A. DEMOGRAPHICS

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

Supporting Definition:

Element: 2010 First Name

Coding Instruction: Indicate the patient's first name.

Target Value: The value on arrival at this facility

Supporting Definition:

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

Supporting Definition:

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

Supporting Definition:

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

Supporting Definition:

A. DEMOGRAPHICS

Element: 2040 Patient ID

Coding Instruction: Indicate the number created and automatically inserted by the software that uniquely identifies this patient.

Note(s):
Once assigned to a patient at the participating facility, this number will never be changed or reassigned to a different patient. If the patient returns to the same participating facility or for follow up, they will receive this same unique patient identifier.

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 2045 Other ID

Coding Instruction: Indicate optional patient identifier, such as medical record number, that can be associated with the patient.

Target Value: N/A

Supporting Definition:

Element: 2050 Birth Date

Coding Instruction: Indicate the patient's date of birth.

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 2060 Sex

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

Target Value: The value on arrival at this facility

Supporting Definition:

Code System	Code	Selection Text	Definition
HL7 Administrative Gender	M	Male	
HL7 Administrative Gender	F	Female	

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

Supporting Definition:

A. DEMOGRAPHICS

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

Supporting Definition:

Element: 2070 Race - White

Coding Instruction: Indicate if the patient is White as determined by the patient/family.

Note(s):
If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Supporting Definition: **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.

Note(s):
If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Supporting Definition: **Black/African American (race)**

Having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Element: 2072 Race - Asian

Coding Instruction: Indicate if the patient is Asian as determined by the patient/family.

Note(s):
If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Supporting Definition: **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

A. DEMOGRAPHICS

Element: 2073 Race - American Indian/Alaskan Native

Coding Instruction: Indicate if the patient is American Indian or Alaskan Native as determined by the patient/family.

Note(s):
If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

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: 2074 Race - Native Hawaiian/Pacific Islander

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

Note(s):
If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Supporting Definition: **Native Hawaiian**

Having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Element: 2076 Hispanic or Latino Ethnicity

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

Note(s):
If the patient has multiple hispanic or latin ethnicity, specify them using the other ethnicity selections in addition to this one.

Target Value: The value on arrival at this facility

Supporting Definition: **Hispanic or Latino Ethnicity**

A person of Cuban, 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: 2080 Race - Asian Indian

Coding Instruction: Indicate if the patient is Asian Indian as determined by the patient/family.

Note(s):
If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Supporting Definition: **Asian Indian**

Having origins in any of the original peoples of India.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

A. DEMOGRAPHICS

Element: 2081 Race - Chinese

Coding Instruction: Indicate if the patient is Chinese as determined by the patient/family.

Note(s):
If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Supporting Definition: **Asian - Chinese**

Having origins in any of the original peoples of China.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Element: 2082 Race - Filipino

Coding Instruction: Indicate if the patient is Filipino as determined by the patient/family.

Note(s):
If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Supporting Definition: **Asian - Filipino**

Having origins in any of the original peoples of the Philippines.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Element: 2083 Race - Japanese

Coding Instruction: Indicate if the patient is Japanese as determined by the patient/family.

Note(s):
If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Supporting Definition: **Asian - Japanese**

Having origins in any of the original peoples of Japan.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Element: 2084 Race - Korean

Coding Instruction: Indicate if the patient is Korean as determined by the patient/family.

Note(s):
If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Supporting Definition: **Asian - Korean**

Having origins in any of the original peoples of Korea.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

A. DEMOGRAPHICS

Element: 2085 Race - Vietnamese

Coding Instruction: Indicate if the patient is Vietnamese as determined by the patient/family.

Note(s):
If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Supporting Definition: **Asian - Vietnamese**

Having origins in any of the original peoples of Viet Nam.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

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Element: 2086 Race - Other Asian

Coding Instruction: Indicate if the patient is of Other Asian descent as determined by the patient/family.

Note(s):
If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Supporting Definition: **Asian - Other Asian**

Having origins in any of the original peoples elsewhere in Asia.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

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Element: 2090 Race - Native Hawaiian

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

Note(s):
If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Supporting Definition: **Native Hawaiian/Pacific Islander - Native Hawaiian**

Having origins in any of the original peoples of the islands of Hawaii.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

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Element: 2091 Race - Guamanian or Chamorro

Coding Instruction: Indicate if the patient is Guamanian or Chamorro as determined by the patient/family.

Note(s):
If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Supporting Definition: **Native Hawaiian/Pacific Islander - Guamanian or Chamorro**

Having origins in any of the original peoples of the Mariana Islands or the island of Guam.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

A. DEMOGRAPHICS

Element: 2092 Race - Samoan

Coding Instruction: Indicate if the patient is Samoan as determined by the patient/family.

Note(s):
If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Supporting Definition: **Native Hawaiian/Pacific Islander - Samoan**

Having origins in any of the original peoples of the island of the Somoa.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Element: 2093 Race - Other Pacific Islander

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

Note(s):
If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Supporting Definition: **Native Hawaiian/Pacific Islander - Other Pacific Island**

Having origins in any of the original peoples of any other island in the Pacific.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Element: 2100 Hispanic Ethnicity Type - Mexican, Mexican-American, Chicano

Coding Instruction: Indicate if the patient is Mexican, Mexican - American, or Chicano as determined by the patient/family.

Note(s):
If the patient has multiple hispanic or latin ethnicity, specify them using the other ethnicity selections in addition to this one.

Target Value: The value on arrival at this facility

Supporting Definition: **Hispanic Ethnicity - Mexican/Mexican American/Chicano**

Having origins in any of the original peoples of Mexico.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Element: 2101 Hispanic Ethnicity Type - Puerto Rican

Coding Instruction: Indicate if the patient is Puerto Rican as determined by the patient/family.

Note(s):
If the patient has multiple hispanic or latin ethnicity, specify them using the other ethnicity selections in addition to this one.

Target Value: The value on arrival at this facility

Supporting Definition: **Hispanic Ethnicity - Puerto Rican**

Having origins in any of the original peoples of Puerto Rico.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

A. DEMOGRAPHICS

Element: 2102 Hispanic Ethnicity Type - Cuban

Coding Instruction: Indicate if the patient is Cuban as determined by the patient/family.

Note(s):
If the patient has multiple hispanic or latin ethnicity, specify them using the other ethnicity selections in addition to this one.

Target Value: The value on arrival at this facility

Supporting Definition: **Hispanic Ethnicity - Cuban**

Having origins in any of the original peoples of Cuba.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

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Element: 2103 Hispanic Ethnicity Type - Other Hispanic, Latino or Spanish Origin

Coding Instruction: Indicate if the patient is another Hispanic, Latino, or Spanish origin as determined by the patient/family.

Note(s):
If the patient has multiple hispanic or latin ethnicity, specify them using the other ethnicity selections in addition to this one.

Target Value: The value on arrival at this facility

Supporting Definition: **Hispanic Ethnicity - Other Hispanic/Latino/Spanish Origin**

Having origins in any of the originals peoples in other Hispanic, Latino or Spanish territories.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

B. EPISODE OF CARE (ADMISSION)

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

Supporting Definition:

Element: 3000 Arrival Date

Coding Instruction: Indicate the date the patient arrived at your facility.

Target Value: N/A

Supporting Definition:

Element: 3005 Health Insurance

Coding Instruction: Indicate if the patient has health insurance.

Target Value: The value on arrival at this facility

Supporting Definition:

B. EPISODE OF CARE (ADMISSION)

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.

Target Value: The value on arrival at this facility

Supporting Definition:

Code System	Code	Selection Text	Definition
PHDSC	5	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.
PHDSC	1	Medicare	Medicare is the Federal program which helps pay health care costs for people 65 and older and for certain people under 65 with long-term disabilities.
PHDSC	2	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.
PHDSC	31	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).
PHDSC	36	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.
PHDSC	33	Indian Health Service	Indian Health Service (IHS) is a health care program through which the Department of Health and Human Services provides medical assistance to eligible American Indians at IHS facilities. In addition, the IHS helps pay the cost of selected health care services provided at non-HIS facilities.
ACC NCDR	100000812	Non-US Insurance	Non-US insurance refers to individuals with a payor that does not originate in the United States.

B. EPISODE OF CARE (ADMISSION)

Element: 3015 Health Insurance Claim Number (HIC)

Coding Instruction: Indicate the patient's Health Insurance Claim (HIC) number.

Note(s):
Enter the Health Insurance Claim (HIC) number for those patients covered by Medicaid. Patients with other insurances will not have a HIC number.

Target Value: The value on arrival at this facility

Supporting Definition: **Health Insurance Claim Number**

The Health Insurance Claim (HIC) number is the unique identifier issued to all Medicare eligible beneficiaries by either the Social Security Administration (SSA) or the Centers for Medicare & Medicaid Services.

Source: Centers for Medicare and Medicaid Services

Element: 3020 Patient Enrolled in Research Study

Coding Instruction: Indicate if the patient is enrolled in an ongoing research study during the episode of care.

Note(s):
Code 'Yes' for those patients enrolled in an research study.

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

Supporting Definition: **Patient Enrolled in Research Study**

A clinical or research study is one in which participants are assigned to receive one or more interventions (or no intervention) so that researchers can evaluate the effects of the interventions on biomedical or health-related outcomes. The assignments are determined by the study protocol. Participants may receive diagnostic, therapeutic, or other types of interventions.

Source: Clinicaltrials.gov Glossary of Common Site Terms retrieved from http://clinicaltrials.gov/ct2/about-studies/glossary#interventional-study

Element: 3035 Patient Restriction

Coding Instruction: Indicate if the patient requested for their information not to be used for any research or studies for the associated episode of care.

Note(s):
Documentation must be found in the patient record to support the request of removal of their information.

Target Value: The value on arrival at this facility

Supporting Definition:

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

Supporting Definition:

B. EPISODE OF CARE (ADMISSION)

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

Supporting Definition:

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4005 CHA2DS2-VASc Congestive Heart Failure

Coding Instruction: Indicate if the patient has been diagnosed with heart failure.

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

Supporting Definition: **CHA2DS2-VASc Congestive Heart Failure**

The presence of signs and symptoms of either right (elevated central venous pressure, hepatomegaly, dependent edema) or left ventricular failure (exertionaldyspnea, cough, fatigue, orthopnea, paroxysmal nocturnal dyspnea, cardiac enlargement, rales, gallop rhythm, pulmonary venous congestion) or both, confirmed by non-invasive or invasive measurements demonstrating objective evidence of cardiac dysfunction.

Source: Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest.2010;137(2):263-272.

Element: 4010 NYHA Functional Classification

Coding Instruction: Indicate the patient's New York Heart Association (NYHA) Functional Classification based upon the physician documented classification at the time of the current procedure.

Note(s):
The NYHA Functional Classification must be specifically documented in the medical record and not coded by the abstractor based upon patient symptoms.

Target Value: The highest value on the first procedure in this admission

Supporting Definition: **NYHA**

The NYHA classes focus on exercise capacity and the symptomatic status of the disease.

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

Code System	Code	Selection Text	Definition
SNOMED CT	420300004	Class I	Patients with cardiac disease but without resulting limitations of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnea.
SNOMED CT	421704003	Class II	Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, or dyspnea.
SNOMED CT	420913000	Class III	Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, or dyspnea.
SNOMED CT	422293003	Class IV	Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms are present even at rest or minimal exertion. If any physical activity is undertaken, discomfort is increased.

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4015 CHA2DS2-VASc LV Dysfunction

Coding Instruction: Indicate if the patient has been diagnosed with LV Dysfunction.

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

Supporting Definition: **CHA2DS2 -VASc LV Dysfunction**

Left Ventricular Ejection Fraction < 40 %.

Source: Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest.2010;137(2):263-272.

Element: 4020 CHA2DS2-VASc Hypertension

Coding Instruction: Indicate if the patient has been diagnosed with hypertension.

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

Supporting Definition: **CHA2DS2-VASc Hypertension**

A resting blood pressure >140mmHg systolic and/or >90mmHg diastolic on atleast 2 occasions or current antihypertensive pharmacologic treatment.

Source: Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest.2010;137(2):263-272.

Element: 4025 CHA2DS2-VASc Diabetes Mellitus

Coding Instruction: Indicate if the patient has been diagnosed with diabetes mellitus.

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

Supporting Definition: **CHA2DS2-VASc Diabetes Mellitus**

Fasting plasma glucose level ≥7.0 mmol/L (126 mg/dL) or treatment with oral hypoglycaemic agent and/or insulin.

Source: Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest.2010;137(2):263-272.

Element: 4030 CHA2DS2-VASc Stroke

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

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **CHA2DS2-VASc Stroke**

Ischemic stroke is defined as a focal neurologic deficit of sudden onset as diagnosed by a neurologist, lasting > 24 h and caused by ischemia.

Source: Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest.2010;137(2):263-272.

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4035 CHA2DS2-VASc TIA

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

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **CHA2DS2-VASc TIA**

Transient ischemic attack (TIA) is defined as a focal neurologic deficit of sudden onset as diagnosed by a neurologist, lasting < 24 h.

Source: Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation. Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest. 2010;137(2):263-272.

Element: 4040 CHA2DS2-VASc Thromboembolic Event

Coding Instruction: Indicate if the patient has been diagnosed with a thromboembolic event.

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **Thromboembolic Events (peripheral)**

Peripheral embolism is defined as a thromboembolic event (TE) outside the brain, heart, eyes, and lungs. Pulmonary embolism is defined by the responsible physician.

TE is defined as either an ischemic stroke, peripheral embolism, or pulmonary embolism.

Source: Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation. Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest. 2010;137(2):263-272.

Element: 4045 CHA2DS2-VASc Vascular Disease

Coding Instruction: Indicate if the patient has been diagnosed with vascular disease.

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **CHA2DS2-VASc Vascular Disease**

Coronary artery - disease Prior myocardial infarction, angina pectoris, percutaneous coronary intervention or coronary artery bypasses surgery.

Peripheral vascular disease The presence of any the following: intermittent claudication, previous surgery or percutaneous intervention on the abdominal aorta or the lower extremity vessels, abdominal or thoracic surgery, arterial and venous thrombosis.

Source: Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest.2010;137(2):263-272.

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4050 Vascular Disease Type

Coding Instruction: Indicate if the patient has a history of a prior MI, PAD or Known Aortic Plaque.

Note(s):
If the patient has multiple vascular diseases, select all disease types.

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **Prior MI**

Criteria for prior myocardial infarction is any one of the following criteria meets the diagnosis for prior MI:
- Pathological Q waves with or without symptoms in the absence of non-ischemic causes.
- Imaging evidence of a region of loss of viable myocardium that is thinned and fails to contract, in the absence of a non-ischemic cause.
- Pathological findings of a prior MI.

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.

Peripheral Artery Disease

Current or previous history of peripheral arterial disease (includes subclavian, iliac, femoral, and upper- and lower-extremity vessels; excludes renal, coronary, cerebral, and mesenteric vessels and aneurysms). This can include:
- Claudication on exertion
- Amputation for arterial vascular insufficiency
- Vascular reconstruction, bypass surgery, or percutaneous revascularization in the arteries of the extremities
- Positive noninvasive test (e.g., ankle brachial index <= 0.9, ultrasound, MR or CT imaging of >50% diameter stenosis in any peripheral artery (i.e., subclavian, femoral, iliac) or angiographic imaging)

Source: ACCF/AHA 2011 Key Data Elements and Definitions of a Base Cardiovascular Vocabulary for Electronic Health Records (JACC 2011;58;202-222).

Known Aortic Plaque

Discovery of a complex aortic plaque (>4 mm thick, or mobile, ulcerated, or pedunculated) may occur when TEE is performed as part of the evaluation for an acute stroke, peripheral embolism. Imaging techniques used for detection of aortic plaques have included TEE, computed tomography (CT), magnetic resonance imaging (MRI), and transthoracic echocardiography.

Source: Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the Euro Heart Survey on atrial fibrillation. Lip GY, Nieuwlaat R, Pisters R, et al. Chest. 2010;137:263-72.

Code System	Code	Selection Text	Definition
SNOMED CT	22298006	Myocardial infarction	
SNOMED CT	399957001	Peripheral arterial occlusive disease	
SNOMED CT	1522000|15825003	Known Aortic Plaque	

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4055 HAS-BLED Hypertension (Uncontrolled)

Coding Instruction: Indicate if the patient has been diagnosed with uncontrolled hypertension as defined HAS- BLED Risk Model. HAS-BLED Hypertension is not a history of hypertension. If the patient's current, actual systolic blood pressure is ≥160 mmHg, code "Yes".

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

Supporting Definition: **HAS-BLED Hypertension (Uncontrolled)**

Uncontrolled Hypertension is defined as a systolic blood pressure >160 mmHg despite medical therapy to lower the patient's blood pressure. This may also be documented as Hypertension resistant to medical therapy within the medical record.

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

Element: 4060 HAS-BLED Abnormal Renal Function

Coding Instruction: Indicate if the patient has been diagnosed with abnormal renal function as defined by the HAS-BLED Risk Model.

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

Supporting Definition: **HAS-BLED Abnormal Renal Function**

Abnormal Renal Function is defined by the HAS-BLED Risk Model by any one of the following variables: a history of being the recipient of at least one kidney transplant or chronic dialysis in the past or a dialysis treatment in the week prior to admission or serum creatinine ≥ 200 micromole/L (≥2.6 mg/dL). Chronic is defined as three months or greater.

Dialysis treatment includes hemodialysis and peritoneal dialysis.

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

Element: 4065 HAS-BLED Abnormal Liver Function

Coding Instruction: Indicate if the patient has been diagnosed with abnormal liver function as defined by the HAS-BLED Risk Model.

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

Supporting Definition: **HAS-BLED Abnormal Liver Function**

Abnormal liver function is defined by the HAS-BLED Risk Model as chronic hepatic disease (eg, cirrhosis) or biochemical evidence of significant hepatic derangement (eg, bilirubin more than two times the upper limit of normal, in association with aspartate transaminase/alanine transaminase/alkaline phosphatase more than three times the upper limit normal).

Chronic is defined as three months or greater.

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

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4070 HAS-BLED Stroke

Coding Instruction: Indicate if the patient has experienced a stroke in the past as defined by the HAS-BLED Risk Model.

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **HAS-BLED Stroke**

A stroke is defined by the HASBLED Risk Model as an acute episode of focal or global neurological dysfunction caused by brain, spinal cord, or retinal vascular injury as a result of hemorrhage or infarction.

Source: A novel user-friendly score (HAS-BLED) to assess 1-year risk of major bleeding in patients with atrial fibrillation: the Euro Heart Survey. Pisters R, Lane DA, Nieuwlaat R, et al. Chest. 2010;138(5):1093-1100Lip GY. Implications of the CHA(2)DS(2)-VASc and HAS-BLED Scores for thromboprophylaxis in atrial fibrillation. Am J Med. 2011 Feb;124(2):111-4.

Element: 4095 HAS-BLED Bleeding

Coding Instruction: Indicate if the patient has a history of a major or a minor bleeding event as defined by the HAS-BLED Risk Model.

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **HAS-BLED Bleeding**

Bleeding is defined by the HAS-BLED Risk Model as a history of a major bleeding event or predisposition to bleeding (eg, bleeding diathesis, anemia).

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

Element: 4100 HAS-BLED Labile INR

Coding Instruction: Indicate if the patient has experienced a labile INR while on Warfarin therapy as defined by the HAS-BLED Risk Model.

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

Supporting Definition: **HAS-BLED Labile INR**

Labile INR is defined by the HAS-BLED Risk Model as unstable/high international normalized ratios (INR) or <60 percent of INR values in therapeutic range. Therapeutic range is defined as 2 - 3 inclusive.

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

Element: 4105 HAS-BLED Alcohol

Coding Instruction: Indicate if the patient uses alcohol in excess.

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

Supporting Definition: **HAS-BLED Alcohol**

Alcohol excess is defined by the HAS-BLED Risk Model as consuming >=8 units/week.

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

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4110 HAS-BLED Drugs - Antiplatelet

Coding Instruction: Indicate if the patient is taking antiplatelet medications.

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

Supporting Definition: **HAS-BLED Drugs - Antiplatelets**

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

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

Element: 4115 HAS-BLED Drugs - NSAIDS

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

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

Supporting Definition: **HAS-BLED Drugs - NSAIDS**

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

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

Element: 4375 Symptoms Experienced During Afib/Aflutter

Coding Instruction: Indicate if the patient is symptomatic during the atrial fibrillation or atrial flutter episodes.

Target Value: Any occurrence between birth and the procedure

Supporting Definition:

Code System	Code	Selection Text	Definition
ACC NCDR	100000932	Asymptomatic	
SNOMED CT	418799008 + 106063007: = 195080001	Symptomatic	

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4400 Atrial Fibrillation Classification

Coding Instruction: Indicate the type of atrial fibrillation experienced by the patient.

Target Value: Any occurrence between birth and the first procedure in this admission

Supporting Definition: **Atrial Fibrillation Classification**

Atrial Fibrillation is a supraventricular tachyarrhythmia with uncoordinated atrial activation and consequently ineffective atrial contraction.

Electrocardiogram (ECG) characteristics include:
1) irregular R-R intervals (when atrioventricular [AV] conduction is present),
2) absence of distinct repeating P waves, and
3) irregular atrial activity.

Atrial Fibrillation can be further characterized as:

- Paroxysmal AF is defined as AF that terminates spontaneously or with intervention within seven days of onset. Episodes may recur with variable frequency.
- Persistent AF is defined as AF that fails to self-terminate within seven days. Episodes often require pharmacologic or electrical cardioversion to restore sinus rhythm.
- Long-standing persistent AF is defined as AF that has lasted for more than 12 month
-Permanent AF is defined as when the patient and clinician make a joint decision to stop further attempts to restore and/or maintain sinus rhythm. Acceptance of AF represents a therapeutic attitude on the part of the patient and clinician rather than an inherent pathophysiological attribute of AF. Acceptance of AF may change as symptoms, efficacy of therapeutic interventions, and patient and clinician preferences evolve.

Source: January CT, Wann LS, Alpert JS, et al. 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol 2014. DOI: 10.1016/j.jacc.2014.03.022

Code System	Code	Selection Text	Definition
SNOMED CT	26593000	Paroxysmal	AF that terminates spontaneously or with intervention within 7 days of onset. Episodes may recur with variable frequency.
SNOMED CT	62459000	Persistent	Continuous AF that is sustained >7 days or with electrical or pharmacological termination.
ACC NCDR	100001029	Long-standing Persistent	Continuous AF of >12 months duration.
SNOMED CT	6934004	Permanent	The term “permanent AF” is used when the patient and clinician make a joint decision to stop further attempts to restore and/or maintain sinus rhythm. - Acceptance of AF represents a therapeutic attitude on the part of the patient and clinician rather than an inherent pathophysiological attribute of the AF. - Acceptance of AF may change as symptoms, the efficacy of therapeutic interventions, and patient and clinician preferences evolve.

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4380 Valvular Atrial Fibrillation

Coding Instruction: Indicate if the patient has atrial fibrillation occurring in the setting of valvular heart disease and believed to be, at least in part, directly attributable to valvular heart disease (especially mitral valvular disease).

Target Value: Any occurrence between birth and the procedure

Supporting Definition:

Element: 4385 History of Mitral Valve Replacement

Coding Instruction: Indicate if the patient has a history of mitral valve replacement either via open surgical or a percutaneous transcatheter intervention.

Target Value: Any occurrence between birth and the procedure

Supporting Definition:

Element: 4390 Mechanical Valve in Mitral Position

Coding Instruction: Indicate if the patient has a mechanical valve placed in the mitral position.

Target Value: Any occurrence between birth and the procedure

Supporting Definition:

Element: 4395 History of Mitral Valve Repair

Coding Instruction: Indicate if the patient has a history of mitral valve repair, specifically via the surgical route. Either a surgical repair of a mitral valve leaflet or mitral annuloplasty qualifies as repair.

Target Value: Any occurrence between birth and the procedure

Supporting Definition:

Element: 4410 Attempt at Atrial Fibrillation Termination

Coding Instruction: Indicate if the patient has had previous attempts to terminate the atrial fibrillation.

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **Previous Attempt at Atrial Fibrillation Termination**

Therapeutic options for conversion of AF to sinus rhythm includes: antiarrhythmic drugs, direct current cardioversion, catheter ablation and surgical ablation.

Source: McNamara RL, Brass LM, Drozda JP, Jr, et al. ACC/AHA key data elements and definitions for measuring the clinical management and outcomes of patients with atrial fibrillation: A report of the American College of Cardiology/American Heart Association Task Force on clinical data standards (writing committee to develop data standards on atrial fibrillation). J Am Coll Cardiol. 2004;44(2):475-495

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4415 Atrial Fibrillation Termination - Pharmacologic Cardioversion

Coding Instruction: Indicate if the patient has a history of pharmacological cardioversion.

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **Pharmacologic Cardioversion**

Antiarrhythmic drugs can be administered for attempted conversion of AF to sinus rhythm or to facilitate electrical cardioversion.

Source: January CT, Wann LS, Alpert JS, et al. 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol 2014. DOI: 10.1016/j.jacc.2014.03.022

Element: 4420 Atrial Fibrillation Termination - DC Cardioversion

Coding Instruction: Indicate if the patient has a history of DC cardioversion.

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **DC Cardioversion**

Direct-current cardioversion involves the delivery of an electrical shock synchronized with the QRS complex to avoid inducing ventricular fibrillation as can occur by a shock applied during ventricular repolarization on the T wave.

Source: January CT, Wann LS, Alpert JS, et al. 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol 2014. DOI: 10.1016/j.jacc.2014.03.022

Element: 4425 Atrial Fibrillation Termination - Catheter Ablation

Coding Instruction: Indicate if the patient has a history of catheter ablation.

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **Catheter Ablation**

Various methods of catheter ablation are used. Currently most techniques focus on isolating the triggers in the pulmonary veins (PVs) from the vulnerable substrate in the left atrium. The majority of ablations performed use radiofrequency energy or cryothermy (cryoballoon ablation).

Source: January CT, Wann L, Alpert JS, et al. 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol. 2014;64(21):e1-e76.

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4430 Atrial Fibrillation Most Recent Catheter Ablation Date

Coding Instruction: Indicate the date of the most recent attempt to terminate the atrial fibrillation via catheter ablation.

Note(s):
If the month or day is unknown, please code 01/01/YYYY. If the specific year is unknown in the current record, the year may be estimated based on timeframes found in prior medical record documentation (Example: If the patient had "most recent ablation" documented in a record from 2011, then the year 2011 can be utilized and coded as 01/01/2011).

Target Value: Any occurrence between birth and the procedure

Supporting Definition:

Element: 4435 Prior Catheter Ablation Strategy

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

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

Target Value: Any occurrence between birth and the procedure

Supporting Definition:

Element: 4440 Atrial Fibrillation Termination - Surgical Ablation

Coding Instruction: Indicate if the patient has a history of surgical ablation.

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **Surgical Ablation**

The Maze operation is one surgical ablation option treat patients with both paroxysmal and chronic AF refractory to antiarrhythmic therapy.

Source: The surgical treatment of atrial fibrillation. IV. Surgical technique. Cox JL . J Thorac Cardiovasc Surg. 1991;101(4):584.

Element: 4445 Atrial Fibrillation, Most Recent Surgical Ablation Date

Coding Instruction: Indicate the date of the most recent attempt to terminate the atrial fibrillation via surgical ablation.

Note(s):
If the month or day is unknown, please code 01/01/YYYY. If the specific 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 surgical ablation" documented in a record from 2011, then the year 2011 can be utilized and coded as 01/01/2011).

Target Value: N/A

Supporting Definition:

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4450 Atrial Flutter

Coding Instruction: Indicate if the patient has a history of atrial flutter.

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **Atrial Flutter**

Atrial flutter is defined as a cardiac arrhythmia arising in the atrium which has a regular rate typically between 250 and 350 bpm (cycle length 240-170 ms) in the absence of antiarrhythmic drugs.

Source: January CT, Wann LS, Alpert JS, Calkins H, Cleveland Jr JC, Cigarroa JE, Conti JB, Ellinor PT, Ezekowitz MD, Field ME, Murray KT, Sacco RL, Stevenson WG, Tchou PJ, Tracy CM, Yancy CW, 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation, Journal of the American College of Cardiology (2014), doi: 10.1016/j.jacc.2014.03.022.

Element: 4455 Atrial Flutter Classification

Coding Instruction: Indicate the predominate type of atrial flutter experienced by the patient.

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **Atrial Flutter Type**

Atrial flutter is further classified into typical or atypical dependent on whether or not re-entry is dependent upon conduction through the cavotricuspid isthmus.

Source: January CT, Wann LS, Alpert JS, Calkins H, Cleveland Jr JC, Cigarroa JE, Conti JB, Ellinor PT, Ezekowitz MD, Field ME, Murray KT, Sacco RL, Stevenson WG, Tchou PJ, Tracy CM, Yancy CW, 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation, Journal of the American College of Cardiology (2014), doi: 10.1016/j.jacc.2014.03.022.

Code System	Code	Selection Text	Definition
ACC NCDR	100000982	Typical/Cavotricuspid Isthmus (CTI) Dependent	Typical atrial flutter is a macro-re-entrant atrial tachycardia that usually proceeds up the atrial septum, down the lateral atrial wall, and through the cavotricuspid (subeustachian) isthmus between the tricuspid valve annulus and inferior vena cava, where it is commonly targeted for ablation.
SNOMED CT	112231000	Atypical	Atypical flutter, or "noncavotricuspid isthmus-dependent macro-re-entrant atrial tachycardia", describes macro-re-entrant atrial tachycardias that are not one of the typical forms of atrial flutter that use the cavotricuspid isthmus.

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4460 Attempt at Atrial Flutter Termination

Coding Instruction: Indicate if the patient has had previous attempts to terminate the atrial flutter.

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **Previous Attempt at Atrial Flutter Termination**

Therapeutic options for conversion of atrial flutter to sinus rhythm includes: antiarrhythmic drugs, direct current cardioversion, and catheter ablation.

Source: McNamara RL, Brass LM, Drozda JP, Jr, et al. ACC/AHA key data elements and definitions for measuring the clinical management and outcomes of patients with atrial fibrillation: A report of the American College of Cardiology/American Heart Association Task Force on clinical data standards (writing committee to develop data standards on atrial fibrillation). J Am Coll Cardiol. 2004;44(2):475-495.

Element: 4465 Atrial Flutter Termination - Pharmacologic Cardioversion

Coding Instruction: Indicate if the patient has a history of pharmacologic cardioversion to terminate the atrial flutter.

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **Pharmacologic Cardioversion**

Antiarrhythmic drugs can be administered for attempted conversion of AF to sinus rhythm or to facilitate electrical cardioversion.

Source: January CT, Wann LS, Alpert JS, et al. 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol 2014. DOI: 10.1016/j.jacc.2014.03.022

Element: 4470 Atrial Flutter Termination - DC Cardioversion

Coding Instruction: Indicate if the patient has a history of DC cardioversion to terminate the atrial flutter.

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **DC Cardioversion**

Direct-current cardioversion involves the delivery of an electrical shock synchronized with the QRS complex to avoid inducing ventricular fibrillation as can occur by a shock applied during ventricular repolarization on the T wave.

Source: January CT, Wann LS, Alpert JS, et al. 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol 2014. DOI: 10.1016/j.jacc.2014.03.022

Element: 4475 Atrial Flutter Termination - Catheter Ablation

Coding Instruction: Indicate if the patient has a history of catheter ablation to terminate the atrial flutter.

Target Value: Any occurrence between birth and the procedure

Supporting Definition:

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4480 Atrial Flutter Most Recent Catheter Ablation Date

Coding Instruction: Indicate the date of the most recent catheter ablation.

Note(s):
If the month or day is unknown, please code 01/01/YYYY. If the specific year is unknown in the current record, the year may be estimated based on timeframes found in prior medical record documentation (Example: If the patient had "most recent ablation" documented in a record from 2011, then the year 2011 can be utilized and coded as 01/01/2011).

Target Value: N/A

Supporting Definition:

Element: 4485 AV Node ablation with Pacemaker Implantation

Coding Instruction: Indicate if the patient has had a previous AV node ablation with subsequent pacemaker implantation.

Note(s):
Code "Yes" if the patient has had an ablation of the AV node and subsequent implantation of any device with pacemaker functionality. This can include, but not limited to, a dual chamber ICD, dual chamber pacemaker, or CRT-D.

Target Value: Any occurrence between birth and the procedure

Supporting Definition:

Element: 4565 Cardiomyopathy (CM)

Coding Instruction: Indicate if the patient has a history of cardiomyopathy.

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **Cardiomyopathy (CM)**

Cardiomyopathies are a heterogeneous group of diseases of the myocardium associated with mechanical and/or electrical dysfunction that usually (but not invariably) exhibit inappropriate ventricular hypertrophy or dilatation and are due to a variety of causes that frequently are genetic. Cardiomyopathies either are confined to the heart or are a part of generalized systemic disorders, often leading to cardiovascular death or progressive heart failure-related disability.

Source: McNamara RL, Brass LM, Drozda JP, Jr, et al. ACC/AHA key data elements and definitions for measuring the clinical management and outcomes of patients with atrial fibrillation: A report of the American College of Cardiology/American Heart Association Task Force on clinical data standards (writing committee to develop data standards on atrial fibrillation). J Am Coll Cardiol. 2004;44(2):475-495

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4570 Cardiomyopathy Type

Coding Instruction: Indicate the type of cardiomyopathy experienced by the patient.

Note(s):
If the patient has had multiple cardiomyopathies, select all types.

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **Cardiomyopathy Type**

Hypertrophic:
Characterized morphologically and defined by a hypertrophied, nondilated LV in the absence of another systemic or cardiac disease that is capable of producing the magnitude of wall thickening evident (eg, systemic hypertension, aortic valve stenosis). Clinical diagnosis is customarily made with 2-dimensional echocardiography (or alternatively with cardiac magnetic resonance imaging) by detection of otherwise unexplained LV wall thickening, usually in the presence of a small LV cavity, after suspicion is raised by the clinical profile or as part of family screening. [1]

Restrictive:
Non Hypertrophied, Non Dilated: A rare form of heart muscle disease and a cause of heart failure that is characterized by normal or decreased volume of both ventricles associated with biatrial enlargement, normal LV wall thickness and AV valves, impaired ventricular filling with restrictive physiology, and normal (or near normal) systolic function. [1]

Non ischemic:
Includes cardiomyopathies resulting from volume or pressure overload, such as hypertension or valvular heart disease. [2]

Ischemic:
Considered to be present in patients with HF who have had a myocardial infarction (MI) or have evidence of viable hibernating myocardium or, on angiography, severe coronary disease.

The term ischemic cardiomyopathy has been used to describe significantly impaired left ventricular function (left ventricular ejection fraction ≤35 to 40 percent) that results from coronary artery disease. Despite the common clinical use of the term ischemic cardiomyopathy, ventricular dysfunction caused by coronary disease is not a cardiomyopathy as defined by the 2006 American Heart Association and 2008 European Society of Cardiology statements. [2]

Other cardiomyopathy type:
The term "unclassified cardiomyopathy" was included in the 2008 ESC classification system to describe disorders that do not readily fit into any of the above phenotypic categories [3]. Examples cited include LV noncompaction and stress-induced (takotsubo) cardiomyopathy. [3]

Source: [1] Barry J. Maron, MD, Chair;
Jeffrey A. Towbin, MD, FAHA;
Gaetano Thiene, MD;
Charles Antzelevitch, PhD, FAHA;
Domenico Corrado, MD, PhD;
Donna Arnett, PhD, FAHA;
Arthur J. Moss, MD, FAHA;
Christine E. Seidman, MD, FAHA;
James B. Young, MD, FAHA. Contemporary definitions and classification of the cardiomyopathies: an American Heart Association Scientific Statement from the Council on Clinical Cardiology, Heart Failure and Transplantation Committee; Quality of Care and Outcomes Research and Functional Genomics and Translational Biology Interdisciplinary Working Groups; and Council on Epidemiology and Prevention. Circulation. 2006;113(14):1807.

[2] Yancy CW, Jessup M, Bozkurt B, et al. 2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. J Am Coll Cardiol. 2013;62(16):e147-e239. doi:10.1016/j.jacc.2013.05.019.

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

[3] Richardson P, McKenna W, Bristow M, Maisch B, Mautner B, O'Connell J, Olsen E, Thiene G, Goodwin J, Gyarfas I, Martin I, Nordet P . Report of the 1995 World Health Organization/International Society and Federation of Cardiology Task Force on the Definition and Classification of cardiomyopathies. Circulation. 1996;93(5):841

Code System	Code	Selection Text	Definition
SNOMED CT	111000119104	Non-ischemic cardiomyopathy	Includes cardiomyopathies resulting from volume or pressure overload, such as hypertension or valvular heart disease.
SNOMED CT	426856002	Ischemic cardiomyopathy	Considered to be present in patients with HF who have had a myocardial infarction (MI) or have evidence of viable hibernating myocardium or, on angiography, severe coronary disease. The term ischemic cardiomyopathy has been used to describe significantly impaired left ventricular function (left ventricular ejection fraction ≤35 to 40 percent) that results from coronary artery disease. Despite the common clinical use of the term ischemic cardiomyopathy, ventricular dysfunction caused by coronary disease is not a cardiomyopathy as defined by the 2006 American Heart Association and 2008 European Society of Cardiology statements.
SNOMED CT	415295002	Restrictive cardiomyopathy	Non Hypertrophied, Non Dilated: A rare form of heart muscle disease and a cause of heart failure that is characterized by normal or decreased volume of both ventricles associated with biatrial enlargement, normal LV wall thickness and AV valves, impaired ventricular filling with restrictive physiology, and normal (or near normal) systolic function.
SNOMED CT	233873004	Hypertrophic cardiomyopathy	Characterized morphologically and defined by a hypertrophied, nondilated LV in the absence of another systemic or cardiac disease that is capable of producing the magnitude of wall thickening evident (eg, systemic hypertension, aortic valve stenosis). Clinical diagnosis is customarily made with 2-dimensional echocardiography (or alternatively with cardiac magnetic resonance imaging) by detection of otherwise unexplained LV wall thickening, usually in the presence of a small LV cavity, after suspicion is raised by the clinical profile or as part of family screening.
ACC NCDR	100001065	Other Cardiomyopathy Type	The term "unclassified cardiomyopathy" was included in the 2008 ESC classification system to describe disorders that do not readily fit into any of the above phenotypic categories [3]. Examples cited include LV noncompaction and stress-induced (takotsubo) cardiomyopathy.

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4575 Chronic Lung Disease

Coding Instruction: Indicate if the patient has a history of chronic lung disease.

Note(s):
A history of chronic inhalation reactive disease (asbestosis, mesothelioma, black lung disease or pneumoconiosis) may qualify as chronic lung disease. Radiation induced pneumonitis or radiation fibrosis also qualifies as chronic lung disease. A history of atelectasis is a transient condition and does not qualify.

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **Chronic Lung Disease**

Chronic lung disease can include patients with chronic obstructive pulmonary disease, chronic bronchitis, or emphysema. It can also include a patient who is currently being chronically treated with inhaled or oral pharmacological therapy (e.g., beta-adrenergic agonist, anti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patients with asthma or seasonal allergies are not considered to have chronic lung disease.

Source: ACC/AHA Key Data Elements and Definitions for Measuring the Clinical Management and Outcomes of Patients With Chronic Heart Failure Circulation. 2005;112:1888-1916

Element: 4285 Coronary Artery Disease

Coding Instruction: Indicate if the patient has a history of coronary artery disease (CAD).

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **Coronary Artery Disease**

Current or previous history of any of the following:
- Coronary artery stenosis >=50% (by cardiac catheterization or other modality or of direct imaging of the coronary arteries)
- Previous CABG surgery
- Previous PCI
- Previous MI

Source: ACCF/AHA 2011 Key Data Elements and Definitions of a Base Cardiovascular Vocabulary for Electronic Health Records (JACC 2011;58;202-222).

Element: 4580 Sleep Apnea

Coding Instruction: Indicate if the patient has a history of sleep apnea that has been diagnosed by a sleep study.

Note(s):
Code 'No' if sleep apnea has been surgically corrected.

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

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

Target Value: Any occurrence between birth and the procedure

Supporting Definition:

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4585 Sleep Apnea Recommended Treatment Followed

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

Target Value: Any occurrence between birth and the procedure

Supporting Definition:

Element: 4700 AFEQT Patient Questionnaire Performed

Coding Instruction: Indicate if the baseline Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire was performed.

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition:

Element: 4705 Are you currently in atrial fibrillation?

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 1 - Question 1 "Are you currently in atrial fibrillation?"

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 1, Q1**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Element: 4710 When was the last time you were aware of having had an episode of atrial fibrillation?

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 1 - Question 2 "When was the last time your were aware of having had an episode of atrial fibrillation?"

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 1, Q2**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001148	Earlier today	
ACC NCDR	100001149	Within the past week	
ACC NCDR	100001150	Within the past month	
ACC NCDR	100001151	1 month to 1 year ago	
ACC NCDR	100001152	More than 1 year ago	
ACC NCDR	100001153	Never aware of having atrial fibrillation	

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4715 Q1: Palpitations: Heart fluttering, skipping or racing

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 2 - Question 1 "Over the past four weeks, as a result of your atrial fibrillation, how much were you bothered by Palpitations: Heart fluttering, skipping or racing"?

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 2, Q1**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001158	Not at all bothered or I did not have this symptom	
ACC NCDR	100001159	Hardly bothered	
ACC NCDR	100001160	A little bothered	
ACC NCDR	100001161	Moderately bothered	
ACC NCDR	100001162	Quite a bit bothered	
ACC NCDR	100001163	Very bothered	
ACC NCDR	100001164	Extremely bothered	

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4720 Q2: Irregular heart beat

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 2 -Question 2."Over the past four weeks, as a result of your atrial fibrillation, how much were you bothered by irregular heart beat"?

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 2, Q2**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001158	Not at all bothered or I did not have this symptom	
ACC NCDR	100001159	Hardly bothered	
ACC NCDR	100001160	A little bothered	
ACC NCDR	100001161	Moderately bothered	
ACC NCDR	100001162	Quite a bit bothered	
ACC NCDR	100001163	Very bothered	
ACC NCDR	100001164	Extremely bothered	

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4725 Q3: Pause in Heart Activity

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 2 - Question 3 "Over the past four weeks, as a result of your atrial fibrillation, how much were you bothered by a pause in heart activity?"

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 2, Q3**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001158	Not at all bothered or I did not have this symptom	
ACC NCDR	100001159	Hardly bothered	
ACC NCDR	100001160	A little bothered	
ACC NCDR	100001161	Moderately bothered	
ACC NCDR	100001162	Quite a bit bothered	
ACC NCDR	100001163	Very bothered	
ACC NCDR	100001164	Extremely bothered	

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4730 Q4: Lightheadedness or dizziness

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 2 - Question 4 "Over the past four weeks, as a result of your atrial fibrillation, how much were you bothered by lightheadedness or dizziness?"

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 2, Q4**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001158	Not at all bothered or I did not have this symptom	
ACC NCDR	100001159	Hardly bothered	
ACC NCDR	100001160	A little bothered	
ACC NCDR	100001161	Moderately bothered	
ACC NCDR	100001162	Quite a bit bothered	
ACC NCDR	100001163	Very bothered	
ACC NCDR	100001164	Extremely bothered	

Element: 4735 Q5: Ability to have recreational pastimes, sports, and hobbies

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 2 - Question 5 "Over the past four weeks, have you been limited by your atrial fibrillation in your: ability to have recreational pastimes, sports, and hobbies?"

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 2, Q5**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001167	Not at all limited	
ACC NCDR	100001168	Hardly limited	
ACC NCDR	100001169	A little limited	
ACC NCDR	100001170	Moderately limited	
ACC NCDR	100001171	Quite a bit limited	
ACC NCDR	100001172	Very limited	
ACC NCDR	100001173	Extremely limited	

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4740 Q6: Ability to have a relationship and do things with friends and family

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 2 - Question 6 "Over the past four weeks, have you been limited by your atrial fibrillation in your: ability to do things with friends and family"?

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 2, Q6**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001167	Not at all limited	
ACC NCDR	100001168	Hardly limited	
ACC NCDR	100001169	A little limited	
ACC NCDR	100001170	Moderately limited	
ACC NCDR	100001171	Quite a bit limited	
ACC NCDR	100001172	Very limited	
ACC NCDR	100001173	Extremely limited	

Element: 4745 Q7: Difficulty doing any activity because you felt tired, fatigued, or low on energy

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 2 - Question 7 "Over the past four weeks, as a result of your atrial fibrillation, how much difficulty have you had in: doing any activity because you felt tired, fatigued, or low on energy?"

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 2, Q7**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001180	No difficulty at all	
ACC NCDR	100001181	Hardly any difficulty	
ACC NCDR	100001182	A little difficulty	
ACC NCDR	100001183	Moderate difficulty	
ACC NCDR	100001184	Quite a bit of difficulty	
ACC NCDR	100001185	A lot of difficulty	
ACC NCDR	100001186	Extreme difficulty	

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4750 Q8: Difficulty doing physical activity because of shortness of breath

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 2 - Question 8 "Over the past four weeks, as a result of your atrial fibrillation, how much difficulty have you had in: doing physical activity because of shortness of breath?"

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 2, Q8**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001180	No difficulty at all	
ACC NCDR	100001181	Hardly any difficulty	
ACC NCDR	100001182	A little difficulty	
ACC NCDR	100001183	Moderate difficulty	
ACC NCDR	100001184	Quite a bit of difficulty	
ACC NCDR	100001185	A lot of difficulty	
ACC NCDR	100001186	Extreme difficulty	

Element: 4755 Q9: Difficulty exercising

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 2 - Question 9 "Over the past four weeks, as a result of your atrial fibrillation, how much difficulty have you had in: exercising?"

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 2, Q9**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001180	No difficulty at all	
ACC NCDR	100001181	Hardly any difficulty	
ACC NCDR	100001182	A little difficulty	
ACC NCDR	100001183	Moderate difficulty	
ACC NCDR	100001184	Quite a bit of difficulty	
ACC NCDR	100001185	A lot of difficulty	
ACC NCDR	100001186	Extreme difficulty	

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4760 Q10: Difficulty walking briskly

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 2 - Question 10 "Over the past four weeks, as a result of your atrial fibrillation, how much difficulty have you had in: walking briskly?"

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 2, Q10**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001180	No difficulty at all	
ACC NCDR	100001181	Hardly any difficulty	
ACC NCDR	100001182	A little difficulty	
ACC NCDR	100001183	Moderate difficulty	
ACC NCDR	100001184	Quite a bit of difficulty	
ACC NCDR	100001185	A lot of difficulty	
ACC NCDR	100001186	Extreme difficulty	

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4765 Q11: Difficulty walking briskly uphill or carrying groceries or other items, up a flight of stairs without stopping

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 2 - Question 11 "Over the past four weeks, as a result of your atrial fibrillation, how much difficulty have you had in: walking briskly uphill or carrying groceries or other items, up a flight of stairs without stopping?"

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 2, Q11**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001180	No difficulty at all	
ACC NCDR	100001181	Hardly any difficulty	
ACC NCDR	100001182	A little difficulty	
ACC NCDR	100001183	Moderate difficulty	
ACC NCDR	100001184	Quite a bit of difficulty	
ACC NCDR	100001185	A lot of difficulty	
ACC NCDR	100001186	Extreme difficulty	

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4770 Q12: Difficulty doing vigorous activities such as lifting or moving heavy furniture, running, or participating in strenuous sports like tennis or racquetball

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 2 - Question 12 "Over the past four weeks, as a result of your atrial fibrillation, how much difficulty have you had in: doing vigorous activities such as lifting or moving heavy furniture, running, or participating in strenuous sports like tennis or racquetball?"

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 2, Q12**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001180	No difficulty at all	
ACC NCDR	100001181	Hardly any difficulty	
ACC NCDR	100001182	A little difficulty	
ACC NCDR	100001183	Moderate difficulty	
ACC NCDR	100001184	Quite a bit of difficulty	
ACC NCDR	100001185	A lot of difficulty	
ACC NCDR	100001186	Extreme difficulty	

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4775 Q13: Feeling worried or anxious that atrial fibrillation can start anytime

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 2- Question 13 "Over the past four weeks, as a result of your atrial fibrillation, how much did feeling worried or anxious that your atrial fibrillation can start anytime?"

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 2, Q13**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001250	Not at all bothered	
ACC NCDR	100001159	Hardly bothered	
ACC NCDR	100001160	A little bothered	
ACC NCDR	100001161	Moderately bothered	
ACC NCDR	100001162	Quite a bit bothered	
ACC NCDR	100001163	Very bothered	
ACC NCDR	100001164	Extremely bothered	

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4780 Q14: Feeling worried that atrial fibrillation may worsen other medical conditions in the long run

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 2- Question 14 "Over the past four weeks, as a result of your atrial fibrillation, how much did feeling worried that your atrial fibrillation may worsen other medical conditions in the long run?"

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 2, Q14**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001250	Not at all bothered	
ACC NCDR	100001159	Hardly bothered	
ACC NCDR	100001160	A little bothered	
ACC NCDR	100001161	Moderately bothered	
ACC NCDR	100001162	Quite a bit bothered	
ACC NCDR	100001163	Very bothered	
ACC NCDR	100001164	Extremely bothered	

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4785 Q15: Worrying about the treatment side effects from medications

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 2 - Question 15 "Over the past four weeks, as a result of your atrial fibrillation treatment, how much were you bothered by worrying about the treatment side effects from medication?"

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 2, Q15**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001250	Not at all bothered	
ACC NCDR	100001159	Hardly bothered	
ACC NCDR	100001160	A little bothered	
ACC NCDR	100001161	Moderately bothered	
ACC NCDR	100001162	Quite a bit bothered	
ACC NCDR	100001163	Very bothered	
ACC NCDR	100001164	Extremely bothered	

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4790 Q16: Worrying about complications or side effects from procedures like catheter ablation, surgery, or pacemakers therapy

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 2 - Question 16 "Over the past four weeks, as a result of your atrial fibrillation treatment, how much were you bothered by worrying about complications or side effects from procedures like catheter ablation, surgery or pacemaker therapy?"

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 2, Q16**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001250	Not at all bothered	
ACC NCDR	100001159	Hardly bothered	
ACC NCDR	100001160	A little bothered	
ACC NCDR	100001161	Moderately bothered	
ACC NCDR	100001162	Quite a bit bothered	
ACC NCDR	100001163	Very bothered	
ACC NCDR	100001164	Extremely bothered	

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4795 Q17: Worrying about side effects of blood thinners such as nosebleeds, bleeding gums when brushing teeth heavy bleeding from cuts, or bruising

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 2 - Question 17 "Over the past four weeks, as a result of your atrial fibrillation treatment, how much were you bothered by worrying about side effects of blood thinners such as nosebleeds, bleeding gums when brushing teeth, heavy bleeding from cuts, or bruising?"

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 2, Q17**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001250	Not at all bothered	
ACC NCDR	100001159	Hardly bothered	
ACC NCDR	100001160	A little bothered	
ACC NCDR	100001161	Moderately bothered	
ACC NCDR	100001162	Quite a bit bothered	
ACC NCDR	100001163	Very bothered	
ACC NCDR	100001164	Extremely bothered	

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4800 Q18: Worrying or feeling anxious that treatment interferes with daily activities

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 2 - Question 18 "Over the past four weeks, as a result of your atrial fibrillation treatment, how much were you bothered by worrying or feeling anxious that your treatment interferes with your daily activities?"

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 2, Q18**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001250	Not at all bothered	
ACC NCDR	100001159	Hardly bothered	
ACC NCDR	100001160	A little bothered	
ACC NCDR	100001161	Moderately bothered	
ACC NCDR	100001162	Quite a bit bothered	
ACC NCDR	100001163	Very bothered	
ACC NCDR	100001164	Extremely bothered	

Element: 4805 Q19: How well current treatment controls atrial fibrillation

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 2 - Question 19 "Overall how satisfied are you at the present time with how well your current treatment controls your atrial fibrillation?"

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 2, Q19**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001195	Extremely satisfied	
ACC NCDR	100001196	Very satisfied	
ACC NCDR	100001197	Somewhat satisfied	
ACC NCDR	100001198	Mixed with satisfied and dissatisfied	
ACC NCDR	100001199	Somewhat dissatisfied	
ACC NCDR	100001228	Very Dissatisfied	
ACC NCDR	100001200	Extremely dissatisfied	

C. HISTORY AND RISK FACTOR (PRIOR TO FIRST PROCEDURE)

Element: 4810 Q20: The extent to which treatment has relieved symptoms of atrial fibrillation

Coding Instruction: Indicate the patient's response to the Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire Section 2- Question 20 "Overall how satisfied are you at the present time with the extent to which your treatment has relieved your symptoms of atrial fibrillation?"

Target Value: Any occurrence between four weeks prior to the procedure and the procedure

Supporting Definition: **Section 2, Q20**

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Source: Development and Validation of the Atrial Fibrillation Effect on QualiTy-of-Life (AFEQT) Questionnaire in Patients With Atrial Fibrillation. Spertus J, Dorian P, Bubien, R, et al. Circ Arrhythm Electrophysiol. 2011;4:15-25.

Code System	Code	Selection Text	Definition
ACC NCDR	100001195	Extremely satisfied	
ACC NCDR	100001196	Very satisfied	
ACC NCDR	100001197	Somewhat satisfied	
ACC NCDR	100001198	Mixed with satisfied and dissatisfied	
ACC NCDR	100001199	Somewhat dissatisfied	
ACC NCDR	100001228	Very Dissatisfied	
ACC NCDR	100001200	Extremely dissatisfied	

D. DIAGNOSTIC STUDIES (MOST RECENT VALUES PRIOR TO THE START OF THE FIRST PROCEDURE)

Element: 5100 Atrial Rhythm

Coding Instruction: Indicate the patient's atrial rhythm at the start of the procedure.

Note(s):
If the patient has multiple atrial rhythms, select all that apply.

In the event that a patient is ventricular paced, indicate the underlying atrial rhythm.

Target Value: Any occurrence between birth and the first procedure in this admission

Supporting Definition:

Code System	Code	Selection Text	Definition
SNOMED CT	106067008	Sinus node rhythm	
SNOMED CT	49436004	Atrial fibrillation	
SNOMED CT	276796006	Atrial tachycardia	
SNOMED CT	5370000	Atrial flutter	
SNOMED CT	5609005	Sinus arrest	
ACC NCDR	100000941	Atrial paced	
ACC NCDR	100001116	Undocumented atrial rhythm	

Element: 5110 LVEF Assessed

Coding Instruction: Indicate if a left ejection fraction percentage has been assessed.

Target Value: Last value between 90 days prior to the start of the current procedure and the start of procedure

Supporting Definition:

Element: 5115 Most Recent LVEF %

Coding Instruction: Indicate the most recent left ventricular ejection fraction.

Note(s):
Enter a percentage in the range of 01 - 99. If a percentage range was reported, report the lowest number of the range (i.e.50-55%, is reported as 50%).

Target Value: Last value between 90 days prior to the start of the current procedure and the start of procedure

Supporting Definition: **Most Recent LVEF %**

The left ventricular ejection fraction is the percentage of blood emptied from the left ventricle at the end of contraction.

Source: ACC Clinical Data Standards, Society for Thoracic Surgeons Adult Cardiac Surgery Database (STS)

D. DIAGNOSTIC STUDIES (MOST RECENT VALUES PRIOR TO THE START OF THE FIRST PROCEDURE)

Element: 5120 Transthoracic Echo (TTE) Performed

Coding Instruction: Indicate if a transthoracic echo was performed prior to the ablation procedure.

Target Value: Last value between 90 days prior to the start of the current procedure and the start of procedure

Supporting Definition:

Element: 5125 Most Recent TTE Date

Coding Instruction: Indicate the date of the most recent transthoracic echo study performed and used to evaluate the patient for this intervention.

Target Value: N/A

Supporting Definition:

Element: 5130 LV Hypertrophy

Coding Instruction: Indicate if the patient has left ventricular hypertrophy.

Target Value: Last value between 90 days prior to the start of the current procedure and the start of procedure

Supporting Definition:

Code System	Code	Selection Text	Definition
ACC NCDR	100001231	None	
SNOMED CT	255604002	Mild	
SNOMED CT	6736007	Moderate	
SNOMED CT	24484000	Severe	

D. DIAGNOSTIC STUDIES (MOST RECENT VALUES PRIOR TO THE START OF THE FIRST PROCEDURE)

Element: 5135 LA Size

Coding Instruction: Indicate the size of the left atrium.

Target Value: Last value between 90 days prior to the start of the current procedure and the start of procedure

Supporting Definition: **LA Size**

LA size is measured at the end-ventricular systole when the LA chamber is at its greatest dimension. While recording images for computing LA volume, care should be taken to avoid foreshortening of the LA. The base of the LA should be at its largest size indicating that the imaging plane passes through the maximal short-axis area. The LA length should also be maximized ensuring alignment along the true long axis of the LA.

Source: Recommendations for Chamber Quantification: A Report from the American Society of Echocardiography's Guidelines and Standards Committee and the Chamber Quantification Writing Group, Developed in Conjunction with the European Association of Echocardiography, a Branch of the European Society of Cardiology. J Am Soc Echocardiogr 2005;18:1440-1463

Code System	Code	Selection Text	Definition
SNOMED CT	253352002:116676008 = 442021009,17621005	Normal	Women LA diameter, cm: 2.7-3.8 LA diameter/BSA, cm/m2: 1.5-2.3 Atrial area : LA area, cm2 : < 20 Atrial volumes LA volume, mL: 22-52 LA volume/BSA, mL/m2: 22 ± 6 Men LA diameter, cm: 3.0-4.0 LA diameter/BSA, cm/m2L: 1.5-2.3 Atrial area: LA area, cm2: < 20 Atrial volumes LA volume, mL: 18-58 LA volume/BSA, mL/m2: 22 ± 6
SNOMED CT	253352002:116676008 = 442021009, 2556040	Mild enlargement	Women LA diameter, cm: 3.9- 4.2 LA diameter/BSA, cm/m2: 2.4 -2.6 Atrial area : LA area, cm2 : 20 -30 Atrial volumes LA volume, mL: 53-62 LA volume/BSA, mL/m2: 29-33 Men LA diameter, cm: 4.1 -4.6 LA diameter/BSA, cm/m2L: 2.4-2.6 Atrial area: LA area, cm2: 20-30 Atrial volumes LA volume, mL: 59-68 LA volume/BSA, mL/m2: 29-33

D. DIAGNOSTIC STUDIES (MOST RECENT VALUES PRIOR TO THE START OF THE FIRST PROCEDURE)

SNOMED CT	253352002:116676008 = 442021009,6736007	Moderate enlargement	Women LA diameter, cm: 4.3-4.6 LA diameter/BSA, cm/m2: 2.7-2.9 Atrial area : LA area, cm2 : 30-40 Atrial volumes LA volume, mL: 63-72 LA volume/BSA, mL/m2: 34-39 Men LA diameter, cm: 4.7- 5.2 LA diameter/BSA, cm/m2L: 2.7-2.9 Atrial area: LA area, cm2: 30-40 Atrial volumes LA volume, mL: 69-78 LA volume/BSA, mL/m2: 34-3
SNOMED CT	253352002:116676008 = 442021009, 24484000	Severe enlargement	Women LA diameter, cm: >=4.7 LA diameter/BSA, cm/m2: >=3.0 Atrial area : LA area, cm2 : >40 Atrial volumes LA volume, mL: >=73 LA volume/BSA, mL/m2: >=40 Men LA diameter, cm: >=5.2 LA diameter/BSA, cm/m2L: >=3.0 Atrial area: LA area, cm2: >40 Atrial volumes LA volume, mL: >=79 LA volume/BSA, mL/m2: >=40

D. DIAGNOSTIC STUDIES (MOST RECENT VALUES PRIOR TO THE START OF THE FIRST PROCEDURE)

Element: 5140 RA Size

Coding Instruction: Indicate the size of the right atrium.

Target Value: Last value between 90 days prior to the start of the current procedure and the start of procedure

Supporting Definition: **RA Size**

The RA can be assessed from many different views, quantification of RA size is most commonly performed from the apical 4-chamber view. The minor-axis dimension should be taken in a plane perpendicular to the long axis of the RA and extends from the lateral border of the RA to the interatrial septum.

Source: Recommendations for Chamber Quantification: A Report from the American Society of Echocardiography's Guidelines and Standards Committee and the Chamber Quantification Writing Group, Developed in Conjunction with the European Association of Echocardiography, a Branch of the European Society of Cardiology. J Am Soc Echocardiogr 2005;18:1440-1463

Code System	Code	Selection Text	Definition
SNOMED CT	253339007:16676008= 442021009,17621005	Normal	RA minor-axis dimension, cm: 2.9 -4.5 RA minor-axis dimension/BSA, (cm/m2): 1.7-2.5
SNOMED CT	253339007: 116676008= 442021009, 255604002	Mild enlargement	RA minor-axis dimension, cm: 4.6 -4.9 RA minor-axis dimension/BSA, (cm/m2): 2.6-2.8
SNOMED CT	253339007:116676008 = 442021009, 6736007	Moderate enlargement	RA minor-axis dimension, cm: 5.0-5.4 RA minor-axis dimension/BSA, (cm/m2): 2.9-3.1
SNOMED CT	253339007:116676008 = 442021009, 24484000	Severe enlargement	RA minor-axis dimension, cm: >=5.5 RA minor-axis dimension/BSA, (cm/m2): >=3.2

D. DIAGNOSTIC STUDIES (MOST RECENT VALUES PRIOR TO THE START OF THE FIRST PROCEDURE)

Element: 5145 Mitral Regurgitation

Coding Instruction: Indicate the severity of regurgitation through the mitral valve.

Note(s):
Code the highest value or most severe regurgitation when a range is reported.

Target Value: Last value between 90 days prior to the start of the current procedure and the start of procedure

Supporting Definition: **Mitral Regurgitation**

The approach to the evaluation of mitral regurgitation (aka. Mitral insufficiency) severity ideally integrates multiple parameters rather than depends on a single measurement.

Source: Recommendations for Evaluation of the Severity of Native Valvular Regurgitation with Two-dimensional and Doppler Echocardiography: J Am Soc Echocardiogr 2003;16:777-802

Code System	Code	Selection Text	Definition
ACC NCDR	100001231	None	No mitral regurgitation is noted in the medical documentation.
ACC NCDR	100001111	Trace/Trivial	
SNOMED CT	255604002	Mild	Structural parameters LA size: Normal LV size: Normal Mitral leaflets or support apparatus: Normal or abnormal Doppler parameters Color flow jet area: Small, central jet (usually < 4 cm2 or < 20% of LA area) Mitral inflow - PW: A wave dominant Jet density - CW: Incomplete or faint Jet contour - CW: Parabolic Pulmonary vein flow: Systolic dominance Quantitative parameters VC width (cm) < 0.3 R Vol (ml/beat) < 30 RF (%) < 30 EROA (cm2) < 0.20
SNOMED CT	6736007	Moderate	Structural parameters LA size: Normal or dilated LV size: Normal or dilated Mitral leaflets or support apparatus: Normal or abnormal Doppler parameters Color flow jet area: Variable Mitral inflow - PW: Variable Jet density - CW: Dense Jet contour - CW: Usually parabolic Pulmonary vein flow: Systolic blunting Quantitative parameters VC width (cm): 0.3-0.69 R Vol (ml/beat): 30-44 45-59 RF (%): 30-39 40-49 EROA (cm2): 0.20-0.29 0.30-0.39

D. DIAGNOSTIC STUDIES (MOST RECENT VALUES PRIOR TO THE START OF THE FIRST PROCEDURE)

ACC NCDR	100001045	Moderate-Severe	Structural parameters LA size: Usually dilated LV size: Usually dilated Mitral leaflets or support apparatus: Abnormal/Flail leaflet/ Ruptured papillary muscle Doppler parameters Color flow jet area - Large central jet (usually > 10 cm2 or > 40% of LA area) or variable size wall impinging jet swirling in LA Mitral inflow - PW: E wave dominant (E usually 1.2 m/s) Jet density - CW: Dense Jet contour- CW: Early peaking - triangular Pulmonary vein flow: Systolic flow reversal Quantitative parameters VC width (cm) > = 0.7 R Vol (ml/beat) > = 60 RF (%) > = 50 EROA (cm2) > = 0.40
SNOMED CT	24484000	Severe	Mitral leaflets or support apparatus: Abnormal/Flail leaflet/ Ruptured papillary muscle Doppler parameters - Color flow jet area - Large central jet (usually > 10 cm2 or > 40% of LA area) or variable size wall impinging jet swirling in LA - Mitral inflow - PW: E wave dominant (E usually 1.2 m/s) - Jet density - CW: Dense - Jet contour- CW: Early peaking - triangular - Pulmonary vein flow: Systolic flow reversal Quantitative parameterst - VC width (cm) > = 0.7 - R Vol (ml/beat) > = 60 - RF (%) > = 50 - EROA (cm2) > = 0.40

Element: 5150 Mitral Stenosis

Coding Instruction: Indicate if the patient has mitral valve stenosis.

Target Value: Last value between 90 days prior to the start of the current procedure and the start of procedure

Supporting Definition:

Element: 5155 Transesophageal Echocardiogram (TEE) Performed

Coding Instruction: Indicate if transesophageal echocardiogram (TEE) was performed prior to the procedure.

Target Value: Last value between 90 days prior to the start of the current procedure and the start of procedure

Supporting Definition:

D. DIAGNOSTIC STUDIES (MOST RECENT VALUES PRIOR TO THE START OF THE FIRST PROCEDURE)

Element: 5160 Most Recent TEE Date

Coding Instruction: Indicate the date of the most recent trans-esophageal echocardiogram.

Target Value: N/A

Supporting Definition:

Element: 5165 Atrial Thrombus Detected

Coding Instruction: Indicate if an atrial thrombus was detected.

Note(s):
Code 'Yes' for either probable or definitive diagnoses of thrombus.

Target Value: Last value between 90 days prior to the start of the current procedure and the start of procedure

Supporting Definition: **Atrial Thrombus Detected**

Presence of thrombus is considered to be definite if 3 of the following 5 criteria are present: Clear borders, echogenicity from the surrounding structures, independent mobility, longest diameter > 15mm, seen in more than one echocardiographic plane.

Source: Buxton AE, Calkins H, Callans DJ, et al. ACC/AHA/HRS 2006 Key Data Elements and Definitions for Electrophysiological Studies and Procedures: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Data Standards (ACC/AHA/HRS Writing Committee to Develop Data Standards on Electrophysiology). J Am Coll Cardiol. 2006;48(11):2360-2396.

Element: 5170 Baseline Imaging Performed

Coding Instruction: Indicate if pre-procedure imaging was performed.

Target Value: Last value between 90 days prior to the start of the current procedure and the start of procedure

Supporting Definition:

Element: 5175 Baseline CT Performed

Coding Instruction: Indicate if pre-procedure imaging was performed via CT.

Target Value: Last value between 90 days prior to the start of the current procedure and the start of procedure

Supporting Definition:

Element: 5180 Most Recent CT Date

Coding Instruction: Indicate the date of the most recent CT imaging.

Target Value: Last value between 90 days prior to the start of the current procedure and the start of procedure

Supporting Definition:

D. DIAGNOSTIC STUDIES (MOST RECENT VALUES PRIOR TO THE START OF THE FIRST PROCEDURE)

Element: 5185 Baseline MRI Performed

Coding Instruction: Indicate if pre-procedure imaging was performed via MRI.

Target Value: Last value between 90 days prior to the start of the current procedure and the start of procedure

Supporting Definition:

Element: 5190 Most Recent MRI Date

Coding Instruction: Indicate the date of the most recent MRI imaging.

Target Value: Last value between 90 days prior to the start of the current procedure and the start of procedure

Supporting Definition:

E. PHYSICAL EXAM AND LABS

Element: 6000 Height

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

Target Value: The last value prior to the start of the first procedure

Supporting Definition:

Element: 6005 Weight

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

Target Value: The last value prior to the start of the first procedure

Supporting Definition:

Element: 6010 Pulse

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

Target Value: The last value prior to the start of the first procedure

Supporting Definition:

Element: 6015 Systolic BP

Coding Instruction: Indicate the patient's systolic blood pressure in mmHg.

Target Value: The last value prior to the start of the first procedure

Supporting Definition:

Element: 6020 Diastolic BP

Coding Instruction: Indicate the patient's diastolic blood pressure in mmHg.

Target Value: The last value prior to the start of the first procedure

Supporting Definition:

Element: 6040 Prothrombin (PT)

Coding Instruction: Indicate the last prothrombin (PT) time in seconds.

Note(s):
This may include POC (Point of Care) testing results.

Most recent values prior to the start of the procedure.

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

Supporting Definition:

E. PHYSICAL EXAM AND LABS

Element: 6041 Prothrombin Not Drawn

Coding Instruction: Indicate if prothrombin (PT) was not drawn.

Target Value: N/A

Supporting Definition:

Element: 6045 International Normalized Ratio (INR)

Coding Instruction: Indicate the international normalized ratio (INR) if the patient was on routine Warfarin/Coumadin therapy.

Note(s):
This may include POC (Point of Care) testing results.

Most recent values prior to the start of the procedure.

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

Supporting Definition:

Element: 6046 International Normalized Ratio Not Drawn

Coding Instruction: Indicate if INR was not drawn.

Target Value: N/A

Supporting Definition:

Element: 6050 Creatinine

Coding Instruction: Indicate the creatinine (Cr) level (mg/Dl).

Note(s):
This may include POC (Point of Care) testing results.

Target Value: The last value between 30 days prior to the procedure and the current procedure

Supporting Definition:

Element: 6051 Creatinine Not Drawn

Coding Instruction: Indicate if a creatinine level was not drawn

Target Value: N/A

Supporting Definition:

E. PHYSICAL EXAM AND LABS

Element: 6055 Bilirubin (Total)

Coding Instruction: Indicate the total bilirubin (mg/dL)

Note(s):
This may include POC (Point of Care) testing results.

Target Value: The last value between 30 days prior to the procedure and the current procedure

Supporting Definition:

Element: 6056 Bilirubin Not Drawn

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

Target Value: N/A

Supporting Definition:

Element: 6060 Aspartate Aminotransferase

Coding Instruction: Indicate the aspartate aminotransferase (AST) level (U/dl).

Note(s):
Lab values listed as SGOT can also be reported as AST.

This may include POC (Point of Care) testing results.

Target Value: The last value between 30 days prior to the procedure and the current procedure

Supporting Definition:

Element: 6061 Aspartate Aminotransferase Not Drawn

Coding Instruction: Indicate if the AST was not drawn.

Target Value: N/A

Supporting Definition:

Element: 6065 Alanine Aminotransferase

Coding Instruction: Indicate the alanine aminotransferase (ALT) level (U/dl).

Note(s):
This may include POC (Point of Care) testing results.

Lab values listed as SGPT can also be reported as ALT.

Target Value: The last value between 30 days prior to the procedure and the current procedure

Supporting Definition:

E. PHYSICAL EXAM AND LABS

Element: 6066 Alanine Aminotransferase Not Drawn

Coding Instruction: Indicate if the ALT was not drawn.

Target Value: N/A

Supporting Definition:

Element: 6070 Alkaline Phosphatase

Coding Instruction: Indicate the alkaline phosphatase (AP) level (IU/dl).

Target Value: The last value between 30 days prior to the procedure and the current procedure

Supporting Definition:

Element: 6071 Alkaline Phosphatase Not Drawn

Coding Instruction: Indicate if the AP was not drawn.

Target Value: N/A

Supporting Definition:

F. MEDICATIONS

Element: 6985 Pre-procedure Medication Code

Coding Instruction: Indicate the assigned identification number for the medications the patient was taking or administered prior to procedure.

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

Target Value: The value between 24 hours prior to the start of current procedure and end of current procedure

Supporting Definition:

Element: 6990 Pre-procedure Medication Administered

Coding Instruction: Indicate when the medication was administered.

Target Value: The value between 24 hours prior to the start of current procedure and end of current procedure

Supporting Definition:

Code System	Code	Selection Text	Definition
ACC NCDR	100001070	Past	Code 'Past' if the medication was tried previously prior this hospital visit, and then discontinued with no intent to resume the medication after recovering from the ablation procedure.
ACC NCDR	100000987	Current	Code 'Current' if the patient is taking this medication prior to the procedure and the medication has neither been held nor stopped for the procedure or if the patient has an active or a new prescription and is taking this medication.
ACC NCDR	100001010	Held	Code 'Held' if the patient is routinely taking this medication, yet the medication was temporarily not administered prior to the procedure with an intent to resume the medication after recovering from the procedure.
ACC NCDR	100001046	Never	Code 'Never' if this medication was never prescribed for this patient.

G. PROCEDURE INFORMATION

Element: 7000 Procedure Start Date and Time

Coding Instruction: Indicate the date and time the procedure started. The time of the procedure is the time that the skin incision, vascular access, or its equivalent, was made in order to start the procedure.

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

Target Value: Any occurrence on current procedure

Supporting Definition:

Element: 7025 Procedure Status

Coding Instruction: Indicate the status of the procedure.

Target Value: The value on current procedure

Supporting Definition:

Code System	Code	Selection Text	Definition
SNOMED CT	71388002:260870009=103390000	Elective Procedure	Elective indicates this ablation procedure was scheduled prior to the patient's arrival to the hospital. The patient is an outpatient prior to this procedure.
SNOMED CT	71388002:260870009=103391001	Urgent Procedure	Urgent indicates that the patient was an inpatient prior to the medical decision to perform the ablation. It was deemed necessary to perform the ablation prior to discharging the patient from the episode of care that initiated for a reason other than performing the ablation.

Element: 7100 Operator Last Name

Coding Instruction: Indicate the last name of operator responsible for the ablation procedure.

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

Target Value: The value on current procedure

Supporting Definition:

Element: 7105 Operator First Name

Coding Instruction: Indicate the first name of operator responsible for the ablation procedure.

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

Target Value: The value on current procedure

Supporting Definition:

G. PROCEDURE INFORMATION

Element: 7110 Operator Middle Name

Coding Instruction: Indicate the middle name of operator responsible for the ablation procedure.

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

Supporting Definition:

Element: 7115 Operator NPI

Coding Instruction: Indicate the National Provider Identifier (NPI) of the operator who is performing the ablation procedure. NPI's, assigned by the Centers for Medicare and Medicaid Services (CMS), are used to uniquely identify physicians for Medicare billing purposes.

Target Value: The value on current procedure

Supporting Definition:

Element: 7120 Phrenic Nerve Evaluation

Coding Instruction: Indicate if the phrenic nerve was evaluated.

Target Value: The value on current procedure

Supporting Definition:

Element: 7125 Evaluated By Pacing Maneuvers

Coding Instruction: Indicate if the phrenic nerve was evaluated by pacing maneuvers.

Target Value: The value on current procedure

Supporting Definition:

G. PROCEDURE INFORMATION

Element: 7130 Sedation

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

Target Value: The value on current procedure

Supporting Definition: **Sedation**

1. Minimal Sedation (Anxiolysis) is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilatory and cardiovascular functions are unaffected.

2. Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.

3. Deep Sedation/Analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

4. General Anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Source: American Society of Anesthesiologists
http://www.asahq.org/publicationsAndServices/standards/20.pdf

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

Element: 7135 Current Ablation Strategy

Coding Instruction: Indicate the currently attempted catheter ablation strategy used to treat the atrial fibrillation.

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

Target Value: The value on current procedure

Supporting Definition:

G. PROCEDURE INFORMATION

Element: 7140 PVI Assessed with Circumferential Vein Catheter

Coding Instruction: Indicate if PVI was assessed with a circumferential vein catheter.

Target Value: The value on current procedure

Supporting Definition:

Element: 7145 Number of Veins Present

Coding Instruction: Indicate the number of pulmonary veins present.

Target Value: The value on current procedure

Supporting Definition:

Code System	Code	Selection Text	Definition
ACC NCDR	100001062	One Vein	
ACC NCDR	100001113	Two Vein	
ACC NCDR	100001110	Three Vein	
ACC NCDR	100001009	Four Vein	
ACC NCDR	100001008	Five Vein	
ACC NCDR	100001103	Six Vein	

Element: 7150 Number of Veins Targeted

Coding Instruction: Indicate the number of pulmonary veins targeted for ablation.

Target Value: The value on current procedure

Supporting Definition:

Code System	Code	Selection Text	Definition
ACC NCDR	100001062	One Vein	
ACC NCDR	100001113	Two Vein	
ACC NCDR	100001110	Three Vein	
ACC NCDR	100001009	Four Vein	
ACC NCDR	100001008	Five Vein	
ACC NCDR	100001103	Six Vein	

G. PROCEDURE INFORMATION

Element: 7155 Number of Veins Isolated

Coding Instruction: Indicate the number of pulmonary veins isolated.

Target Value: The value on current procedure

Supporting Definition:

Code System	Code	Selection Text	Definition
ACC NCDR	100001062	One Vein	
ACC NCDR	100001113	Two Vein	
ACC NCDR	100001110	Three Vein	
ACC NCDR	100001009	Four Vein	
ACC NCDR	100001008	Five Vein	
ACC NCDR	100001103	Six Vein	

Element: 7160 Isolation Confirmation

Coding Instruction: Indicate if the pulmonary vein has been electrically isolated.

Target Value: The value on current procedure

Supporting Definition:

Code System	Code	Selection Text	Definition
ACC NCDR	100000999	Entrance Block	Refers to the inability of electrical activity in the LA to reach the PVs.
ACC NCDR	100001002	Exit Block	Refers to the inability of electrical activity in the PVs to reach the LA.
ACC NCDR	100000945	Bidirectional Block	Refers to both entrance and exit block

Element: 7165 Adjunctive Ablation Lesions

Coding Instruction: Indicate if additional lesions were created during the ablation procedure.

Target Value: The value on current procedure

Supporting Definition: **Adjunctive Ablation Lesions**

Additional locations treated with ablation to increase the efficacy or safety of the primary procedure.

Source: NCDR

G. PROCEDURE INFORMATION

Element: 7170 Adjunctive Ablation Location

Coding Instruction: Indicate the location targeted for ablation during this procedure.

Note(s):
If the patient has multiple locations select all location targeted for ablation.

Target Value: The value on current procedure

Supporting Definition:

Code System	Code	Selection Text	Definition
SNOMED CT	48345005	SVC	
SNOMED CT	90219004	Coronary sinus	
SNOMED CT	5208200	Ligament/Vein of Marshall	
ACC NCDR	100000981	CTI	
ACC NCDR	100000943	Atypical Atrial Flutter Lines	
ACC NCDR	100001063	Other	

Element: 7175 Transseptal Catheterization

Coding Instruction: Indicate if the procedure was performed with a single or a double transseptal catheterization.

Target Value: The value on current procedure

Supporting Definition:

Code System	Code	Selection Text	Definition
SNOMED CT	50607009	Singular	
SNOMED CT	1305003	Double	Double may include either a single-puncture and double wiring of the transseptal catheterization technique or a second transseptal puncture for catheter access.

Element: 7180 Cardioversion (CV) Performed During Procedure

Coding Instruction: Indicate if cardioversion was performed during this procedure.

Target Value: The value on current procedure

Supporting Definition:

Element: 7185 Pharmacologic Cardioversion Performed During Procedure

Coding Instruction: Indicate if pharmacological cardioversion was performed during this procedure.

Target Value: The value on current procedure

Supporting Definition:

G. PROCEDURE INFORMATION

Element: 7190 Direct Current (DC) Cardioversion

Coding Instruction: Indicate if direct current (DC) cardioversion was performed during this procedure.

Target Value: The value on current procedure

Supporting Definition:

Element: 7195 Atrial Flutter/Tachycardia Present

Coding Instruction: Indicate if atrial flutter/tachycardia was present during procedure.

Note(s):
Code 'Yes' if atrial flutter/tachycardia was induced during the procedure.

Target Value: The value on current procedure

Supporting Definition:

Element: 7200 Guidance Method

Coding Instruction: Indicate the assigned identification number associated with the guidance method used for this procedure.

Note(s):
The method(s) that should be collected in your application are controlled by a Guidance Method Master file. This file is maintained by the NCDR and will be made available on the internet for downloading and importing/updating into your application.

Target Value: The value on current procedure

Supporting Definition:

Element: 7205 Catheter Manipulation

Coding Instruction: Indicatethe method used for catheter manipulation during the procedure.

Target Value: The value on current procedure

Supporting Definition:

Code System	Code	Selection Text	Definition
ACC NCDR	100000958	Catheter Manipulation - Manual	
ACC NCDR	100000957	Catheter Manipulation - Magnetic	
ACC NCDR	100000959	Catheter Manipulation - Robotic	

G. PROCEDURE INFORMATION

Element: 7210 Cumulative Air Kerma

Coding Instruction: Indicate the total radiation dose (Cumulative Air Kerma, or Reference Air Kerma) recorded to the nearest milligray (mGy) or gray (Gy). The value recorded should include the total dose for the lab visit. Cumulative air kerma is the total air kerma accrued from the beginning of an examination or procedure and includes all contributions from fluoroscopic and radiographic irradiation.

Target Value: The total between start of current procedure and end of current procedure

Supporting Definition: **Cumulative (Reference) Air kerma**

Cumulative air kerma (also known as reference, reference dose, cumulative dose, or cumulative dose at a reference point) is the air kerma accumulated at a specific point in space (the patient entrance reference point) relative to the gantry of the fluoroscopy system.

The quantity, kerma, originated from the acronym, KERMA, for Kinetic Energy Released per unit Mass (of air).

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

Element: 7220 Dose Area Product

Coding Instruction: Indicate the total fluoroscopy dose to the nearest integer. The value recorded should include the total dose for the lab visit.

Target Value: The total between start of current procedure and end of current procedure

Supporting Definition: **Dose Area Product**

Dose Air Product is the integral of air kerma (the energy extracted from an x-ray beam per unit mass of air in a small irradiated air volume; for diagnostic x-rays, the dose delivered to that volume of air) across the entire x-ray beam emitted from the x-ray tube. It is a surrogate measure of the amount of energy delivered to the patient.

Also known as KAP (Kerma Air Product).

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

Element: 7225 Intraprocedure Anticoagulation

Coding Instruction: Indicate if intraprocedure anticoagulation therapy was provided.

Target Value: The value on current procedure

Supporting Definition:

Element: 7230 Uninterrupted Warfarin Therapy

Coding Instruction: Indicate if the patient continued on warfarin therapy and it was not held for the procedure.

Target Value: The value on current procedure

Supporting Definition:

G. PROCEDURE INFORMATION

Element: 7235 Heparin Administered During Procedure

Coding Instruction: Indicate if heparin was administered during the procedure.

Target Value: The value on current procedure

Supporting Definition:

Element: 7240 Heparin Initial Administration

Coding Instruction: Indicate the timing of initial administration of heparin.

Target Value: The value on current procedure

Supporting Definition:

Code System	Code	Selection Text	Definition
ACC NCDR	100001082	Pre-transseptal Puncture	
ACC NCDR	100001081	Post-transseptal Puncture	

Element: 7245 Bivalirudin

Coding Instruction: Indicate if bivalirudin was administered during the procedure.

Target Value: The value on current procedure

Supporting Definition:

Element: 7250 Other Anticoagulant

Coding Instruction: Indicate if any other anticoagulation medical therapy, not listed above, was used during the procedure.

Target Value: The value on current procedure

Supporting Definition:

Element: 7255 Catheter Ablation Device

Coding Instruction: Indicate the assigned identification number associated with the catheter ablation device.

Note(s):
The devices that should be collected in your application are controlled by a Catheter Ablation Device 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

Supporting Definition:

G. PROCEDURE INFORMATION

Element: 7260 Catheter Ablation Unique Device Identifier

Coding Instruction: Indicate the direct identifier portion of the Unique Device Identifier (UDI) associated with the device used for implant. This ID is provided by the device manufacturer, and is either a GTIN or HIBBC number.

Target Value: Any occurrence on current procedure

Supporting Definition: **Unique Device Identifier (UDI)**

An identifier that is the main (primary) lookup for a medical device product and meets the requirements to uniquely identify a device through its distribution and use. This value is supplied to the FDA by the manufacturer.

Source: US FDA

H. INTRA OR POST-PROCEDURE EVENTS

Element: 9000 Cardiac Arrest

Coding Instruction: Indicate if the patient experienced cardiac arrest.

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

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: ACCF/AHA 2011 Key Data Elements and Definitions of a Base Cardiovascular Vocabulary for Electronic Health Records. JACC Vol. 58, No. 2, 2011 Weintraub et al. 203; July 5, 2011:202-22

H. INTRA OR POST-PROCEDURE EVENTS

Element: 9005 Myocardial Infarction

Coding Instruction: Indicate if the patient had a myocardial infarction.

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

Supporting Definition: **Myocardial Infarction/Prior MI**

Criteria for acute myocardial infarction:
The term acute myocardial infarction (MI) should be used when there is evidence of myocardial necrosis in a clinical setting consistent with acute myocardial ischemia. Under these conditions any one of the following criteria meets the diagnosis for MI:
- Detection of a rise and/or fall of cardiac biomarker values [preferably cardiac troponin (cTn) with at least one value above the 99th percentile upper reference limit (URL) and with at least one of the following:

Symptoms of ischemia.
New or presumed new significant ST-segment-T wave (ST-T) changes or new left bundle branch block (LBBB).
Development of pathological Q waves in the ECG.
Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality. Identification of an intracoronary thrombus by angiography or autopsy.

- Cardiac death with symptoms suggestive of myocardial ischemia and presumed new ischemic ECG changes or new LBBB, but death occurred before cardiac biomarkers were obtained, or before cardiac biomarker values would be increased.

- Percutaneous coronary intervention (PCI) related MI is arbitrarily defined by elevation of cTn values (>5 x 99th percentile URL) in patients with normal baseline values (99th percentile URL) or a rise of cTn values >20% if the baseline values are elevated and are stable or falling. In addition, either (i) symptoms suggestive of myocardial ischemia or (ii) new ischemic ECG changes or (iii) angiographic findings consistent with a procedural complication or (iv) imaging demonstration of new loss of viable myocardium or new regional wall motion abnormality are required.

- Stent thrombosis associated with MI when detected by coronary angiography or autopsy in the setting of myocardial ischemia and with a rise and/or fall of cardiac biomarker values with at least one value above the 99th percentile URL.

- Coronary artery bypass grafting (CABG) related MI is arbitrarily defined by elevation of cardiac biomarker values (>10 x 99th percentile URL) in patients with normal baseline cTn values (99th percentile URL). In addition, either (i) new pathological Q waves or new LBBB, or (ii) angiographic documented new graft or new native coronary artery occlusion, or (iii) imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

Any one of the following criteria meets the diagnosis for prior MI:
- Pathological Q waves with or without symptoms in the absence of non-ischemic causes.
- Imaging evidence of a region of loss of viable myocardium that is thinned and fails to contract, in the absence of a non-ischemic cause.
- Pathological findings of a prior MI.

Source: Thygesen K, Alpert JS, Jaffe AS, et al. Third Universal Definition of Myocardial Infarction. J Am Coll Cardiol. 2012;60(16):1581-1598. doi:10.1016/j.jacc.2012.08.001.

Element: 9020 Air Embolism

Coding Instruction: Indicate if the patient was diagnosed with an air embolism.

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

Supporting Definition:

H. INTRA OR POST-PROCEDURE EVENTS

Element: 9025 Bradycardia Adverse Events

Coding Instruction: Indicate if the patient was diagnosed with a slow heart rate from the natural pacemaker of the heart.

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

Supporting Definition:

Element: 9030 Bradycardia Requiring Permanent Pacemaker

Coding Instruction: Indicate if the patient required a permanent pacemaker.

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

Supporting Definition:

Element: 9035 Cardiac Thromboembolic Event

Coding Instruction: Indicate if the patient was diagnosed with a cardiac thromboembolic event.

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

Supporting Definition:

Element: 9040 Heart Failure

Coding Instruction: Indicate if the patient was diagnosed with an acute decompensation or new diagnosis of heart failure.

Note(s):
Code 'Yes' if the patient either experienced a decompensation of previously diagnosed HF OR if the patient is newly diagnosed with HF intra or post procedure.

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

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: 9045 Heart Valve Damage

Coding Instruction: Indicate if the patient was diagnosed with a new cardiac valve injury.

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

Supporting Definition:

H. INTRA OR POST-PROCEDURE EVENTS

Element: 9050 Left Atrial Thrombus

Coding Instruction: Indicate if the patient was diagnosed with a new left atrial (LA) thrombus.

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

Supporting Definition:

Element: 9060 Pericardial Effusion Resulting in Cardiac Tamponade

Coding Instruction: Indicate if the patient was diagnosed with a cardiac tamponade resulting from a pericardial effusion.

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

Supporting Definition: **Pericardial Effusion Resulting in Cardiac Tamponade**

Indicate if the patient experienced fluid in the pericardial space compromising cardiac filling and requiring intervention. A perforation of the myocardium, aortic annulus or aorta, with or without tamponade associated with the perforation. If tamponade occurs there would be fluid in the pericardial space compromising cardiac filling, and requiring intervention such as pericardiocentesis or returning to the operating room. This should be documented by either:
1. Echo showing pericardial fluid and signs of tamponade such as right heart compromise, or

2. Systemic hypotension due to pericardial fluid compromising cardiac function.

Source: McNamara RL, Brass LM, Drozda JP, Jr, et al. ACC/AHA Key data elements and definitions for measuring the clinical management and outcomes of patients with atrial fibrillation: A report of the American College of Cardiology/American Heart Association Task Force on clinical data standards (writing committee to develop data standards on atrial fibrillation). J Am Coll Cardiol. 2004;44(2):475-495.

Element: 9065 Pericardial Effusion Requiring Intervention

Coding Instruction: Indicate if the patient required pericardiocentesis or surgical intervention for patients diagnosed with a new pericardial effusion.

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

Supporting Definition:

Element: 9070 Cardiac Surgery

Coding Instruction: Indicate if the patient required an unplanned and emergent cardiac surgery.

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

Supporting Definition:

Element: 9075 Anaphylaxis

Coding Instruction: Indicate if the patient was diagnosed with anaphylaxis resulting from a drug reaction.

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

Supporting Definition:

H. INTRA OR POST-PROCEDURE EVENTS

Element: 9080 Hemorrhage (non access site)

Coding Instruction: Indicate if the patient was diagnosed with a hemorrhage at a site other than the access site used for the intervention.

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

Supporting Definition:

Element: 9085 Sepsis

Coding Instruction: Indicate if the patient was diagnosed with sepsis.

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

Supporting Definition:

Element: 9090 Acute Renal Failure

Coding Instruction: Indicate if the patient experienced acute or worsening renal failure.

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

Supporting Definition:

Element: 9095 Genitourinary Bleeding

Coding Instruction: Indicate if the patient experienced genital or urinary bleeding.

Note(s):
The patient experienced genital or urinary bleeding. To qualify, the bleeding should be associated with any of the following documented in the medical record:
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.

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

Supporting Definition:

Element: 9100 Gastrointestinal Hypomotility

Coding Instruction: Indicate if the patient was diagnosed with gastrointestinal (GI) hypomotility.

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

Supporting Definition:

Element: 9160 Access Site Bleeding Requiring Transfusion

Coding Instruction: Indicate if there was bleeding at the percutaneous access site that required a transfusion.

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

Supporting Definition:

H. INTRA OR POST-PROCEDURE EVENTS

Element: 9165 Arterial Thrombosis

Coding Instruction: Indicate if the patient was diagnosed with an arterial thrombosis.

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

Supporting Definition:

Element: 9170 Arteriovenous Fistula Requiring Intervention

Coding Instruction: Indicate if the patient was diagnosed with an arteriovenous (AV) fistula that required an intervention for treatment.

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

Supporting Definition:

Element: 9175 Deep Vein Thrombosis

Coding Instruction: Indicate if the patient was diagnosed with a deep vein thrombosis (DVT).

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

Supporting Definition:

Element: 9185 Hematoma at Access Site

Coding Instruction: Indicate if the patient experienced a hematoma at the percutaneous access site that required evacuation or transfusion.

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

Supporting Definition:

Element: 9190 Pseudoaneurysm Requiring Intervention

Coding Instruction: Indicate if the patient was diagnosed with a pseudoaneurysm (PSA) that required treatment.

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

Supporting Definition:

Element: 9200 Vascular Injury Requiring Surgical Intervention

Coding Instruction: Indicate if the patient experienced a vascular injury intra or post procedure that required treatment with surgical intervention.

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

Supporting Definition:

H. INTRA OR POST-PROCEDURE EVENTS

Element: 9105 Phrenic Nerve Damage

Coding Instruction: Indicate if the patient experienced phrenic nerve damage.

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

Supporting Definition: **Phrenic Nerve Injury**

Development of new sensory or motor loss of the phrenic nerve function from external nerve compression (e.g., as a result of positioning during a procedure), or internal compression or direct nerve damage from the procedure, occurring within 72 h of a procedure.

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: 9110 Phrenic Nerve Damage Confirmation Type

Coding Instruction: Indicate if the phrenic nerve damage was confirmed via chest X-ray or fluoroscopy.

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

Supporting Definition:

Code System	Code	Selection Text	Definition
SNOMED CT	413815006	Chest imaging	
SNOMED CT	44491008	Fluoroscopy	

Element: 9115 Peripheral Nerve Injury

Coding Instruction: Indicate if the patient experienced peripheral nerve injury.

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

Supporting Definition:

H. INTRA OR POST-PROCEDURE EVENTS

Element: 9120 Stroke

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

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

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: 9125 Modified Rankin Scale

Coding Instruction: Indicate the Modified Rankin Scale administered after the current procedure.

Note(s):
The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.

Target Value: The highest value between start of current procedure and until next procedure or discharge

Supporting Definition:

Code System	Code	Selection Text	Definition
LOINC	LA6111-4	No symptoms	
LOINC	LA6112-2	No significant disability despite symptoms	Able to carry out all usual duties and activities.
LOINC	LA6113-0	Slight disability	Unable to carry out all previous activities, but able to look after own affairs without assistance.
LOINC	LA6114-8	Moderate disability	Requiring some help, but able to walk without assistance.
LOINC	LA6115-5	Moderately severe disability	Unable to walk without assistance and unable to attend to own bodily needs without assistance.
LOINC	LA10137-0	Severe disability	Bedridden, incontinent and requiring constant nursing care and attention.
LOINC	LA10138-8	Death	

Element: 9130 Modified Rankin Scale Not Administered

Coding Instruction: Indicate if the Modified Rankin Scale was not administered after the current procedure.

Target Value: N/A

Supporting Definition:

H. INTRA OR POST-PROCEDURE EVENTS

Element: 9140 Transient Ischemic Attack (TIA)

Coding Instruction: Indicate if the patient had a transient ischemic attack (TIA).

Note(s):
Persistence of symptoms is an acceptable indicator of acute infarction. If it is used, duration of symptom persistence that will be used to distinguish between transient ischemia and acute infarction should be defined for any clinical trial in which it is used.

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

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: 9205 Hemothorax

Coding Instruction: Indicate if the patient experienced a hemothorax as documented by accumulation of blood in the thorax.

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

Supporting Definition:

Element: 9210 Hemothorax Requiring Drainage

Coding Instruction: Indicate if the patient was diagnosed with a hemothorax that required drainage.

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

Supporting Definition:

Element: 9215 Pneumothorax

Coding Instruction: Indicate if the patient experienced a pneumothorax as documented by air in the thorax.

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

Supporting Definition:

Element: 9220 Pneumothorax Requiring Drainage

Coding Instruction: Indicate if a chest tube or any form of drainage was required for patients experiencing a pneumothorax.

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

Supporting Definition:

H. INTRA OR POST-PROCEDURE EVENTS

Element: 9225 Respiratory Failure

Coding Instruction: Indicate if the patient was diagnosed with respiratory failure.

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

Supporting Definition:

Element: 9230 Pleural Effusion

Coding Instruction: Indicate if the patient experienced a pleural effusion.

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

Supporting Definition:

Element: 9235 Pneumonia

Coding Instruction: Indicate if the patient developed pneumonia intra or post procedure.

Note(s):
Pneumonia is an infection of one or both lungs caused by bacteria, viruses, fungi, chemicals or aspiration. It can be community acquired or acquired in a health care setting. Typical symptoms associated with pneumonia include cough, chest pain, fever, and difficulty in breathing. Diagnostic tools include x-rays and examination of the sputum. Treatment depends on the cause of pneumonia; bacterial pneumonia is treated with antibiotics.

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

Supporting Definition:

Element: 9240 Pulmonary Embolism

Coding Instruction: Indicate if the patient developed a pulmonary embolism.

Note(s):
A sudden interruption in arterial blood flow to an organ or body part (extremity). The blockage is caused by a blot clot or atherosclerotic plaque that has moved through the arterial circulation from one position to another.

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

Supporting Definition:

Element: 9245 Pulmonary Vein Damage/Dissection

Coding Instruction: Indicate if the patient experienced a disruption or tear within the venous intima of the pulmonary vein.

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

Supporting Definition:

I. DISCHARGE

Element: 10025 Discharge Atrial Rhythm

Coding Instruction: Indicate the patient's atrial rhythm at the time of discharge.

Note(s):
If the patient has multiple atrial rhythms, select all that apply.

In the event that a patient is ventricular paced, indicate the underlying atrial rhythm.

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

Supporting Definition:

Code System	Code	Selection Text	Definition
SNOMED CT	106067008	Sinus node rhythm	
SNOMED CT	49436004	Atrial fibrillation	
SNOMED CT	276796006	Atrial tachycardia	
SNOMED CT	5370000	Atrial flutter	
SNOMED CT	5609005	Sinus arrest	
ACC NCDR	100000941	Atrial paced	
ACC NCDR	100001116	Undocumented atrial rhythm	

Element: 10100 Discharge Date

Coding Instruction: Indicate the date on which the patient was discharged from your facility.

Target Value: The value on discharge

Supporting Definition:

Element: 10105 Discharge Status

Coding Instruction: Indicate whether the patient was alive or deceased at discharge.

Target Value: The value on discharge

Supporting Definition:

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

I. DISCHARGE

Element: 10110 Discharge Location

Coding Instruction: Indicate the location to which the patient was discharged.

Target Value: The value on discharge

Supporting Definition:

Code System	Code	Selection Text	Definition
HL7 Discharge disposition	01	Home	
HL7 Discharge disposition	62	Discharged/transferred to an Extended care/TCU/rehab	Continued "non-acute" care at an extended care facility, transitional care unit, or rehabilitation unit.
HL7 Discharge disposition	02	Other acute care hospital	
HL7 Discharge disposition	64	Skilled Nursing facility	
HL7 Discharge disposition	07	Left against medical advice (AMA)	The patient was discharged or eloped against medical advice.
ACC NCDR	100001249	Other Discharge Location	

Element: 10115 Hospice Care

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

Target Value: The value on discharge

Supporting Definition:

Element: 10120 Death During the Procedure

Coding Instruction: Indicate if the patient expired during the procedure.

Target Value: Any occurrence on discharge

Supporting Definition:

I. DISCHARGE

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

Supporting Definition: **Cause of Death**

Death is classified into 1 of 3 categories: 1) cardiovascular death; 2) non - cardiovascular death; and 3) undetermined cause of death.

The intent of the classification schema is to identify one, and only one, of the categories as the underlying cause of death. The key priority is differentiating between cardiovascular and non-cardiovascular causes of death.

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.

Code System	Code	Selection Text	Definition
ACC NCDR	100000960	Acute myocardial infarction	Death by any cardiovascular mechanism (e.g., arrhythmia, sudden death, heart failure, stroke, pulmonary embolus, peripheral arterial disease) within 30 days after an acute myocardial infarction, related to the immediate consequences of the MI, such as progressive HF or recalcitrant arrhythmia. There may be other assessable (attributable) mechanisms of cardiovascular death during this time period, but for simplicity, if the cardiovascular death occurs <=30 days of an acute myocardial infarction, it will be considered a death due to myocardial infarction.
ACC NCDR	100000978	Sudden cardiac death	Death that occurs unexpectedly, and not within 30 days of an acute MI.
ACC NCDR	100000964	Heart failure	Death associated with clinically worsening symptoms and/or signs of heart failure.
ACC NCDR	100000977	Stroke	Death after a stroke that is either a direct consequence of the stroke or a complication of the stroke.
ACC NCDR	100000962	Cardiovascular procedure	Death caused by the immediate complication(s) of a cardiovascular procedure.
ACC NCDR	100000961	Cardiovascular hemorrhage	Death related to hemorrhage such as a non-stroke intracranial hemorrhage, non-procedural or non-traumatic vascular rupture (e.g., aortic aneurysm), or hemorrhage causing cardiac tamponade.
ACC NCDR	100000972	Other cardiovascular reason	Cardiovascular death not included in the above categories but with a specific, known cause (e.g., pulmonary embolism, peripheral arterial disease).
ACC NCDR	100000975	Pulmonary	Non-cardiovascular death attributable to disease of the lungs (excludes malignancy).
ACC NCDR	100000976	Renal	Non-cardiovascular death attributable to renal failure.

I. DISCHARGE

ACC NCDR	100000963	Gastrointestinal	Non-cardiovascular death attributable to disease of the esophagus, stomach, or intestines (excludes malignancy).
ACC NCDR	100000966	Hepatobiliary	Non-cardiovascular death attributable to disease of the liver, gall bladder, or biliary ducts (exclude malignancy).
ACC NCDR	100000974	Pancreatic	Non-cardiovascular death attributable to disease of the pancreas (excludes malignancy).
ACC NCDR	100000967	Infection	Non-cardiovascular death attributable to an infectious disease.
ACC NCDR	100000968	Inflammatory/Immunologic	Non-cardiovascular death attributable to an inflammatory or immunologic disease process.
ACC NCDR	100000965	Hemorrhage	Non-cardiovascular death attributable to bleeding that is not considered cardiovascular hemorrhage or stroke per this classification.
ACC NCDR	100000971	Non-cardiovascular procedure or surgery	Death caused by the immediate complication(s) of a non-cardiovascular procedure or surgery.
ACC NCDR	100000980	Trauma	Non-cardiovascular death attributable to trauma.
ACC NCDR	100000979	Suicide	Non-cardiovascular death attributable to suicide.
ACC NCDR	100000970	Neurological	Non-cardiovascular death attributable to disease of the nervous system (excludes malignancy).
ACC NCDR	100000969	Malignancy	Non-cardiovascular death attributable to malignancy.
ACC NCDR	100000973	Other non-cardiovascular reason	Non-cardiovascular death attributable to a cause other than those listed in this classification (specify organ system).

Element: 10200 Discharge Medication Code

Coding Instruction: Indicate the assigned identification number associated with the medications the patient was prescribed upon discharge.

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

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

Target Value: The value on discharge

Supporting Definition:

I. DISCHARGE

Element: 10205 Discharge Medication Prescribed

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

Target Value: The value on discharge

Supporting Definition:

Code System	Code	Selection Text	Definition
ACC NCDR	100001247	Yes - Prescribed	Code 'Yes' if this medication was initiated (or prescribed) post procedure and for discharge.
ACC NCDR	100001048	Not Prescribed - No Reason	Code 'No' if this medication was not prescribed post procedure or for discharge and there was no mention of a reason why it was not ordered within the medical documentation.
ACC NCDR	100001034	Not Prescribed - Medical Reason	Code 'No Medical Reason' if this medication was not prescribed post procedure or for discharge and there was a reason documented related to a medical issue or medical concern for not prescribing the medicine.
ACC NCDR	100001071	Not Prescribed - Patient Reason	Code 'No, Patient Reason' if this medication was not prescribed post procedure or for discharge and there was a reason documented related to the patient's preference.

Z. ADMINISTRATION

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:

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

Supporting Definition:

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

Supporting Definition:

Z. ADMINISTRATION

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

Supporting Definition:

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

Supporting Definition:

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

Supporting Definition: