest pain), arrhythmias, and/or a fall in blood pressure during or immediately after the procedure. Stress Test: Stress Echocardiogram • The imaging study was abnormal. There were changes that reflected wall motion abnormalities during the procedure. Stress Test: Stress Nuclear • The result of the imaging study revealed one or more stress-induced myocardial perfusion defects. Stress Test: Stress Imaging with CMR • The result of the imaging study revealed one or more stress-induced myocardial perfusion defects.	100013093	ACC NCDR
Indeterminate	The results of the study were uninterpretable. They cannot be considered to be positive or negative.	100013094	ACC NCDR

Element: 15581 Cardiac Computed Tomography Angiography (CTA) Performed

Coding Instruction: Indicate if cardiac computed tomography angiography (CTA) was performed.

Target Value: Any occurrence between arrival at this facility and discharge

Test Administration - 1.3.6.1.4.1.19376.1.4.1.6.5.925

Selection	Definition	Source	Code	Code System
Yes	The test was completed.		100013072	ACC NCDR
No - No reason	The test was not completed. There is neither a medical reason nor a patient reason documented explaining why it was not done.		112000000195	ACC NCDR
No - Medical reason	The test was not completed. There is clear documentation of a reason related to the patient's medical issue or concern explaining why it was not done.		112000000199	ACC NCDR
No - Patient reason	The test was not completed. There is clear documentation of a reason related to the patient's and/or family's preference explaining why it was not done.		112000000197	ACC NCDR

Element: 15580 Cardiac Computed Tomography Angiography (CTA) Ordered Date and Time

Coding Instruction: Indicate the date and time the cardiac CTA was ordered.

Note: If more than one cardiac CTA was ordered at your hospital, note the date and time of the first test.

Target Value: The first value between arrival at this facility and discharge

Element: 15582 Cardiac Computed Tomography Angiography (CTA) Performed Date and Time

Coding Instruction: Indicate the date and time the cardiac CTA was performed.

Note: If more than one cardiac CTA was performed at your hospital, note the date and time of the first test.

Section: Non-Invasive Testing **Parent: Patient Evaluation**

Target Value: The first value between arrival at this facility and discharge

Element: 15473 Cardiac Computed Tomography Angiography (CTA) Results

Coding Instruction: Indicate the results of the cardiac computerized tomographic angiography (CTA) performed.

Target Value: The first value between arrival at this facility and discharge

Cardiac CTA result - 1.3.6.1.4.1.19376.1.4.1.6.5.908

Selection	Definition	Source	Code	Code System
No CAD	The patient has clear coronary arteries, no disease identified in any >2mm native or graft vessel.		699196002	SNOMED CT
Non-obstructive CAD	Non-obstructive disease (disease <50% in all coronary vessels and left main disease <50%) Note: Only disease found in vessels >=2mm is captured unless a vessel <2mm is intended for PCI and/or the patient's overall coronary anatomy is <2mm		719678003	SNOMED CT
Moderate CAD	Moderate disease (disease 50-69% in any coronary vessel defined as: LAD and any of its branches, LCX and any of its branches, RCA and any of its branches, a true RAMUS branch >2 mm, any bypass graft and left main disease <50%) Note: Only disease found in vessels >=2mm is captured unless a vessel <2mm is intended for PCI and/or the patient's overall coronary anatomy is <2mm		112000003539	ACC NCDR
Obstructive CAD	Obstructive coronary atherosclerotic disease is disease >=70% in any coronary vessel defined as: LAD and any of its branches, LCX and any of its branches, RCA and any of its branches, a true RAMUS branch >2 mm, any bypass graft and/or left main disease >=50%. Note: Only disease found in vessels >=2mm is captured unless a vessel <2mm is intended for PCI and/or the patient's overall coronary anatomy is <2mm.		26036001	SNOMED CT

Section: Emergency Department Disposition — Parent: Patient Evaluation

Element: 12362 Emergency Department Disposition

Coding Instruction: Indicate where the patient went from the Emergency Department.

Target Value: The first value between arrival at this facility and discharge

Emergency Department Disposition - 1.3.6.1.4.1.19376.1.4.1.6.5.919

Selection	Definition	Source	Code	Code System
Observation	Observation orders were written.		100013061	ACC NCDR
Inpatient	Admission orders were written.	ACC	440654001	SNOMED CT
Discharged	The patient was discharged from the hospital.		309039003	SNOMED CT

Element: 12361 Transferred out of Emergency Department Date and Time

Coding Instruction: Indicate the date and time the patient was moved out of the emergency department, either to another location within your facility or to another acute care center.

Note(s):
Indicate the date/time (mm/dd/yyyy hours:minutes) using the military 24-hour clock, beginning at midnight (0000 hours).

Target Value: The first value between arrival at this facility and discharge

Vendor Instruction: Transferred out of Emergency Department Date and Time (12361) must be Less than or Equal to Discharge Date and Time (10101)

Element: 12417 Observation Order Date and Time

Coding Instruction: Indicate the date and time that the observation bed order was written.

Note(s):
Indicate the date/time (mm/dd/yyyy hours:minutes) using the military 24-hour clock, beginning at midnight (0000 hours).

Target Value: The first value between arrival at this facility and discharge

Vendor Instruction: Observation Order Date and Time (12417) must be Greater than Arrival Date and Time (3001)

Observation Order Date and Time (12417) must be Less than Discharge Date and Time (10101)

Observation Order Date and Time (12417) must be Less than Admission Date and Time (12217)

Section: Home Medications **Parent: Home Medications**

Element: 12297 Home Medication Code

Coding Instruction: The medications listed in this field are controlled by the Medication Master file. This file is maintained by the NCDR and will be made available for downloading and importing/updating into your application.

Target Value: N/A

Vendor Instruction: A Home Medication Code (12297) should not be duplicated in an episode

Home Medications - 2.16.840.1.113883.3.3478.6.5.302

Selection	Definition	Source	Code	Code System
Prasugrel			613391	RxNorm

Element: 12359 Home Medication Prescribed

Coding Instruction: Indicate if the medication was previously prescribed.

Note(s):
Code 'Yes' if the medication was prescribed, regardless of the patient's compliance in taking the medication.

Target Value: Any occurrence between 2 weeks prior to first medical contact and first medical contact

Vendor Instruction: When a Home Medication Code (12297) is selected, Home Medication Prescribed (12359) cannot be Null

Home Meds Administered

Selection	Definition	Source	Code	Code System
No			100013073	ACC NCDR
Yes			100013072	ACC NCDR

Section: Arrival Medications **Parent: Arrival Medications**

Element: 12430 Arrival Medication Code

Coding Instruction: The medications listed in this field are controlled by the Medication Master file. This file is maintained by the NCDR and will be made available for downloading and importing/updating into your application.

Target Value: N/A

Vendor Instruction: An Arrival Medication Code (12430) should not be duplicated in an episode

Arrival Medications - 2.16.840.1.113883.3.3478.6.5.303

Selection	Definition	Source	Code	Code System
Aspirin (Any)			1191	RxNorm

Element: 12355 Medications Administered on Arrival

Coding Instruction: Indicate if the medication (or any medication in the class), was taken by the patient.

Note(s):
Code 'Yes' if the patient took the medication as directed by a healthcare professional or of their own accord, and this is documented in the medical record.

Code 'Contraindicated' if the patient refused to take the recommended medication.

Target Value: The first value between 24 hours before and after arrival

Vendor Instruction: When an Arrival Medication Code (12430) is selected, Medications Administered on Arrival (12355) cannot be Null

Pre-Procedure Y/N/C Medication Administration

Selection	Definition	Source	Code	Code System
No			100013073	ACC NCDR
Yes			100013072	ACC NCDR
Contraindicated	A contraindication is a specific situation in which a drug should not be used because a clinician deems it may be harmful to the patient. Examples include allergy, adverse drug interaction, comorbid condition, pregnancy.		100013074	ACC NCDR

Section: Initial Creatinine **Parent: Labs**

Element: 12256 Initial Creatinine

Coding Instruction: Indicate the initial creatinine value in mg/dL.

Note(s):
This may include point of care (POC) assay results or results obtained prior to arrival at this facility.

The lab value is entered as documented in the medical record, i.e., enter the string of numbers sequentially to the point where the tool no longer accepts the number. Lab values are not altered.

Target Value: The first value between first medical contact 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: 15531 Initial Creatinine Not Drawn

Coding Instruction: Indicate if the creatinine 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: Peak Creatinine — Parent: Labs

Element: 12259 — Peak Creatinine

Coding Instruction: Indicate the peak creatinine value in mg/dL.

Note(s):
If only one creatinine was drawn, use that value for both the initial and the peak value.

The lab value is entered as documented in the medical record, i.e., enter the string of numbers sequentially to the point where the tool no longer accepts the number. Lab values are not altered.

Target Value: The highest value between first medical contact 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: 15534 — Peak Creatinine Not Drawn

Coding Instruction: Indicate if the creatinine 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

Element: 12260 — Peak Creatinine Date and Time

Coding Instruction: Indicate the date and time of the peak creatinine value.

Note(s):
When there are two or more identical 'peak' values, code the date and time of the first sample drawn.

Target Value: The highest value between first medical contact 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

Vendor Instruction: Peak Creatinine Date and Time (12260) must be Less than Discharge Date and Time (10101)

Peak Creatinine Date and Time (12260) must be Greater than or Equal to the minimum of (Arrival at Outside Facility Date and Time (12426), Arrival Date and Time (3001), Emergency Medical Services First Medical Contact Date and Time (12197))

Section: Initial Hemoglobin **Parent: Labs**

Element: 12397 Initial Hemoglobin Value

Coding Instruction: Indicate the hemoglobin (Hgb) value in g/dL.

Note(s):
This may include point of care (POC) assay results or results obtained prior to arrival at this facility.

The lab value is entered as documented in the medical record, i.e., enter the string of numbers sequentially to the point where the tool no longer accepts the number. Lab values are not altered.

Target Value: The first value between first medical contact 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: 15535 Initial Hemoglobin Not Drawn

Coding Instruction: Indicate if the hemoglobin was not drawn.

Target Value: N/A

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

Section: Additional Labs **Parent: Labs**

Element: 12404 Lowest Hemoglobin Value

Coding Instruction: Indicate the lowest hemoglobin (Hgb) value in g/dL.

Note(s):
If only one hemoglobin was drawn, use that value for both the initial and the lowest value.

The lab value is entered as documented in the medical record, i.e., enter the string of numbers sequentially to the point where the tool no longer accepts the number. Lab values are not altered.

Target Value: The lowest value between first medical contact 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: 15536 Lowest Hemoglobin Not Drawn

Coding Instruction: Indicate if the hemoglobin was not drawn.

Target Value: N/A

Element: 12400 Lowest Hemoglobin Date and Time

Coding Instruction: Indicate the date and time of the lowest hemoglobin (Hgb) value.

Note(s):
When there are two or more identical 'lowest' values, code the date and time of the first sample drawn.

Target Value: The lowest value between first medical contact 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

Vendor Instruction: Lowest Hemoglobin Date and Time (12400) must be Less than Discharge Date and Time (10101)

Lowest Hemoglobin Date and Time (12400) must be Greater than or Equal to the earliest of the following elements: Arrival at Outside Facility Date and Time (12426), Arrival Date and Time (3001), Emergency Medical Services First Medical Contact Date and Time (12197)

Element: 15544 Initial Hemoglobin A1c Value

Coding Instruction: Indicate the glycated hemoglobin A1C (HbA1c) value in percent (%).

Note(s):
The lab value is entered as documented in the medical record, i.e., enter the string of numbers sequentially to the point where the tool no longer accepts the number. Lab values are not altered.

Target Value: The first value between first medical contact and discharge

Supporting Definition: **Hemoglobin A1c**

Hemoglobin A1c lab value identifies the patient's average blood sugar level for the past 2 to 3 months.

Source:

Element: 15537 Initial Hemoglobin A1c Not Drawn

Coding Instruction: Indicate if the glycated hemoglobin A1C (HbA1c) was not drawn.

Target Value: N/A

Element: 12265 Initial International Normalized Ratio

Coding Instruction: Indicate the international normalized ratio (INR).

Note(s): The lab value is entered as documented in the medical record, i.e., enter the string of numbers sequentially to the point where the tool no longer accepts the number. Lab values are not altered.

Section: Additional Labs **Parent: Labs**

Target Value: The first value between first medical contact and discharge

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 evalulate 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.

Source: http://s.details.loinc.org/LOINC/6301-6.html?sections=Simple

Element: 15538 Initial International Normalized Ratio Not Drawn

Coding Instruction: Indicate if the international normalized ratio (INR) was not calculated.

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 evalulate 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.

Source: http://s.details.loinc.org/LOINC/6301-6.html?sections=Simple

Section: Lipids **Parent: Labs**

Element: 12268 Total Cholesterol

Coding Instruction: Indicate the total cholesterol value in mg/dL.

Note(s):
The lab value is entered as documented in the medical record, i.e., enter the string of numbers sequentially to the point where the tool no longer accepts the number. Lab values are not altered.

Target Value: The last value between 6 months before first medical contact and discharge

Supporting Definition: **Cholesterol**

Cholesterol is a lipidic, waxy alcohol found in the cell membranes and transported in the blood plasma of all animals. It is an essential component of mammalian cell membranes where it establishes proper membrane permeability and fluidity. Cholesterol is the principal sterol synthesized by animals, but small quantities are synthesized in other eukaryotes, such as plants and fungi. It is almost completely absent among prokaryotes, which include bacteria. Cholesterol is classified as a sterol.

Element: 15539 Total Cholesterol Not Drawn

Coding Instruction: Indicate if the total cholesterol was not drawn.

Target Value: N/A

Supporting Definition: **Cholesterol**

Cholesterol is a lipidic, waxy alcohol found in the cell membranes and transported in the blood plasma of all animals. It is an essential component of mammalian cell membranes where it establishes proper membrane permeability and fluidity. Cholesterol is the principal sterol synthesized by animals, but small quantities are synthesized in other eukaryotes, such as plants and fungi. It is almost completely absent among prokaryotes, which include bacteria. Cholesterol is classified as a sterol.

Element: 12270 High-density Lipoprotein

Coding Instruction: Indicate the high-density lipoprotein (HDL) cholesterol value in mg/dL.

Note(s):
The lab value is entered as documented in the medical record, i.e., enter the string of numbers sequentially to the point where the tool no longer accepts the number. Lab values are not altered.

Target Value: The last value between 6 months before first medical contact and discharge

Supporting Definition: **High-density lipoprotein**

High-density lipoprotein (HDL) is one of the five major groups of lipoproteins (chylomicrons, VLDL, IDL, LDL, HDL) which enable lipids like cholesterol and triglycerides to be transported within the water based blood stream. In healthy individuals, about thirty percent of blood cholesterol is carried by HDL. High levels of cholesterol in the blood have been linked to damage to arteries and cardiovascular disease.

Element: 15540 High-density Lipoprotein Not Drawn

Coding Instruction: Indicate if the high-density lipoprotein (HDL) cholesterol was not drawn.

Target Value: N/A

Supporting Definition: **High-density lipoprotein**

High-density lipoprotein (HDL) is one of the five major groups of lipoproteins (chylomicrons, VLDL, IDL, LDL, HDL) which enable lipids like cholesterol and triglycerides to be transported within the water based blood stream. In healthy individuals, about thirty percent of blood cholesterol is carried by HDL. High levels of cholesterol in the blood have been linked to damage to arteries and cardiovascular disease.

Element: 12273 LDL Cholesterol

Coding Instruction: Indicate the low-density lipoprotein (LDL) cholesterol value in mg/dL.

Note(s): The lab value is entered as documented in the medical record, i.e., enter the string of numbers sequentially to the point where

Section: Lipids **Parent: Labs**

the tool no longer accepts the number. Lab values are not altered.

Target Value: The last value between 6 months before first medical contact and discharge

Supporting Definition: **Cholesterol in LDL**

A small dense LDL fraction, reported as part of LDL Subclasses panel. Seven LDL subclasses and 3 mid-band fractions can be determined by linear polyacrylamide gel electrophoresis and densitometric scanning.

Source: Regenstrief Institute

Element: 13010 Low Density Lipoprotein Cholesterol Not Drawn

Coding Instruction: Indicate if a low density lipoprotein (LDL) cholesterol was not drawn (or calculated).

Target Value: N/A

Supporting Definition: **Cholesterol in LDL**

A small dense LDL fraction, reported as part of LDL Subclasses panel. Seven LDL subclasses and 3 mid-band fractions can be determined by linear polyacrylamide gel electrophoresis and densitometric scanning.

Source: Regenstrief Institute

Element: 12271 Triglycerides

Coding Instruction: Indicate the triglyceride value in mg/dL.

Note(s):
The lab value is entered as documented in the medical record, i.e., enter the string of numbers sequentially to the point where the tool no longer accepts the number. Lab values are not altered.

Target Value: The last value between 6 months before first medical contact and discharge

Supporting Definition: **Triglyceride**

A triglyceride (TG, triacylglycerol, TAG, or triacylglyceride) is an ester derived from glycerol and three fatty acids. There are many triglycerides, depending on the oil source, some are highly unsaturated, some less so. Triglycerides are the main constituents of vegetable oil (typically more unsaturated) and animal fats (typically more saturated). In humans, triglycerides are a mechanism for storing unused calories, and their high concentrations in blood correlates with the consumption of starchy and fatty foods. High levels of triglycerides in the bloodstream have been linked to atherosclerosis and, by extension, the risk of heart disease and stroke. Diets high in carbohydrates, with carbohydrates accounting for more than 60% of the total energy intake, can increase triglyceride levels.

Source: https://s.details.loinc.org/LOINC/2571-8.html?sections=Comprehensive

Element: 15541 Triglycerides Not Drawn

Coding Instruction: Indicate if the triglyceride level was not drawn.

Target Value: N/A

Supporting Definition: **Triglyceride**

A triglyceride (TG, triacylglycerol, TAG, or triacylglyceride) is an ester derived from glycerol and three fatty acids. There are many triglycerides, depending on the oil source, some are highly unsaturated, some less so. Triglycerides are the main constituents of vegetable oil (typically more unsaturated) and animal fats (typically more saturated). In humans, triglycerides are a mechanism for storing unused calories, and their high concentrations in blood correlates with the consumption of starchy and fatty foods. High levels of triglycerides in the bloodstream have been linked to atherosclerosis and, by extension, the risk of heart disease and stroke. Diets high in carbohydrates, with carbohydrates accounting for more than 60% of the total energy intake, can increase triglyceride levels.

Source: https://s.details.loinc.org/LOINC/2571-8.html?sections=Comprehensive

Section: Cath Lab Visit **Parent: Treatment Strategy**

Element: 12309 Coronary Angiography

Coding Instruction: Indicate if the patient had a diagnostic coronary angiography procedure.

Target Value: Any occurrence between arrival at this facility and discharge

Supporting Definition: **Coronary Angiography**

Coronary angiography is defined as the passage of a catheter into the aortic root or other great vessels for angiography of the native coronary arteries or bypass grafts supplying native coronary arteries. This element would NOT include noninvasive CT angiography.

Source: American College of Cardiology and American Heart Association Task Force on Clinical Data Standards (Writing Committee to Develop Artery Disease: A Report of the American College of Cardiology Foundation/American.
Management and Outcomes of Patients With Acute Coronary Syndromes and Coronary 2013 ACCF/AHA Key Data Elements and Definitions for Measuring the Clinical Circulation. 2013;127:1052-1089; originally published online January 28, 2013;

Vendor Instruction: When Coronary Angiography (12309) is 'No - Performed at transferring facility', Transferred from Outside Facility (12421) must be 'Yes'.

Dx Coronary Angiography - 1.3.6.1.4.1.19376.1.4.1.6.5.316

Selection	Definition	Source	Code	Code System
Yes	The test was completed.		100013072	ACC NCDR
No - No reason	The test was not completed. There is neither a medical reason nor a patient reason documented explaining why it was not done.		112000000195	ACC NCDR
No - Medical reason	The test was not completed. There is clear documentation of a reason related to the patient's medical issue or concern explaining why it was not done.		112000000199	ACC NCDR
No - Patient reason	The test was not completed. There is clear documentation of a reason related to the patient's and/or family's preference explaining why it was not done.		112000000197	ACC NCDR
No - System reason	The test was not completed. There is clear documentation of a reason related to the healthcare system explaining why it was not done.		112000000198	ACC NCDR
No - Performed at transferring facility	The treatment option was not delivered here but was performed prior to arrival at this facility at the transferring facility.		112000003558	ACC NCDR

Element: 7046 Diagnostic Catheterization Operator Last Name

Coding Instruction: Indicate the last name of the operator who is performing the diagnostic catheterization.

Note(s):
If the name exceeds 50 characters, enter the first 50 letters only.

Target Value: The value on current procedure

Vendor Instruction: Diagnostic Catheterization Operator Last Name (7046) cannot be Null

Element: 7047 Diagnostic Catheterization Operator First Name

Coding Instruction: Indicate the first name of the operator who is performing the diagnostic catheterization.

Note(s):
If the name exceeds 50 characters, enter the first 50 letters only.

Target Value: The value on current procedure

Vendor Instruction: Diagnostic Catheterization Operator First Name (7047) cannot be Null

Element: 7048 Diagnostic Catheterization Operator Middle Name

Coding Instruction: Indicate the middle name of the operator who is performing the diagnostic catheterization.

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 current procedure

Element: 7049 Diagnostic Catheterization Operator NPI

Section: Cath Lab Visit | **Parent: Treatment Strategy**

Coding Instruction: Indicate the National Provider Identifier (NPI) of the operator who is performing the diagnostic catheterization.

National Provider Identifier (NPI) numbers, assigned by the Centers for Medicare and Medicaid Services (CMS), are used to uniquely identify professionals for Medicare billing purposes.

Target Value: The value on current procedure

Vendor Instruction: Diagnostic Catheterization Operator NPI (7049) cannot be Null

Element: 12311 Catheterization Laboratory Arrival Date and Time

Coding Instruction: Indicate the date and time the patient arrived in the cath lab procedure room.

Note(s):
Indicate the date/time (mm/dd/yyyy hours:minutes) using the military 24-hour clock, beginning at midnight (0000 hours).

Target Value: The first value between arrival at this facility and discharge

Vendor Instruction: Catheterization Laboratory Arrival Date and Time (12311) must be Less than First Device Activation Date and Time (7845)

Catheterization Laboratory Arrival Date and Time (12311) must be Less than Discharge Date and Time (10101)

Element: 12312 Diagnostic Coronary Angiography Date and Time

Coding Instruction: Indicate the date and time the diagnostic coronary angiography procedure started.

Note(s):
Indicate the date/time (mm/dd/yyyy hours:minutes) using the military 24-hour clock, beginning at midnight (0000 hours).

The time the procedure started is defined as the time at which local anesthetic was first administered for vascular access, or the time of the first attempt at vascular access for the cardiac catheterization (use whichever is earlier).

Target Value: The first value between arrival at this facility and discharge

Supporting Definition: **Coronary Angiography**

Coronary angiography is defined as the passage of a catheter into the aortic root or other great vessels for angiography of the native coronary arteries or bypass grafts supplying native coronary arteries. This element would NOT include noninvasive CT angiography.

Source: American College of Cardiology and American Heart Association Task Force on Clinical Data Standards (Writing Committee to Develop Artery Disease: A Report of the American College of Cardiology Foundation/American.
Management and Outcomes of Patients With Acute Coronary Syndromes and Coronary 2013 ACCF/AHA Key Data Elements and Definitions for Measuring the Clinical Circulation. 2013;127:1052-1089; originally published online January 28, 2013;

Vendor Instruction: Diagnostic Coronary Angiography Date and Time (12312) must be Less than Discharge Date and Time (10101)

Diagnostic Coronary Angiography Date and Time (12312) must be Greater than Arrival at First Facility Date and Time (12612)

Element: 15500 NSTEMI Patient Centered Reason for Delay in Angiography

Coding Instruction: Indicate if there was a patient-centered issue that delayed performing coronary angiography.

Note(s):
A patient-centered reason for delay is an issue/condition understood and documented to originate with the patient. It is not associated with the health care system (i.e. facility, staff or processes, etc.).

Examples: Patient or family delays in providing consent for angiography, patient is too unstable for angiography (i.e., cardiovascular instability, acute heart failure, cardiogenic shock).

Target Value: Any occurrence within the first 24 hours after arrival at this facility (or after NSTEMI diagnosis)

Element: 15530 Resuscitated pre-admit STEMI Patient Centered Reason for Delay in Angiography

Coding Instruction: Indicate if there was a patient-centered issue that delayed performing coronary angiography after the patient was resuscitated.

Note(s):
A patient-centered reason for delay is an issue/condition understood and documented to originate with the patient. It is not associated with the health care system (i.e. facility, staff or processes, etc.).

Examples: Patient or family delays in providing consent for angiography, patient is too unstable for angiography (i.e., cardiovascular instability, acute heart failure, cardiogenic shock)..

Target Value: Any occurrence within 120 minutes after resuscitation

Element: 15497 Coronary Angiography Results

Coding Instruction: Indicate if the results of the coronary angiography showed evidence of coronary artery disease.

Target Value: The highest value between arrival at this facility and discharge

Section: Cath Lab Visit **Parent: Treatment Strategy**

Angiography Results - 1.3.6.1.4.1.19376.1.4.1.6.5.239

Selection	Definition	Source	Code	Code System
No CAD	The patient has clear coronary arteries, no disease identified in any >2mm native or graft vessel.		699196002	SNOMED CT
CAD	Coronary atherosclerotic disease was identified in at least one >2mm native or graft vessel.		53741008	SNOMED CT
Unavailable	There are no results available.		100000646	ACC NCDR

Element: 15498 Coronary Artery Disease Type

Coding Instruction: Indicate the type of coronary artery disease.

Target Value: The highest value between arrival at this facility and discharge

Type of Coronary Artery Disease - 1.3.6.1.4.1.19376.1.4.1.6.5.904

Selection	Definition	Source	Code	Code System
Non-obstructive	Non-obstructive disease (disease <50% in all coronary vessels and left main disease <50%) Note: Only disease found in vessels >=2mm is captured unless a vessel <2mm is intended for PCI and/or the patient's overall coronary anatomy is <2mm		719678003	SNOMED CT
Moderate	Moderate disease (disease 50-69% in any coronary vessel defined as: LAD and any of its branches, LCX and any of its branches, RCA and any of its branches, a true RAMUS branch >2 mm, any bypass graft and left main disease <50%) Note: Only disease found in vessels >=2mm is captured unless a vessel <2mm is intended for PCI and/or the patient's overall coronary anatomy is <2mm		112000003539	ACC NCDR
Obstructive	Obstructive coronary atherosclerotic disease is disease >=70% in any coronary vessel defined as: LAD and any of its branches, LCX and any of its branches, RCA and any of its branches, a true RAMUS branch >2 mm, any bypass graft and/or left main disease >=50%. Note: Only disease found in vessels >=2mm is captured unless a vessel <2mm is intended for PCI and/or the patient's overall coronary anatomy is <2mm.		26036001	SNOMED CT
Unknown			261665006	SNOMED CT

Section: Reperfusion **Parent: Treatment Strategy**

Element: 12295 Thrombolytic

Coding Instruction: Indicate if the patient received thrombolytic therapy as an urgent treatment for STEMI.

Target Value: Any occurrence between first medical contact and discharge

Thrombolytic Administration

Selection	Definition	Source	Code	Code System
Yes	Code Yes if this medication was initiated.		100001247	ACC NCDR
No - No reason			112000000195	ACC NCDR
No - Medical reason	Clear documentation of a reason related to the patient's medical issue or concern.		112000000199	ACC NCDR
No - Patient reason	Documentation of a patient reason (eg, initial patient concern with bleeding hazards).		100001071	ACC NCDR

Element: 12296 Thrombolytic Therapy Date and Time

Coding Instruction: Indicate the date and time of either the first bolus or the beginning of the infusion.

Note(s):
If your facility receives a patient transfer with infusion ongoing, record the date and time that infusion was started at the transferring facility.

Indicate the time (hours:minutes) using the military 24-hour clock, beginning at midnight (00:00 hours).

Target Value: The first value between first medical contact and discharge

Vendor Instruction: Thrombolytic Therapy Date and Time (12296) must be Less than Discharge Date and Time (10101)

Thrombolytic Therapy Date and Time (12296) must be Greater than the earliest of the following elements: Arrival at Outside Facility Date and Time (12426), Arrival Date and Time (3001), Emergency Medical Services First Medical Contact Date and Time (12197)

Element: 14207 Medical Reason for Delay in Thrombolytic

Coding Instruction: Indicate if there was a medical reason for delay in administering a thrombolytic.

Target Value: Any occurrence between first medical contact and discharge

Supporting Definition: **Medical Reason for Delay in Thrombolytics**

Documentation of a medical reason for delayed fibrinolytic therapy (e.g., cardiopulmonary arrest, initial suspicion of bleeding/stroke or other contraindications to use fibrinolytic therapy, respiratory failure requiring intubation, intra-aortic balloon pump insertion, late presentation >12 h after symptom onset).

Source: Jneid, H., Addison, D., Bhatt, D. L., Fonarow, G. C. Gokak, S., Grady, K. L., Green, L. A., Heidenreich, P. A., Ho, P. M., Jurgens, C. Y., King, M. L., Kumbhani, D. J., Pancholy, S. (in press) 2017 AHA/ACC Clinical Performance and Quality Measures for Adults With ST-Elevation and Non–ST-Elevation Myocardial Infarction. Journal of the American College of Cardiology. doi: 10.1016/j.jacc.2017.06.032

Element: 14208 Patient Reason for Delay in Thrombolytic

Coding Instruction: Indicate if there was a patient reason for delay in administering a thrombolytic.

Target Value: Any occurrence between first medical contact and discharge

Element: 15502 Percutaneous Coronary Intervention

Coding Instruction: Indicate if the patient had a percutaneous coronary intervention (PCI).

Target Value: Any occurrence between first medical contact and discharge

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

Revascularization Performed - 1.3.6.1.4.1.19376.1.4.1.6.5.922

Selection	Definition	Source	Code	Code System
Yes			100013072	ACC NCDR
No - No reason	The treatment option was not performed and there is no documentation of a reason why it was not performed.		112000000195	ACC NCDR
No - Medical reason	The treatment option was not performed and there is clear documentation of a medical reason why it was not performed.		112000000199	ACC NCDR

Section: Reperfusion **Parent: Treatment Strategy**

No - Patient reason	The treatment option was not performed and there is clear documentation of a patient's medical issue or concern why it was not performed.	112000000197	ACC NCDR

Element: 15501 Coronary Artery Bypass Graft

Coding Instruction: Indicate if coronary artery bypass graft (CABG) surgery was performed.

Target Value: Any occurrence between first medical contact and discharge

Supporting Definition: **Coronary Artery Bypass Graft**

Coronary artery bypass graft surgery is when the native vessels of the heart are bypassed with other vessels (internal mammary artery, radial artery or saphenous vein) to restore normal blood flow to the obstructed coronary arteries.

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.

Revascularization Performed - 1.3.6.1.4.1.19376.1.4.1.6.5.922

Selection	Definition	Source	Code	Code System
Yes			100013072	ACC NCDR
No - No reason	The treatment option was not performed and there is no documentation of a reason why it was not performed.		112000000195	ACC NCDR
No - Medical reason	The treatment option was not performed and there is clear documentation of a medical reason why it was not performed.		112000000199	ACC NCDR
No - Patient reason	The treatment option was not performed and there is clear documentation of a patient's medical issue or concern why it was not performed.		112000000197	ACC NCDR

Element: 10011 Coronary Artery Bypass Graft Date and Time

Coding Instruction: Indicate the date and time of the coronary artery bypass graft (CABG) surgery.

Note(s):
Indicate the time (hours:minutes) using the military 24-hour clock, beginning at midnight (00:00 hours).

Target Value: The first value between arrival and discharge

Supporting Definition: **Coronary Artery Bypass Graft**

Coronary artery bypass graft surgery is when the native vessels of the heart are bypassed with other vessels (internal mammary artery, radial artery or saphenous vein) to restore normal blood flow to the obstructed coronary arteries.

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.

Vendor Instruction: Coronary Artery Bypass Graft Date and Time (10011) must be Greater than Arrival Date and Time (3001)

Coronary Artery Bypass Graft Date and Time (10011) must be Less than Discharge Date and Time (10101)

Section: PCI Procedure **Parent: Treatment Strategy**

Element: 15499 Percutaneous Coronary Intervention Date and Time

Coding Instruction: Indicate the date and time the PCI started.

Target Value: The first value between arrival and discharge

Element: 7051 PCI Operator Last Name

Coding Instruction: Indicate the last name of the operator who is performing the percutaneous coronary intervention.

Note(s):
If the name exceeds 50 characters, enter the first 50 letters only.

Target Value: The value on current procedure

Vendor Instruction: PCI Operator Last Name (7051) cannot be Null

Element: 7052 PCI Operator First Name

Coding Instruction: Indicate the first name of the operator who is performing the percutaneous coronary intervention.

Note(s):
If the name exceeds 50 characters, enter the first 50 letters only.

Target Value: The value on current procedure

Vendor Instruction: PCI Operator First Name (7052) cannot be Null

Element: 7053 PCI Operator Middle Name

Coding Instruction: Indicate the middle name of the operator who is performing the percutaneous coronary intervention.

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 current procedure

Element: 7054 PCI Operator NPI

Coding Instruction: Indicate the National Provider Identifier (NPI) of the operator who is performing the PCI procedure.

National Provider Identifier (NPI) numbers, assigned by the Centers for Medicare and Medicaid Services (CMS), are used to uniquely identify professionals for Medicare billing purposes.

Target Value: The value on current procedure

Vendor Instruction: PCI Operator NPI (7054) cannot be Null

Element: 15433 Fellow Last Name

Coding Instruction: Indicate the last name of the Fellow who is involved with the percutaneous coronary intervention.

Note(s):
If the name exceeds 50 characters, enter the first 50 letters only.

Target Value: The value on current procedure

Element: 15434 Fellow First Name

Coding Instruction: Indicate the first name of the Fellow who is involved in the percutaneous coronary intervention.

Note(s):
If the name exceeds 50 characters, enter the first 50 letters only.

Target Value: The value on current procedure

Element: 15435 Fellow Middle Name

Coding Instruction: Indicate the middle name of the Fellow who is involved with the percutaneous coronary intervention.

Section: PCI Procedure **Parent: Treatment Strategy**

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 current procedure

Element: 15436 Fellow NPI

Coding Instruction: Indicate the National Provider Identifier (NPI) of the Fellow involved with the PCI procedure.

National Provider Identifier (NPI) numbers, assigned by the Centers for Medicare and Medicaid Services (CMS), are used to uniquely identify professionals for Medicare billing purposes.

Target Value: The value on current procedure

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.

Source: A list of programs by specialty can be found here: ACGME - Accreditation Data System (ADS): https://apps.acgme.org/ads/Public/Reports/Report/1 .

Element: 12326 Percutaneous Coronary Intervention Indication

Coding Instruction: Indicate the primary reason PCI was performed or attempted.

Target Value: The first value between arrival at this facility and discharge

Vendor Instruction: When Thrombolytic (12295) is Yes, Percutaneous Coronary Intervention Indication (12326) must be Null or in (STEMI-Other, NSTEMI, Unstable angina, Other).

PCI Indication - 2.16.840.1.113883.3.3478.6.7.2

Selection	Definition	Source	Code	Code System
STEMI - Immediate PCI for acute STEMI	Immediate PCI for STEMI (or STEMI equivalent) PCI is performed emergently and without delay after diagnosis. This includes Unstable <= 12 hours in selection definition.		100000570	ACC NCDR
STEMI - Other			112000003559	ACC NCDR
NSTEMI			112000000794	ACC NCDR
Unstable angina			4557003	SNOMED CT
Other			10001424795	ACC NCDR

Element: 7422 Mechanical Ventricular Support

Coding Instruction: Indicate if the patient required mechanical ventricular support.

Target Value: Any occurrence on current procedure

Element: 7423 Mechanical Ventricular Support Device

Coding Instruction: Indicate the mechanical ventricular support device used.

Note(s):
The device that should be collected in your application are controlled by a Mechanical Ventricular Support 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 on current procedure

Mechanical Ventricular Support Device - 2.16.840.1.113883.3.3478.6.1.24

Selection	Definition	Source	Code	Code System
Cardiopulmonary Support (CPS)	The cardiopulmonary support system is an extracorporeal device that allows for rapid cardiopulmonary support of the critically ill patient in the		1000142428	ACC NCDR

Section: PCI Procedure **Parent: Treatment Strategy**

	intensive care unit. It provides immediate and complete support of cardiac and pulmonary functions to maintain perfusion to vital organs in patients who are severely physiologically compromised (eg, in cardiogenic shock, adult respiratory distress syndrome or pulmonary edema).		
Extracorporeal membrane oxygenation (ECMO)	Extracorporeal membrane oxygenation (ECMO) or extracorporeal life support (ECLS) is an extracorporeal technique of providing both cardiac and respiratory support to persons whose heart and lungs are unable to provide an adequate amount of gas exchange to sustain life.	233573008	SNOMED CT
Impella: Left Ventricular Support	The Impella device is a minimally invasive, catheter-based cardiac assist device. It is the smallest rotary blood pump in the world. The pump is inserted percutaneously through the femoral artery and into the left ventricle.	100014011	ACC NCDR
Impella: Right Ventricular Support		112000000188	ACC NCDR
Intra-aortic balloon pump (IABP)	An intra-aortic balloon pump (IABP) is a mechanical device that helps the heart pump blood.	442807006	SNOMED CT
Left ventricular assist device (LVAD)	A ventricular assist device (VAD) is an electromechanical circulatory device that is used to partially or completely replace the function of a failing heart.	232967006	SNOMED CT
Right Ventricular Assist Device (RVAD)		360065002	SNOMED CT
Percutaneous Heart Pump (PHP)	A percutaneous heart pump provides hemodynamic support for compromised patients.	1000142429	ACC NCDR
TandemHeart	The TandemHeart Percutaneous Ventricular Assist Device (pVAD) differs from other assist devices in that it can be inserted either by cardiovascular surgeons in the operating room or by cardiologists in the cardiac catheterization laboratory. The TandemHeart pVAD is a continuous-flow centrifugal assist device placed outside the body (extracorporeally).	100014010	ACC NCDR
Biventricular Axial Flow Impella Catheters (BiPella)		112000001980	ACC NCDR
Combined Extracorporeal Membrane Oxygenation and Percutaneous Left Ventricular Assist Device (ECPELLA)		112000002051	ACC NCDR

Element: 7320 Arterial Access Site

Coding Instruction: Indicate the location of percutaneous entry for the procedure.

Target Value: The last value on current procedure

Arterial Access Site - 1.3.6.1.4.1.19376.1.4.1.6.5.310

Selection	Definition	Source	Code	Code System
Femoral			7657000	SNOMED CT
Radial			45631007	SNOMED CT
Other	Specific artery not available for selection in registry.		100013029	ACC NCDR

Element: 12327 Stent(s) Placed

Coding Instruction: Indicate if a stent or stents were placed in the affected coronary artery.

Target Value: The first value on current procedure

Element: 12328 Stent Type

Coding Instruction: Indicate the type of stent used during the PCI.

Target Value: The first value on current procedure

Stent Device Type - 1.3.6.1.4.1.19376.1.4.1.6.5.307

Selection	Definition	Source	Code	Code System
Bare Metal Stent	A bare metal stent (BMS) is a coronary stent without eluting drugs.		464052002	SNOMED CT
Drug-Eluting Stent	A drug-eluting stent is a coronary stent placed into narrowed, diseased coronary arteries that slowly releases a drug to prevent cell proliferation, thereby preventing fibrosis, that together with clots, could block		411191007	SNOMED CT

Section: PCI Procedure **Parent: Treatment Strategy**

the stented artery (restenosis).

Element: 12449 Stent Type Unknown

Coding Instruction: Indicate if the type of stent used in the current procedure is unknown.

Target Value: The value on current procedure

Section: PCI for Acute STEMI **Parent: Treatment Strategy**

Element: 15445 STEMI (or STEMI Equivalent) Noted on First ECG

Coding Instruction: Indicate if STEMI (or a STEMI equivalent) was noted on the first ECG.

Target Value: The first value between first medical contact and discharge

Element: 7845 First Device Activation Date and Time

Coding Instruction: Indicate the date and time the first device was activated regardless of type of device used.

Note(s):
Indicate the time (hours:minutes) using the military 24-hour clock, beginning at midnight (00:00 hours).

Use the earliest time from the following:
1. Time of the first balloon inflation.

2. Time of the first stent deployment.

3. Time of the first treatment of lesion (AngjoJet or other thrombectomy/aspiration device, laser, rotational atherectomy).

4. If the lesion cannot be crossed with a guidewire or device (and thus none of the above apply), use the time of guidewire introduction.

This is a process measure about the timeliness of treatment. It is NOT a clinical outcomes measure based on TIMI flow or clinical reperfusion. It does not matter whether the baseline angiogram showed TIMI 3 flow or if the final post-PCI angiogram showed TIMI 0 flow. What is being measured is the time of the first mechanical treatment of the culprit lesion, not the time when TIMI 3 flow was (or was not) restored.

Target Value: The first value on current procedure

Vendor Instruction: First Device Activation Date and Time (7845) must be Greater than Arrival Date and Time (3001)

First Device Activation Date and Time (7845) must be Less than Discharge Date and Time (10101)

Element: 7850 Patient Centered Reason for Delay in PCI

Coding Instruction: Indicate if there was a patient-centered reason for delay in performing the percutaneous coronary intervention (PCI).

Note(s):
A patient-centered reason for delay is an issue/condition understood and documented to originate with the patient. It is not associated with the health care system (i.e. facility, staff or processes, etc.).

To warrant coding 'Yes' the patient-centered reason(s) must be identified in the first 90 minutes after arrival at this facility, or in the first 90 minutes after an in-hospital diagnosis of STEMI, and be responsible for affecting the time to PCI.

If the issue is documented in the medical record and the effect on timing is self-evident, it can be coded.

If the effect on timing/delay to PCI is unclear, then there must be specific documentation by a physician/APN/PA that establishes the linkage between the patient issue/condition and the timing/delay in PCI.

Target Value: Any occurrence in the first 90 minutes after arrival at this facility (or within the first 90 minutes after STEMI diagnosis)

Element: 7851 Patient Centered Reason for Delay in PCI Reason

Coding Instruction: Indicate the patient-centered reason for delay in performing the percutaneous coronary intervention (PCI).

Target Value: Any occurrence in the first 90 minutes after arrival at this facility (or within the first 90 minutes after STEMI diagnosis)

Patient Reason for Delay in PCI - 1.3.6.1.4.1.19376.1.4.1.6.5.509

Selection	Definition	Source	Code	Code System
Patient delays in providing consent for PCI			100000349	ACC NCDR
Difficult vascular access	The patient's anatomy is torturous, obstructive or otherwise prohibitive to the vascular access device. Do not select if the operator is unable to gain access due to inexperience or device selection, etc.		100000881	ACC NCDR
Emergent placement of left ventricular support device			1000142391	ACC NCDR
Cardiac arrest and/or need for intubation			100013001	ACC NCDR
Difficulty crossing the culprit lesion	The patient's anatomy is torturous, obstructive or otherwise prohibitive to guidewire or device access. Do not select if the operator is unable to cross the culprit lesion due to inexperience or device selection, etc.		100000350	ACC NCDR
Other	Not otherwise specified.		100000351	ACC NCDR

Section: Events **Parent: Episode Events**

Element: 12342 Episode Events

Coding Instruction: The events listed in this field are controlled by the Events Master file. This file is maintained by the NCDR and will be made available for downloading and importing/updating into your application.

Target Value: N/A

Vendor Instruction: An Episode - combination Events (12342), Occurred (12344) and Date and Time (12343) - may only be entered/selected once

Post-Procedure Events - 2.16.840.1.113883.3.3478.6.3.10

Selection	Definition	Source	Code	Code System
Atrial fibrillation			49436004	SNOMED CT
Bleeding - Access site			1000142440	ACC NCDR
Bleeding - Gastrointestinal			74474003	SNOMED CT
Bleeding - Genitourinary			417941003	SNOMED CT
Bleeding - Hematoma at access site			385494008	SNOMED CT
Bleeding - Other			1000142371	ACC NCDR
Bleeding - Retroperitoneal			95549001	SNOMED CT
Bleeding - Surgical procedure or intervention required			112000000213	ACC NCDR
Cardiac arrest			410429000	SNOMED CT
Cardiogenic shock			89138009	SNOMED CT
Heart failure			84114007	SNOMED CT
Myocardial infarction			22298006	SNOMED CT
New requirement for dialysis			100014076	ACC NCDR
Respiratory support - Bi-PAP			243142003	SNOMED CT
Respiratory support - High-flow oxygen			426854004	SNOMED CT
Respiratory support - Intubation			52765003	SNOMED CT
Stroke - Hemorrhagic			230706003	SNOMED CT
Stroke - Ischemic			422504002	SNOMED CT
Stroke - Undetermined			230713003	SNOMED CT
Transient ischemic attack (TIA)			266257000	SNOMED CT
Ventricular fibrillation			71908006	SNOMED CT
Sustained ventricular tachycardia			25569003	SNOMED CT

Element: 12344 Episode Events Occurred

Coding Instruction: Indicate the event(s) that did or did not occur during the episode of care.

Atrial fibrillation
Indicate if atrial fibrillation was documented in the medical record.

Bleeding - Access site
Indicate if the patient experienced a confirmed bleeding event at the access site observed and documented in the medical record that was associated with any of the following:
1. Hemoglobin drop of >=3 g/dL;
2. Transfusion of whole blood or packed red blood cells;
3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding (such as surgical closures/exploration of the arteriotomy site, balloon angioplasty to seal an arterial tear, endoscopy with cautery of a GI bleed).

Bleeding - Gastrointestinal
Indicate if the patient experienced a confirmed gastrointestinal bleeding event observed and documented in the medical record that was associated with any of the following:
1. Hemoglobin drop of >=3 g/dL;
2. Transfusion of whole blood or packed red blood cells;
3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding (such as surgical closures/exploration of the arteriotomy site, balloon angioplasty to seal an arterial tear, endoscopy with cautery of a GI bleed).

Bleeding - Genitourinary
Indicate if the patient experienced a confirmed genitourinary bleeding event observed and documented in the medical record that was associated with any of the following:
1. Hemoglobin drop of >=3 g/dL;
2. Transfusion of whole blood or packed red blood cells;
3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding (such as surgical closures/exploration of the arteriotomy site, balloon angioplasty to seal an arterial tear, endoscopy with cautery of a GI bleed).

Bleeding - Hematoma at access site
Indicate if the patient experienced a confirmed hematoma at the access site observed and documented in the medical record that was associated with any of the following:

Section: Events **Parent: Episode Events**

1. Hemoglobin drop of >=3 g/dL;
2. Transfusion of whole blood or packed red blood cells;
3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding (such as surgical closures/exploration of the arteriotomy site, balloon angioplasty to seal an arterial tear, endoscopy with cautery of a GI bleed).

Bleeding - Retroperitoneal
Indicate if the patient experienced a confirmed retroperitoneal bleeding event observed and documented in the medical record that was associated with any of the following:
1. Hemoglobin drop of >=3 g/dL;
2. Transfusion of whole blood or packed red blood cells;
3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding (such as surgical closures/exploration of the arteriotomy site, balloon angioplasty to seal an arterial tear, endoscopy with cautery of a GI bleed).

Bleeding – Other
Indicate if the patient experienced a confirmed bleeding event not available for selection within the registry that was observed and documented in the medical record that was associated with any of the following:
1. Hemoglobin drop of >=3 g/dL;
2. Transfusion of whole blood or packed red blood cells;
3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding (such as surgical closures/exploration of the arteriotomy site, balloon angioplasty to seal an arterial tear, endoscopy with cautery of a GI bleed).

Bleeding - Surgical procedure or intervention required
Indicate if the patient required a surgical procedure or intervention to address a bleeding event.

Cardiac Arrest
Indicate if the patient experienced cardiac arrest, defined as an acute event documented as any of the following:
• Ventricular fibrillation
• Rapid ventricular tachycardia or bradycardia rhythms with hemodynamic compromise causing loss of consciousness
• Pulseless rhythms (PEA)
• Asystole
Requiring cardiopulmonary resuscitation (two or more chest compressions or open chest massage, emergency temporary pacing, pericardiocentesis, institution of ECMO, or defibrillation) and without these measures death would have almost certainly resulted.
Note: If an event occurs that meets the above definition of cardiac arrest, code “yes” regardless of a resuscitation status of DNR/hospice/comfort care.

Cardiogenic shock
Indicate if the patient experienced new onset or an acute recurrence of cardiogenic shock.
Cardiogenic shock is defined as a sustained (>30 min) episode of systolic blood pressure <90 mm Hg and/or cardiac index <2.2 L/min per square meter determined to be secondary to cardiac dysfunction and/or the requirement for parenteral inotropic or vasopressor agents or mechanical support (eg, IABP, extracorporeal circulation, VADs) to maintain blood pressure and cardiac index above those specified levels.
Note: Transient episodes of hypotension reversed with IV fluid or atropine do not constitute cardiogenic shock. The hemodynamic compromise (with or without extraordinary supportive therapy) must persist for at least 30 min.

Heart failure
Indicate if the patient experienced new onset or acute recurrence of heart failure which necessitated new or increased pharmacologic therapy.
A low EF alone, without clinical evidence of heart failure, does not qualify as heart failure.

Myocardial infarction
Indicate if a clinical diagnosis of NSTEMI or STEMI was documented in the medical record (and it is secondary to the presenting complaint).

New requirement for dialysis
Indicate if the patient experienced acute onset or worsening renal failure necessitating renal dialysis.

Respiratory support - Bi-PAP
Indicate if the patient had an airway event requiring Bi-PAP.

Respiratory support- High-flow oxygen
Indicate if the patient had an airway event requiring high-flow oxygen. Planned oxygen support for procedures, surgery, etc. do not qualify as an event.

Respiratory support – Intubation
Indicate if the patient had an airway event requiring intubation. An airway event can include episodes of apnea, hypoxia, or obstruction requiring intubation. Planned intubation support for procedures, surgery, etc. do not qualify as an event.

Stroke: Hemorrhagic
Indicate if the patient experienced an acute episode of focal or global neurological dysfunction of the brain, spinal cord or retina caused by intraparenchymal, intraventricular, or subarachnoid bleeding, where the neurological dysfunction lasts for greater than 24 hours. Subdural hematomas are intracranial hemorrhagic events and not strokes.

Stroke: Ischemic
Indicate if the patient experienced an acute episode of focal, cerebral, spinal, or retinal dysfunction caused by infarction of the central nervous system tissue where the neurological dysfunction lasts for greater than 24 hours. Hemorrhage may be a consequence of ischemic stroke. In this situation, the stroke is an ischemic stroke with hemorrhagic transformation.

Stroke: Undetermined

Section: Events | **Parent: Episode Events**

Indicate if the patient experienced an acute episode of focal or global neurological dysfunction caused by presumed brain, spinal cord, or retinal vascular injury as a result of hemorrhage or infarction but with insufficient information to allow categorization as either ischemic or hemorrhagic, where the neurological dysfunction lasts for greater than 24 hours.

Transient ischemic attack (TIA)
Indicate if the patient experienced a transient episode of focal neurological dysfunction caused by brain, spinal cord, or retinal ischemia without acute infarction that is documented to be a transient ischemic attack (TIA).

Ventricular fibrillation
Indicate if ventricular fibrillation is documented in the medical record.

Sustained ventricular tachycardia
Indicate if a run of greater than or equal to 7 beats of ventricular tachycardia is documented in the medical record.

Target Value: Any occurrence between arrival at this facility and discharge

Element: 12343 Episode Event Date and Time

Coding Instruction: Indicate the date and time the event occurred.

Note(s):
Indicate the time (hours:minutes) using the military 24-hour clock, beginning at midnight (00:00 hours).

If an event occurred more than once on the same date, record the event multiple times with the same date.

If an event occurred more than once in the target timeframe but on different dates, record the event multiple times but with unique dates.

Target Value: Any occurrence between arrival at this facility and discharge

Vendor Instruction: Episode Event Date and Time (12343) must be Greater than or Equal to Arrival Date and Time (3001)

Episode Event Date and Time (12343) must be Less than or Equal to Discharge Date and Time (10101)

Section: Additional Events **Parent: Episode Events**

Element: 12345 Packed Red Blood Cell Transfusion

Coding Instruction: Indicate if there was a transfusion(s) of packed red blood cells.

Target Value: Any occurrence between arrival at this facility and discharge

Element: 12354 Packed Red Blood Cell Transfusion Date

Coding Instruction: Indicate the date of the first red blood cell transfusion.

Target Value: The first value between arrival at this facility and discharge

Vendor Instruction: Packed Red Blood Cell Transfusion Date (12354) must be Greater than or Equal to Arrival Date and Time (3001)

Packed Red Blood Cell Transfusion Date (12354) must be Less than or Equal to Discharge Date and Time (10101)

Element: 12353 Transfusion Related to CABG

Coding Instruction: Indicate if any red blood cell/whole blood transfusion was related to CABG.

Note(s):
If any units were given for reasons not related to CABG, check "No." Check "Yes" only if all transfusions given were related to CABG.

Target Value: Any occurrence between arrival at this facility and discharge

Element: 12304 Non-steroidal anti-inflammatory agent therapy

Coding Instruction: Indicate if a non-steroidal anti-inflammatory drug (NSAID) was administered during the hospitalization.

Target Value: Any occurrence between arrival at this facility and discharge

Element: 14212 Medical Reason for Administering Non-Steroidal Anti- Inflammatory Drug

Coding Instruction: Indicate if there was a medical reason the patient was administered an NSAID.

Note: For example patient with refractory arthritis pain that are unresponsive to other analgesics.

Target Value: Any occurrence between arrival at this facility and discharge

Section: Targeted Temperature Management — Parent: Episode Events

Element: 12339 Hypothermia Induced

Coding Instruction: Indicate if targeted temperature management was initiated following cardiac arrest.

Target Value: Any occurrence between first medical contact and discharge

Supporting Definition: **Targeted temperature Management**

Targeted temperature management (TTM) is a clinical treatment strategy to control core body temperature (target temperature) for a certain duration to reduce secondary brain injury for unconscious patients after cardiac arrest.

Source: Donnino MW, Andersen LW, Berg KM, et al. Temperature Management After Cardiac Arrest: An Advisory Statement by the Advanced Life Support Task Force of the International Liaison Committee on Resuscitation and the American Heart Association Emergency Cardiovascular Care Committee and the Council on Cardiopulmonary, Critical Care, Perioperative and Resuscitation. Resuscitation. 2016 Jan;98:97-104. doi: 10.1016/j.resuscitation.2015.09.396. Epub 2015 Oct 9. PMID: 26449873.

Hypothermia Induced

Selection	Definition	Source	Code	Code System
Yes			100013072	ACC NCDR
No - No Reason	The treatment option was not performed and there is no documentation of a reason why it was not performed.		112000000195	ACC NCDR
No - Medical Reason	The treatment option was not performed and there is clear documentation of a medical reason why it was not performed.		112000000199	ACC NCDR

Element: 12340 Hypothermia Induced Date and Time

Coding Instruction: Indicate the date and time target temperature management (TTM) was initiated.

Note(s):
Indicate the date and time (mm/dd/yyyy hours:minutes) using the military 24-hour clock, beginning at midnight (0000 hours).

Target Value: The first value between first medical contact and discharge

Vendor Instruction: Hypothermia Induced Date and Time (12340) must be Less than Discharge Date and Time (10101)

Hypothermia Induced Date and Time (12340) must be Greater than or Equal to Emergency Medical Services First Medical Contact Date and Time (12197)

Element: 15517 Patient Location (Temperature Management)

Coding Instruction: Indicate where the patient was located when the targeted temperature management protocol was initiated.

Note(s):
The completion of this data element is only required for facilities seeking Chest Pain Center (CPC) Accreditation or Chest Pain Center (CPC) Certification.

Target Value: The first value between arrival at this facility and discharge

Healthcare Service Location - 1.3.6.1.4.1.19376.1.4.1.6.5.920

Selection	Definition	Source	Code	Code System
EMS			409971007	SNOMED CT
Emergency Department			112000000164	ACC NCDR
Cath Lab			112000000165	ACC NCDR
ICU/CCU			112000000241	ACC NCDR
Other			100000351	ACC NCDR

Element: 15487 Initial Target Temperature Goal

Coding Instruction: Indicate the initial target temperature goal (in degrees Celsius).

Note(s):
The completion of this data element is only required for facilities seeking Chest Pain Center (CPC) Accreditation or Chest Pain Center (CPC) Certification.

Target Value: The first value between first medical contact and discharge

Element: 15488 Target Temperature Achieved Date and Time

Coding Instruction: Indicate the date and time the target temperature was achieved.

Note(s):
The completion of this data element is only required for facilities seeking Chest Pain Center (CPC) Accreditation or Chest Pain Center (CPC) Certification.

If the target temperature was not achieved (any reason) and/or the date/time were not documented, leave blank.

Section: Targeted Temperature Management **Parent: Episode Events**

Target Value: The first value between first medical contact and discharge

Element: 15489 Rewarming Phase Initiated Date and Time

Coding Instruction: Indicate the date and time the rewarming phase was initiated.

Note(s):
If a rewarming phase was not applicable (any reason) and/or the date/time were not documented, leave blank.

The completion of this data element is only required for facilities seeking Chest Pain Center (CPC) Accreditation or Chest Pain Center (CPC) Certification.

Target Value: The first value between first medical contact and discharge

Section: Discharge **Parent: Root**

Element: 10101 Discharge Date and Time

Coding Instruction: Indicate the date and time the patient was discharged from your facility as identified in the medical record.

Note(s):
Indicate the time (hours:minutes) using the military 24-hour clock, beginning at midnight (00:00 hours).

If the exact discharge time is not specified in the medical record, then code the appropriate time as below.

0000 - 0559 (midnight to before 6AM) code 0300
0600 - 1159 (6AM - before noon) code 0900
1200 - 1759 (noon before 6PM) code 1500
1800 - 2359 (6PM to before midnight) code 2100

Target Value: The value on discharge

Vendor Instruction: Discharge Date and Time (10101) must be greater than or equal to '07/01/2023'

Discharge Date and Time (10101) and Arrival Date and Time (3001) must not overlap on multiple episodes

Discharge Date and Time (10101) and Admission Date and Time (12217) must not overlap on multiple episodes

Discharge Date and Time (10101) must be Greater than Arrival Date and Time (3001)

Element: 10105 Discharge Status

Coding Instruction: Indicate the patient's vital status.

Target Value: The value on discharge

Discharge Life Status - 1.3.6.1.4.1.19376.1.4.1.6.5.42

Selection	Definition	Source	Code	Code System
Alive			438949009	SNOMED CT
Deceased			20	HL7 Discharge disposition

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

Cause of Death Clinical Finding - 1.3.6.1.4.1.19376.1.4.1.6.5.88

Selection	Definition	Source	Code	Code System
Cardiac	Attribution of death to a cardiovascular etiology are acute myocardial infarction, sudden cardiac death, heart failure, stroke, cardiovascular procedure, cardiovascular hemorrhage, and other cardiovascular causes. “Death due to other cardiovascular causes” refers to a cardiovascular death not included in the above categories but with a specific known cause, such as a pulmonary embolism or peripheral arterial disease. In addition, “death due to cardiovascular hemorrhage” refers to a death related to hemorrhage such as a non-stroke intracranial hemorrhage, non-procedural or non-traumatic vascular rupture (e.g., aortic aneurysm), or pulmonary hemorrhage from a pulmonary embolism. In contrast, if a pulmonary hemorrhage were a result of a contusion from a motor vehicle accident, the cause of death would be non-cardiovascular (death due to trauma).	Hicks KA, Tcheng JE, Bozkurt B. 2014 ACC/AHA key data elements and definitions for cardiovascular endpoint events in clinical trials: a report of the ACC/AHA Task Force on Clinical Data Standards (Writing Committee to Develop Cardiovascular Endpoints Data Standards). J Am Coll Cardiol 2015;66:403-69	100014107	ACC NCDR
Non-Cardiac	Mortality attributed to any non-cardiovascular organ, system, infection, malignancy, trauma or drug reaction/overdose.	Hicks KA, Tcheng JE, Bozkurt B. 2014 ACC/AHA key data elements and definitions for cardiovascular endpoint events in clinical trials: a report of the ACC/AHA Task Force on Clinical Data Standards (Writing Committee to Develop Cardiovascular Endpoints Data Standards). J Am Coll Cardiol 2015;66:403-69	112000000343	ACC NCDR
Undetermined	Attribution of causality may be limited or impossible if information available at the time of death is minimal or nonexistent. In such cases, the date of death may be the only data element captured and 'undetermined' should be selected for cause of death.	Hicks KA, Tcheng JE, Bozkurt B. 2014 ACC/AHA key data elements and definitions for cardiovascular endpoint events in clinical trials: a report of the ACC/AHA Task Force on Clinical Data Standards (Writing Committee to Develop Cardiovascular Endpoints Data Standards). J Am Coll Cardiol	112000000342	ACC NCDR

Section: Discharge **Parent: Root**

2015;66:403-69

Element: 10070 Discharge Provider Last Name

Coding Instruction: Indicate the last name of the discharge professional.

Note(s):
If the name exceeds 50 characters, enter the first 50 characters only.

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the professional level, which may assist professionals with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging professionals' roles, as supported by the patient medical record.

Target Value: The value on discharge

Element: 10071 Discharge Provider First Name

Coding Instruction: Indicate the first name of the discharge professional.

Note(s):
If the name exceeds 50 characters, enter the first 50 characters only.

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the professional level, which may assist professionals with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging professionals' roles, as supported by the patient medical record.

Target Value: The value on discharge

Element: 10072 Discharge Provider Middle Name

Coding Instruction: Indicate the middle name of the discharge professional.

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.

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the professional level, which may assist professionals with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging professionals' roles, as supported by the patient medical record.

Target Value: The value on discharge

Element: 10073 Discharge Provider NPI

Coding Instruction: Indicate the National Provider Identifier (NPI) of the professional that discharged the patient.

National Provider Identifier (NPI) numbers, assigned by the Centers for Medicare and Medicaid Services (CMS), are used to uniquely identify professionals for Medicare billing purposes.

Note(s):
The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the professional level, which may assist professionals with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging professionals' roles, as supported by the patient medical record.

Target Value: The value on discharge

Vendor Instruction: A partial response for Discharge Provider is not allowed. NPI (10073), First Name (10071), and Last Name (10070) must all be answered or left NULL

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.

Target Value: Any occurrence between arrival at this facility and discharge

Section: Research Study **Parent: Discharge**

Element: 3025 Research Study Name

Coding Instruction: 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.

Target Value: N/A

Vendor Instruction: A Research Study - combination Name (3025) and Patient ID (3030) - may only be entered/selected once

Element: 3030 Research Study Patient ID

Coding Instruction: 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.

Target Value: N/A

Section: Left Ventricular Ejection Fraction — Parent: Discharge

Element: 15521 Left Ventricular Ejection Fraction Assessed

Coding Instruction: Indicate if the left ventricular ejection fraction (LVEF) was assessed.

Note(s):
If the LVEF is measured during the episode of care, and documented in the medical record, it can be used. There is no requirement for the LVEF to be documented in a formal diagnostic report.

LVEF values obtained prior to first medical contact are not used for coding.

Target Value: The last value between arrival at first facility and discharge

Supporting Definition: **Left Ventricular Ejection Fraction**

Imaging modality used to assess the LV function include: CT, 2D or 3D transthoracic echocardiogram, transesophageal echocardiogram, gated SPECT, CMR and RNA.

Source: Dehmer GJ, Badhwar V, Bermudez EA, et al. 2020 AHA/ACC key data elements and definitions for coronary revascularization: a report of the ACC/AHA Task Force on Clinical Data Standards (Writing Committee to Develop Clinical Data Standards for Coronary Revascularization). J Am Coll Cardiol 2020;75:1975–2088.

Test Administration - 1.3.6.1.4.1.19376.1.4.1.6.5.925

Selection	Definition	Source	Code	Code System
Yes	The test was completed.		100013072	ACC NCDR
No - No reason	The test was not completed. There is neither a medical reason nor a patient reason documented explaining why it was not done.		112000000195	ACC NCDR
No - Medical reason	The test was not completed. There is clear documentation of a reason related to the patient's medical issue or concern explaining why it was not done.		112000000199	ACC NCDR
No - Patient reason	The test was not completed. There is clear documentation of a reason related to the patient's and/or family's preference explaining why it was not done.		112000000197	ACC NCDR

Element: 12307 Left Ventricular Ejection Fraction Measurement

Coding Instruction: Indicate the best estimate of the left ventricular ejection fraction (LVEF).

Note(s):
If the LVEF is measured during the episode of care, and documented in the medical record, it can be used. There is no requirement for the LVEF to be documented in a formal diagnostic report.

LVEF values obtained prior to first medical contact are not used for coding.

Enter a percentage in the range of 1-99.

If a percentage range is reported, code the lowest number in the range (i.e. 50-55%, is reported as 50%).
In cases of conflicting measurements, the clinician should specify which value best represents the LVEF closest to discharge and this should be noted in the medical record to support coding.

If only a descriptive value is reported (i.e. normal), enter the corresponding percentage value from the list below:
Normal = 60%
Good function = 50%
Mildly reduced = 45%
Fair function = 40%
Moderately reduced = 30%
Poor function = 25%
Severely reduced = 20%

Target Value: The last value between arrival at first facility and discharge

Supporting Definition: **Left Ventricular Ejection Fraction**

The left ventricular ejection fraction is the number reflecting the percentage of blood ejected from the left ventricle.

Source: Dehmer GJ, Badhwar V, Bermudez EA, et al. 2020 AHA/ACC key data elements and definitions for coronary revascularization: a report of the ACC/AHA Task Force on Clinical Data Standards (Writing Committee to Develop Clinical Data Standards for Coronary Revascularization). J Am Coll Cardiol 2020;75:1975–2088.

Element: 12308 Left Ventricular Ejection Fraction Planned for after Discharge

Coding Instruction: Indicate if the LVEF assessment is planned for after discharge.

Target Value: The last value between arrival at first facility and discharge

Element: 15491 Left Ventricular Ejection Fraction after Discharge Not Indicated

Section: Left Ventricular Ejection Fraction **Parent: Discharge**

Coding Instruction: Indicate if a measurement of the patient's left ventricular ejection fraction (LVEF) after discharge was not indicated.

Target Value: N/A

Section: Additional Discharge Details **Parent: Discharge**

Element: 15490 Cerebral Performance Category (CPC) Score

Coding Instruction: Indicate the patient's neurological status using the cerebral performance category score.

Target Value: The value on discharge

Cerebral Performance Category - 1.3.6.1.4.1.19376.1.4.1.6.5.917

Selection	Definition	Source	Code	Code System
1 - Good cerebral performance	Conscious, alert, able to work, might have mild neurologic or psychologic deficit.	Jennett B, Bond M. Assessment of outcome after severe brain damage. Lancet. 1975 Mar 1;1(7905):480-4. doi: 10.1016/s0140-6736(75)92830-5. PMID: 46957.	106165002	SNOMED CT
2 - Moderate cerebral disability	Conscious. Sufficient cerebral function for independent activities of daily life. Able to work in sheltered environment.	Jennet and Bond, 1975.	112000003556	ACC NCDR
3 - Severe cerebral disability	Conscious; dependent on others for daily support because of impaired brain function. Ranges from ambulatory state to severe dementia or paralysis.	Jennet and Bond, 1975.	112000003557	ACC NCDR
4 - Coma or vegetative state	Any degree of coma without the presence of all brain death criteria. Unawareness, even if appears awake (vegetative state) without interaction with environment; may have spontaneous eye opening and sleep/awake cycles. Cerebral unresponsiveness.	Jennet and Bond, 1975.	723151005	SNOMED CT
5 - Brain death	Apnea, areflexia, EEG silence, etc.	Jennet and Bond, 1975.	230802007	SNOMED CT

Element: 12412 Enrolled in Clinical Trial During Hospitalization

Coding Instruction: Indicate if the patient was participating in a clinical trial during his/her hospitalization.

Note: “Yes” is only coded when the clinical trial pertains to:
- Precluding the use of aspirin
- Reperfusion therapy
- New antiplatelet therapies
- Renin-angiotensin-aldosterone system inhibitor
- Lipid lowering therapy
- AMI
- STEMI

Target Value: Any occurrence between arrival at this facility and discharge

Element: 12456 Type of Clinical Trial

Coding Instruction: Indicate the type of clinical trial.

Target Value: Any occurrence between arrival at this facility and discharge

Clinical Trial Exclusions DynamicList - 1.3.6.1.4.1.19376.1.4.1.6.5.926

Selection	Definition	Source	Code	Code System
Precluding the use of aspirin in protocol			112000000243	ACC NCDR
Related to reperfusion therapy			112000000245	ACC NCDR
Involving new antiplatelet therapies			112000000247	ACC NCDR
Involving renin-angiotensin-aldosterone system inhibitor			112000000249	ACC NCDR
Related to lipid lowering therapy			112000000244	ACC NCDR
Related to AMI			112000000246	ACC NCDR
Related to STEMI			112000000248	ACC NCDR

Element: 10075 Comfort Measures Only

Coding Instruction: Indicate if the patient was receiving comfort measures documented by a medical professional (i.e. a physician, nurse practitioner, or a physician assistant).

Note(s):
The patient status of 'Comfort Measures' is not equivalent to the following: Do Not Resuscitate (DNR) orders, a Living Will, No Code, or No Heroic Measures.

Target Value: The value on discharge

Supporting Definition: **Comfort Measures Only**

Comfort Measures Only refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient's family. Comfort Measures Only is commonly referred to as ""comfort care"" by the general public. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).

Section: Additional Discharge Details **Parent: Discharge**

Source: Specifications Manual for Joint Commission National Quality Measures (v2015A)

Element: 12413 Comfort Measures Only Date and Time

Coding Instruction: Indicate the date and time the comfort measures order was written.

Note(s):
Indicate the date/time (mm/dd/yyyy hours:minutes) using the military 24-hour clock, beginning at midnight (0000 hours).

Target Value: The value on discharge

Supporting Definition: **Comfort Measures Only**

Comfort Measures Only refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient's family. Comfort Measures Only is commonly referred to as ""comfort care"" by the general public. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).

Source: Specifications Manual for Joint Commission National Quality Measures (v2015A)

Vendor Instruction: Comfort Measures Only Date and Time (12413) must be Less than or Equal to Discharge Date and Time (10101)

Element: 10115 Hospice Care

Coding Instruction: Indicate if the patient was discharged to hospice care.

Target Value: The value on discharge

Element: 12411 Hospice Care Order Date and Time

Coding Instruction: Indicate the date and time the hospice order was written.

Note(s):
Indicate the date/time (mm/dd/yyyy hours:minutes) using the military 24-hour clock, beginning at midnight (0000 hours).

Target Value: The value on discharge

Vendor Instruction: Hospice Care Order Date and Time (12411) must be Less than or Equal to Discharge Date and Time (10101)

Element: 10116 Cardiac Rehabilitation Referral

Coding Instruction: Indicate if a cardiac rehabilitation referral was provided.

Target Value: The value on discharge

Cardiac Rehab - 1.3.6.1.4.1.19376.1.4.1.6.5.334

Selection	Definition	Source	Code	Code System
Yes	1. Documented communication between the healthcare provider and the patient to recommend an outpatient cardiac rehabilitation (CR) program AND 2A. Official referral order is sent to outpatient cardiac rehabilitation program OR 2B. Documentation of patient refusal to justify why patient information was not sent to the cardiac rehabilitation program. Note: Code 'yes' when step 1 AND either 2A or 2B are completed and documented. The program may include a traditional cardiac rehabilitation program based on face-to-face interactions and training sessions or may include other options such as home-based approaches.		100013072	ACC NCDR
No - Reason not documented			100014064	ACC NCDR
No - Medical reason documented	Patient deemed by a medical professional to have a medically unstable, life-threatening condition or has other cognitive or physical impairments that preclude cardiac rehabilitation participation.		100014066	ACC NCDR
No - Health care system reason documented	Patient is discharged to a nursing care or long-term care facility, or patient lacks medical coverage for CR.	Thomas, R.J., et al. 2018 ACC/AHA Clinical Performance and Quality Measures for Cardiac Rehabilitation: A Report of the American College of Cardiology/American Heart Association Task Force on Performance Measures. Journal of the American College of Cardiology, Vol 71, Issue 16, April 2018, pages 1814-1837	100014065	ACC NCDR
No - Patient-oriented reason	No traditional cardiac rehabilitation (CR) program		112000000520	ACC NCDR

Section: Additional Discharge Details **Parent: Discharge**

available to the patient, within a 60 minute travel time from the patient's home, or patient does not have access to an alternative model of CR delivery that meets all criteria for a CR program.

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 System
Home	The patient's home may be a traditional residence (home, apartment, etc.) or an alternate yet primary residence on discharge such as living with a friend or family member, a homeless shelter or an assisted living facility.		01	HL7 Discharge disposition
Skilled nursing facility	Skilled nursing facilities are typically for longer anticipated length of stay, as there are fewer requirements placed on subacute programs. An acute rehabilitation unit may be part of a skilled nursing facility (SNF), however, it is the higher level of care (acute rehab).		64	HL7 Discharge disposition
Extended care/transitional care unit/Rehab	An Extended Care/transitional care/rehab unit typically provides a high level of intensive therapy as well as specialized nursing and physician care. This discharge setting may also be called subacute care or long term acute care (LTACH).		62	HL7 Discharge disposition
Other			100001249	ACC NCDR
Other acute care hospital			02	HL7 Discharge disposition
Left against medical advice (AMA)	The patient was discharged or eloped against medical advice.		07	HL7 Discharge disposition

Element: 12414 Transfer Date and Time

Coding Instruction: Indicate the date and time the patient was transferred to another acute-care hospital for further management.

Note(s):
Indicate the date/time (mm/dd/yyyy hours:minutes) using the military 24-hour clock, beginning at midnight (0000 hours).

Target Value: The value on discharge

Vendor Instruction: Transfer Date and Time (12414) must be Greater than or Equal to Discharge Date and Time (10101)

Element: 15492 Patient Centered Reason for Delay to Transfer Out

Coding Instruction: Indicate if there was a patient-centered reason that delayed the patient's departure.

Note(s):
A patient-centered reason for delay is an issue and/or condition understood and documented to originate with the patient. It is not associated with the health care system (i.e., facility, staff or processes, etc.).

To warrant coding 'Yes' the patient-centered reason(s) must be identified within the first 30 minutes of the patient's arrival or after the diagnosis of STEMI and be responsible for affecting the patient's departure time.

Examples: Patient delays in providing consent for transfer, patient has cardiac arrest and/or need for intubation before transfer, emergent CT scan for r/o CVA, is too unstable for transport (i.e., cardiovascular instability, acute heart failure, cardiogenic shock).

Target Value: Any occurrence in the first 30 minutes after arrival at this facility (or within the first 30 minutes after STEMI diagnosis)

Element: 15493 Transfer for Cardiac Evaluation

Coding Instruction: Indicate if the patient was transferred to another facility for additional cardiac evaluation.

Target Value: The value on time of transfer

Supporting Definition: **Cardiac Evaluation**

Additional testing may be helpful to identify the cause that may alter an ensuing therapeutic strategy. When the initial facility in which the patient presented does not have the capacity for these additional tests, the patient is transferred for additional cardiac assessment and testing.

Source:

Element: 12415 Transfer for Primary Percutaneous Coronary Intervention

Coding Instruction: Indicate if the patient was transferred to another facility for percutaneous coronary intervention (PCI).

Section: Additional Discharge Details **Parent: Discharge**

Target Value: The value on time of transfer

Element: 12416 Transfer for Coronary Artery Bypass Graft

Coding Instruction: Indicate if the patient was transferred to another facility for coronary artery bypass graft (CABG) surgery.

Target Value: The value on time of transfer

Element: 15545 Canadian Study of Health and Aging (CSHA) Clinical Frailty Scale

Coding Instruction: Indicate the Canadian Study of Health and Aging (CSHA) Clinical Frailty Scale of the patient.

Target Value: The value on discharge

CSHA Clinical Frailty Score - 1.3.6.1.4.1.19376.1.4.1.6.5.338

Selection	Definition	Source	Code	Code System
1: Very fit	CHSA Clinical Frailty Scale 1: Very Fit - People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.		1000142382	ACC NCDR
2: Well	CHSA Clinical Frailty Scale 2: Well - People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.		1000142383	ACC NCDR
3: Managing well	CHSA Clinical Frailty Scale 3: Managing Well - People whose medical problems are well controlled, but are not regularly active beyond routine walking.		1000142384	ACC NCDR
4: Vulnerable	CHSA Clinical Frailty Scale 4: Vulnerable - While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.		1000142385	ACC NCDR
5: Mildly frail	CHSA Clinical Frailty Scale 5: Mildly Frail - These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.		1000142386	ACC NCDR
6: Moderately frail	CHSA Clinical Frailty Scale 6: Moderately Frail - People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.		1000142387	ACC NCDR
7: Severely frail	CHSA Clinical Frailty Scale 7: Severely Frail - Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).		1000142388	ACC NCDR
8: Very severely frail	CHSA Clinical Frailty Scale 8: Very Severely Frail - Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.		1000142389	ACC NCDR
9: Terminally ill	CHSA Clinical Frailty Scale 9: Terminally Ill - Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.		1000142390	ACC NCDR

Section: Discharge Medications — Parent: Discharge

Element: 10200 Discharge Medication Code

Coding Instruction: The medication(s) listed in this field are controlled by the Medication Master file. This file is maintained by the NCDR and will be made available for downloading and importing/updating into your application.

Target Value: N/A

Vendor Instruction: A Discharge Medication Code (10200) should not be duplicated in an episode

Discharge Medication - 1.3.6.1.4.1.19376.1.4.1.6.5.165

Selection	Definition	Source	Code	Code System
Aspirin (Any)			1191	RxNorm
Clopidogrel			32968	RxNorm
Prasugrel			613391	RxNorm
Ticagrelor			1116632	RxNorm
Beta blocker (Any)			33252009	SNOMED CT
Angiotensin converting enzyme inhibitor (ACE-I) (Any)			41549009	SNOMED CT
Angiotensin receptor blocker (ARB) (Any)			372913009	SNOMED CT
Angiotensin II receptor blocker neprilysin inhibitor (ARNI)			786885008	SNOMED CT
Aldosterone receptor antagonist (Any)			372603003	SNOMED CT
Direct oral anticoagulants (DOAC) (Any)			112000001416	ACC NCDR
Warfarin			11289	RxNorm
Statin (Any)			96302009	SNOMED CT

Element: 10205 Discharge Medication Prescribed

Coding Instruction: Indicate if the medication was prescribed at discharge.

Note(s):
Discharge medications are not required for patients with a Discharge Status of 'deceased' or on Comfort Measures or receiving Hospice Care or with a Discharge Location of 'other acute care hospital', or 'left against medical advice (AMA)'.

Target Value: The value on discharge

Vendor Instruction: When a Discharge Medication Code (10200) is selected, Discharge Medication Prescribed (10205) cannot be Null

Discharge Medication Administration - 1.3.6.1.4.1.19376.1.4.1.6.5.86

Selection	Definition	Source	Code	Code System
Yes	Code ‘Yes’ if this medication was prescribed at discharge		100001247	ACC NCDR
No - No Reason	Code "No" if this medication was not prescribed at discharge and there is no documented reason why.		100001048	ACC NCDR
No - Medical Reason	Code ‘No’ Medical Reason’ if this medication was not prescribed at discharge because of a (documented) medical issue/reason.		100001034	ACC NCDR
No - Patient Reason	Code ‘No Patient Reason’ if this medication was not prescribed at discharge due to the (documented) patient’s preference		100001071	ACC NCDR

Element: 10207 Discharge Medication Dose

Coding Instruction: Indicate the medication dose prescribed.

Note(s):
If the statin dose prescribed is outside (either higher or lower) the intensity category, leave the dose blank.

If the statin dose prescribed overlaps two intensity categories, code the lower intensity category.

Target Value: The value on discharge

Vendor Instruction: Parent/Child Validation Notes: See Medications Master dynamic list. Enable the element when Discharge Medication Prescribed (10205) is Yes and the element reference number is listed under the enableElements column applicable to the Discharge Medication Code (10200) under the dynamic list.

Medication Dose - 1.3.6.1.4.1.19376.1.4.1.6.5.321

Selection	Definition	Source	Code	Code System
Low	Daily dose lowers LDL-C, on average, by <30% Fluvastatin 20-40 mg Lovastatin 20 mg	Grundy SM, Stone NJ, Bailey AL., et al. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA guideline on the management of blood cholesterol: a report of the ACC/AHA Task Force on Clinical Practice Guidelines. J Am Coll Cardiol	100014036	ACC NCDR

Section: Discharge Medications		Parent: Discharge		
	Pitavastatin 1 mg Pravastatin 10-20 mg Rosuvastatin <5 mg Simvastatin 10 mg	2019;73:e285–350		
Moderate	Daily dose lowers LDL-C, on average, by approximately 30% to <50% Atorvastatin 10-20 mg Fluvastatin 40 mg twice daily Fluvastatin XL 80 mg Lovastatin 40 mg Pitavastatin 2-4 mg Pravastatin 40-80 mg Rosuvastatin 5-10 mg Simvastatin 20-40 mg	Grundy et al., 2019.	100014035	ACC NCDR
High	Daily dose lowers LDL-C, on average, by approximately >=50% Atorvastatin 40-80 mg Rosuvastatin 20-40 mg	Grundy et al., 2019.	100014034	ACC NCDR

Section: Discharge Medication Details **Parent: Discharge**

Element: 15520 Aspirin Prescribed Dose Greater Than 100 Milligram

Coding Instruction: Indicate if the aspirin dose prescribed was greater than 100 milligrams (mg).

Target Value: The value on discharge

Element: 15546 Patient or Medical Reason for Not Prescribing High-Dose Statin

Coding Instruction: Indicate if there was either a patient or medical reason that a high-dose statin was not prescribed if a moderate or low-dose statin was prescribed.

Target Value: The last value on discharge

Section: Follow-Up — Parent: Root

Element: 10999 — Follow-Up Unique Key

Coding Instruction: Indicate the unique key associated with each patient follow-up record as assigned by the EMR/EHR or your software application.

Target Value: N/A

Element: 11000 — Follow-Up Assessment Date

Coding Instruction: Indicate the date the follow-up assessment was performed.

Target Value: The value on Follow-up

Vendor Instruction: Follow-Up Assessment Date (11000) must be Greater than Follow-Up Reference Episode Discharge Date and Time (11015)

Follow-Up Assessment Date (11000) may only be entered/selected once

Element: 12537 — Follow-Up Reference Admission Date Time

Coding Instruction: Indicate the date and time of admission for the reference episode of care.

Note(s):
Indicate the date/time (mm/dd/yyyy hours:minutes) using the military 24-hour clock, beginning at midnight (0000 hours).

Target Value: The value on Follow-up

Element: 11015 — Follow-Up Reference Episode Discharge Date and Time

Coding Instruction: Indicate the date and time of discharge for the relevant episode of care.

Target Value: The value on Follow-up

Element: 11003 — Method to Determine Follow-Up Status

Coding Instruction: Indicate the method(s) used to determine the follow-up status.

Target Value: The value on Follow-up

Method to Determine Follow-up status - 1.3.6.1.4.1.19376.1.4.1.6.5.370

Selection	Definition	Source	Code	Code System
Office visit			183654001	SNOMED CT
Medical records			100014060	ACC NCDR
Letter from medical provider			100014061	ACC NCDR
Phone call			100014062	ACC NCDR
Social Security death master file			1000142362	ACC NCDR
Hospitalization			1000142363	ACC NCDR
Other	Not otherwise specified.		100000351	ACC NCDR

Element: 11004 — Follow-Up Status

Coding Instruction: Indicate the patient status as of the date on which the follow-up assessment was performed.

Target Value: The value on Follow-up

Follow-Up Status - 1.3.6.1.4.1.19376.1.4.1.6.5.372

Selection	Definition	Source	Code	Code System
Alive			438949009	SNOMED CT
Deceased			20	HL7 Discharge disposition
Lost to follow-up			399307001	SNOMED CT

Element: 15514 — Enrolled in Cardiac Rehabilitation Program

Coding Instruction: Indicate if the patient enrolled in a cardiac rehabilitation program.

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

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 or Equal to Follow-Up Reference Episode Discharge Date and Time (11015)

Follow-Up Date of Death (11006) must be Greater than or Equal to Follow-Up Assessment Date (11000)

Section: Follow-Up **Parent: Root**

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

Cause of Death Clinical Finding - 1.3.6.1.4.1.19376.1.4.1.6.5.88

Selection	Definition	Source	Code	Code System
Cardiac	Attribution of death to a cardiovascular etiology are acute myocardial infarction, sudden cardiac death, heart failure, stroke, cardiovascular procedure, cardiovascular hemorrhage, and other cardiovascular causes. "Death due to other cardiovascular causes" refers to a cardiovascular death not included in the above categories but with a specific known cause, such as a pulmonary embolism or peripheral arterial disease. In addition, "death due to cardiovascular hemorrhage" refers to a death related to hemorrhage such as a non-stroke intracranial hemorrhage, non-procedural or non-traumatic vascular rupture (e.g., aortic aneurysm), or pulmonary hemorrhage from a pulmonary embolism. In contrast, if a pulmonary hemorrhage were a result of a contusion from a motor vehicle accident, the cause of death would be non-cardiovascular (death due to trauma).	Hicks KA, Tcheng JE, Bozkurt B. 2014 ACC/AHA key data elements and definitions for cardiovascular endpoint events in clinical trials: a report of the ACC/AHA Task Force on Clinical Data Standards (Writing Committee to Develop Cardiovascular Endpoints Data Standards). J Am Coll Cardiol 2015;66:403-69	100014107	ACC NCDR
Non-Cardiac	Mortality attributed to any non-cardiovascular organ, system, infection, malignancy, trauma or drug reaction/overdose.	Hicks KA, Tcheng JE, Bozkurt B. 2014 ACC/AHA key data elements and definitions for cardiovascular endpoint events in clinical trials: a report of the ACC/AHA Task Force on Clinical Data Standards (Writing Committee to Develop Cardiovascular Endpoints Data Standards). J Am Coll Cardiol 2015;66:403-69	112000000343	ACC NCDR
Undetermined	Attribution of causality may be limited or impossible if information available at the time of death is minimal or nonexistent. In such cases, the date of death may be the only data element captured and 'undetermined' should be selected for cause of death.	Hicks KA, Tcheng JE, Bozkurt B. 2014 ACC/AHA key data elements and definitions for cardiovascular endpoint events in clinical trials: a report of the ACC/AHA Task Force on Clinical Data Standards (Writing Committee to Develop Cardiovascular Endpoints Data Standards). J Am Coll Cardiol 2015;66:403-69	112000000342	ACC NCDR

Section: Follow-Up Events **Parent: Follow-Up**

Element: 11011 Follow-Up Events

Coding Instruction: The events listed in this field are controlled by the Event Master file. This file is maintained by the NCDR and will be made available for downloading and importing/updating into your application.

Target Value: N/A

Vendor Instruction: A Follow-up - combination Events (11011), Occurred (11012) and Dates (11014) - may only be entered/selected once

Follow-up Events - 2.16.840.1.113883.3.3478.6.3.20

Selection	Definition	Source	Code	Code System
CABG - Planned			112000000308	ACC NCDR
CABG - Unplanned			112000000309	ACC NCDR
Heart failure			84114007	SNOMED CT
Myocardial infarction - NSTEMI			401314000	SNOMED CT
Myocardial infarction - STEMI			401303003	SNOMED CT
PCI - Planned			112000000310	ACC NCDR
PCI Unplanned			112000000311	ACC NCDR
Readmission			112000000312	ACC NCDR
New requirement for dialysis			100014076	ACC NCDR
Stroke - Hemorrhagic			230706003	SNOMED CT
Stroke - Ischemic			422504002	SNOMED CT
Stroke - Undetermined			230713003	SNOMED CT

Element: 11012 Follow-Up Events Occurred

Coding Instruction: Indicate the event(s) that did or did not occur during the follow-up timeframe.

CABG: Planned
A planned coronary artery bypass graft (CABG) surgery includes a documented plan for the patient to receive a CABG, or a patient referral for a CABG or a CABG date scheduled.

CABG: Unplanned
An unplanned coronary artery bypass graft (CABG) surgery is when:
1. Surgical coronary revascularization is required to address a complication of another cardiac surgical procedure performed; or,
2. Surgical coronary revascularization is necessitated by disease or anatomy that was not anticipated and/or recognized.

Heart Failure
Indicate if the patient experienced new onset or acute recurrence of heart failure which necessitated new or increased pharmacologic therapy.
A low EF alone, without clinical evidence of heart failure, does not qualify as heart failure.

Myocardial Infarction: NSTEMI
A clinical diagnosis of NSTEMI.

Myocardial Infarction: STEMI
A clinical diagnosis of STEMI.

PCI Planned
A planned percutaneous coronary intervention (PCI) includes a documented plan for the patient to receive a PCI, or a patient referral for a PCI or a PCI date scheduled.

PCI Unplanned
An unplanned percutaneous coronary intervention (PCI) is when:
1. PCI is required to address a complication of another cardiac procedure performed; or,
2. PCI is necessitated by disease or anatomy that was not anticipated and/or recognized.

Readmission
Orders are written for an observation or inpatient unit. An emergency department visit without orders for either observation or an inpatient unit does not qualify as a readmission. A planned readmission for a staged PCI procedure does not qualify.

New Requirement for Dialysis
Indicate if the patient experienced acute or worsening renal failure necessitating renal dialysis.

Stroke: Hemorrhagic
Indicate if the patient experienced an acute episode of focal or global neurological dysfunction of the brain, spinal cord or retina caused by intraparenchymal, intraventricular, or subarachnoid bleeding, where the neurological dysfunction lasts for greater than 24 hours. Subdural hematomas are intracranial hemorrhagic events and not strokes.

Stroke: Ischemic
Indicate if the patient experienced an acute episode of focal, cerebral, spinal, or retinal dysfunction caused by infarction of the central nervous system tissue where the neurological dysfunction lasts for greater than 24 hours. Hemorrhage may be a consequence of ischemic stroke. In this situation, the stroke is an ischemic stroke with hemorrhagic transformation.

Stroke: Undetermined

Section: Follow-Up Events **Parent: Follow-Up**

Indicate if the patient experienced an acute episode of focal or global neurological dysfunction caused by presumed brain, spinal cord, or retinal vascular injury as a result of hemorrhage or infarction but with insufficient information to allow categorization as either ischemic or hemorrhagic, where the neurological dysfunction lasts for greater than 24 hours..

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Vendor Instruction: When a Follow-Up Events (11011) is selected, Follow-Up Events Occurred (11012) must not be Null

Element: 11014 Follow-Up Event Dates

Coding Instruction: Indicate the date the event occurred.

Note(s):

If an event occurred more than once on the same date, indicate only the first event.

If an event occurred more than once in the target timeframe but on different dates, record the event multiple times but with unique dates.

For events that occurred and the full date is unknown, leave the date field blank.

Target Value: All values between discharge (or previous follow-up) and current follow-up assessment

Vendor Instruction: Follow-Up Event Dates (11014) must be Greater than or Equal to Follow-Up Reference Episode Discharge Date and Time (11015)

Follow-Up Event Dates (11014) must be Less than or Equal to Follow-Up Assessment Date (11000)

Follow-Up Event Dates (11014) must be Less than or Equal to Follow-Up Date of Death (11006)

Section: Administration — Parent: Root

Element: 1000 — Participant ID

Coding Instruction: Indicate the participant ID of the submitting facility.

Target Value: N/A

Supporting Definition: **Participant ID**

Participant ID is a unique number assigned to each database participant by NCDR. A database participant is defined as one entity that signs a Participation Agreement with the NCDR, submits one data submission file to the harvest, and receives one report on their data.

Each participant's data if submitted to harvest must be in one data submission file for a quarter. If one participant keeps their data in more than one file (e.g. at two sites), then the data must be combined into a single data submission to the system to file for the harvest. If two or more participants share a single purchased software, and enter cases into one database, then the data must be exported into different data submission files, one for each participant ID.

Source: NCDR

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

Supporting Definition: **Participant Name**

Indicate the full name of the facility where the procedure was performed. Values should be full, official hospital names with no abbreviations or variations in spelling.

Source: NCDR

Element: 1020 — Time Frame of Data Submission

Coding Instruction: Indicate the time frame of data included in the data submission. Format: YYYYQQ. e.g.,2016Q1

Target Value: N/A

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

Coding Instruction: Vendor identification (agreed upon by mutual selection between the vendor and the NCDR) to identify software vendor. This is entered 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: N/A

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: N/A

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 software.

Target Value: N/A

Section: Administration — Parent: Root

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 2017Q1 Base Registry Record file, but the Follow-up data will be transmitted in the 2017Q2 Follow-Up File.

Target Value: N/A

Submission Type

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

Element: 15569 Submission Dataset

Coding Instruction: Indicate if the dataset being submitted is from a STEMI Referring Facility (STRF), or STEMI receiving center (FDS).

Target Value: N/A

Source of Dataset - 1.3.6.1.4.1.19376.1.4.1.6.5.933

Selection	Definition	Source	Code	Code System
FDS	Full Dataset		FDS	ACC NCDR
STRF	STEMI Referral Facility		STRF	ACC NCDR

Element: 1090 Patient Population

Coding Instruction: Indicate the population of patients and procedures that are included in the data submission.

Target Value: N/A

Patient Population - 1.3.6.1.4.1.19376.1.4.1.6.5.241

Selection	Definition	Source	Code	Code System
All Patient Types			100000930	ACC NCDR
NSTEMI/STEMI Types			112000003577	ACC NCDR
STEMI Type			401303003	SNOMED CT

Element: 12594 Sampling

Coding Instruction: Indicate if the site is sampling any patient types.

Target Value: N/A

Element: 12595 Sampling Patients Types

Coding Instruction: Indicate which patient types are being included for sampling.

Target Value: N/A

Vendor Instruction: Sampling Patients Types (12595) cannot be Null

Sampling Patients Types - 1.3.6.1.4.1.19376.1.4.1.6.5.394

Selection	Definition	Source	Code	Code System
Low Risk			112000000217	ACC NCDR
Unstable Angina			4557003	SNOMED CT