A. Demographics

Seq. #: 2000 **Name:** Last Name

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

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2010 **Name:** First Name

Coding Instructions: Indicate the patient's first name.

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2020 **Name:** Middle Name

Coding Instructions: 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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2030 **Name:** SSN

Coding Instructions: 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

Selections: (none)

Supporting Definitions: (none)

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A. Demographics

Seq. #: 2031 **Name:** SSN N/A

Coding Instructions: Indicate if the patient does not have a United States Social Security Number (SSN).

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 2040 **Name:** Patient ID

Coding Instructions: 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 should never be changed or reassigned to a different patient. If the patient returns to the same participating facility or for follow-up, they must receive this same unique patient identifier.

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2045 **Name:** Other ID

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2050 **Name:** Birth Date

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

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

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A. Demographics

Seq. #: 2060 **Name:** Sex

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

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
Male	
Female	

Supporting Definitions: (none)

Seq. #: 2070 **Name:** Race - White

Coding Instructions: 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **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

---

Seq. #: 2071 **Name:** Race - Black/African American

Coding Instructions: 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **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

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A. Demographics

Seq. #: 2072 **Name:** Race - Asian

Coding Instructions: 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **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

---

Seq. #: 2073 **Name:** Race - American Indian/Alaskan Native

Coding Instructions: 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **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

---

Seq. #: 2074 **Name:** Race - Native Hawaiian/Pacific Islander

Coding Instructions: 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Native Hawaiian/Pacific Islander:**

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

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A. Demographics

Seq. #: 2076 **Name:** Hispanic or Latino Ethnicity

Coding Instructions: Indicate if the patient is of Hispanic or Latino ethnicity 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **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

---

Seq. #: 2080 **Name:** Race - Asian Indian

Coding Instructions: 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 2081 **Name:** Race - Chinese

Coding Instructions: 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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A. Demographics

Seq. #: 2082 **Name:** Race - Filipino

Coding Instructions: 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 2083 **Name:** Race - Japanese

Coding Instructions: 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 2084 **Name:** Race - Korean

Coding Instructions: 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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A. Demographics

Seq. #: 2085 **Name:** Race - Vietnamese

Coding Instructions: 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 2086 **Name:** Race - Other Asian

Coding Instructions: 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 2090 **Name:** Race - Native Hawaiian

Coding Instructions: 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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A. Demographics

Seq. #: 2091 **Name:** Race - Guamanian or Chamorro

Coding Instructions: 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 2092 **Name:** Race - Samoan

Coding Instructions: 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 2093 **Name:** Race - Other Pacific Islander

Coding Instructions: 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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A. Demographics

Seq. #: 2100 **Name:** Hispanic Ethnicity Type - Mexican, Mexican-American, Chicano

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

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2101 **Name:** Hispanic Ethnicity Type - Puerto Rican

Coding Instructions: Indicate if the patient is Puerto Rican 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 2102 **Name:** Hispanic Ethnicity Type - Cuban

Coding Instructions: Indicate if the patient is Cuban 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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A. Demographics

Seq. #: 2103 **Name:** Hispanic Ethnicity Type - Other Hispanic, Latino or Spanish Origin

Coding Instructions: Indicate if the patient is another Hispanic, Latino, or Spanish origin 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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B. Episode of Care

Seq. #: 2065 **Name:** Patient Zip Code

Coding Instructions: 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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2066 **Name:** Zip Code N/A

Coding Instructions: 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 3000 **Name:** Arrival Date

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3005 **Name:** Health Insurance

Coding Instructions: Indicate if the patient has health insurance.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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B. Episode of Care

Seq. #: 3010 **Name:** Health Insurance Payment Source

Coding Instructions: 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

Selections:

Selection Text	*Definition*
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.
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.
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 in different states.
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).
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.
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.
Non-US Insurance	Non-US insurance refers to individuals with a payor that does not originate in the United States.

Supporting Definitions: (none)

Seq. #: 3015 **Name:** Health Insurance Claim Number (HIC)

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

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions:

Health Insurance Claim Number (HIC):

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: Center for Medicare and Medicaid Services

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B. Episode of Care

Seq. #: 3020 **Name:** Patient Enrolled in Research Study

Coding Instructions: Indicate if the patient is enrolled in an ongoing ACC - NCDR research study related to this registry.

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

Selections:

Selection Text	*Definition*
No	No should be selected if the patient is enrolled in a non-ACC sponsored study or is not enrolled in any clinical trial/research study.
Yes	Yes should be selected only for those patients enrolled in an ACC-sponsored study involving the LAAO Registry.

Supporting Definitions: (none)

Seq. #: 3025 **Name:** Research Study Name

Coding Instructions: Indicate the research study name as provided by ACC - NCDR Research Staff.

Note(s):

If the patient is in more than one research study, list each separately.

Study names must follow the format indicated by ACC - NCDR Research Staff. Deviations will result in an error message.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3030 **Name:** Research Study Patient ID

Coding Instructions: Indicate the research study patient identification number as assigned by ACC - NCDR Research Staff.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3035 **Name:** Patient Restriction

Coding Instructions: 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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B. Episode of Care

Seq. #: 3045 **Name:** Admitted for LAA Occlusion Intervention

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

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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C. History and Risk Factors

Seq. #: 4005 **Name:** CHA2DS2-VASc Congestive Heart Failure

Coding Instructions: Indicate if the patient has been diagnosed with heart failure according to the CHA2DS2-VASc definition.

Note(s):

CHA2DS2-VASc Score

Congestive HF/LV Dysfunction: If Yes (to either or both) = + 1 (No = 0 points)

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **CHAD2DS2-VASc Congestive Heart Failure:**

The presence of signs and symptoms of either right (elevated central venous pressure, hepatomegaly, dependent edema) or left ventricular failure (exertional dyspnea, 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: Lip G.Y., Nieuwlaat R., Pisters R., et al; 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. Chest. 2010;137:263-272.

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Source: ACC — NCDR

C. History and Risk Factors

Seq. #: 4010 **Name:** NYHA Functional Classification

Coding Instructions: Indicate the New York Heart Association (NYHA) functional classification for patients diagnosed with heart failure.

Note(s):

NYHA classification is based upon the patient's report of symptoms.

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

Selections:

Selection Text	*Definition*
Class I	
Class II	
Class III	
Class IV	

Supporting Definitions:

NYHA Functional Classification:

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

Class I:

Patients with cardiac disease but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.

Source: The Criteria Committee of the New York Heart Association. (1994). Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Great Vessels. (9th ed.). Boston: Little, Brown & Co. pp. 253–256.

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, dyspnea, or anginal pain.

Source: The Criteria Committee of the New York Heart Association. (1994). Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Great Vessels. (9th ed.). Boston: Little, Brown & Co. pp. 253–256.

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, dyspnea, or anginal pain.

Source: The Criteria Committee of the New York Heart Association. (1994). Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Great Vessels. (9th ed.). Boston: Little, Brown & Co. pp. 253–256.

Class IV:

Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of heart failure or the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

Source: The Criteria Committee of the New York Heart Association. (1994). Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Great Vessels. (9th ed.). Boston: Little, Brown & Co. pp. 253–256.

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C. History and Risk Factors

Seq. #: 4015 **Name:** CHA2DS2-VASc LV Dysfunction

Coding Instructions: Indicate if the patient has been diagnosed with Left Ventricular (LV) Dysfunction according to the CHA2DS2-VASC definition.

Note(s):

CHA2DS2-VASc Score

Congestive HF/LV Dysfunction: If Yes (to either or both) = + 1 (No = 0 points)

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

CHAD2DS2-VASC LV Dysfunction:

Left Ventricular (LV) Dysfunction is defined as Left Ventricular Ejection Fraction (LVEF) < 40 %.

Source: Lip G.Y., Nieuwlaat R., Pisters R., et al; 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. Chest. 2010;137:263-272.

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Source: ACC — NCDR

Seq. #: 4020 **Name:** CHA2DS2-VASc Hypertension

Coding Instructions: Indicate if the patient has been diagnosed with hypertension according to the CHA2DS2-VASc definition.

Note(s):

CHA2DS2-VASc Score

Hypertension: If Yes = + 1 (No = 0 points)

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

CHAD2DS2-VASc Hypertension:

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

Source: Lip G.Y., Nieuwlaat R., Pisters R., et al; 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. Chest. 2010;137:263-272.

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C. History and Risk Factors

Seq. #: 4025 **Name:** CHA2DS2-VASc Diabetes Mellitus

Coding Instructions: Indicate if the patient has been diagnosed with diabetes mellitus according to the CHA2DS2-VASc definition.

Note(s):

CHA2DS2-VASc Score

Diabetes Mellitus: If Yes = + 1 (No = 0 points)

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

CHAD2DS2-VASc Diabetes Mellitus:

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

Source: Lip G.Y., Nieuwlaat R., Pisters R., et al; 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. Chest. 2010;137:263-272.

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Source: ACC — NCDR

Seq. #: 4030 **Name:** CHA2DS2-VASc Stroke

Coding Instructions: Indicate if the patient has been diagnosed with an ischemic stroke according to the CHA2DS2-VASc definition.

Note(s):

CHA2DS2-VASc Score

Stroke (Ischemic) / Transient Ischemic Attack (TIA) / Thromboembolic event (TE): If Yes (to any or all) = + 2

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	No indicates either the patient has had no stroke in the past, or if there is a positive history of a stroke, it was not ischemic.
Yes	Yes indicates the patient is documented as having a stroke, specifically an ischemic stroke, in the past.

Supporting Definitions:

CHAD2DS2-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: Lip G.Y., Nieuwlaat R., Pisters R., et al; 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. Chest. 2010;137:263-272.

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Source: ACC — NCDR

C. History and Risk Factors

Seq. #: 4035 **Name:** CHA2DS2-VASc TIA

Coding Instructions: Indicate if the patient has been diagnosed with a transient ischemic attack (TIA) according to the CHA2DS2-VASc definition.

Note(s):

CHA2DS2-VASc Score

Stroke (Ischemic) / Transient Ischemic Attack (TIA) / Thromboembolic event (TE): If Yes (to any or all) = + 2

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

CHA2DS2-VASc TIA:

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

Source: Lip G.Y., Nieuwlaat R., Pisters R., et al; 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. Chest. 2010;137:263-272.

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Source: ACC — NCDR

Seq. #: 4040 **Name:** CHA2DS2-VASc Thromboembolic Event

Coding Instructions: Indicate if the patient has been diagnosed with a thromboembolic event (TE) according to the CHA2DS2-VASc definition.

Note(s):

CHA2DS2-VASc Score

Stroke (Ischemic) / Transient Ischemic Attack (TIA) / Thromboembolic event (TE): If Yes (to any or all) = + 2

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

CHA2DS2-VASc Thromboembolic Event:

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: Lip G.Y., Nieuwlaat R., Pisters R., et al; 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. Chest. 2010;137:263-272.

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C. History and Risk Factors

Seq. #: 4045 **Name:** CHA2DS2-VASc Vascular Disease

Coding Instructions: Indicate if the patient has been diagnosed with vascular disease according to the CHA2DS2-VASc definition.

Note(s):

CHA2DS2-VASc Score

Vascular disease (defined as prior MI, PAD, or aortic plaque) if Yes = + 1

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

CHA2DS2-VASc 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: Lip G.Y., Nieuwlaat R., Pisters R., et al; 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. Chest. 2010;137:263-272.

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Source: ACC — NCDR

C. History and Risk Factors

Seq. #: 4050 **Name:** Vascular Disease Type

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

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
Myocardial Infarction (MI)	
Peripheral arterial occlusive disease (PAD)	
Known Aortic Plaque	

Supporting Definitions:

Myocardial Infarction (MI):

Criteria for prior myocardial infarction is any one of the following criteria meets the diagnosis for prior MI:

1. Pathological Q waves with or without symptoms in the absence of non-ischemic causes.
2. 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.
3. 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 arterial occlusive disease (PAD):

Current or previous history of peripheral arterial disease (includes subclavian, iliac, femoral, and upper- and lower-extremity vessels; excludes renal, coronary, cerebral, and mesenteric vessels and aneurysms). This can include:

1. Claudication on exertion
2. Amputation for arterial vascular insufficiency
3. Vascular reconstruction, bypass surgery, or percutaneous revascularization in the arteries of the extremities
4. 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 or peripheral embolism.

Imaging techniques used for detection of aortic plaques have included transesophageal echocardiogram (TEE), computed tomography (CT), magnetic resonance imaging (MRI), and transthoracic echocardiogram (TTE).

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.

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C. History and Risk Factors

Seq. #: 4055 **Name:** HAS-BLED Hypertension (Uncontrolled)

Coding Instructions: Indicate if the patient has been diagnosed with uncontrolled hypertension as defined by the HAS-BLED Risk Model.

Note(s):

HAS-BLED Score

Hypertension (+ 1 point)

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

Selections:

Selection Text	*Definition*
No	
Yes	Coding "Yes" implies the patient's current, actual systolic blood pressure is greater than 160 mmHg. ("HAS-BLED Hypertension" is not a history of hypertension.)

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

Uncontrolled Hypertension is defined by the HAS-BLED Risk Model 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.

HAS-BLED Hypertension is not a history of hypertension.

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

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Source: ACC — NCDR

Seq. #: 4060 **Name:** HAS-BLED Abnormal Renal Function

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

Note(s):

HAS-BLED Score

Abnormal renal function (+ 1 point)

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

Selections:

Selection Text	*Definition*
No	
Yes	

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

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C. History and Risk Factors

Seq. #: 4065 **Name:** HAS-BLED Abnormal Liver Function

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

Note(s):

HAS-BLED Score

Abnormal liver function (+ 1 point)

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

HAS-BLED Abnormal Liver Function:

Abnormal liver function is defined by the HAS-BLED Risk Model as chronic hepatic disease (e.g., cirrhosis) or biochemical evidence of significant hepatic derangement (e.g., 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: Pisters R., Lane D.A., Nieuwlaat R., et al; A novel user-friendly score (HAS-BLED) to assess 1-year risk of major bleeding in patients with atrial fibrillation: the Euro Heart Survey. Chest. 2010;138:1093-1100.

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Source: ACC — NCDR

Seq. #: 4070 **Name:** HAS-BLED Stroke

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

Note(s):

HAS-BLED Score

Stroke (any type) (+1 point)

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

HAS-BLED Stroke:

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

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Source: ACC — NCDR

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C. History and Risk Factors

Seq. #: 4075 **Name:** Hemorrhagic Stroke

Coding Instructions: Indicate if the patient experienced a hemorrhagic stroke as defined by an acute episode of focal or global cerebral or spinal dysfunction caused by intraparenchymal, intraventricular, or subarachnoid hemorrhage.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Hemorrhagic Stroke:

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.

Hemorrhagic stroke is defined as an acute episode of focal or global cerebral or spinal dysfunction caused by intraparenchymal, intraventricular, or subarachnoid hemorrhage.

Subdural hematomas are intracranial hemorrhagic events and not strokes.

Source: Standardized Definitions for Cardiovascular Endpoints in Clinical Trials (FDA Draft) Cardiovascular Trials

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Seq. #: 4080 **Name:** Ischemic Stroke

Coding Instructions: Indicate if the patient experienced an ischemic stroke, as defined by an acute episode of focal cerebral, spinal, or retinal dysfunction caused by 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.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Ischemic Stroke:

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.

Source: Standardized Definitions for Cardiovascular Endpoints in Clinical Trials(FDA Draft) Cardiovascular Trials

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Seq. #: 4085 **Name:** Undetermined Stroke

Coding Instructions: Indicate if the patient experienced an undetermined stroke, as defined by an acute episode of focal or global neurological dysfunction caused by presumed brain, spinal cord, or retinal vascular injury as a result of hemorrhage or infarction but with insufficient information to allow categorization as either an ischemic stroke or hemorrhagic stroke.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Undetermined Stroke:

A stroke of undetermined origin is defined as an acute episode of focal or global neurological dysfunction caused by presumed brain, spinal cord, or retinal vascular injury as a result of hemorrhage or infarction but with insufficient information to allow categorization as ischemic or hemorrhagic.

Source: Standardized Definitions for Cardiovascular Endpoints in Clinical Trials (FDA Draft)

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C. History and Risk Factors

Seq. #: 4095 **Name:** HAS-BLED Bleeding

Coding Instructions: Indicate if the patient has a history of a major bleeding event or predisposition to bleeding (e.g., bleeding diathesis, anemia) as defined by the HAS-BLED Risk Model.

Note(s):

Major bleeding defined as any bleeding requiring hospitalization, and/or causing a decrease in hemoglobin level > 3 g/dL, and/or requiring blood transfusion that was not hemorrhagic stroke.

HAS-BLED Score

Bleeding tendency or predisposition for bleeding (+1 point)

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

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

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Source: ACC—NCDR

Seq. #: 4100 **Name:** HAS-BLED Labile INR

Coding Instructions: Indicate if the patient has experienced labile international normalized ratios (INR) while on Warfarin therapy as defined by the HAS-BLED Risk Model.

Note(s):

HAS-BLED Score

Labile INRs (for patients taking Warfarin) (+1 point)

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

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

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C. History and Risk Factors

Seq. #: 4105 **Name:** HAS-BLED Alcohol

Coding Instructions: Indicate if the patient uses alcohol in excess as defined by the HAS-BLED Risk Score.

Note(s):

HAS-BLED Score

Alcohol abuse (+ 1 point)

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **HAS-BLED Alcohol:**

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

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

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Source: ACC — NCDR

Seq. #: 4110 **Name:** HAS-BLED Drugs - Antiplatelet

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

Note(s):

If the patient is taking 325 mg Aspirin code as 'Yes'.

HAS-BLED Score

Drugs [Concomitant use of Aspirin and a non steriodal anti - inflammatory drug (NSAID)] (1 point total if both Antiplatet SEQ 4110 and NSAID SEQ 4115 are coded Yes. If Alcohol Abuse is coded Yes, then a total of 2 points allotted to the HAS - BLED score for Yes selections to SEQ 4105, 4110 and 4115.)

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

Selections:

Selection Text	*Definition*
No	Code 'No' if the patient takes neither ASA or any other antiplatelet medication on a regular basis.
Yes	Code 'Yes' if the patient currently uses or is prescribed Aspirin or any other antiplatelet medication.

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

Concomitant use of ASA or other antiplatelet medication or NSAID with alcohol may predispose the patient to bleeding per the HAS-BLED Risk Model.

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

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Seq. #: 4115 **Name:** HAS-BLED Drugs - NSAIDS

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

Note(s):

If the patient is taking 81mg Aspirin code as 'Yes'.

HAS-BLED Score

Drugs [Concomitant use of Aspirin and a non steroidal anti - inflammatory drug (NSAID)] (1 point total if both Antiplatet SEQ 4110 and NSAID SEQ 4115 are coded Yes. If Alcohol Abuse is coded Yes, then a total of 2 points allotted to the HAS - BLED score for Yes selections to SEQ 4105, 4110 and 4115.)

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

Selections:

Selection Text	*Definition*
No	Select No if the patient does not use any NSAID medication on a regular basis.
Yes	Select Yes if the patient currently uses or is prescribed any NSAID medication.

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

Concomitant use of ASA or other antiplatelet medication or NSAID with alcohol may predispose the patient to bleeding per the HAS-BLED Risk Model.

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

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Source: ACC — NCDR

Seq. #: 4120 **Name:** Increased Fall Risk

Coding Instructions: Indicate if the patient has an increased susceptibility to falling that may cause physical harm as defined by the American Geriatrics Society.

Target Value: Any occurrence between 12 months prior to the procedure and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Increased Fall Risk:**

A patient is at increased risk for falls if they have experienced any of the following: two or more falls in the prior 12 months; presents with an acute fall for this episode of care; or experiences difficultly walking or balancing.

Source: American Geriatrics Society/British Geriatrics Society Clinical Practice Guideline for Prevention of Falls in Older Persons. J Am Geriatr Soc. 2010.

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C. History and Risk Factors

Seq. #: 4125 **Name:** Clinically Relevant Bleeding Event

Coding Instructions: Indicate if the patient has a history of a clinically relevant bleeding event.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Clinically Relevant Bleeding Event:**

A clinically relevant bleeding event is defined as any one of the following:
1. Hemoglobin drop of >=3 g/dL;
2. Transfusion of packed red blood cells;
3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding
4. Hospital admission with primary discharge diagnosis related to a bleeding event

Source: NCDR

Seq. #: 4130 **Name:** Bleeding Event Type

Coding Instructions: Indicate if the patient has a history of a prior Intracranial, Epistaxis, Gastrointestinal, or Other. If the patient has multiple bleeding events, select all bleeding types.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
Intracranial	
Epistaxis	
Gastrointestinal	
Other	

Supporting Definitions: (none)

Seq. #: 4135 **Name:** Genetic Coagulopathy

Coding Instructions: Indicate if the patient has been diagnosed with a genetic coagulopathy.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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C. History and Risk Factors

Seq. #: 4140 **Name:** Concurrent Anticoagulant Therapy

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

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4285 **Name:** Coronary Artery Disease

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

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Coronary Artery Disease (CAD):**

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

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

Seq. #: 4380 **Name:** Valvular Atrial Fibrillation

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

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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C. History and Risk Factors

Seq. #: 4381 **Name:** History of Rheumatic Valve Disease

Coding Instructions: Indicate if the patient has a history of rheumatic valve disease.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4385 **Name:** History of Mitral Valve Replacement

Coding Instructions: 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4390 **Name:** Mechanical Valve in Mitral Position

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

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4395 **Name:** History of Mitral Valve Repair

Coding Instructions: 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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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C. History and Risk Factors

Seq. #: 4400 **Name:** Atrial Fibrillation Classification

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

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

Selections:

Selection Text	*Definition*
Paroxysmal	AF that terminates spontaneously or with intervention within 7 days of onset. Episodes may recur with variable frequency.
Persistent	Continuous AF that is sustained >7 days or with electrical or pharmacological termination.
Long-standing Persistent	Continuous AF of >12 months duration.
Permanent	Permanent AF is used when there has been a joint decision by the patient and clinician to cease 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.

Supporting Definitions:

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.

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

Seq. #: 4410 **Name:** Attempt at Atrial Fibrillation Termination

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

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Attempt at Atrial Fibrillation Termination:

Therapeutic options for conversion of AF to sinus rhythm includes: anti-arrhythmic 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

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C. History and Risk Factors

Seq. #: 4415 **Name:** Atrial Fibrillation Termination - Pharmacologic Cardioversion

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

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Pharmacologic Cardioversion:**

Anti-arrhythmic 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

Seq. #: 4420 **Name:** Atrial Fibrillation Termination - DC Cardioversion

Coding Instructions: Indicate if the patient has a history of direct current (DC) cardioversion.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **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

Seq. #: 4425 **Name:** Atrial Fibrillation Termination - Catheter Ablation

Coding Instructions: Indicate if the patient has a history of catheter ablation for termination of atrial fibrillation.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **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 radio frequency 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.

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C. History and Risk Factors

Seq. #: 4430 **Name:** Atrial Fibrillation, Most Recent Catheter Ablation Date

Coding Instructions: 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 time-frames found in prior medical record documentation (Example: If the patient had "most recent electrocardiogram" documented in a record from 2015, then the year 2015 can be utilized and coded as 01/01/2015).

Target Value: The last value between birth and the procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 4435 **Name:** Prior Catheter Ablation Strategy

Coding Instructions: Indicate the previously attempted catheter ablation strategy used to treat the atrial fibrillation.

Note(s):

From the supplied list, select all applicable strategies which were performed during the most recent ablation.

Target Value: Any occurrence between birth and the procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 4440 **Name:** Atrial Fibrillation Termination - Surgical Ablation

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

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Surgical Ablation:

The Maze operation is one surgical ablation option to 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.

Seq. #: 4445 **Name:** Atrial Fibrillation, Most Recent Surgical Ablation Date

Coding Instructions: 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 time-frames found in prior medical record documentation (Example: If the patient had "most recent electrocardiogram" documented in a record from 2015, then the year 2015 can be utilized and coded as 01/01/2015).

Target Value: The last value between birth and the procedure

Selections: (none)

Supporting Definitions: (none)

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C. History and Risk Factors

Seq. #: 4450 **Name:** Atrial Flutter

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

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **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.

Seq. #: 4455 **Name:** Atrial Flutter Classification

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

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
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.
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.

Supporting Definitions: **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: anuary 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.

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C. History and Risk Factors

Seq. #: 4460 **Name:** Attempt at Atrial Flutter Termination

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

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

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.

Seq. #: 4465 **Name:** Atrial Flutter Termination - Pharmacologic Cardioversion

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

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

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.

Seq. #: 4470 **Name:** Atrial Flutter Termination - DC Cardioversion

Coding Instructions: Indicate if the patient has a history of direct current (DC) cardioversion to terminate the atrial flutter.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

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.

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C. History and Risk Factors

Seq. #: 4475 **Name:** Atrial Flutter Termination - Catheter Ablation

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

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4480 **Name:** Atrial Flutter Most Recent Catheter Ablation Date

Coding Instructions: Indicate the date of the most recent catheter ablation to terminate the atrial flutter.

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 time-frames found in prior medical record documentation (Example: If the patient had "most recent electrocardiogram" documented in a record from 2015, then the year 2015 can be utilized and coded as 01/01/2015).

Target Value: The last value between birth and the procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 4565 **Name:** Cardiomyopathy (CM)

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

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

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.

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C. History and Risk Factors

Seq. #: 4570 **Name:** Cardiomyopathy Type

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

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
Non-ischemic cardiomyopathy	Includes cardiomyopathies resulting from volume or pressure overload, such as hypertension or valvular heart disease. [2]
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. [2]
Restrictive cardiomyopathy	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]
Hypertrophic cardiomyopathy	Characterized morphologically and defined by a hypertrophied, non-dilated 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]
Other Cardiomyopathy Type	The term "unclassified cardiomyopathy" was included in the 2008 European Heart Journal (ESC) classification system to describe disorders that do not readily fit into any of the above phenotypic categories. Examples cited include LV noncompaction and stress -induced (takotsubo) cardiomyopathy. [3]

Supporting Definitions: **Cardiomyopathy Type:**

Supporting definitions are provided in the selection text.

Source: [1] Barry J. Maron, MD, et al. 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. [3] Richardson P, McKenna W, et al . 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

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C. History and Risk Factors

Seq. #: 4575 **Name:** Chronic Lung Disease

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

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

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

Seq. #: 4580 **Name:** Sleep Apnea

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

Note(s):

Do not capture suspected sleep apnea or that reported by family members as sleep apnea. Sleep apnea must be diagnosed by a physician. A patient documented to be on CPAP or BiPAP therapy may equate with evidence that sleep apnea has been diagnosed and coding may reflect "Yes".

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4585 **Name:** Sleep Apnea Recommended Treatment Followed

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

Note(s):

CPAP or BiPAP therapy is not a requirement to code 'Yes' for sleep apnea.
Both Obstructive Sleep Apnea (recurrent collapse of the pharynx during sleep) and Central Sleep Apnea (transient cessation of neural drive to respiratory muscles) should be considered.
Capture patients with prescribed home therapy despite frequency of use.

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

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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C. History and Risk Factors

Seq. #: 4590 **Name:** Cardiac Structural Intervention

Coding Instructions: Indicate if the patient has a history of cardiac structural interventions (percutaneously or surgically).

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4595 **Name:** Cardiac Structural Intervention Type

Coding Instructions: Indicate the type of prior cardiac structural intervention.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
Aortic Balloon Valvuloplasty	
Transcatheter Aortic Valve Replacement (TAVR)	
Aortic Valve Replacement – Surgical	
Aortic Valve Repair – Surgical	
Mitral Balloon Valvuloplasty	
Transcatheter Mitral Valve Repair (TMVR)	
Mitral Valve Replacement – Surgical	
Mitral Valve Repair – Surgical	
Mitral Annuloplasty Ring – Surgical	
Mitral Transcatheter – Valve-in-Valve	
Atrial Septal Defect Closure	
Patent Foramen Ovale Closure	
Pulmonic Replacement	
Pulmonic Repair	
Tricuspid Replacement	
Tricuspid Repair	

Supporting Definitions: (none)

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C. History and Risk Factors

Seq. #: 4600 **Name:** Left Atrial Appendage (LAA) Intervention

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

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4605 **Name:** Left Atrial Appendage (LAA) Intervention Type

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

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
Epicardial Ligation	Ligation via an epicardial approach, isolating the left atrial appendage (LAA) from circulation via inside the pericardial space.
Percutaneous Occlusion	Occlusion of the left atrial appendage (LAA) using solely a percutaneous, catheter-based method.

Supporting Definitions: (none)

Seq. #: 4815 **Name:** Epicardial Approach Considered

Coding Instructions: Indicate if an epicardial approach to the left atrial appendage intervention was considered for this episode of care.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4820 **Name:** Cardiac Surgery

Coding Instructions: Indicate if the patient has a history of cardiac surgery.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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C. History and Risk Factors

Seq. #: 4825 **Name:** Pericarditis

Coding Instructions: Indicate if the patient has a history of pericarditis.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4830 **Name:** Epicardial Access

Coding Instructions: Indicate if the patient has a history of epicardial access.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4835 **Name:** Autoimmune Disease

Coding Instructions: Indicate if the patient has a history of any autoimmune disease.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4836 **Name:** Lupus

Coding Instructions: Indicate if the patient has a history of lupus.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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C. History and Risk Factors

Seq. #: 4840 **Name:** Thoracic Radiation Therapy

Coding Instructions: Indicate if the patient has a history of thoracic radiation therapy.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4845 **Name:** Pectus excavatum

Coding Instructions: Indicate if the patient has a history of pectus excavatum.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4850 **Name:** Epigastric Surgery

Coding Instructions: Indicate if the patient has a history of epigastric surgery.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4855 **Name:** Hepatomegaly

Coding Instructions: Indicate if the patient has a history of hepatomegaly.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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C. History and Risk Factors

Seq. #: 4860 **Name:** Hiatal Hernia

Coding Instructions: Indicate if the patient has a history of a hiatal hernia.

Target Value: Any occurrence between birth and the procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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D. Diagnostic Studies

Seq. #: 5100 **Name:** Atrial Rhythm

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

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

Selections:

Selection Text	*Definition*
Sinus node rhythm	
Atrial fibrillation	
Atrial tachycardia	
Atrial flutter	
Sinus arrest	
Atrial paced	
Undocumented atrial rhythm	

Supporting Definitions: (none)

Seq. #: 5110 **Name:** LVEF Assessed

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

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5115 **Name:** LVEF %

Coding Instructions: Indicate the most recent left ventricular ejection fraction

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

Selections: (none)

Supporting Definitions: (none)

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D. Diagnostic Studies

Seq. #: 5120 **Name:** Transthoracic Echo (TTE) Performed

Coding Instructions: Indicate if a transthoracic echocardiogram (TTE) was performed prior to the procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5125 **Name:** Most Recent TTE Date

Coding Instructions: Indicate the date of the most recent transthoracic echocardiogram (TTE) performed and used to evaluate the patient for this intervention.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5170 **Name:** Baseline Imaging Performed

Coding Instructions: Indicate if other pre-procedure imaging was performed.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5175 **Name:** Baseline CT Performed

Coding Instructions: Indicate if pre-procedure imaging was performed via computed tomography (CT).

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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D. Diagnostic Studies

Seq. #: 5180 **Name:** Most Recent CT Date

Coding Instructions: Indicate the date of the most recent computed tomography (CT).

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5185 **Name:** Baseline MRI Performed

Coding Instructions: Indicate if pre-procedure imaging was performed via magnetic resonance imaging (MRI).

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5190 **Name:** Most Recent MRI Date

Coding Instructions: Indicate the date of the most recent magnetic resonance imaging (MRI).

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

Selections: (none)

Supporting Definitions: (none)

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E. Physical Exam and Labs

Seq. #: 6000 **Name:** Height

Coding Instructions: Indicate height in centimeters.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6005 **Name:** Weight

Coding Instructions: Indicate weight in kilograms.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6010 **Name:** Pulse

Coding Instructions: Indicate heart rate (beats per minute).

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6015 **Name:** Systolic BP

Coding Instructions: Indicate systolic blood pressure in mmHg.

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

Selections: (none)

Supporting Definitions: (none)

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E. Physical Exam and Labs

Seq. #: 6020 **Name:** Diastolic BP

Coding Instructions: Indicate diastolic blood pressure in mmHg.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6030 **Name:** Hemoglobin

Coding Instructions: Indicate the most recent hemoglobin (Hgb) value (g/dL).

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6031 **Name:** Hemoglobin Not Drawn

Coding Instructions: Indicate if the hemoglobin value was not drawn.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6040 **Name:** Prothrombin (PT)

Coding Instructions: Indicate the most current prothrombin (PT) time in seconds.

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

Selections: (none)

Supporting Definitions: (none)

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E. Physical Exam and Labs

Seq. #: 6041 **Name:** Prothrombin Not Drawn

Coding Instructions: Indicate if the prothrombin time (PT) was not drawn.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6045 **Name:** International Normalized Ratio (INR)

Coding Instructions: Indicate the pre procedure international normalized ratio (INR) if applicable.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6046 **Name:** International Normalized Ratio Not Drawn

Coding Instructions: Indicate if the INR was not drawn.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6050 **Name:** Creatinine

Coding Instructions: Indicate the creatinine (Cr) level (mg/dL).

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

Selections: (none)

Supporting Definitions: (none)

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E. Physical Exam and Labs

Seq. #: 6051 **Name:** Creatinine Not Drawn

Coding Instructions: Indicate if the creatinine level was not drawn.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6075 **Name:** Albumin

Coding Instructions: Indicate the albumin level (g/dL).

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6076 **Name:** Albumin Not Drawn

Coding Instructions: Indicate if the albumin level was not drawn.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6080 **Name:** Platelet Count

Coding Instructions: Indicate the platelet count (1,000/µL).

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

Selections: (none)

Supporting Definitions: (none)

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E. Physical Exam and Labs

Seq. #: 6081 **Name:** Platelet Count Not Drawn

Coding Instructions: Indicate if the platelet count was not drawn.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6085 **Name:** Modified Rankin Scale

Coding Instructions: Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered pre-procedure.

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

Selections:

Selection Text	*Definition*
0: No symptoms at all	
1: No significant disability despite symptoms	Able to carry out all usual duties and activities
2: Slight disability	Unable to carry out all previous activities, but able to look after own affairs without assistance
3: Moderate disability	Requiring some help, but able to walk without assistance.
4: Moderately severe disability	Unable to walk without assistance and unable to attend to own bodily needs without assistance
5: Severe disability	Bedridden, incontinent and requiring constant nursing care and attention

Supporting Definitions: **Modified Rankin Scale (mRS):**

The modified Rankin Scale (mRS) is a commonly used scale for measuring the degree of disability or dependence in the daily activities of people who have suffered a stroke or other causes of neurological disability.

Source: Rankin J (May 1957). "Cerebral vascular accidents in patients over the age of 60. II. Prognosis". Scott Med J 2 (5): 200–15.

Seq. #: 6086 **Name:** Modified Rankin Scale Not Administered

Coding Instructions: Indicate if the modified Rankin Scale (mRS) was not administered pre-procedure.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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F. Pre-Procedure Medications

Seq. #: 6985 **Name:** Pre-Procedure Medication Code

Coding Instructions: Indicate the NCDR assigned identification number for the pre-procedure medication and medication history.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6990 **Name:** Pre-Procedure Medication Administered

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

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

Selections:

Selection Text	*Definition*
Past	Code 'Past' if the medication was tried previously prior to this hospital visit, and then discontinued with no intent to resume the medication after recovering from the procedure.
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.
Held	Code 'Held' if the patient is routinely taking this medication, yet the medication was temporarily not administered prior to the procedure with intent to resume the medication after recovering from the procedure.
Never	Code 'Never' if this medication was never prescribed for this patient.

Supporting Definitions: (none)

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G. Procedure Information

Seq. #: 5156 **Name:** Transesophageal Echocardiogram (TEE) Performed

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

Target Value: The last value between 7 days prior to the start of the current procedure and start of procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5157 **Name:** Most Recent TEE Date

Coding Instructions: Indicate the date of the most recent transesophageal echocardiogram (TEE) performed and used to evaluate the patient for this intervention.

Target Value: The last value between 7 days prior to the start of the current procedure and start of procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5158 **Name:** Atrial Thrombus Detected

Coding Instructions: Indicate if an atrial thrombus was detected or suspected.

Target Value: The last value between 7 days prior to the start of the current procedure and start of procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5166 **Name:** LAA Orifice Maximal Width

Coding Instructions: Indicate the maximal orifice width of the left atrial appendage (LAA) in mm.

Target Value: The last value between 7 days prior to the start of the current procedure and start of procedure

Selections: (none)

Supporting Definitions: (none)

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G. Procedure Information

Seq. #: 7001 **Name:** Procedure Start Date

Coding Instructions: Indicate the date the procedure started.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7002 **Name:** Procedure Start Time

Coding Instructions: Indicate the procedure start time as the time that the patient entered the location in which the procedure is intended to be performed.

Note(s):

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

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7006 **Name:** Procedure Stop Date

Coding Instructions: Indicate the date the procedure stopped.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7007 **Name:** Procedure Stop Time

Coding Instructions: Indicate the procedure stop time as the time when the operator breaks scrub at the end of the procedure.

Note(s):

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

If more than one operator is involved in the case then use the time the last operator breaks scrub.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

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G. Procedure Information

Seq. #: 7030 **Name:** Procedure Location

Coding Instructions: Indicate the location within the hospital in which the procedure was performed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
OR	
Hybrid OR	
Cath Lab	
Hybrid Cath Lab	
EP Lab	

Supporting Definitions: (none)

Seq. #: 7035 **Name:** LAA Occlusion Indication

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

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Increased thromboembolic stroke risk	
History of major bleed	Defined as a history of any one of the following: 1. Hemoglobin drop of >=3 g/dL; 2. Transfusion of packed red blood cells; 3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding 4. Hospital admission with primary discharge diagnosis related to a bleeding event
High fall risk	A patient is at increased risk for falls if they have experienced any of the following: two or more falls in the prior 12 months; presents with an acute fall for this episode of care; or experiences difficultly walking or balancing.
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.
Patient preference	Shared decision making (SDM) is a collaborative process that allows patients and their health care providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's values and preferences. Select "Patient Preference" if other options for treatment were indicated and the patient chose to proceed with this approach.
Non-compliance with anticoagulation therapy	

Supporting Definitions: (none)

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G. Procedure Information

Seq. #: 7040 **Name:** Procedure Canceled

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

Note(s):

Once the patient is in the procedure room, if venous or epicardial access was attempted and no access was obtained in order to proceed with the LAAO intervention, the procedure will still be considered canceled.
After the point of obtaining either venous or epicardial access, a procedure that stops for any reason is considered 'aborted' for the purpose of the LAAO Registry and 'Procedure Canceled' would be coded as 'No'.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7041 **Name:** Procedure Canceled Reason

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

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Anatomy not conducive for implant	
Appendage too large (for device implant)	
Appendage too small (for device implant)	
Catheterization challenge	
Decompensation in patient condition	
Epicardial access issue	
Thrombus detected	
Unanticipated patient condition	
Patient/Family choice	

Supporting Definitions: (none)

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G. Procedure Information

Seq. #: 7100 **Name:** Operator Last Name

Coding Instructions: Indicate the last name of operator.

Note(s):

If the name exceeds 50 characters, enter the first 50 letters only.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7105 **Name:** Operator First Name

Coding Instructions: Indicate the first name of operator.

Note(s):

If the name exceeds 50 characters, enter the first 50 letters only.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7110 **Name:** Operator Middle Name

Coding Instructions: Indicate the middle name of operator.

Note(s):

If the name exceeds 50 characters, enter the first 50 letters only.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7115 **Name:** Operator NPI

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

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

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G. Procedure Information

Seq. #: 7130 **Name:** Sedation

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

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Minimal Sedation/Anxiolysis	
Moderate Sedation/Analgesia (Conscious Sedation)	
Deep Sedation/Analgesia	
General Anesthesia	

Supporting Definitions:

Minimal Sedation/Anxiolysis:

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.

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

Moderate Sedation/Analgesia (Conscious Sedation):

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.

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

Deep Sedation/Analgesia:

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.

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

General Anesthesia:

General Anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilator 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/standar ds/20.pdf

Seq. #: 7200 **Name:** Guidance Method

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

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

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G. Procedure Information

Seq. #: 7210 **Name:** Cumulative Air Kerma

Coding Instructions: 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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7211 **Name:** Cumulative Air Kerma Units

Coding Instructions: Indicate the unit reported for radiation dose (Cumulative Air Kerma, or Reference Air Kerma) recorded.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
mGy	
Gy	

Supporting Definitions: (none)

Seq. #: 7215 **Name:** Contrast Volume

Coding Instructions: Indicate the total procedure contrast volume in mL.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7220 **Name:** Dose Area Product

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

Note(s):

DAP (Gy-cm2): 1 - 700 (usual range)
DAP (dGy-cm2): 10 - 7000 (usual range)
DAP (cGy-cm2): 100 - 70000 (usual range)
DAP (mGy-cm2): 1000 - 700000 (usual range)
DAP (µGy-M2): 100 - 70000 (usual range)

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

Selections: (none)

Supporting Definitions:

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 xrays, 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.)

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G. Procedure Information

Seq. #: 7221 **Name:** Dose Area Product Units

Coding Instructions: Indicate the unit reported for radiation dose area product (Kerma area product).

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Gy-cm2	
dGy-cm2	
cGy-cm2	
mGy-cm2	
µGy-M2	

Supporting Definitions: (none)

Seq. #: 7225 **Name:** Intraprocedure Anticoagulation

Coding Instructions: Indicate if intraprocedure anticoagulation therapy was provided.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7230 **Name:** Uninterrupted Warfarin Therapy

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

Note(s):

"Continuous warfarin therapy" suggests the medication was not held for the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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G. Procedure Information

Seq. #: 7235 **Name:** Heparin Administered During Procedure

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

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7240 **Name:** Heparin Initial Administration Timing

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

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
Pre-transseptal Puncture	Code pre-transseptal if the first procedural heparin dose was administered prior to the transseptal puncture.
Post-transseptal Puncture	Code post-transseptal if the first procedural heparin dose was administered after the transseptal puncture.

Supporting Definitions: (none)

Seq. #: 7245 **Name:** Bivalirudin

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

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7250 **Name:** Other Anticoagulant

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

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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G. Procedure Information

Seq. #: 7265 **Name:** Anticoagulation Reversal

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

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7269 **Name:** Access System Counter

Coding Instructions: The access system counter distinguishes an individual access system when multiple are used during one procedure.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7270 **Name:** Access System ID

Coding Instructions: Indicate the access system(s) utilized during the current procedure.

Note(s):

Code all access systems used during the procedure.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7274 **Name:** Device Counter

Coding Instructions: The device counter distinguishes individual devices when multiple are used during one procedure.

Note(s):

The software-assigned device counter should start at one and be incremented by one for each device used.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

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G. Procedure Information

Seq. #: 7275 **Name:** Device ID

Coding Instructions: Indicate the device(s) utilized during the current procedure.

Note(s):

Code all devices used during the procedure.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7280 **Name:** Device UDI Direct Identifier

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

Target Value: N/A

Selections: (none)

Supporting Definitions: **Unique Device Identification (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: U.S. Food and Drug Administration Unique Device Identification - UDI
http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/UniqueDeviceIdentification/default.htm

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Seq. #: 7285 **Name:** LAA Isolation Approach

Coding Instructions: Indicate which approach was used to deliver the closure device.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Epicardial	Ligation via an epicardial approach, isolating the left atrial appendage (LAA) from circulation via inside the pericardial space.
Percutaneous	Occlusion of the left atrial appendage (LAA) using solely a percutaneous, catheter-based method.

Supporting Definitions: (none)

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G. Procedure Information

Seq. #: 7290 **Name:** Device Outcome

Coding Instructions: Indicate the outcome of the device listed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Deployed, released	The device was deployed and released in the intended location and no retrieval was indicated.
Deployed, not released	The device was deployed and not released from the delivery system.
Not Deployed	The device was advanced into the patient and was never deployed.
Device retrieved	The device was deployed and released and the device subsequently required retrieval due to placement issues.

Supporting Definitions: (none)

Seq. #: 7295 **Name:** Procedure Aborted

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

Note(s):

Aborted would imply that venous or epicardial access was obtained and then the procedure had to be stopped without a final device being deployed and released.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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G. Procedure Information

Seq. #: 7296 **Name:** Procedure Aborted Reason

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

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Anatomy not conducive for implant	
Appendage too large (for device implant)	
Appendage too small (for device implant)	
Catheterization challenge	
Decompensation in patient condition	
Device related	
Device retrieval	
Device release criteria not met	
Epicardial access issue	
Open heart device retrieval	
Thrombus developed during procedure	
Unanticipated patient condition	
Patient/Family choice	

Supporting Definitions: (none)

Seq. #: 7300 **Name:** Conversion to Open Heart Surgery

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

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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G. Procedure Information

Seq. #: 7301 **Name:** Conversion to Open Heart Surgery Reason

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

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Complication	
Device Retrieval	
Unfavorable anatomy	
Medical decision for open ligation of appendage	

Supporting Definitions: (none)

Seq. #: 7305 **Name:** Device Margin Residual Leak

Coding Instructions: Indicate the size (in mm) of the residual leak noted at the device margin.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7306 **Name:** Device Margin Residual Leak Not Assessed

Coding Instructions: Indicate if the device margin was not assessed for any potential residual leak.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7310 **Name:** Concomitant Procedures Performed

Coding Instructions: Indicate if other procedures (Afib Ablation, ICD, PCI, TAVR or TMVR) were performed during the same lab visit as this procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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G. Procedure Information

Seq. #: 7315 **Name:** Concomitant Procedures

Coding Instructions: Indicate which specific other procedures were performed during the same lab visit.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
AFib Ablation	
ICD	
PCI	
TAVR	
TMVR	

Supporting Definitions: (none)

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H. Intra or Post-Procedure Events

Seq. #: 9984 **Name:** Intra or Post Procedure Events Occurred

Coding Instructions: Indicate if any Intra or Post Procedure Events occurred from the NCDR provided list.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 9985 **Name:** Event ID

Coding Instructions: Indicate the NCDR assigned identification number for the patient's history of intra or post procedure events.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 9990 **Name:** Event Occurred

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

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 9995 **Name:** Event Date

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

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

Selections: (none)

Supporting Definitions: (none)

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I. Post-Procedure Labs

Seq. #: 8500 **Name:** Post Procedure Peak Creatinine

Coding Instructions: Indicate the post-procedure peak creatinine (Cr) level (mg/dL).

Target Value: The highest value between the end of the procedure and prior to the time of discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8501 **Name:** Post Procedure Peak Creatinine Not Drawn

Coding Instructions: Indicate if post-procedure peak creatinine level could not be assessed as either only one level or no creatinine labs were drawn.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8505 **Name:** Post Procedure Hemoglobin

Coding Instructions: Indicate the post-procedure hemoglobin (Hgb) value (g/dL).

Target Value: The lowest value between the end of the procedure and the time of discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8506 **Name:** Post Procedure Hemoglobin Not Drawn

Coding Instructions: Indicate if the post-procedure hemoglobin was not drawn.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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I. Post-Procedure Labs

Seq. #: 8510 **Name:** Post Procedure Creatinine

Coding Instructions: Indicate the post-procedure creatinine (Cr) level (mg/dL).

Target Value: The last value between the end of the procedure and the time of discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8511 **Name:** Post Procedure Creatinine Not Drawn

Coding Instructions: Indicate if the post-procedure creatinine level was not drawn.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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J. Discharge

Seq. #: 10000 **Name:** Surgery

Coding Instructions: Indicate if the patient had an inpatient operation during this episode of care.

Note(s):

Code "Yes" to "Surgery" if the inpatient operation meets all the these conditions:
1. It was performed in the OR;
2. It was performed by a surgeon;
3. The patient was under deep sedation or general anesthesia at the time of the operation. Code "No" for outpatient procedures, endoscopies or percutaneous interventions.

Target Value: The value on discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10001 **Name:** Percutaneous Coronary Interventions (Other)

Coding Instructions: Indicate if the patient had any other percutaneous coronary artery, coronary valvular or coronary structural interventions during this episode of care.

Target Value: The value on discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10100 **Name:** Discharge Date

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

Target Value: The value on discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10105 **Name:** Discharge Status

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

Target Value: The value on discharge

Selections:

Selection Text	*Definition*
Alive	
Deceased	

Supporting Definitions: (none)

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J. Discharge

Seq. #: 10110 **Name:** Discharge Location

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

Target Value: The value on discharge

Selections:

Selection Text	*Definition*
Home	Discharged to home or Self-care (routine discharge).
Extended care/TCU/Rehab	Discharged/transferred to an inpatient rehabilitation facility (IRF). Continued "non-acute" care at an extended care facility, transitional care unit, or rehabilitation unit.
Other acute care hospital	
Skilled nursing facility	Discharged/transferred to a skilled nursing facility.
Other	
Left against medical advice or discontinued care	The patient was discharged or eloped against medical advice.

Supporting Definitions: (none)

Seq. #: 10115 **Name:** Hospice Care

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

Target Value: The value on discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10120 **Name:** Death during the Procedure

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

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10125 **Name:** Cause of Death

Coding Instructions: 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

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Selections:

Selection Text	*Definition*
Acute myocardial infarction	Death by any cardiovascular mechanism (e.g., arrhythmia, sudden death, heart failure, stroke, pulmonary embolus, peripheral arterial disease) = 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.
Sudden cardiac death	Death that occurs unexpectedly, and not within 30 days of an acute MI.
Heart failure	Death associated with clinically worsening symptoms and/or signs of heart failure.
Stroke	Death after a stroke that is either a direct consequence of the stroke or a complication of the stroke.
Cardiovascular procedure	Death caused by the immediate complication(s) of a cardiovascular procedure.
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.
Other cardiovascular reason	Cardiovascular death not included in the above categories but with a specific, known cause (e.g., pulmonary embolism, peripheral arterial disease).
Pulmonary	Non-cardiovascular death attributable to disease of the lungs (excludes malignancy).
Renal	Non-cardiovascular death attributable to renal failure.
Gastrointestinal	Non-cardiovascular death attributable to disease of the esophagus, stomach, or intestines (excludes malignancy).
Hepatobiliary	Non-cardiovascular death attributable to disease of the liver, gall bladder, or biliary ducts (exclude malignancy).
Pancreatic	Non-cardiovascular death attributable to disease of the pancreas (excludes malignancy).
Infection	Non-cardiovascular death attributable to an infectious disease.
Inflammatory/Immunologic	Non-cardiovascular death attributable to an inflammatory or immunologic disease process.
Hemorrhage	Non-cardiovascular death attributable to bleeding that is not considered cardiovascular hemorrhage or stroke per this classification.
Non-cardiovascular procedure or surgery	Death caused by the immediate complication(s) of a non-cardiovascular procedure or surgery.
Trauma	Non-cardiovascular death attributable to trauma.
Suicide	Non-cardiovascular death attributable to suicide.
Neurological	Non-cardiovascular death attributable to disease of the nervous system (excludes malignancy).
Malignancy	Non-cardiovascular death attributable to malignancy.
Other non-cardiovascular reason	Non-cardiovascular death attributable to a cause other than those listed in this classification (specify organ system).

Supporting Definitions: (none)

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J. Discharge

Seq. #: 10200 **Name:** Discharge Medication Code

Coding Instructions: Indicate the NCDR assigned identification number associated with the medications the patient was prescribed upon discharge

Target Value: The value on discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10205 **Name:** Discharge Medication Prescribed

Coding Instructions: 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

Selections:

Selection Text	*Definition*
Yes - Prescribed	
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.
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.
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.

Supporting Definitions: (none)

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K. In-hospital Adjudication

Seq. #: 12000 **Name:** Adjudication Status

Coding Instructions: Indicate whether the patient was alive or deceased on the date the adjudication was performed.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
Alive	
Deceased	

Supporting Definitions: (none)

Seq. #: 12005 **Name:** Adjudication Date of Death

Coding Instructions: Indicate the date the patient was declared dead.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12010 **Name:** Symptom Onset Date

Coding Instructions: Indicate the date of symptom onset associated with this event.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12015 **Name:** Neurologic Deficit with Rapid Onset

Coding Instructions: Indicate if the patient had a sudden onset of a focal or global neurologic deficit regardless of the duration of symptoms.

Note(s):

At least one of the following symptoms might be present to code 'Yes' : change in level of consciousness, hemiplegia, hemiparesis, numbness or sensory loss affecting one side of the body, dysphasia or aphasia, hemianopia, amaurosis fugax.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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K. In-hospital Adjudication

Seq. #: 12020 **Name:** Neurologic Deficit Clinical Presentation

Coding Instructions: Indicate the clinical presentation of the neurologic deficit.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
Stroke-related	Neurologic deficits in the form of signs or symptoms associated with an acute episode of focal or neurological dysfunction caused by presumed brain, spinal cord, or retinal vascular injury as a result of ischemia, hemorrhage or infarction.
Non-Stroke-related	Neurologic deficits in the form of signs or symptoms due to non-stroke cause. Potential non stroke related causes include brain tumor, trauma, infection, hypoglycemia, peripheral lesion, pharmacological influence.

Supporting Definitions: (none)

Seq. #: 12025 **Name:** Diagnosis Confirmation by Neurology

Coding Instructions: Indicate if the diagnosis was confirmed by a neurologist or a neurosurgeon.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
No	'No' indicates that the diagnosis was not confirmed by either Neurology or Neurosurgery.
Yes	'Yes' indicates either Neurology or Neurosurgery confirmed the diagnosis.

Supporting Definitions: (none)

Seq. #: 12030 **Name:** Brain Imaging Performed

Coding Instructions: Indicate if neuro imaging (such as CT, MRI, cerebral angiography) was performed in an attempt to confirm the diagnosis.

Note(s):

The intent of asking 'Brain Imaging Performed' is to identify if the imaging tests were ordered and the patient underwent imaging in order for the working diagnosis to be confirmed or ruled out. This data element is not asking whether or not the imaging confirmed or ruled out the diagnosis.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
No	'No' indicates neuroimaging was not performed for this event.
Yes	'Yes' indicates neuroimaging was performed in an attempt to confirm the diagnosis.

Supporting Definitions: (none)

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K. In-hospital Adjudication

Seq. #: 12035 **Name:** Deficit Type

Coding Instructions: Indicate the type of deficit identified by the neuroimaging study.

Note(s):

In the event that multiple modes of imaging were performed for diagnosis, for the purpose of this adjudication code based on the type of deficit identified using the results that provided the final, confirmed diagnosis (if available).

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
No deficit	No deficit noted at the time of imaging.
Infarction	
Hemorrhage	
Both	

Supporting Definitions: (none)

Seq. #: 12040 **Name:** Intracranial Hemorrhage Type

Coding Instructions: For patients presenting with an intracranial hemorrhage, indicate the hemorrhage location.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
Intracerebral	Intracerebral hemorrhage (ICH) bleeding is usually derived from arterioles. The bleeding is directly into the brain, forming a localized hematoma that spreads along white matter pathways. Accumulation of blood occurs over minutes or hours and the neurologic symptoms usually increase gradually over minutes or a few hours.
Subarachnoid	Subarachnoid hemorrhage (SAH) occurs with the rupture of an aneurysm releasing blood directly into the cerebrospinal fluid (CSF) under arterial pressure. The blood spreads quickly within the CSF, rapidly increasing intracranial pressure. Death or deep coma ensues if the bleeding continues. The bleeding usually lasts only a few seconds but re-bleeding is very common. With causes of SAH other than aneurysm rupture, the bleeding is less abrupt and may continue over a longer period of time.
Subdural	Subdural hematomas form between the dura and the arachnoid membranes and often require surgical treatment to prevent irreversible brain injury and death caused by hematoma expansion, elevated intracranial pressure, and brain herniation.

Supporting Definitions: (none)

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K. In-hospital Adjudication

Seq. #: 12045 **Name:** Subsequent IV rtPA Administered

Coding Instructions: Indicate if intravascular (IV) recombinant tissue plasminogen activator (rtPA) was used as a treatment option related to this event.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12050 **Name:** Subsequent Endovascular Therapeutic Intervention

Coding Instructions: Indicate if an endovascular interventional therapy was performed as a treatment option related to this event.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12055 **Name:** Symptoms Duration

Coding Instructions: Indicate the duration (in hours) of the neurologic symptoms.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
< 1 Hour	
1 – 24 Hours	
> 24 Hours	

Supporting Definitions: (none)

Seq. #: 12060 **Name:** Trauma

Coding Instructions: Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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K. In-hospital Adjudication

Seq. #: 12065 **Name:** Modified Rankin Scale

Coding Instructions: Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the event.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
0: No symptoms at all	
1: No significant disability despite symptoms	Able to carry out all usual duties and activities
2: Slight disability	Unable to carry out all previous activities, but able to look after own affairs without assistance
3: Moderate disability	Requiring some help, but able to walk without assistance
4: Moderately severe disability	Unable to walk without assistance and unable to attend to own bodily needs without assistance
5: Severe disability	Bedridden, incontinent and requiring constant nursing care and attention
6: Death	

Supporting Definitions: (none)

Seq. #: 12066 **Name:** Adjudication Modified Rankin Scale Not Administered

Coding Instructions: Indicate if the modified Rankin Scale (mRS) was not administered following the event.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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K. In-hospital Adjudication

Seq. #: 12070 **Name:** Procedure Related Neurologic Event

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

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

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

Supporting Definitions:

Procedure Related Neurologic Event:

It is optimal to have the implanting physician or consulting neurologist/neurosurgeon complete this data element.

Source: Adapted from Olsson S (Ed). National Pharmacovigilance Systems. World Health Organization (WHO) Collaborating Centre for International Drug Monitoring, Uppsala, Sweden. 2nd ed 1999, ISBN 91-630-7678-0. Retrieved from http://apps.who.int/medicinedocs/en/d/Jh2934e/15.html

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K. In-hospital Adjudication

Seq. #: 12075 **Name:** Device Related Neurologic Event

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

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

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

Supporting Definitions: **Device Related Neurologic Event:**

It is optimal to have the implanting physician or consulting neurologist/neurosurgeon complete this data element.

Source: Adapted from Olsson S (Ed). National Pharmacovigilance Systems. World Health Organization (WHO) Collaborating Centre for International Drug Monitoring, Uppsala, Sweden. 2nd ed 1999, ISBN 91-630-7678-0. Retrieved from http://apps.who.int/medicinedocs/en/d/Jh2934e/15.html

Seq. #: 12080 **Name:** Adjudication Status

Coding Instructions: Indicate whether the patient was alive or deceased on the date the adjudication was performed.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
Alive	
Deceased	

Supporting Definitions: (none)

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K. In-hospital Adjudication

Seq. #: 12085 **Name:** Adjudication Date of Death

Coding Instructions: Indicate the date the patient was declared dead.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12090 **Name:** Invasive Intervention Required

Coding Instructions: Indicate if there was a surgical or percutaneous intervention required to treat the patient for this bleeding event.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12095 **Name:** RBC Transfusion

Coding Instructions: Indicate if there was at least one transfusion of PRBCs given to treat the patient for this bleeding event.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12100 **Name:** Number of RBC Units Transfused

Coding Instructions: Indicate the number of PRBC units transfused for treatment of this bleeding event.

Note(s):

Do not include autologous, cell-saver or chest tube recirculated blood.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections: (none)

Supporting Definitions: (none)

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K. In-hospital Adjudication

Seq. #: 12105 **Name:** Hemoglobin Pre-Transfusion

Coding Instructions: Indicate the patient's hemoglobin level immediately prior to the transfusion.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12110 **Name:** Diagnostic Imaging Performed

Coding Instructions: Indicate if imaging (such as CT, MRI) was performed in an attempt to confirm the diagnosis.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12115 **Name:** End Organ Damage

Coding Instructions: Indicate if the patient was diagnosed with end organ damage after this bleeding event.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12120 **Name:** Major Surgery within Past 30 days

Coding Instructions: Indicate if the patient underwent surgery within 30 days prior to this bleeding event.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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K. In-hospital Adjudication

Seq. #: 12125 **Name:** Percutaneous Coronary Intervention within Past 30 days

Coding Instructions: Indicate if the patient had a percutaneous coronary artery or percutaneous valvular intervention within 30 days prior to this bleeding event.

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12130 **Name:** Procedure Related Bleeding Event

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

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

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

Supporting Definitions: **Procedure Related Bleeding Event:**

It is optimal to have the implanting physician or consulting neurologist/neurosurgeon complete this data element.

Source: Adapted from Olsson S (Ed). National Pharmacovigilance Systems. World Health Organization (WHO) Collaborating Centre for International Drug Monitoring, Uppsala, Sweden. 2nd ed 1999, ISBN 91-630-7678-0. Retrieved from http://apps.who.int/medicinedocs/en/d/Jh2934e/15.html

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K. In-hospital Adjudication

Seq. #: 12135 **Name:** Device Related Bleeding Event

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

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
Certain	The clinical adverse event occurs in a plausible time relationship to the procedure and cannot be explained by concurrent disease or other drugs or devices.
Probable	The clinical adverse event occurs within a reasonable time sequence to the procedure and it is unlikely to be attributed to concurrent disease or other drugs or devices.
Possible	The clinical adverse event occurs within a reasonable time sequence to the procedure and it is unlikely to be attributed to concurrent disease or other drugs or devices.
Unlikely	The clinical adverse event, based upon its temporal relationship to the procedure, makes a causal relationship improbable. Additionally, other drugs, devices or underlying disease provide plausible explanations.
Unclassifiable	The clinical adverse event is reported yet more data is essential for a proper assessment OR the clinical adverse event is reported yet the causality cannot be judged because information is insufficient or contradictory, and cannot be supplemented or verified.

Supporting Definitions: **Device Related Bleeding Event:**

It is optimal to have the implanting physician or consulting neurologist/neurosurgeon complete this data element.

Source: Adapted from Olsson S (Ed). National Pharmacovigilance Systems. World Health Organization (WHO) Collaborating Centre for International Drug Monitoring, Uppsala, Sweden. 2nd ed 1999, ISBN 91-630-7678-0. Retrieved from http://apps.who.int/medicinedocs/en/d/Jh2934e/15.html

Seq. #: 12140 **Name:** Adjudication Medication Code

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

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections: (none)

Supporting Definitions: (none)

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K. In-hospital Adjudication

Seq. #: 12145 **Name:** Current Medications at Time of Event

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

Target Value: The value on the in-hospital event occurring between procedure start and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13000 **Name:** Follow-up Assessment Date

Coding Instructions: Indicate the date the follow-up assessment was performed.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 13005 **Name:** Follow-up Status Method - Office Visit

Coding Instructions: Indicate if the method to determine follow-up status was an office or clinic visit.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13006 **Name:** Follow-up Status Method - Medical Records

Coding Instructions: Indicate if the method to determine follow-up status was from medical records.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13007 **Name:** Follow-up Status Method - Letter from Medical Provider

Coding Instructions: Indicate if the method to determine follow-up status was from a letter from the medical provider.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13008 **Name:** Follow-up Status Method - Phone call

Coding Instructions: Indicate if the method to determine follow-up status was from a phone call.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13009 **Name:** Follow-up Status Method - Social Security Death Master File

Coding Instructions: Indicate if the method to determine follow-up status was from using Social Security Death Master file.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13010 **Name:** Follow-up Status Method - Hospitalized

Coding Instructions: Indicate if the method to determine follow-up status was that the patient was hospitalized.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13011 **Name:** Follow-up Status Method - Other

Coding Instructions: Indicate if the method to determine follow-up status was a means other than listed.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13015 **Name:** Follow-up Status

Coding Instructions: Indicate whether the patient was alive or deceased at the date the follow-up was performed.

Note(s):

If a follow up was unable to be performed, code “Lost to Follow-up”.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Alive	
Deceased	
Lost to Follow-up	

Supporting Definitions: (none)

Seq. #: 13020 **Name:** Follow-up Date of Death

Coding Instructions: Indicate the date the patient was declared deceased.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 13025 **Name:** Follow-up Cause of Death

Coding Instructions: Indicate the PRIMARY cause of death (i.e. the first significant event which ultimately led to death).

Target Value: The value on follow-up

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Selections:

Selection Text	*Definition*
Acute myocardial infarction	Death by any cardiovascular mechanism (e.g., arrhythmia, sudden death, heart failure, stroke, pulmonary embolus, peripheral arterial disease) = 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.
Sudden cardiac death	Death that occurs unexpectedly, and not within 30 days of an acute MI.
Heart failure	Death associated with clinically worsening symptoms and/or signs of heart failure.
Stroke	Death after a stroke that is either a direct consequence of the stroke or a complication of the stroke.
Cardiovascular procedure	Death caused by the immediate complication(s) of a cardiovascular procedure.
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.
Other cardiovascular reason	Cardiovascular death not included in the above categories but with a specific, known cause (e.g., pulmonary embolism, peripheral arterial disease).
Pulmonary	Non-cardiovascular death attributable to disease of the lungs (excludes malignancy).
Renal	Non-cardiovascular death attributable to renal failure.
Gastrointestinal	Non-cardiovascular death attributable to disease of the esophagus, stomach, or intestines (excludes malignancy).
Hepatobiliary	Non-cardiovascular death attributable to disease of the liver, gall bladder, or biliary ducts (exclude malignancy).
Pancreatic	Non-cardiovascular death attributable to disease of the pancreas (excludes malignancy).
Infection	Non-cardiovascular death attributable to an infectious disease.
Inflammatory/Immunologic	Non-cardiovascular death attributable to an inflammatory or immunologic disease process.
Hemorrhage	Non-cardiovascular death attributable to bleeding that is not considered cardiovascular hemorrhage or stroke per this classification.
Non-cardiovascular procedure or surgery	Death caused by the immediate complication(s) of a non-cardiovascular procedure or surgery.
Trauma	Non-cardiovascular death attributable to trauma.
Suicide	Non-cardiovascular death attributable to suicide.
Neurological	Non-cardiovascular death attributable to disease of the nervous system (excludes malignancy).
Malignancy	Non-cardiovascular death attributable to malignancy.
Other non-cardiovascular reason	Non-cardiovascular death attributable to a cause other than those listed in this classification (specify organ system).

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13030 **Name:** Follow-up LVEF Assessed

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

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13035 **Name:** Follow-up Most Recent LVEF %

Coding Instructions: Indicate the most recent left ventricular ejection fraction (LVEF) percentage (%).

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 13040 **Name:** Follow-up Transthoracic Echo (TTE) Performed

Coding Instructions: Indicate if a transthoracic echocardiogram (TTE) was performed.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13045 **Name:** Follow-up TTE Date

Coding Instructions: Indicate the date of the most recent transthoracic echo study performed.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13050 **Name:** Follow-up Transesophageal Echocardiogram (TEE) Performed

Coding Instructions: Indicate if transesophageal echocardiogram (TEE) was performed.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13055 **Name:** Follow-up Most Recent TEE Date

Coding Instructions: Indicate the date of the most recent transesophageal echocardiogram (TEE).

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 13060 **Name:** Follow-up Atrial Thrombus Detected

Coding Instructions: Indicate if an atrial thrombus was detected.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13065 **Name:** Follow-up Residual Leak at Device Margin

Coding Instructions: Indicate the residual leak at the device margin in millimeters (mm).

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13066 **Name:** Follow-up Residual Leak at Device Margin Not Assessed

Coding Instructions: Indicate if the residual leak at the device margin was not assessed.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13070 **Name:** Follow-up Creatinine

Coding Instructions: Indicate the most recent creatinine (Cr) level (mg/dL).

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 13071 **Name:** Follow-up Creatinine Not Drawn

Coding Instructions: Indicate if the creatinine level was not drawn.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13075 **Name:** Follow-up Hemoglobin

Coding Instructions: Indicate the most recent hemoglobin (Hgb) value (g/dL).

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13076 **Name:** Follow-up Hemoglobin Not Drawn

Coding Instructions: Indicate if the hemoglobin was not drawn.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13080 **Name:** Follow-up Modified Rankin Scale

Coding Instructions: Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered at follow-up.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
0: No symptoms at all	
1: No significant disability despite symptoms	Able to carry out all usual duties and activities
2: Slight disability	Unable to carry out all previous activities, but able to look after own affairs without assistance
3: Moderate disability	Requiring some help, but able to walk without assistance
4: Moderately severe disability	Unable to walk without assistance and unable to attend to own bodily needs without assistance
5: Severe disability	Bedridden, incontinent and requiring constant nursing care and attention
6: Death	

Supporting Definitions: (none)

Seq. #: 13081 **Name:** Follow-up Modified Rankin Scale Not Administered

Coding Instructions: Indicate if the modified Rankin Scale (mRS) was not administered at follow-up.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13085 **Name:** Follow-up Barthel Index Evaluation

Coding Instructions: Indicate if the Barthel Index Evaluation was performed. The Barthel Index (BI) or Barthel ADL index is a scale used to measure performance in basic activities of daily living (ADL).

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13086 **Name:** Follow-up Barthel Index Evaluation Feeding

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

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Unable	Complete assist for feeding required.
Needs Help	Some help is necessary (with cutting up food, use salt and pepper, spread butter, etc).
Independent	The patient can feed themselves a meal from a tray or table when someone puts the food within reach. They must be able to cut up the food, use salt and pepper, spread butter, etc. The patient must accomplish this in a reasonable time.

Supporting Definitions:

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

Seq. #: 13087 **Name:** Follow-up Barthel Index Evaluation Bathing

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

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Dependent	Patient requires assistance for bathing.
Independent	Patient may use a bath tub, a shower, or take a complete sponge bath. They must be able to do all the steps involved in whichever method is employed without another person being present.

Supporting Definitions:

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

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L. Follow-up

Seq. #: 13088 **Name:** Follow-up Barthel Index Evaluation Grooming

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

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Needs Help	Patient needs assistance with any aspect of grooming.
Independent	Patient can wash hands and face, comb hair, clean teeth, and shave. They may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style hair.

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

Seq. #: 13089 **Name:** Follow-up Barthel Index Evaluation Dressing

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

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Dependent	Patient is unable to assist with any dressing.
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the work themselves. They must accomplish this in a reasonable time. Women need not be scored on use of a brassiere or girdle unless these are prescribed garments.
Independent	Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.

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

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L. Follow-up

Seq. #: 13090 **Name:** Follow-up Barthel Index Evaluation Bowels

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

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Incontinent	Patient has routine incontinence.
Inconsistent	Patient needs help in using a suppository or taking an enema or has occasional accidents.
Continent	Patient is able to control bowels and has no accidents. They can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).

Supporting Definitions:

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

Seq. #: 13091 **Name:** Follow-up Barthel Index Evaluation Bladder

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

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Incontinent	Patient has routine incontinence.
Inconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.
Continent	Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.

Supporting Definitions:

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

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L. Follow-up

Seq. #: 13092 **Name:** Follow-up Barthel Index Evaluation Toilet Use

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

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Dependent	Patient requires full assistance.
Needs Help	Patient needs help because of imbalance or in handling clothes or in using toilet paper.
Independent	Patient is able to get on and off toilet, fasten and unfasten clothes, prevent soiling of clothes, and use toilet paper without help. They may use a wall bar or other stable object for support if needed. If it is necessary to use a bed pan instead of a toilet, they must be able to place it on a chair, empty it, and clean it.

Supporting Definitions:

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

Seq. #: 13093 **Name:** Follow-up Barthel Index Evaluation Transfers

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

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Unable	Patient is unable to assist with any transfer.
Major Assist Needed	Patient can come to a sitting position without the help of a second person but needs to be lifted out of bed, or if they transfer with a great deal of help.
Minor Assist Needed	Either some minimal help is needed in some step of this activity or the patient needs to be reminded or supervised for safety of one or more parts of this activity.
Independent	Independent in all phases of this activity. Patient can safely approach the bed in his wheelchair, lock brakes, lift footrests, move safely to bed, lie down, come to a sitting position on the side of the bed, change the position of the wheelchair, if necessary, to transfer back into it safely, and return to the wheelchair.

Supporting Definitions:

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

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L. Follow-up

Seq. #: 13094 **Name:** Follow-up Barthel Index Evaluation Mobility

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

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Immobile	Patient is immobile.
Wheelchair	If a patient cannot ambulate but can propel a wheelchair independently. They must be able to go around corners, turn around, maneuver the chair to a table, bed, toilet, etc. They must be able to push a chair at least 50 yards. Do not score this item if the patient gets score for walking.
One Person Assist	Patient needs help or supervision in any of the above but can walk at least 50 yards with a little help.
Independent	Patient can walk at least 50 yards without help or supervision. They may wear braces or prostheses and use crutches, canes, or a walkerette but not a rolling walker. They must be able to lock and unlock braces if used, assume the standing position and sit down, get the necessary mechanical aides into position for use, and dispose of them when he sits. (Putting on and taking off braces is scored under dressing.)

Supporting Definitions:

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

Seq. #: 13095 **Name:** Follow-up Barthel Index Evaluation Stairs

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

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Unable	Patient is unable to use stairs.
Needs Help	Patient needs help with or supervision to go up or down stairs safely.
Independent	Patient is able to go up and down a flight of stairs safely without help or supervision. They may and should use handrails, canes, or crutches when needed. They must be able to carry canes or crutches as they ascend or descend stairs.

Supporting Definitions:

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

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L. Follow-up

Seq. #: 13110 **Name:** Follow-up Medication Code

Coding Instructions: Indicate the NCDR assigned identification number for the medications the patient was taking at the time of follow-up.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 13115 **Name:** Follow-up Current Medications at Time of Follow-up

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

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Yes	Code ‘Yes’ if the patient was taking the medication at the time of follow-up.
No (No Reason)	Code ‘No – No Reason’ if the patient was not taking the medication at the time of follow-up and there was no mention of a reason why it was not ordered within the medical documentation.
No (Medical Reason)	Code ‘No – Medical Reason’ if the patient was not taking the medication at the time of follow-up because they were not prescribed the medication for a reason documented to be related to a medical issue or medical concern.
No (Patient Reason)	Code ‘No – Patient Reason’ if the patient was not taking the medication at the time of the follow-up because of a reason documented to be related to the patient’s preference.

Supporting Definitions: (none)

Seq. #: 13120 **Name:** Follow-up Warfarin Discontinued

Coding Instructions: Indicate if the patient discontinued Warfarin at any time since the last follow-up (or since discharge if this is the 45-day follow-up).

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	Code 'No' if the patient did not discontinue Warfarin at any point since the last follow-up. The medication was either continued or it was not part of the patient’s medical regimen.
Yes	Code 'Yes' if the patient was taking Warfarin at the last follow-up and stopped taking it at any point since then.

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13125 **Name:** Follow-up Warfarin Discontinued Date

Coding Instructions: Indicate the date the Warfarin was discontinued.

Note(s):

The value should be a date between the time of the previous follow-up (or at hospital discharge if this is the 45-day follow-up) and the current follow-up.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 13130 **Name:** Follow-up Warfarin Resumed

Coding Instructions: Indicate if the patient resumed Warfarin at any time since the last follow-up (or since discharge if this is the 45-day follow-up).

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	Code 'No' if the patient did not resume taking Warfarin at any point since the last follow-up, the medication had been previously discontinued or the medication was not part of the patient's medical regimen.
Yes (Thrombotic Event)	Code 'Yes (Thrombotic Event)' if the Warfarin had at one point been discontinued AND then was prescribed again at any point since the last follow-up, specifically for the treatment of a thrombotic event.
Yes (Other)	Code 'Yes (Other)' if the Warfarin had at one point been discontinued AND then was prescribed again at any point since the last follow-up, for an indication other than a thrombotic event.

Supporting Definitions: (none)

Seq. #: 13135 **Name:** Follow-up Warfarin Resumed Date

Coding Instructions: Indicate the date the Warfarin was resumed.

Note(s):

The value should be a date between the time of the previous follow-up (or at hospital discharge if this is the 45-day follow-up) and the current follow-up.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13140 **Name:** Follow-up NOAC Therapy Discontinued

Coding Instructions: Indicate if the patient discontinued Novel Oral Anticoagulant Therapy at any time since the last follow-up (or since discharge if this is the 45-day follow-up).

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	Code 'No' if the patient did not discontinue Novel Oral Anticoagulant Therapy at any point since the last follow-up. The medication was either continued or it was not part of the patient's medication regimen.
Yes	Code 'Yes' if the patient was taking Novel Oral Anticoagulant Therapy at the last follow-up and stopped taking it at any point since then.

Supporting Definitions: (none)

Seq. #: 13145 **Name:** Follow-up NOAC Therapy Discontinued Date

Coding Instructions: Indicate the date the NOAC was discontinued.

Note(s):

The value should be a date between the time of the previous follow-up (or at hospital discharge if this is the 45-day follow-up) and the current follow-up.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 13150 **Name:** Follow-up NOAC Therapy Resumed

Coding Instructions: Indicate if the patient resumed Novel Oral Anticoagulant Therapy at any time since the last follow-up (or since discharge if this is the 45-day follow-up).

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	Code 'No' if the patient did not resume or initiate taking NOAC Therapy at any point since the last follow-up. The medication had been previously discontinued or the medication was not part of the patient's medical regimen.
Yes (Thrombotic Event)	Code 'Yes (Thrombotic Event)' if the NOAC Therapy had at one point been discontinued AND then was prescribed again at any point since the last follow-up, specifically for the treatment of a thrombotic event.
Yes (Other)	Code 'Yes (Other)' if the NOAC Therapy had one point been discontinued AND then was prescribed again at any point since the last follow-up, for an indication other than a thrombotic event.

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13155 **Name:** Follow-up NOAC Therapy Resumed Date

Coding Instructions: Indicate the date the NOAC was resumed.

Note(s):

The value should be a date between the time of the previous follow-up (or at hospital discharge if this is the 45-day follow-up) and the current follow-up.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 13160 **Name:** Follow-up Events Occurred

Coding Instructions: Indicate if any event from the NCDR-provided list had occurred between the time of the last follow-up (or discharge if this is the 45-day follow-up) and the current follow-up.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13165 **Name:** Follow-up Event ID

Coding Instructions: Indicate the NCDR assigned IDs for any events that occurred between the time of the last follow-up (or discharge if this is the 45-day follow-up) and the current follow-up.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 13170 **Name:** Follow-up Event Occurred

Coding Instructions: Indicate if the specific event occurred between the time of the last follow-up (or discharge if this is the 45-day follow-up) and the current follow-up.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13175 **Name:** Follow-up Event Date

Coding Instructions: Indicate all dates of events that occurred between the time of the last follow-up (or discharge if this is the 45-day follow-up) and the current follow-up.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 13180 **Name:** Follow-up Adjudication Status

Coding Instructions: Indicate whether the patient was alive or deceased on the date the adjudication was performed.

Target Value: The value on the follow-up event

Selections:

Selection Text	*Definition*
Alive	
Deceased	

Supporting Definitions: (none)

Seq. #: 13185 **Name:** Follow-up Adjudication Date of Death

Coding Instructions: Indicate the date the patient was declared dead.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 13190 **Name:** Follow-up Symptom Onset Date

Coding Instructions: Indicate the date of symptom onset associated with this event.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13195 **Name:** Follow-up Neurologic Deficit with Rapid Onset

Coding Instructions: Indicate if the patient had a sudden onset of a focal or global neurologic deficit regardless of the duration of symptoms.

Note(s):

At least one of the following symptoms might be present to code 'Yes': change in level of consciousness, hemiplegia, hemiparesis, numbness or sensory loss affecting one side of the body, dysphasia or aphasia, hemianopia, amaurosis fugax.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13200 **Name:** Follow-up Neurologic Deficit Clinical Presentation

Coding Instructions: Indicate the clinical presentation of the neurologic deficit.

Target Value: N/A

Selections:

Selection Text	*Definition*
Stroke-related	Neurologic deficits in the form of signs or symptoms associated with an acute episode of focal or neurological dysfunction caused by presumed brain, spinal cord, or retinal vascular injury as a result of ischemia, hemorrhage or infarction.
Non-Stroke-related	Neurologic deficits in the form of signs or symptoms due to non-stroke cause. Potential non stroke related causes include brain tumor, trauma, infection, hypoglycemia, peripheral lesion, pharmacological influence.

Supporting Definitions: (none)

Seq. #: 13205 **Name:** Follow-up Confirmation of Diagnosis by Neurology

Coding Instructions: Indicate if the diagnosis was confirmed by a neurologist or a neurosurgeon.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	'No' indicates that the diagnosis was not confirmed by either Neurology or Neurosurgery.
Yes	'Yes' indicates either Neurology or Neurosurgery confirmed the diagnosis.

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13210 **Name:** Follow-up Brain Imaging Performed

Coding Instructions: Indicate if neuro imaging (such as CT, MRI, cerebral angiography) was performed in an attempt to confirm the diagnosis.

Note(s):

The intent of asking 'Brain Imaging Performed' is to identify if the imaging tests were ordered and the patient underwent imaging in order for the working diagnosis to be confirmed or ruled out.
This data element is not asking whether or not the imaging confirmed or ruled out the diagnosis.
'No' indicates neuro imaging was not performed for this event.
'Yes' indicates neuro imaging was performed in an attempt to confirm the diagnosis.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13215 **Name:** Follow-up Deficit Type

Coding Instructions: Indicate the type of deficit identified by the neuroimaging study.

Note(s):

In the event that multiple modes of imaging were performed for diagnosis, for the purpose of this adjudication code based on the type of deficit identified using the results that provided the final, confirmed diagnosis (if available).

Target Value: N/A

Selections:

Selection Text	*Definition*
No deficit	
Infarction	
Hemorrhage	
Both	

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13220 **Name:** Follow-up Intracranial Hemorrhage Type

Coding Instructions: For patients presenting with an intracranial hemorrhage, indicate the hemorrhage location.

Target Value: N/A

Selections:

Selection Text	*Definition*
Intracerebral	Intracerebral hemorrhage (ICH) bleeding is usually derived from arterioles. The bleeding is directly into the brain, forming a localized hematoma that spreads along white matter pathways. Accumulation of blood occurs over minutes or hours and the neurologic symptoms usually increase gradually over minutes or a few hours.
Subarachnoid	SAH occurs with the rupture of an aneurysm releasing blood directly into the cerebrospinal fluid (CSF) under arterial pressure. The blood spreads quickly within the CSF, rapidly increasing intracranial pressure. Death or deep coma ensues if the bleeding continues. The bleeding usually lasts only a few seconds but rebleeding is very common. With causes of SAH other than aneurysm rupture, the bleeding is less abrupt and may continue over a longer period of time.
Subdural	Subdural hematomas form between the dura and the arachnoid membranes and often require surgical treatment to prevent irreversible brain injury and death caused by hematoma expansion, elevated intracranial pressure, and brain herniation.

Supporting Definitions: (none)

Seq. #: 13225 **Name:** Follow-up Subsequent IV rtPA Administered

Coding Instructions: Indicate if intravascular (IV) recombinant tissue Plasminogen Activator (rtPA) was used as a treatment option related to this event.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13230 **Name:** Follow-up Subsequent Endovascular Therapeutic Intervention

Coding Instructions: Indicate if an endovascular interventional therapy was performed as treatment option related to this event.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13235 **Name:** Follow-up Symptoms Duration

Coding Instructions: Indicate the duration (in hours) of the neurologic symptoms.

Target Value: N/A

Selections:

Selection Text	*Definition*
< 1 Hour	
1 – 24 Hours	
> 24 Hours	

Supporting Definitions: (none)

Seq. #: 13240 **Name:** Follow-up Trauma

Coding Instructions: Indicate if the patient experienced a traumatic event within 24 hours prior the neurologic event.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13245 **Name:** Follow-up Modified Rankin Scale

Coding Instructions: Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the event.

Target Value: N/A

Selections:

Selection Text	*Definition*
0: No symptoms at all	
1: No significant disability despite symptoms	Able to carry out all usual duties and activities
2: Slight disability	Unable to carry out all previous activities, but able to look after own affairs without assistance
3: Moderate disability	Requiring some help, but able to walk without assistance
4: Moderately severe disability	Unable to walk without assistance and unable to attend to own bodily needs without assistance
5: Severe disability	Bedridden, incontinent and requiring constant nursing care and attention
6: Death	

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13246 **Name:** Follow-up Adjudication Modified Rankin Scale Not Administered

Coding Instructions: Indicate if the modified Rankin Scale (mRS) was not administered following the event.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13250 **Name:** Follow-up Procedure Related Neurologic Event

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

Target Value: N/A

Selections:

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

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13255 **Name:** Follow-up Device Related Neurologic Event

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

Target Value: N/A

Selections:

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

Supporting Definitions: (none)

Seq. #: 13260 **Name:** Follow-up Adjudication Status

Coding Instructions: Indicate whether the patient was alive or deceased on the date the adjudication was performed.

Target Value: N/A

Selections:

Selection Text	*Definition*
Alive	
Deceased	

Supporting Definitions: (none)

Seq. #: 13265 **Name:** Follow-up Adjudication Date of Death

Coding Instructions: Indicate the date the patient was declared dead.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13270 **Name:** Follow-up Invasive Intervention Required

Coding Instructions: Indicate if there was a surgical or percutaneous intervention was required to treat the patient for this bleeding event.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13275 **Name:** Follow-up RBC Transfusion

Coding Instructions: Indicate if there was at least one transfusion of PRBCs given to treat the patient for this bleeding event.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13280 **Name:** Follow-up Number of RBC Units Transfused

Coding Instructions: Indicate the number of PRBC units transfused for treatment of this bleeding event.

Note(s):

Do not include autologous, cell-saver or chest tube recirculated blood.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 13285 **Name:** Follow-up Hemoglobin Pre-Transfusion

Coding Instructions: Indicate the patient's hemoglobin level immediately prior to the transfusion.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13290 **Name:** Follow-up Diagnostic Imaging Performed

Coding Instructions: Indicate if imaging (such as CT, MRI) was performed in an attempt to confirm the diagnosis.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13295 **Name:** Follow-up End Organ Damage

Coding Instructions: Indicate if the patient was diagnosed with end organ damage after this bleeding event.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13300 **Name:** Follow-up Bleeding Event Readmission

Coding Instructions: Indicate if a readmission was associated with a bleeding related diagnosis.

Note(s):

This data element "Follow-up Bleeding Event Readmission" is not relevant for patients who have an event during the index episode of care. Code "No" if this bleeding event occurred during the index episode of care before the patient was discharged.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	'No' in this case implies either, the event occurred prior to discharge and thus this data element is not relevant or a readmission did occur and it was not bleeding related.
Yes	'Yes' implies this patient experienced a bleeding event and subsequent hospitalization that was related to bleeding.

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13305 **Name:** Follow-up Major Surgery within Past 30 days

Coding Instructions: Indicate if the patient underwent surgery within 30 days prior to this bleeding event.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 13310 **Name:** Follow-up Percutaneous Coronary Intervention within Past 30 days

Coding Instructions: Indicate if the patient had a percutaneous coronary artery or valvular intervention within 30 days prior to the bleeding event date.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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L. Follow-up

Seq. #: 13315 **Name:** Follow-up Procedure Related Bleeding Event

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

Target Value: N/A

Selections:

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

Supporting Definitions:

Procedure Related Bleeding Event:

It is optimal to have the implanting physician or consulting neurologist/neurosurgeon complete this data element.

Source: Adapted from Olsson S (Ed). National Pharmacovigilance Systems. World Health Organization (WHO) Collaborating Centre for International Drug Monitoring, Uppsala, Sweden. 2nd ed 1999, ISBN 91-630-7678-0. Retrieved from http://apps.who.int/medicinedocs/en/d/Jh2934e/15.html

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L. Follow-up

Seq. #: 13320 **Name:** Follow-up Device Related Bleeding Event

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

Target Value: N/A

Selections:

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

Supporting Definitions: **Device Related Bleeding Event:**

It is optimal to have the implanting physician or consulting neurologist/neurosurgeon complete this data element.

Source: Adapted from Olsson S (Ed). National Pharmacovigilance Systems. World Health Organization (WHO) Collaborating Centre for International Drug Monitoring, Uppsala, Sweden. 2nd ed 1999, ISBN 91-630-7678-0. Retrieved from http://apps.who.int/medicinedocs/en/d/Jh2934e/15.html

Seq. #: 13325 **Name:** Follow-up Adjudication Medication Code

Coding Instructions: Indicate the NCDR assigned identification number associated with the medications the patient was taking at the time of the event.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

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Z. Administration

Seq. #: 13330 **Name:** Follow-up Current Medications at Time of Event

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

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 1000 **Name:** Participant ID

Coding Instructions: Indicate the participant ID of the submitting facility.

Target Value: N/A

Selections: (none)

Supporting Definitions:

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

Seq. #: 1010 **Name:** Participant Name

Coding Instructions: 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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1020 **Name:** Time Frame of Data Submission

Coding Instructions: Indicate the time frame of data included in the data submission. Format: YYYYQQ. e.g.,2016Q1

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

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Z. Administration

Seq. #: 1040 **Name:** Transmission Number

Coding Instructions: 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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1050 **Name:** Vendor Identifier

Coding Instructions: 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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1060 **Name:** Vendor Software Version

Coding Instructions: 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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1070 **Name:** Registry Identifier

Coding Instructions: 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

Selections: (none)

Supporting Definitions: (none)

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Z. Administration

Seq. #: 1080 **Name:** Registry Version

Coding Instructions: Registry version describes the version number of the Data Specifications/Dictionary, to which each record conforms. It identifies which fields should have data, and what are the valid data for each field. It is the version implemented in the software at the time the data is collected and the records are created. This is entered into the schema automatically by software.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1085 **Name:** Submission Type

Coding Instructions: Indicate if the data contained in the harvest/data file contains either standard patient episode of care records (arrival date to discharge only) or if it contains patient follow-up records. A transmission file with all episode of care records (from Arrival to Discharge only) is considered a "Base Registry Record". A file with patient follow-up records (any follow-up assessments performed during the quarter selected) is considered a "Follow-Up Record".

Note(s):

'Selecting Follow-Up Records Only' will transmit all patient records with Follow-up Assessment Dates (Seq Num 10000) contained in the selected timeframe, regardless of the procedure or discharge date.

For example, if a patient has a procedure on 3/30/2016, is discharged on 3/31/2016, and has a follow-up assessment on 5/6/2016, the patient's episode of care data will be transmitted in the 2016Q1 Base Registry Record file, but the Follow-up data will be transmitted in the 2016Q2 Follow-Up File.

Target Value: N/A

Selections:

Selection Text	*Definition*
Episode of Care Records Only	Contains all patient and episode of care records with eligible procedures with a Discharge Date (Seq Num 9000) in the selected time-frame. An Episode of Care is defined as a patient's admission/arrival to the facility performing the procedure(s), including any symptoms or medical history prior to arrival, ending at discharge or death.
Follow-up Records Only	Contains all patient records with at least one Follow-up Assessment performed (Seq Num 12000) in the selected time-frame.

Supporting Definitions: (none)

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