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 patient's middle initial.

If the patient does not have a middle name, leave the field blank.

If the patient has multiple middle names, enter all of the middle names sequentially.

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)

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 the patient.

Note(s):

Once assigned to a patient at the participating facility, this number must 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 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)

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 or 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

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 or 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 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: **Native Hawaiian:**

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

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

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 - 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: **Asian - Indian:**

Having origins in any of the original peoples of India.

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

---

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: **Asian - Chinese:**

Having origins in any of the original peoples of China.

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

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: **Asian - Filipino:**

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

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

---

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: **Asian - Japanese:**

Having origins in any of the original peoples of Japan.

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

---

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: **Asian - Korean:**

Having origins in any of the original peoples of Korea.

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

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: **Asian - Vietnamese:**

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

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

---

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: **Asian - Other Asian:**

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

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

---

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

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

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

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

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

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

---

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

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

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

---

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

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

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

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.

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 Ethnicity - Mexican/Mexican American/Chicano:**

Having origins in any of the original peoples of Mexico.

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

---

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: **Hispanic Ethnicity - Puerto Rican:**

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

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

---

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: **Hispanic Ethnicity - Cuban:**

Having origins in any of the original peoples of Cuba.

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

A. Demographics

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

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

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

Seq. #: 2500 **Name:** Auxiliary 1

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2501 **Name:** Auxiliary 2

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

B. Episode of Care

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. #: 3001 **Name:** Arrival Time

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

Note(s):

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

If the patient came to your facility for an elective or outpatient procedure and the time was not documented, code the scheduled time of arrival.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3005 **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'.

The Patient Zip Code will display in the Demographics Section of the data collection form however the coding instructions will remain in the Episode of Care Section in the data dictionary.

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3006 **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)

B. Episode of Care

Seq. #: 3010 **Name:** Admit Source

Coding Instructions: Indicate the source of admission for the patient to your facility.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
Emergency department	The patient came to the facility for this episode of care via the emergency department (excludes transfers from other facilities).
Transfer in from another acute care facility	The patient was transferred from another acute care facility (even if he/she was transferred to the emergency department) for this episode of care.
Elective	The patient came to the facility for an elective procedure.
Other	The patient came to this facility for this episode of care by any other means. This includes transfers from non-acute care facilities.

Supporting Definitions: (none)

Seq. #: 3020 **Name:** Insurance Payors - Private Health Insurance

Coding Instructions: Indicate if the patient's insurance payor(s) included private health insurance.

Note(s):

A health maintenance organization (HMO) is considered private health insurance.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

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.

Source: U.S. Census Bureau

Seq. #: 3021 **Name:** Insurance Payors - Medicare

Coding Instructions: Indicate if the patient's insurance payor(s) included Medicare.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

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.

Source: U.S. Census Bureau

Seq. #: 3022 **Name:** Insurance Payors - Medicaid

Coding Instructions: Indicate if the patient's insurance payor(s) included Medicaid.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

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.

Source: U.S. Census Bureau

Seq. #: 3023 **Name:** Insurance Payors - Military Health Care

Coding Instructions: Indicate if the patient's insurance payor(s) included Military Health Care.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

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).

Source: U.S. Census Bureau

Seq. #: 3024 **Name:** Insurance Payors - State-Specific Plan

Coding Instructions: Indicate if the patient's insurance payor(s) included State-specific Plan.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

State Specific Plan:

State-specific plan - 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. (Non-Medicaid)

Source: U.S. Census Bureau

B. Episode of Care

Seq. #: 3025 **Name:** Insurance Payors - Indian Health Service

Coding Instructions: Indicate if the patient's insurance payor(s) included Indian Health Service (IHS).

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

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.

Source: U.S. Census Bureau

Seq. #: 3026 **Name:** Insurance Payors - Non-US Insurance

Coding Instructions: Indicate if the patient's insurance payor(s) included Non-US Insurance.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Non-US Insurance:

Non-U.S. Insurance refers to individuals with a payor that does not originate in the United States.

Source: U.S. Census Bureau

Seq. #: 3027 **Name:** Insurance Payors - None

Coding Instructions: Indicate if the patient has no insurance payor(s).

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

None:

None refers to individuals with no or limited health insurance thus, the individual is the payor regardless of ability to pay.

Source: NCDR

B. Episode of Care

Seq. #: 3030 **Name:** Health Insurance Claim Number

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 (HIC):**

The Health Insurance Claim (HIC) number is the unique identifier issued to all Medicare eligible beneficiaries by the Social Security Administration (SSA). The Railroad Retirement Board (RRB) can also assign HIC to those receiving RRB benefits.

Source: Center for Medicare and Medicaid Services

Seq. #: 3035 **Name:** Patient Enrolled in Research Study

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

Note(s):

Code 'Yes' for those patients enrolled in a research study of any kind.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 3036 **Name:** Research Study Name

Coding Instructions: Indicate the research study name as provided by the research study protocol.

Note(s):

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3037 **Name:** Research Study Patient ID

Coding Instructions: Indicate the research study patient identification number as assigned by the research protocol.

Note(s):

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3040 **Name:** Auxiliary 3

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3045 **Name:** Auxiliary 4

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

C. History

Seq. #: 4000 **Name:** Hypertension

Coding Instructions: Indicate if the patient has a history of hypertension diagnosed and/or treated by a physician.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Hypertension:

Hypertension is defined by any one of the following:
1. History of hypertension diagnosed and treated with medication, diet and/or exercise
2. Prior documentation of blood pressure greater than 140 mm Hg systolic and/or 90 mm Hg diastolic for patients without diabetes or chronic kidney disease, or prior documentation of blood pressure greater than 130 mm Hg systolic and/or 80 mm Hg diastolic on at least two occasions for patients with diabetes or chronic kidney disease
3. Currently on pharmacologic therapy for treatment of hypertension.

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

Seq. #: 4005 **Name:** Dyslipidemia

Coding Instructions: Indicate if the patient has a history of dyslipidemia diagnosed and/or treated by a physician.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Dyslipidemia:

National Cholesterol Education Program criteria include documentation of the following:
1. Total cholesterol greater than 200 mg/dL (5.18 mmol/l); or
2. Low-density lipoprotein (LDL) greater than or equal to 130 mg/dL (3.37 mmol/l); or,
3. High-density lipoprotein (HDL) less than 40 mg/dL (1.04 mmol/l).

For patients with known coronary artery disease, treatment is initiated if LDL is greater than 100 mg/dL (2.59 mmol/l), and this would qualify as hypercholesterolemia

Source: National Heart, Lung and Blood Institute, National Cholesterol Education Program

C. History

Seq. #: 4010 **Name:** Diabetes Mellitus

Coding Instructions: Indicate if the patient has a history of diabetes mellitus regardless of duration of disease or need for anti-diabetic agents.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Diabetes Mellitus:

The American Diabetes Association criteria include documentation of the following:
1. A1c >=6.5%; or
2. Fasting plasma glucose >=126 mg/dl (7.0 mmol/l); or
3. Two-hour plasma glucose >=200 mg/dl (11.1 mmol/l) during an oral glucose tolerance test; or
4. In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose >=200 mg/dl (11.1 mmol/l)

This does not include gestational diabetes.

Source: American Diabetes Association Care. 2011;34 Suppl 1:S4-10., Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 -30), The Society of Thoracic Surgeons

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Seq. #: 4015 **Name:** Diabetes Therapy - None

Coding Instructions: Indicate if the patient with a diagnosis of diabetes is not receiving treatment.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4016 **Name:** Diabetes Therapy - Diet

Coding Instructions: Indicate if the patient with a diagnosis of diabetes is being treated with diet therapy.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

C. History

Seq. #: 4017 **Name:** Diabetes Therapy - Oral

Coding Instructions: Indicate if the patient with a diagnosis of diabetes is being treated with oral therapy.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4018 **Name:** Diabetes Therapy - Insulin

Coding Instructions: Indicate if the patient with a diagnosis of diabetes is being treated with insulin therapy.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4019 **Name:** Diabetes Therapy - Other

Coding Instructions: Indicate if the patient with a diagnosis of diabetes is being treated with a therapy which is not specified.

Note(s):

This can include other subcutaneous medications such as a GLP-1 agonist or other adjunctive treatment.

If a patient had a pancreatic transplant, code "other", since the insulin from the new pancreas is not exogenous insulin.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

C. History

Seq. #: 4020 **Name:** ESRD on Dialysis

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

Note(s):

If a patient is on receiving continuous veno-venous hemofiltration (CVVH) as a result of renal failure (and not as treatment to remove fluid for heart failure), code 'Yes'.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Chronic Kidney Disease:**

Chronic kidney disease is defined as either kidney damage or GFR less than 60 ml/min/1.73 m2 for greater than or equal to 3 months. Kidney damage is defined as pathologic abnormalities or markers of damage, including abnormalities in blood or urine tests or imaging studies:
* Stage 0-No known kidney disease
* Stage 1-Kidney damage with normal or high-GFR greater than or equal to 90 ml/min/1.73 m2
* Stage 2-Kidney damage with mildly decreased-GFR 60 to 89 ml/min/1.73 m2
* Stage 3-Moderately decreased-GFR 30 to 59 ml/min/1.73 m2
* Stage 4-Severely decreased-GFR 15 to 29 ml/min/1.73 m2
* Stage 5-Kidney failure-GFR less than 15 ml/min/1.73 m2 or on dialysis

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

Seq. #: 4025 **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 arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Coronary Artery Disease:**

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

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

C. History

Seq. #: 4030 **Name:** Left Main Coronary Artery Stenosis >= 50%

Coding Instructions: Indicate if the patient has a history of Left Main Coronary Artery stenosis greater than or equal to 50%.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4035 **Name:** 2-3 Vessel (LAD, LCX, RCA) Stenosis >= 70%

Coding Instructions: Indicate if the patient has a history of two or more major coronary arteries (LAD, LCX, or RCA) stenosis greater than or equal to 70%.

Note(s):

Excludes Left Main disease.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Major Coronary Arteries:

Major Coronary Arteries are defined as Left Anterior Descending (LAD), Left Circumflex Artery (LCX) and Right Coronary Artery (RCA). This does not include collaterals.

Source: NCDR

Seq. #: 4040 **Name:** Cerebrovascular Disease

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

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Cerebrovascular Disease:

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

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

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

C. History

Seq. #: 4041 **Name:** Cerebrovascular Disease - Stroke

Coding Instructions: Indicate if the patient has a history of cerebrovascular disease and has experienced a stroke.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Stroke:

A stroke is 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: Standardized Definitions for Cardiovascular Endpoints in Clinical Trials (FDA Draft)

Seq. #: 4042 **Name:** Cerebrovascular Disease - TIA

Coding Instructions: Indicate if the patient has a history of cerebrovascular disease and has experienced a transient ischemic attack (TIA).

Note(s):

A symptom of CVD TIA could be displayed by transient monocular blindness, an episode of total or partial loss of vision in one eye, caused by ischemia of the eye and lasting several minutes or longer. The term is sometimes used synonymously with amaurosis fugax and sometimes to designate an episode of longer duration. Also called transient monocular visual loss.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Transient ischemic attack (TIA):

Transient ischemic attack (TIA) is defined as a transient episode of focal neurological dysfunction caused by brain, spinal cord, or retinal ischemia, without acute infarction. The symptoms typically last less than 24 hours.

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

Seq. #: 4043 **Name:** Cerebrovascular Disease - Carotid Stent

Coding Instructions: Indicate if the patient has a history of cerebrovascular disease and has had a carotid stent.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

C. History

Seq. #: 4044 **Name:** Cerebrovascular Disease - Carotid Endarterectomy

Coding Instructions: indicate if the patient has a history of cerebrovascular disease and has had a carotid endarterectomy.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4045 **Name:** Cerebrovascular Disease - Other

Coding Instructions: Indicate if the patient has a history of cerebrovascular disease and has had other conditions/procedures not listed.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4050 **Name:** Peripheral Arterial Disease

Coding Instructions: Indicate if the patient has a history of peripheral arterial disease.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Peripheral Arterial Disease:

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

* Claudication on exertion
* Amputation for arterial vascular insufficiency
* Vascular reconstruction, bypass surgery, or percutaneous revascularization in the arteries of the extremities
* Positive noninvasive test (e.g., ankle brachial index <= 0.9, ultrasound, MR or CT imaging of >50% diameter stenosis in any peripheral artery (i.e., subclavian, femoral, iliac) or angiographic imaging)

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

C. History

Seq. #: 4051 **Name:** Peripheral Arterial Disease - Claudication

Coding Instructions: Indicate if the patient with PAD has a history of claudication.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Claudication:

Claudication is defined by reproducible, exertional, discomfort characterized by cramping, aching, fatigue of the buttock, hip, thigh, calf or foot that resolves within ten minutes of rest.

Source: Adapted from: 2012 ACCF/AHA/ACR/SCAI/SIR/STS/SVM/SVN/SVS Key Data Elements and Definitions for Peripheral Atherosclerotic Vascular Disease. (JACC Vol. 59, No. 3, 2012)

Seq. #: 4052 **Name:** Peripheral Arterial Disease - Critical Limb Ischemia

Coding Instructions: Indicate if the patient with PAD has a history of critical limb ischemia.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Critical Limb Ischemia:

Critical limb ischemia includes ischemic rest pain, ulceration, or gangrene. This results in tissue loss and may or may not lead to amputation.

Source: NCDR

Seq. #: 4053 **Name:** Peripheral Arterial Disease - Acute Limb Ischemia

Coding Instructions: Indicate if the patient with PAD has a history of acute limb ischemia.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Acute Limb Ischemia:

Acute limb ischemia is defined by a sudden onset of pain or paresthesia of the buttock, hip, thigh, calf or foot.

Source: Adapted from: 2012 ACCF/AHA/ACR/SCAI/SIR/STS/SVM/SVN/SVS Key Data Elements and Definitions for Peripheral Atherosclerotic Vascular Disease. (JACC Vol. 59, No. 3, 2012)

Seq. #: 4054 **Name:** Peripheral Arterial Disease Type - Peripheral Intervention

Coding Instructions: Indicate if the patient with PAD has a history of peripheral catheter-based interventions performed.

Note(s):

Peripheral catheter based intervention, balloon angioplasty, stenting, atherectomy for example.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4055 **Name:** Peripheral Arterial Disease - Peripheral Bypass

Coding Instructions: Indicate if the patient with PAD has a history of peripheral bypass surgery.

Note(s):

Peripheral artery bypass is surgery to reroute the blood supply around a blocked artery in one of your legs.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4056 **Name:** Peripheral Arterial Disease - Other

Coding Instructions: Indicate if the patient with PAD has a history of any other type of peripheral arterial disease, other than claudication, CLI, ALI, peripheral bypass, or peripheral intervention.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

C. History

Seq. #: 4060 **Name:** Severe/Very Severe Lung Disease

Coding Instructions: Indicate if the patient has a history of severe or very severe lung disease.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Severe/Very Severe Lung Disease:

Severe and Very Severe Lung Disease is determined by:
1. Home O2 therapy
2. COPD (GOLD) criteria: FEV1 <50% predicted (with FEV1/FVC <0.70)
3. ILD criteria: DLCO <40%

Source: NCDR

Seq. #: 4065 **Name:** Prior Myocardial Infarction

Coding Instructions: Indicate if the patient has had at least one documented previous myocardial infarction.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Prior Myocardial Infarction:

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: Expert Consensus Document: Third Universal Definition of Myocardial Infarction J Am Coll Cardiol. October 16, 2012,60(16):1581-1598 doi:10.1016/j.jacc.2012.08.001

Seq. #: 4070 **Name:** Prior MI within 30 days

Coding Instructions: Indicate if the patient had an MI within the past 30 days.

Target Value: The last value between 30 days before arrival and arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

C. History

Seq. #: 4075 **Name:** Cardiomyopathy or LV Systolic Dysfunction

Coding Instructions: Indicate if the patient has a history of cardiomyopathy or left ventricular systolic dysfunction.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

LVSD:

LVSD is defined as chart documentation of LVEF less than 40% or a narrative description of left ventricular systolic (LVS) function consistent with moderate or severe systolic dysfunction.

Source: ACC/AHA Clinical Performance Measures for Adults With Chronic Heart Failure. JACC. 2005;46;1144-1178

Seq. #: 4080 **Name:** Prior Heart Failure

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

Note(s):

A previous hospital admission with principal diagnosis of heart failure is considered evidence of heart failure history.

Killip Class 2 is defined as rales covering 50% or less of the lung fields or the presence of an S3. Killip Class 3 is defined as rales covering more than 50% of the lung fields. Either class would qualify as a history of heart failure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Heart Failure:

Heart failure is defined as physician documentation or a report of any of the following clinical symptoms of heart failure described as unusual dyspnea on light exertion, recurrent dyspnea occurring in the supine position, fluid retention, or the description of rales, jugular venous distention, pulmonary edema on physical examination, or pulmonary edema on chest x-ray presumed to be cardiac dysfunction.

A low ejection fraction alone, without clinical evidence of heart failure, does not qualify as heart failure.

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

Seq. #: 4085 **Name:** Atrial Fibrillation/Flutter

Coding Instructions: Indicate if the patient has a history of atrial fibrillation and/or atrial flutter.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

C. History

Seq. #: 4090 **Name:** Prior PCI

Coding Instructions: Indicate if the patient had a previous percutaneous coronary intervention.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **PCI:**

Percutaneous coronary intervention (PCI) is the placement of an angioplasty guide wire, balloon, or other device (e.g. stent, atherectomy, brachytherapy, or thrombectomy catheter) into a native coronary artery or coronary artery bypass graft for the purpose of mechanical coronary revascularization.

Source: NCDR

Seq. #: 4095 **Name:** Prior CABG

Coding Instructions: Indicate if the patient had a previous coronary artery bypass graft (CABG) surgery.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4100 **Name:** Prior Valve Surgery/Procedure

Coding Instructions: Indicate if the patient had a previous surgical replacement and/or repair of a cardiac valve, by any approach.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

C. History

Seq. #: 4105 **Name:** Tobacco Use (< 2 years)

Coding Instructions: Indicate the current or previous use of any tobacco product, including cigarettes, cigars, pipes, and chewing tobacco, within the past two years.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
Never	
Former	Tobacco use prior to the most recent 24 months, without use within the most recent 24 months.
Current - Every Day	Tobacco use within the most recent 24 months - on a daily basis.
Current - Some Days	Tobacco use within the most recent 24 months, but on a less than daily basis.
Current - Frequency Unknown	Tobacco use within the most recent 24 months - frequency of use is unknown.

Supporting Definitions:

Tobacco Use:

Current or previous use of any tobacco product, including cigarettes, cigars, pipes, and chewing tobacco.

Also see CMS Meaningful Use (29)

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

Seq. #: 4110 **Name:** Family History of Premature CAD

Coding Instructions: Indicate if the patient has a family history of premature coronary artery disease.

Note(s):

If the patient is adopted, or the family history is unavailable, code "No".

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Family History of Premature CAD:

Family history includes any direct blood relatives (parents, siblings, children) who have had any of the following diagnosed at age less than 55 years for male relatives or less than 65 years for female relatives:
* Coronary artery disease (i.e., angina, previous CABG or PCI)
* MI
* Sudden cardiac death without obvious cause

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

C. History

Seq. #: 4115 **Name:** Height

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

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 4120 **Name:** Weight

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

Note(s):

The preferred weight reported for this admission would be the weight documented in the patient's medical record.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 4125 **Name:** Previous Neck Radiation

Coding Instructions: Indicate if the patient had previous radiation therapy to the neck.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4130 **Name:** Neck Surgery (other than CEA)

Coding Instructions: Indicate if the patient has a previous extensive (i.e. radical) neck surgery other than carotid endarterectomy.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

C. History

Seq. #: 4135 **Name:** Tracheostomy Present

Coding Instructions: Indicate if the patient has an open tracheostomy.

Note(s):

If a patient has had a Tracheostomy in the past and it is now closed, answer "No" to Tracheostomy present.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4140 **Name:** Laryngeal Nerve Palsy

Coding Instructions: Indicate if the patient has a history of laryngeal nerve palsy and if present, the affected side.

Target Value: Any occurrence on arrival at this facility

Selections:

Selection Text	*Definition*
No	No Laryngeal Nerve Palsy.
Yes - Right	Laryngeal Nerve Palsy located on right side of the neck.
Yes - Left	Laryngeal Nerve Palsy located on the left side of the neck.
Yes - Bilateral	Laryngeal Nerve Palsy located on both sides of the neck.

Supporting Definitions:

Laryngeal Nerve Palsy:

Laryngeal nerve palsy is defined as paralysis of the larynx caused by damage to the recurrent laryngeal nerve or its parent nerve, the vagus nerve.

Source: NCDR

Seq. #: 4145 **Name:** Previous Carotid Revascularization

Coding Instructions: Indicate if the patient had a previous carotid endarterectomy or carotid artery angioplasty or carotid stent procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

C. History

Seq. #: 4150 **Name:** Prior Carotid Artery Stent (Right)

Coding Instructions: Indicate if the patient had a prior stent placed in the right carotid artery.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4155 **Name:** Prior Carotid Artery Stent Date (Right)

Coding Instructions: Indicate the date the patient had a previous stent placed in the right carotid artery.

Note(s):

If month or day are unknown enter 01. The year of the interventions is required.

If there was more than one procedure (i.e. more than one carotid artery stent procedure on the right carotid artery), code the most recent.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 4160 **Name:** Prior Carotid Artery Endarterectomy (Right)

Coding Instructions: Indicate if the patient had a previous carotid artery endarterectomy in the right side.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4165 **Name:** Prior Carotid Artery Endarterectomy Date (Right)

Coding Instructions: Indicate the date the patient had a previous carotid artery endarterectomy in the right side.

Note(s):

If month or day are unknown enter 01. The year of the surgery is required.

If there was more than one procedure (i.e. more than one carotid artery stent procedure on the right carotid artery), code the most recent.

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

Selections: (none)

Supporting Definitions: (none)

C. History

Seq. #: 4170 **Name:** Prior Carotid Artery Stent (Left)

Coding Instructions: Indicate if the patient had a prior stent placed in the left carotid artery.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4175 **Name:** Prior Carotid Artery Stent Date (Left)

Coding Instructions: Indicate the date the patient had a previous stent placed in the left carotid artery.

Note(s):

If month or day are unknown enter 01. The year of the intervention is required.

If there was more than one procedure (i.e. more than one carotid artery stent procedure on the right carotid artery), code the most recent.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 4180 **Name:** Prior Carotid Artery Endarterectomy (Left)

Coding Instructions: Indicate if the patient had a previous carotid artery endarterectomy in the left side.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4185 **Name:** Prior Carotid Artery Endarterectomy Date (Left)

Coding Instructions: Indicate the date the patient had a previous carotid artery endarterectomy on the left side.

Note(s):

If month or day are unknown enter 01. The year of the surgery is required.

If there was more than one procedure (i.e. more than one carotid artery stent procedure on the right carotid artery), code the most recent.

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

Selections: (none)

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5000 **Name:** Peripheral Arterial Disease Presentation (Right)

Coding Instructions: Indicate the patient's peripheral arterial disease (PAD) presentation of the right limb at the time of the procedure.

Note(s):

Complete for the target vessel limb(s) affected, and report the most severe symptom of PAD leading to this procedure. If PAD symptoms are present in the non-treatment limb, provide information if available.

Target Value: The highest value on current procedure

Selections:

Selection Text	*Definition*
Asymptomatic	The patient has no symptoms of claudication, no symptoms of ischemic pain, and no limitation in walking distance.
Atypical Claudication	Exertional limb discomfort which occurs at variable distances, and does not resolve with stopping and standing.
Claudication - Mild (Rutherford 1)	Rutherford 1 is determined by the presence of discomfort that is: -Exertional -Reproducible -Resolves within 10 min of rest
Claudication - Moderate (Rutherford 2)	Indicate claudication as determined by the discomfort that is: -Exertional -Reproducible -Resolves within 20 min of rest
Claudication - Severe (Rutherford 3)	Indicate claudication as determined by the discomfort that is: -Exertional -Reproducible -Resolves within 30 min of rest
Critical Limb Ischemia - Ischemic Pain at Rest (Rutherford 4)	Ischemic pain at rest
Critical Limb Ischemia - Minor Tissue Loss (Rutherford 5)	Minor tissue loss
Critical Limb Ischemia - Major Tissue Loss (Rutherford 6)	Major tissue loss
Acute Limb Ischemia	Acute limb ischemia is characterized by: - Pallor - Pulselessness - Poikilothermia - Paralysis

Supporting Definitions:

D. Presentation and Evaluation

Acute Limb Ischemia:

Acute limb ischemia is characterized by pallor, pulselessness, poikilothermia and /or paralysis.

Source: Adapted from: 2012 ACCF/AHA/ACR/SCAI/SIR/STS/SVM/SVN/SVS Key Data Elements and Definitions for Peripheral Atherosclerotic Vascular Disease. (JACC Vol. 59, No. 3, 2012)

Critical Limb Ischemia:

Critical limb ischemia includes ischemic rest pain, ulceration, or gangrene. This results in tissue loss and may or may not lead to amputation.

Source: Adapted from: 2012 ACCF/AHA/ACR/SCAI/SIR/STS/SVM/SVN/SVS Key Data Elements and Definitions for Peripheral Atherosclerotic Vascular Disease. (JACC Vol. 59, No. 3, 2012)

Claudication:

Claudication is defined by reproducible, exertional, discomfort characterized by cramping, aching, fatique of the buttock, hip, thigh, calf or foot that resolves within ten to thirty minutes of rest.

Source: Adapted from: 2012 ACCF/AHA/ACR/SCAI/SIR/STS/SVM/SVN/SVS Key Data Elements and Definitions for Peripheral Atherosclerotic Vascular Disease. (JACC Vol. 59, No. 3, 2012)

Seq. #: 5005 **Name:** Patient Reported Maximum Claudication Distance (Right)

Coding Instructions: Indicate the patient reported maximum distance at which the pain becomes so severe in the right leg that the patient is forced to stop walking.

Note(s):

If the patient has claudication (Rutherford 1, 2, or 3) in both limbs, code the same claudication distance selection for both limbs.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
<200m	
>=200m (2 blocks)	
Unable to Walk	

Supporting Definitions: (none)

Seq. #: 5010 **Name:** Claudication Location - Buttock (Right)

Coding Instructions: Indicate if there is claudication in the right buttock.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5011 **Name:** Claudication Location - Hip (Right)

Coding Instructions: Indicate if there is claudication in the right hip.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5012 **Name:** Claudication Location - Thigh (Right)

Coding Instructions: Indicate if there is claudication in the right thigh.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5013 **Name:** Claudication Location - Calf (Right)

Coding Instructions: Indicate if there is claudication in the right calf.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5014 **Name:** Claudication Location - Foot (Right)

Coding Instructions: Indicate if there is claudication in the right foot.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5015 **Name:** Claudication Location - Other (Right)

Coding Instructions: Indicate if there is claudication in the right leg which is in another location not listed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5020 **Name:** Critical Limb Ischemia Rest Pain (Right)

Coding Instructions: Indicate if the patient with critical limb ischemia is experiencing rest pain in the right limb.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	
Unknown	

Supporting Definitions: (none)

Seq. #: 5025 **Name:** Critical Limb Ischemia Tissue Loss Location - Shin (Right)

Coding Instructions: Indicate if the patient with critical limb ischemia has tissue loss involving the right shin.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5026 **Name:** Critical Limb Ischemia Tissue Loss Location - Malleolus (Right)

Coding Instructions: Indicate if the patient with critical limb ischemia has tissue loss involving the right malleolus.

Note(s):

Malleolus: bony prominence on each side of the ankle

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5027 **Name:** Critical Limb Ischemia Tissue Loss Location - Heel (Right)

Coding Instructions: Indicate if the patient with critical limb ischemia has tissue loss involving the right heel.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5028 **Name:** Critical Limb Ischemia Tissue Loss Location - Midfoot (Right)

Coding Instructions: Indicate if the patient with critical limb ischemia has tissue loss involving the right midfoot.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5029 **Name:** Critical Limb Ischemia Tissue Loss Location - Forefoot (Right)

Coding Instructions: Indicate if the patient with critical limb ischemia has tissue loss involving the right forefoot.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5030 **Name:** Critical Limb Ischemia Tissue Loss Location - Toes (Right)

Coding Instructions: Indicate if the patient with critical limb ischemia has tissue loss involving the right toes.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5031 **Name:** Critical Limb Ischemia Tissue Loss Location - Other (Right)

Coding Instructions: Indicate if the patient with critical limb ischemia has tissue loss involving the right limb in any other location not listed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5035 **Name:** Acute Limb Ischemia Symptom Onset Date (Right)

Coding Instructions: Indicate the date the patient began experiencing acute right limb ischemic symptoms.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5040 **Name:** Acute Limb Ischemia Location - Thigh (Right)

Coding Instructions: Indicate if the patient with acute limb ischemia is experiencing symptoms in the right thigh.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5041 **Name:** Acute Limb Ischemia Location - Calf (Right)

Coding Instructions: Indicate if the patient with acute limb ischemia is experiencing symptoms in the right calf.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5042 **Name:** Acute Limb Ischemia Location - Ankle (Right)

Coding Instructions: Indicate if the patient with acute limb ischemia is experiencing symptoms in the right ankle.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5043 **Name:** Acute Limb Ischemia Location - Foot (Right)

Coding Instructions: Indicate if the patient with acute limb ischemia is experiencing symptoms in the right foot.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5044 **Name:** Acute Limb Ischemia Location - Toes (Right)

Coding Instructions: Indicate if the patient with acute limb ischemia is experiencing symptoms in the right toes.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5045 **Name:** Acute Limb Ischemia Location - Other (Right)

Coding Instructions: Indicate if the patient with acute limb ischemia is experiencing symptoms in other location not listed in the right limb.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5050 **Name:** Acute Limb Ischemia Motor Symptoms (Right)

Coding Instructions: Indicate if the patient with acute limb ischemia is experiencing motor symptoms in the right limb.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5051 **Name:** Acute Limb Ischemia Sensory Symptoms (Right)

Coding Instructions: Indicate if the patient with acute limb ischemia is experiencing sensory symptoms in the right limb.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5055 **Name:** Acute Limb Ischemia Suspected Occluded Vessel (Right)

Coding Instructions: Indicate the suspected occluded vessel for the patient with acute right limb ischemia.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Aorta	
Iliac	
Femoral	
Popliteal	
Tibioperoneal	
Unknown	

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5060 **Name:** Acute Limb Ischemia Suspected Occluded Vessel Type (Right)

Coding Instructions: Indicate the suspected occluded vessel type for the patient having acute right limb ischemia.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Native Only	
Graft Only	
Both	
Uncertain	

Supporting Definitions: (none)

Seq. #: 5065 **Name:** Acute Limb Ischemia Limb Viability (Right)

Coding Instructions: Indicate the viability of the affected right limb for the patient having acute limb ischemia.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Viable (I)	No immediate threat of tissue loss.
Marginally Threatened (IIa)	Continuous pain is absent, minimal sensory symptoms involving toes only, no motor symptoms, inaudible arterial signal in the presence of venous signal
Immediately Threatened (IIb)	Persistent ischemic rest pain, sensory symptoms extending above the level of the toes, any motor symptoms, inaudible arterial signal, audible venous signal
Non-viable (III)	Limb cannot be salvaged and has to be amputated, no emergency to operate.

Supporting Definitions: (none)

Seq. #: 5070 **Name:** Aneurysm (Right)

Coding Instructions: Indicate if the patient has an aneurysm below the aortic bifurcation in the right lower extremity.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Aneurysm:**

Dilatation of an artery having at least 50% increased diameter compared to the expected normal artery

Source: NCDR

D. Presentation and Evaluation

Seq. #: 5075 **Name:** Aneurysm Presenting Symptoms - Asymptomatic (Right)

Coding Instructions: Indicate if the patient has an asymptomatic aneurysm in the right limb.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5076 **Name:** Aneurysm Presenting Symptoms - Rest Pain (Right)

Coding Instructions: Indicate if rest pain is a symptom of the aneurysm in the right limb.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5077 **Name:** Aneurysm Presenting Symptoms - Claudication (Right)

Coding Instructions: Indicate if claudication is a symptom of the aneurysm in the right limb.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Claudication:**

Claudication is defined by reproducible, exertional, discomfort characterized by cramping, aching, fatique of the buttock, hip, thigh, calf or foot that resolves with in ten minutes of rest.

Source: Adapted from: 2012 ACCF/AHA/ACR/SCAI/SIR/STS/SVM/SVN/SVS Key Data Elements and Definitions for Peripheral Atherosclerotic Vascular Disease. (JACC Vol. 59, No. 3, 2012)

Seq. #: 5078 **Name:** Aneurysm Presenting Symptoms - Venous Obstruction (Right)

Coding Instructions: Indicate if venous obstruction is a symptom of the aneurysm in the right limb.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5079 **Name:** Aneurysm Presenting Symptoms - Other (Right)

Coding Instructions: Indicate if the patient has other symptoms of the aneurysm in the right limb that are not listed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5080 **Name:** Symptomatic Etiology of Symptoms - Thrombosis (Right)

Coding Instructions: Indicate if the symptoms of the aneurysm in the right limb are a result of thrombosis.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5081 **Name:** Symptomatic Etiology of Symptoms - Embolization (Right)

Coding Instructions: Indicate if the symptoms of the aneurysm in the right limb are a result of embolization.

Note(s):

The process by which a blood vessel or organ is obstructed by an embolus or other mass.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5082 **Name:** Symptomatic Etiology of Symptoms - Rupture (Right)

Coding Instructions: Indicate if the symptoms of the aneurysm in the right limb are a result of rupture.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5083 **Name:** Symptomatic Etiology of Symptoms - Other (Right)

Coding Instructions: Indicate if the symptoms of the aneurysm in the right limb are a result of other symptom not listed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5085 **Name:** Aneurysm Location - Common Iliac (Right)

Coding Instructions: Indicate if the symptoms of the aneurysm in the right limb is located in common iliac artery.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5086 **Name:** Aneurysm Location - External Iliac (Right)

Coding Instructions: Indicate if the symptoms of the aneurysm in the right limb is located in external iliac artery.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5087 **Name:** Aneurysm Location - Internal Iliac (Right)

Coding Instructions: Indicate if the symptoms of the aneurysm in the right limb is located in internal iliac artery.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5088 **Name:** Aneurysm Location - Common Femoral (Right)

Coding Instructions: Indicate if the symptoms of the aneurysm in the right limb is located in common femoral artery.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5089 **Name:** Aneurysm Location - Profunda (Right)

Coding Instructions: Indicate if the symptoms of the aneurysm in the right limb is located in profunda artery.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5090 **Name:** Aneurysm Location - Popliteal (Right)

Coding Instructions: Indicate if the location of the aneurysm is the right popliteal artery.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5100 **Name:** Peripheral Arterial Disease Presentation (Left)

Coding Instructions: Indicate the patient's peripheral arterial disease (PAD) presentation of the left limb at the time of the procedure.

Note(s):

Please complete for the target vessel limb(s) affected, and report the most severe symptom of PAD leading to this procedure. If PAD symptoms are present in the non-treatment limb, provide information if available.

Target Value: The highest value on current procedure

Selections:

Selection Text	*Definition*
Asymptomatic	The patient has no symptoms of claudication, no symptoms of ischemic pain, and no limitation in walking distance.
Atypical Claudication	Exertional limb discomfort which occurs at variable distances, and does not resolve with stopping and standing.
Claudication - Mild (Rutherford 1)	Rutherford 1 is determined by the presence of discomfort that is: -Exertional -Reproducible -Resolves within 10 min of rest
Claudication - Moderate (Rutherford 2)	Indicate claudication as determined by the discomfort that is: -Exertional -Reproducible -Resolves within 20 min of rest
Claudication - Severe (Rutherford 3)	Indicate claudication as determined by the discomfort that is: -Exertional -Reproducible -Resolves within 30 min of rest
Critical Limb Ischemia - Ischemic Pain at Rest (Rutherford 4)	Ischemic pain at rest
Critical Limb Ischemia - Minor Tissue Loss (Rutherford 5)	Minor tissue loss
Critical Limb Ischemia - Major Tissue Loss (Rutherford 6)	Major tissue loss
Acute Limb Ischemia	Acute limb ischemia is characterized by: - Pallor - Pulselessness - Poikilothermia - Paralysis

Supporting Definitions:

Acute Limb Ischemia:

Acute limb ischemia is characterized by pallor, pulselessness, poikilothermia and /or paralysis.

Source: Adapted from: 2012 ACCF/AHA/ACR/SCAI/SIR/STS/SVM/SVN/SVS Key Data Elements and Definitions for Peripheral Atherosclerotic Vascular Disease. (JACC Vol. 59, No. 3, 2012)

Critical Limb Ischemia:

Critical limb ischemia includes ischemic rest pain, ulceration, or gangrene. This results in tissue loss and may or may not lead to amputation.

Source: Adapted from: 2012 ACCF/AHA/ACR/SCAI/SIR/STS/SVM/SVN/SVS Key Data Elements and Definitions for Peripheral Atherosclerotic Vascular Disease. (JACC Vol. 59, No. 3, 2012)

Claudication:

Claudication is defined by reproducible, exertional, discomfort characterized by cramping, aching, fatique of the buttock, hip, thigh, calf or foot that resolves within ten to thirty minutes of rest.

Source: Adapted from: 2012 ACCF/AHA/ACR/SCAI/SIR/STS/SVM/SVN/SVS Key Data Elements and Definitions for Peripheral Atherosclerotic Vascular Disease. (JACC Vol. 59, No. 3, 2012)

D. Presentation and Evaluation

Seq. #: 5105 **Name:** Patient Reported Maximum Claudication Distance (Left)

Coding Instructions: Indicate the patient reported maximum distance at which the pain becomes so severe in the left leg that the patient is forced to stop walking.

Note(s):

If the patient has claudication (Rutherford 1, 2, or 3) in both limbs, code the same claudication distance selection for both limbs.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
<200m	
>=200m (2 blocks)	
Unable to Walk	

Supporting Definitions: (none)

Seq. #: 5110 **Name:** Claudication Location - Buttock (Left)

Coding Instructions: Indicate if there is claudication in the left buttock.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5111 **Name:** Claudication Location - Hip (Left)

Coding Instructions: Indicate if there is claudication in the left hip.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5112 **Name:** Claudication Location - Thigh (Left)

Coding Instructions: Indicate if there is claudication in the left thigh.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5113 **Name:** Claudication Location - Calf (Left)

Coding Instructions: Indicate if there is claudication in the left calf.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5114 **Name:** Claudication Location - Foot (Left)

Coding Instructions: Indicate if there is claudication in the left foot.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5115 **Name:** Claudication Location - Other (Left)

Coding Instructions: Indicate if there is claudication in the left leg which is in another location not listed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5120 **Name:** Critical Limb Ischemia Rest Pain (Left)

Coding Instructions: Indicate if the patient with critical limb ischemia is experiencing rest pain in the left limb.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	
Unknown	

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5125 **Name:** Critical Limb Ischemia Tissue Loss Location - Shin (Left)

Coding Instructions: Indicate if the patient with critical limb ischemia has tissue loss involving the left shin.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5126 **Name:** Critical Limb Ischemia Tissue Loss Location - Malleolus (Left)

Coding Instructions: Indicate if the patient with critical limb ischemia has tissue loss involving the left malleolus.

Note(s):

Malleolus: bony prominence on each side of the ankle

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5127 **Name:** Critical Limb Ischemia Tissue Loss Location - Heel (Left)

Coding Instructions: Indicate if the patient with critical limb ischemia has tissue loss involving the left heel.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5128 **Name:** Critical Limb Ischemia Tissue Loss Location - Midfoot (Left)

Coding Instructions: Indicate if the patient with critical limb ischemia has tissue loss involving the left midfoot.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5129 **Name:** Critical Limb Ischemia Tissue Loss Location - Forefoot (Left)

Coding Instructions: Indicate if the patient with critical limb ischemia has tissue loss involving the left forefoot.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5130 **Name:** Critical Limb Ischemia Tissue Loss Location - Toes (Left)

Coding Instructions: Indicate if the patient with critical limb ischemia has tissue loss involving the left toes.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5131 **Name:** Critical Limb Ischemia Tissue Loss Location - Other (Left)

Coding Instructions: Indicate if the patient with critical limb ischemia has tissue loss involving the left limb in any other location not listed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5135 **Name:** Acute Limb Ischemia Symptom Onset Date (Left)

Coding Instructions: Indicate the date the patient began experiencing acute left limb ischemic symptoms.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5140 **Name:** Acute Limb Ischemia Location - Thigh (Left)

Coding Instructions: Indicate if the patient with acute limb ischemia is experiencing symptoms in the left thigh.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5141 **Name:** Acute Limb Ischemia Location - Calf (Left)

Coding Instructions: Indicate if the patient with acute limb ischemia is experiencing symptoms in the left calf.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5142 **Name:** Acute Limb Ischemia Location - Ankle (Left)

Coding Instructions: Indicate if the patient with acute limb ischemia is experiencing symptoms in the left ankle.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5143 **Name:** Acute Limb Ischemia Location - Foot (Left)

Coding Instructions: Indicate if the patient with acute limb ischemia is experiencing symptoms in the left foot.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5144 **Name:** Acute Limb Ischemia Location - Toes (Left)

Coding Instructions: Indicate if the patient with acute limb ischemia is experiencing symptoms in the left toes.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5145 **Name:** Acute Limb Ischemia Location - Other (Left)

Coding Instructions: Indicate if the patient with acute limb ischemia is experiencing symptoms in other location not listed in the left limb.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5150 **Name:** Acute Limb Ischemia Motor Symptoms (Left)

Coding Instructions: Indicate if the patient with acute limb ischemia is experiencing motor symptoms in the left limb.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5151 **Name:** Acute Limb Ischemia Sensory Symptoms (Left)

Coding Instructions: Indicate if the patient with acute limb ischemia is experiencing sensory symptoms in the left limb.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5155 **Name:** Acute Limb Ischemia Suspected Occluded Vessel (Left)

Coding Instructions: Indicate the suspected occluded vessel for the patient with acute left limb ischemia.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Aorta	
Iliac	
Femoral	
Popliteal	
Tibioperoneal	
Unknown	

Supporting Definitions: (none)

Seq. #: 5160 **Name:** Acute Limb Ischemia Suspected Occluded Vessel Type (Left)

Coding Instructions: Indicate the suspected occluded vessel type for the patient having acute left limb ischemia.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Native Only	
Graft Only	
Both	
Uncertain	

Supporting Definitions: (none)

Seq. #: 5165 **Name:** Acute Limb Ischemia Limb Viability (Left)

Coding Instructions: Indicate the viability of the affected left limb for the patient having acute limb ischemia.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Viable (I)	No immediate threat of tissue loss.
Marginally Threatened (IIa)	Continuous pain is absent, minimal sensory symptoms involving toes only, no motor symptoms, inaudible arterial signal in the presence of venous signal
Immediately Threatened (IIb)	Persistent ischemic rest pain, sensory symptoms extending above the level of the toes, any motor symptoms, inaudible arterial signal, audible venous signal
Non-viable (III)	Limb cannot be salvaged and has to be amputated, no emergency to operate.

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5170 **Name:** Aneurysm (Left)

Coding Instructions: Indicate if the patient has an aneurysm below the aortic bifurcation in the left lower extremity.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Aneurysm:**

Dilatation of an artery having at least 50% increased diameter compared to the expected normal artery.
Source: NCDR

Seq. #: 5175 **Name:** Aneurysm Presenting Symptoms - Asymptomatic (Left)

Coding Instructions: Indicate if the patient has an asymptomatic aneurysm in the left limb.

Target Value: The value between current procedure and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5176 **Name:** Aneurysm Presenting Symptoms - Rest Pain (Left)

Coding Instructions: Indicate if rest pain is a symptom of the aneurysm in the left limb.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5177 **Name:** Aneurysm Presenting Symptoms - Claudication (Left)

Coding Instructions: Indicate if claudication is a symptom of the aneurysm in the left limb.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Claudication:**

Claudication is defined by reproducible, exertional, discomfort characterized by cramping, aching, fatique of the buttock, hip, thigh, calf or foot that resolves with in ten minutes of rest.

Source: Adapted from: 2012 ACCF/AHA/ACR/SCAI/SIR/STS/SVM/SVN/SVS Key Data Elements and Definitions for Peripheral Atherosclerotic Vascular Disease. (JACC Vol. 59, No. 3, 2012)

Seq. #: 5178 **Name:** Aneurysm Presenting Symptoms - Venous Obstruction (Left)

Coding Instructions: Indicate if venous obstruction is a symptom of the aneurysm in the left limb.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5179 **Name:** Aneurysm Presenting Symptoms - Other (Left)

Coding Instructions: Indicate if the patient has other symptoms of the aneurysm in the left limb that are not listed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5180 **Name:** Symptomatic Etiology of Symptoms - Thrombosis (Left)

Coding Instructions: Indicate if the symptoms of the aneurysm in the left limb are a result of thrombosis.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5181 **Name:** Symptomatic Etiology of Symptoms - Embolization (Left)

Coding Instructions: Indicate if the symptoms of the aneurysm in the left limb are a result of embolization.

Note(s):

The process by which a blood vessel or organ is obstructed by an embolus or other mass.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5182 **Name:** Symptomatic Etiology of Symptoms - Rupture (Left)

Coding Instructions: Indicate if the symptoms of the aneurysm in the left limb are a result of rupture.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5183 **Name:** Symptomatic Etiology of Symptoms - Other (Left)

Coding Instructions: Indicate if the symptoms of the aneurysm in the left limb are a result of other symptom not listed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5185 **Name:** Aneurysm Location - Common Iliac (Left)

Coding Instructions: Indicate if the symptoms of the aneurysm in the left limb is located in common iliac artery.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5186 **Name:** Aneurysm Location - External Iliac (Left)

Coding Instructions: Indicate if the symptoms of the aneurysm in the left limb is located in external iliac artery.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5187 **Name:** Aneurysm Location - Internal Iliac (Left)

Coding Instructions: Indicate if the symptoms of the aneurysm in the left limb is located in internal iliac artery.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5188 **Name:** Aneurysm Location - Common Femoral (Left)

Coding Instructions: Indicate if the symptoms of the aneurysm in the left limb is located in common femoral artery.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5189 **Name:** Aneurysm Location - Profunda (Left)

Coding Instructions: Indicate if the symptoms of the aneurysm in the left limb is located in profunda artery.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5190 **Name:** Aneurysm Location - Popliteal (Left)

Coding Instructions: Indicate if the location of the aneurysm is the left popliteal artery.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5200 **Name:** CVD Presentation

Coding Instructions: Indicate the patient's cerebral vascular disease (CVD) presentation prior to the procedure. Select the most severe status related to this cath lab visit.

Target Value: The highest value between 2 weeks prior to current procedure and current procedure

Selections:

Selection Text	*Definition*
Asymptomatic	
TIA <= 60 days	
TIA > 60 days	
Ischemic stroke <= 60 days	
Ischemic stroke > 60 days	
IC hemorrhage or hemorrhagic stroke <= 60 days	
IC hemorrhage or hemorrhagic stroke > 60 days	
Acute evolving stroke	

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5205 **Name:** Angina Classification w/in 90 Days

Coding Instructions: Indicate the patient's anginal classification or symptom status within the past 90 days prior to the procedure.

Target Value: The highest value between 90 days prior to current procedure and current procedure

Selections:

Selection Text	*Definition*
No Symptoms, No Angina	The patient has no symptoms, no angina.
Class I	Ordinary physical activity does not cause angina; for example walking or climbing stairs, angina occurs with strenuous or rapid or prolonged exertion at work or recreation.
Class II	Slight limitation of ordinary activity; for example, angina occurs walking or stair climbing after meals, in cold, in wind, under emotional stress or only during the few hours after awakening, walking more than two blocks on the level or climbing more than one flight of ordinary stairs at a normal pace and in normal conditions.
Class III	Marked limitation of ordinary activity; for example, angina occurs walking one or two blocks on the level or climbing one flight of stairs in normal conditions and at a normal pace.
Class IV	Inability to carry on any physical activity without discomfort - angina syndrome may be present at rest.

Supporting Definitions: **Canadian Cardiovascular Society Anginal Classification:**

See selection set definitions.

Source: Canadian Cardiovascular Society

Seq. #: 5210 **Name:** Heart Failure Classification w/in 2 weeks

Coding Instructions: Indicate the patient's most severe dyspnea or functional class as the New York Heart Association (NYHA) classification within the past two weeks.

Target Value: The highest value between 2 weeks prior to current procedure and current procedure

Selections:

Selection Text	*Definition*
No Symptoms	Patient has no symptoms displaying heart failure within the last two weeks.
Class I	Patient has cardiac disease but without resulting limitations of ordinary physical activity. Ordinary physical activity (e.g., walking several blocks or climbing stairs) does not cause undue fatigue, palpitation, dyspnea, or anginal pain. Limiting symptoms may occur with marked exertion.
Class II	Patient has cardiac disease resulting in slight limitation of ordinary physical activity. Patient is comfortable at rest. Ordinary physical activity such as walking more than two blocks or climbing more than one flight of stairs results in limiting symptoms (e.g., fatigue, palpitation, dyspnea, or anginal pain).
Class III	Patient has cardiac disease resulting in marked limitation of physical activity. Patient is comfortable at rest. Less than ordinary physical activity (e.g., walking one to two level blocks or climbing one flight of stairs) causes fatigue, palpitation, dyspnea, or anginal pain.
Class IV	Patient has symptoms at rest that increase with any physical activity. Patient has cardiac disease resulting in inability to perform any physical activity without discomfort. Symptoms may be present even at rest. If any physical activity is undertaken, discomfort is increased.

Supporting Definitions: **NYHA heart failure functional class:**

See selection set definitions.

Source: New York Heart Association (NYHA)

Seq. #: 5300 **Name:** Ankle-Brachial Index Performed (Right)

Coding Instructions: Indicate if an ankle-brachial index (ABI) was performed on the right limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Ankle-Brachial Index:**

Ratio of systolic blood pressure in the ankle (higher of the posterior tibial and dorsal is pedis systolic blood pressures) compared to the higher of the two brachial pressures. Normal ABI 1.0-1.39. Supra-normal >1.40; Borderline 0.91-0.99; Abnormal <0.90.

Source: NCDR

Seq. #: 5305 **Name:** Ankle-Brachial Index Value (Right)

Coding Instructions: Indicate the value of the ankle-brachial index of the right limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5310 **Name:** Ankle-Brachial Index Non-Compressible (Right)

Coding Instructions: Indicate if the ankle-brachial index of the right limb was performed but was non-compressible.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5315 **Name:** Exercise Ankle-Brachial Index Performed (Right)

Coding Instructions: Indicate if an exercise ankle-brachial index was performed on the right lower limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Exercise ABI:**

A slight drop in your ABI with exercise means that you probably have PAD. This drop may be important, because PAD can be linked to a higher risk of heart attack or stroke.
The ABI result can help diagnose peripheral arterial disease (PAD). A lower ABI means you might have PAD. A slight drop in the ABI with exercise, even if you have a normal ABI at rest, means that you probably have PAD.

Source: Rooke TW, et al. (2011). 2011 ACCF/AHA Focused update of the guideline for the management of patients with peripheral artery disease (updating the 2005 guideline): A report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. (Journal of the American College of Cardiology, 58(19): 2020-2045.)

Seq. #: 5320 **Name:** Exercise Ankle-Brachial Index Result (Right)

Coding Instructions: Indicate the result of the exercise ankle-brachial index of the right limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
Negative	Index drop of <= 0.2 or pressure change of <=20mmHg
Positive	Index drop of >0.2 or pressure change of >20mmHg

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5325 **Name:** Pre-Procedure Toe Pressure Performed (Right)

Coding Instructions: Indicate if the toe pressure was assessed in the right limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5330 **Name:** Pre-Procedure Toe Pressure Value (Right)

Coding Instructions: Indicate the value of the right limb toe pressure in mmHg.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5335 **Name:** Duplex Ultrasound Performed (Right)

Coding Instructions: Indicate if a duplex ultrasound was performed on the right limb.

Target Value: Any occurrence between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5340 **Name:** Duplex Ultrasound Maximum Stenosed Segment (Right)

Coding Instructions: Indicate the maximum stenosed segment from the duplex ultrasound of the right limb.

Note(s):

Use PVI segment diagram provided by the NCDR.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
R01	Right Side Segment - Common Iliac Artery
R02	Right Side Segment - External Iliac Artery
R03	Right Side Segment - Internal Iliac Artery
R04	Right Side Segment - Common Femoral Artery
R05	Right Side Segment - Profunda Femoral Artery
R06	Right Side Segment - Superficial Femoral Artery
R07	Right Side Segment - Popliteal Artery
R08	Right Side Segment - Tibioperoneal Trunk
R09	Right Side Segment - Anterior Tibial Artery
R10	Right Side Segment - Posterior Tibial Artery
R11	Right Side Segment - Peroneal Artery
R12	Right Side Segment - Lateral Plantar Artery
R13	Right Side Segment - Medial Plantar Artery
R14	Right Side Segment - Dorsalis Pedis Artery
R15	Right Side Segment - Metatarsal Branches
R20	Right Side Graft - Axillo Femoral
R21	Right Side Graft - Aorto Femoral
R22	Right Side Graft - Femoral Popliteal
R23	Right Side Graft - Femoral Tibial
R24	Right Side Graft - Femoral Femoral
R25	Right Side Graft - Other

Supporting Definitions: (none)

Seq. #: 5345 **Name:** Lower Extremity Duplex Ultrasound Peak Systolic Velocity in Lesion (Right)

Coding Instructions: Indicate the duplex ultrasound peak systolic velocity in lesion in the maximum stenosed segment of the right limb, in centimeters per second (cm/sec).

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5350 **Name:** Lower Extremity Duplex Ultrasound Peak Systolic Velocity Proximal To Lesion (Right)

Coding Instructions: Indicate the patient's peak systolic velocity (PSV) proximal to the lesion in the right lower extremity in centimeters per second (cm/sec).

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5355 **Name:** Duplex Ultrasound Peak Systolic Velocity Ratio (Right)

Coding Instructions: Indicate the duplex ultrasound peak systolic velocity ratio of the right limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5360 **Name:** Carotid Duplex Ultrasound Peak Systolic Velocity Ratio (Right)

Coding Instructions: Indicate if a duplex ultrasound was performed on the right carotid artery.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5365 **Name:** Carotid Duplex Peak Systolic Velocity (Right)

Coding Instructions: Indicate the duplex ultrasound peak systolic velocity in the maximum stenosed segment of the right carotid artery, in centimeters per second (cm/sec).

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5370 **Name:** Carotid Duplex End Diastolic Velocity (Right)

Coding Instructions: Indicate the duplex ultrasound end diastolic velocity in the maximum stenosed segment of the right carotid artery, in centimeters per second (cm/sec).

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5375 **Name:** Carotid Duplex ICA/CCA Ratio (Right)

Coding Instructions: Indicate the ratio of the peak systolic velocity in the right internal carotid artery (ICA) to the peak systolic velocity in the distal right common carotid artery (CCA).

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5380 **Name:** CT Angiography Performed (Right)

Coding Instructions: Indicate if computerized tomographic (CT) angiogram was performed on the right limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5385 **Name:** CT Angiography Maximum Stenosed Segment (Right)

Coding Instructions: Indicate as determined by computerized tomographic (CT) angiogram, the maximum stenosed segment of the right limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
R01	Right Side Segment - Common Iliac Artery
R02	Right Side Segment - External Iliac Artery
R03	Right Side Segment - Internal Iliac Artery
R04	Right Side Segment - Common Femoral Artery
R05	Right Side Segment - Profunda Femoral Artery
R06	Right Side Segment - Superficial Femoral Artery
R07	Right Side Segment - Popliteal Artery
R08	Right Side Segment - Tibioperoneal Trunk
R09	Right Side Segment - Anterior Tibial Artery
R10	Right Side Segment - Posterior Tibial Artery
R11	Right Side Segment - Peroneal Artery
R12	Right Side Segment - Lateral Plantar Artery
R13	Right Side Segment - Medial Plantar Artery
R14	Right Side Segment - Dorsalis Pedis Artery
R15	Right Side Segment - Metatarsal Branches
R20	Right Side Graft - Axillo Femoral
R21	Right Side Graft - Aorto Femoral
R22	Right Side Graft - Femoral Popliteal
R23	Right Side Graft - Femoral Tibial
R24	Right Side Graft - Femoral Femoral
R25	Right Side Graft - Other

Supporting Definitions: (none)

Seq. #: 5390 **Name:** CT Angiography Maximum Percent Stenosis (Right)

Coding Instructions: Indicate the maximum percent stenosis if computerized tomographic (CT) angiogram was performed on the right limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5395 **Name:** Carotid CT Angiography Performed (Right)

Coding Instructions: Indicate if computerized tomographic (CT) angiogram was performed on the right carotid artery.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5400 **Name:** CT Angiography Common Carotid Artery Maximum Percent Stenosis (Right)

Coding Instructions: Indicate maximum percent (%) stenosis in the right common carotid artery, as determined by computerized tomographic (CT) angiogram.

Note(s):

If the vessel is totally occluded, enter 100%. If no stenosis is present, enter 0%.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5405 **Name:** CT Angiography Internal Carotid Artery Maximum Percentage Stenosis (Right)

Coding Instructions: Indicate the maximum percent (%) stenosis in the right internal carotid artery, as determined by computerized tomographic (CT) angiogram.

Note(s):

If the vessel is totally occluded, enter 100%. If no stenosis is present, enter 0%.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5410 **Name:** MR Angiography Performed (Right)

Coding Instructions: Indicate if magnetic resonance (MR) angiography was performed on the right limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5415 **Name:** MR Angiography Maximum Stenosed Segment (Right)

Coding Instructions: Indicate the maximum stenosed segment from the magnetic resonance (MR) of the right limb.

Note(s):

Use segment diagram provided by the NCDR.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
R01	Right Side Segment - Common Iliac Artery
R02	Right Side Segment - External Iliac Artery
R03	Right Side Segment - Internal Iliac Artery
R04	Right Side Segment - Common Femoral Artery
R05	Right Side Segment - Profunda Femoral Artery
R06	Right Side Segment - Superficial Femoral Artery
R07	Right Side Segment - Popliteal Artery
R08	Right Side Segment - Tibioperoneal Trunk
R09	Right Side Segment - Anterior Tibial Artery
R10	Right Side Segment - Posterior Tibial Artery
R11	Right Side Segment - Peroneal Artery
R12	Right Side Segment - Lateral Plantar Artery
R13	Right Side Segment - Medial Plantar Artery
R14	Right Side Segment - Dorsalis Pedis Artery
R15	Right Side Segment - Metatarsal Branches
R20	Right Side Graft - Axillo Femoral
R21	Right Side Graft - Aorto Femoral
R22	Right Side Graft - Femoral Popliteal
R23	Right Side Graft - Femoral Tibial
R24	Right Side Graft - Femoral Femoral
R25	Right Side Graft - Other

Supporting Definitions: (none)

Seq. #: 5420 **Name:** MR Angiography Maximum Percent Stenosis (Right)

Coding Instructions: Indicate the maximum percent stenosis if magnetic resonance (MR) angiography was performed on the right limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions:

Stenosis:

Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

D. Presentation and Evaluation

Seq. #: 5425 **Name:** Carotid MR Angiography Performed (Right)

Coding Instructions: Indicate if magnetic resonance (MR) angiography was performed on the right carotid.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5430 **Name:** MR Angiography Common Carotid Artery Max Percent Stenosis (Right)

Coding Instructions: Indicate the maximum percent (%) stenosis if magnetic resonance (MR) angiography was performed on the right common carotid artery.

Note(s):

If the vessel is totally occluded, enter 100%. If no stenosis is present, enter 0%.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5435 **Name:** MR Angiography Internal Carotid Artery Max Percent Stenosis (Right)

Coding Instructions: Indicate the maximum percent (%) stenosis if magnetic resonance (MR) was performed on the right internal carotid artery.

Note(s):

If the vessel is totally occluded, enter 100%. If no stenosis is present, enter 0%.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5500 **Name:** Ankle-Brachial Index Performed (Left)

Coding Instructions: Indicate if an ankle-brachial index (ABI) was performed on the left limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Ankle-Brachial Index:**

Ratio of systolic blood pressure in the ankle (higher of the posterior tibial and dorsal is pedis systolic blood pressures) compared to the higher of the two brachial pressures. Normal ABI 1.0-1.39. Supra-normal >1.40; Borderline 0.91-0.99; Abnormal <0.90

Source: NCDR

Seq. #: 5505 **Name:** Ankle-Brachial Index Value (Left)

Coding Instructions: Indicate the value of the ankle-brachial index of the left limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5510 **Name:** Ankle-Brachial Index Non-Compressible (Left)

Coding Instructions: Indicate if the ankle-brachial index of the left limb was performed but was non-compressible.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5515 **Name:** Exercise Ankle-Brachial Index Performed (Left)

Coding Instructions: Indicate if an exercise ankle-brachial index was performed on the left lower limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Exercise ABI:**

A slight drop in your ABI with exercise means that you probably have PAD. This drop may be important, because PAD can be linked to a higher risk of heart attack or stroke.
The ABI result can help diagnose peripheral arterial disease (PAD). A lower ABI means you might have PAD. A slight drop in the ABI with exercise, even if you have a normal ABI at rest, means that you probably have PAD.

Source: Rooke TW, et al. (2011). 2011 ACCF/AHA Focused update of the guideline for the management of patients with peripheral artery disease (updating the 2005 guideline): A report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. (Journal of the American College of Cardiology, 58(19): 2020-2045.)

Seq. #: 5520 **Name:** Exercise Ankle-Brachial Index Result (Left)

Coding Instructions: Indicate the result of the exercise ankle-brachial index of the left limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
Negative	Index drop of <= 0.2 or pressure change of <=20mmHg
Positive	Index drop of >0.2 or pressure change of >20mmHg

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5525 **Name:** Pre-Procedure Toe Pressure Performed (Left)

Coding Instructions: Indicate if the toe pressure was assessed in the left limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5530 **Name:** Pre-Procedure Toe Pressure Value (Left)

Coding Instructions: Indicate the value of the left limb toe pressure in mmHg.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5535 **Name:** Duplex Ultrasound Performed (Left)

Coding Instructions: Indicate if a duplex ultrasound was performed on the left limb.

Target Value: Any occurrence between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5540 **Name:** Duplex Ultrasound Maximum Stenosed Segment (Left)

Coding Instructions: Indicate the maximum stenosed segment from the duplex ultrasound of the left limb.

Note(s):

Use PVI segment diagram provided by the NCDR.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
L01	Left Side Segment - Common Iliac Artery
L02	Left Side Segment - External Iliac Artery
L03	Left Side Segment - Internal Iliac Artery
L04	Left Side Segment - Common Femoral Artery
L05	Left Side Segment - Profunda Femoral Artery
L06	Left Side Segment - Superficial Femoral Artery
L07	Left Side Segment - Popliteal Artery
L08	Left Side Segment - Tibioperoneal Trunk
L09	Left Side Segment - Anterior Tibial Artery
L10	Left Side Segment - Posterior Tibial Artery
L11	Left Side Segment - Peroneal Artery
L12	Left Side Segment - Lateral Plantar Artery
L13	Left Side Segment - Medial Plantar Artery
L14	Left Side Segment - Dorsalis Pedis Artery
L15	Left Side Segment - Metatarsal Branches
L20	Left Side Graft - Axillo Femoral
L21	Left Side Graft - Aorto Femoral
L22	Left Side Graft - Femoral Popliteal
L23	Left Side Graft - Femoral Tibial
L24	Left Side Graft - Femoral Femoral
L25	Left Side Graft - Other

Supporting Definitions: (none)

Seq. #: 5545 **Name:** Lower Extremity Duplex Ultrasound Peak Systolic Velocity in Lesion (Left)

Coding Instructions: Indicate the duplex ultrasound peak systolic velocity in lesion in the maximum stenosed segment of the left limb, in centimeters per second (cm/sec).

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5550 **Name:** Lower Extremity Duplex Ultrasound Peak Systolic Velocity Proximal To Lesion (Left)

Coding Instructions: Indicate the patient's peak systolic velocity (PSV) proximal to the lesion in the left lower extremity in centimeters per second (cm/sec).

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5555 **Name:** Duplex Ultrasound Peak Systolic Velocity Ratio (Left)

Coding Instructions: Indicate the duplex ultrasound peak systolic velocity ratio of the left limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5560 **Name:** Carotid Duplex Ultrasound Peak Systolic Velocity Ratio (Left)

Coding Instructions: Indicate if a duplex ultrasound was performed on the left carotid artery.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5565 **Name:** Carotid Duplex Peak Systolic Velocity (Left)

Coding Instructions: Indicate the duplex ultrasound peak systolic velocity in the maximum stenosed segment of the left carotid artery, in centimeters per second (cm/sec).

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5570 **Name:** Carotid Duplex End Diastolic Velocity (Left)

Coding Instructions: Indicate the duplex ultrasound end diastolic velocity in the maximum stenosed segment of the left carotid artery, in centimeters per second (cm/sec).

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5575 **Name:** Carotid Duplex ICA/CCA Ratio (Left)

Coding Instructions: Indicate the ratio of the peak systolic velocity in the left internal carotid artery (ICA) to the peak systolic velocity in the distal left common carotid artery (CCA).

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5580 **Name:** CT Angiography Performed (Left)

Coding Instructions: Indicate if computerized tomographic (CT) angiogram was performed on the left limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5585 **Name:** CT Angiography Maximum Stenosed Segment (Left)

Coding Instructions: Indicate as determined by computerized tomographic (CT) angiogram, the maximum stenosed segment of the left limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
L01	Left Side Segment - Common Iliac Artery
L02	Left Side Segment - External Iliac Artery
L03	Left Side Segment - Internal Iliac Artery
L04	Left Side Segment - Common Femoral Artery
L05	Left Side Segment - Profunda Femoral Artery
L06	Left Side Segment - Superficial Femoral Artery
L07	Left Side Segment - Popliteal Artery
L08	Left Side Segment - Tibioperoneal Trunk
L09	Left Side Segment - Anterior Tibial Artery
L10	Left Side Segment - Posterior Tibial Artery
L11	Left Side Segment - Peroneal Artery
L12	Left Side Segment - Lateral Plantar Artery
L13	Left Side Segment - Medial Plantar Artery
L14	Left Side Segment - Dorsalis Pedis Artery
L15	Left Side Segment - Metatarsal Branches
L20	Left Side Graft - Axillo Femoral
L21	Left Side Graft - Aorto Femoral
L22	Left Side Graft - Femoral Popliteal
L23	Left Side Graft - Femoral Tibial
L24	Left Side Graft - Femoral Femoral
L25	Left Side Graft - Other

Supporting Definitions: (none)

Seq. #: 5590 **Name:** CT Angiography Maximum Percent Stenosis (Left)

Coding Instructions: Indicate the maximum percent stenosis if computerized tomographic (CT) angiogram was performed on the left limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5595 **Name:** Carotid CT Angiography Performed (Left)

Coding Instructions: Indicate if computerized tomographic (CT) angiogram was performed of the left carotid artery.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5600 **Name:** CT Angiography Common Carotid Artery Maximum Percent Stenosis (Left)

Coding Instructions: Indicate the maximum percent (%) stenosis in the left common carotid artery, as determined by computerized tomographic (CT) angiogram.

Note(s):

If the vessel is totally occluded, enter 100%. If no stenosis is present, enter 0%.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5605 **Name:** CT Angiography Internal Carotid Artery Maximum Percentage Stenosis (Left)

Coding Instructions: Indicate the maximum percent (%) stenosis in the left internal carotid artery, as determined by computerized tomographic (CT) angiogram.

Note(s):

If the vessel is totally occluded, enter 100%. If no stenosis is present, enter 0%.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5610 **Name:** MR Angiography Performed (Left)

Coding Instructions: Indicate if magnetic resonance (MR) angiography was performed on the left limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5615 **Name:** MR Angiography Maximum Stenosed Segment (Left)

Coding Instructions: Indicate the maximum stenosed segment from the magnetic resonance (MR) of the left limb.

Note(s):

Use segment diagram provided by the NCDR.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
L01	Left Side Segment - Common Iliac Artery
L02	Left Side Segment - External Iliac Artery
L03	Left Side Segment - Internal Iliac Artery
L04	Left Side Segment - Common Femoral Artery
L05	Left Side Segment - Profunda Femoral Artery
L06	Left Side Segment - Superficial Femoral Artery
L07	Left Side Segment - Popliteal Artery
L08	Left Side Segment - Tibioperoneal Trunk
L09	Left Side Segment - Anterior Tibial Artery
L10	Left Side Segment - Posterior Tibial Artery
L11	Left Side Segment - Peroneal Artery
L12	Left Side Segment - Lateral Plantar Artery
L13	Left Side Segment - Medial Plantar Artery
L14	Left Side Segment - Dorsalis Pedis Artery
L15	Left Side Segment - Metatarsal Branches
L20	Left Side Graft - Axillo Femoral
L21	Left Side Graft - Aorto Femoral
L22	Left Side Graft - Femoral Popliteal
L23	Left Side Graft - Femoral Tibial
L24	Left Side Graft - Femoral Femoral
L25	Left Side Graft - Other

Supporting Definitions: (none)

Seq. #: 5620 **Name:** MR Angiography Maximum Percent Stenosis (Left)

Coding Instructions: Indicate the maximum percent stenosis if magnetic resonance (MR) angiography was performed of the left limb.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions:

Stenosis:

Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

D. Presentation and Evaluation

Seq. #: 5625 **Name:** Carotid MR Angiography (Left)

Coding Instructions: Indicate if magnetic resonance (MR) angiography was performed on the left carotid.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5630 **Name:** MR Angiography Common Carotid Artery Max Percent Stenosis (Left)

Coding Instructions: Indicate the maximum percent (%) stenosis if magnetic resonance (MR) angiography was performed on the left common carotid artery.

Note(s):

If the vessel is totally occluded, enter 100%. If no stenosis is present, enter 0%.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5635 **Name:** MR Angiography Internal Carotid Artery Max Percent Stenosis (Left)

Coding Instructions: Indicate the maximum percent (%) stenosis if magnetic resonance (MR) was performed on the left internal carotid artery.

Note(s):

If the vessel is totally occluded, enter 100%. If no stenosis is present, enter 0%.

Target Value: The last value between 2 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5700 **Name:** Pre-Procedure Left Ventricular Ejection Fraction (LVEF)

Coding Instructions: Code the best estimate of current left ventricular ejection fraction.

Note(s):

If no diagnostic report is in the medical record, a value documented in the medical record is acceptable.

In cases of conflicting measurements, the clinician should specify the value that they think best represents the pre-procedure LVEF.

If only a range is reported, report the center of the range (i.e. 50-55%, is reported as 53%).

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

The Left Ventricular Ejection Fraction can be assessed via invasive (i.e. LV gram) or non-invasive (i.e. Echo, MR, CT or Nuclear) testing.

Target Value: The last value between 6 months prior to arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: **LVEF:**

The Left Ventricular Ejection Fraction is the percentage of the blood emptied from the left ventricle at the end of the contraction.

Source: ACC Clinical Data Standards, The Society of Thoracic Surgeons

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Seq. #: 5701 **Name:** Pre-Procedure Left Ventricular Ejection Fraction (LVEF) Not Assessed

Coding Instructions: Indicate whether the left ventricular ejection fraction was not assessed.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code 'Yes' if the LVEF % was not assessed.

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5705 **Name:** Pre-Procedure Modified Rankin Score

Coding Instructions: Indicate the Modified Rankin Score. The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.

Target Value: The last value between arrival at this facility and start of 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: (none)

Seq. #: 5706 **Name:** Pre-Procedure Modified Rankin Score Date Administered

Coding Instructions: Indicate the date the Modified Rankin Scale was administered pre-procedure.

Target Value: The last value between arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5707 **Name:** Pre-Procedure Modified Rankin Score Not Administered

Coding Instructions: Indicate if the Modified Rankin Scale was not administered.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5710 **Name:** Pre-Procedure NIH Stroke Scale Total Score

Coding Instructions: Indicate the pre-procedure NIH Stroke Scale total score.

Target Value: The last value between arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: **NIH Stroke Scale:**

The National Institute of Health Stroke Scale, or NIH Stroke Scale (NIHSS) is a tool used by healthcare providers to objectively quantify the impairment caused by a stroke. The NIHSS is composed of 11 items, each of which scores a specific ability between a 0 and 4. For each item, a score of 0 typically indicates normal function in that specific ability, while a higher score is indicative of some level of impairment. The individual scores from each item are summed in order to calculate a patient's total NIHSS score. The maximum possible score is 42, with the minimum score being a 0 (zero).

Score	Stroke Severity
0	No Stroke Symptoms
1-4	Minor Stroke
5-15	Moderate Stroke
16-20	Moderate to Severe Stroke
21-42	Severe Stroke

Source: National Institute of Neurological Disorders and Stroke

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Seq. #: 5711 **Name:** Pre-Procedure NIH Stroke Scale Date Administered

Coding Instructions: Indicate the date the National Institutes of Health Stroke Scale (NIHSS) was administered pre-procedure.

Target Value: The last value between arrival at this facility and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5712 **Name:** Pre-Procedure NIH Stroke Scale Not Administered

Coding Instructions: Indicate if the National Institutes of Health Stroke Scale (NIHSS) was not administered pre-procedure.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5715 **Name:** Pre-Procedure NIH Stroke Scale Examiner Last Name

Coding Instructions: Indicate the last name of the NIH Stroke Scale (NIHSS) examiner who administered the pre-procedure NIH Stroke Scale.

Note(s):

The Stroke Scale assessment should be conducted by someone other than the operator performing this procedure.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

D. Presentation and Evaluation

Seq. #: 5720 **Name:** Pre-Procedure NIH Stroke Scale Examiner First Name

Coding Instructions: Indicate the first name of the NIH Stroke Scale (NIHSS) examiner who administered the pre-procedure NIH Stroke Scale.

Note(s):

The Stroke Scale assessment should be conducted by someone other than the operator performing this procedure.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5725 **Name:** Pre-Procedure NIH Stroke Scale Examiner Middle Name

Coding Instructions: Indicate the middle name of the NIH Stroke Scale (NIHSS) examiner who administered the pre-procedure NIH Stroke Scale.

Note(s):

The Stroke Scale assessment should be conducted by someone other than the operator performing this procedure.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5730 **Name:** Pre-Procedure NIH Stroke Scale Examiner Certified

Coding Instructions: Indicate if the NIH Stroke Scale (NIHSS) examiner who administered the pre-procedure stroke scale is certified to administer the stroke scale exam.

Note(s):

The Stroke Scale assessment should be conducted by someone other than the operator performing this procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

E. Procedure

Seq. #: 6000 **Name:** Procedure Start Date

Coding Instructions: Indicate the date the procedure was initiated.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6001 **Name:** Procedure Start Time

Coding Instructions: Indicate the time the procedure was initiated.

Note(s):

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

If an arterial sheath is already in place, use the time of the introduction of a catheter or the time the sheath was exchanged.

Target Value: N/A

Selections: (none)

Supporting Definitions: **Time of Procedure:**

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

Source: NCDR

Seq. #: 6005 **Name:** Procedure End Date

Coding Instructions: Indicate the ending date at which the operator breaks scrub at the end of the procedure.

Note(s):

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6006 **Name:** Procedure End Time

Coding Instructions: Indicate the ending time at which 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 operator is involved in the case then use the date/time the last operator breaks scrub.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

E. Procedure

Seq. #: 6010 **Name:** PVI Procedure Type

Coding Instructions: Indicate the procedure performed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Carotid Artery Stent	
Carotid Endarterectomy	
Lower Extremity Catheter-Based Intervention	

Supporting Definitions: (none)

Seq. #: 6015 **Name:** Operator Last Name

Coding Instructions: Indicate the procedure's primary operator's last name.

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. #: 6020 **Name:** Operator First Name

Coding Instructions: Indicate the procedure's primary operator's first name.

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. #: 6025 **Name:** Operator Middle Name

Coding Instructions: Indicate the procedure's primary operator's middle name.

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)

E. Procedure

Seq. #: 6030 **Name:** Operator NPI

Coding Instructions: Indicate the primary operator's National Provider Identifier. NPIs, assigned by the Center 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)

Seq. #: 6035 **Name:** Procedure Status

Coding Instructions: Indicate the procedure status at the start of the procedure. The status is determined when the decision is made to activate the cath lab or the surgery suite is prepared.

Target Value: The highest value on start of current procedure

Selections:

Selection Text	*Definition*
Elective	The procedure can be performed on an outpatient basis or during a subsequent hospitalization without significant risk of tissue ischemia or tissue loss. For stable inpatients, the procedure is being performed during this hospitalization for convenience and ease of scheduling and NOT because the patient's clinical situation demands the procedure prior to discharge.
Urgent	The procedure is being performed on an inpatient basis and prior to discharge because of significant concerns that there is risk of ischemia, infarction and/or death. Patients who are outpatients or in the emergency department at the time that the procedure is requested would warrant an admission based on their clinical presentation.
Emergency	The procedure is being performed as soon as possible because of substantial concerns that ongoing ischemia and/or infarction could lead to death. "As soon as possible" refers to a patient who is of sufficient acuity that you would cancel a scheduled case to perform this procedure immediately in the next available room during business hours, or you would activate the on call team were this to occur during off-hours.

Supporting Definitions: (none)

E. Procedure

Seq. #: 6040 **Name:** Lower Extremity Intervention Procedure Indication

Coding Instructions: Indicate the primary reason the lower extremity interventional procedure is being performed.

Target Value: The highest value on start of current procedure

Selections:

Selection Text	*Definition*
Typical Claudication	
Atypical Claudication	
Maintenance of Patency (Asymptomatic)	
Critical Limb Ischemia	
Acute Limb Ischemia	
Prevention of Aneurysm	
Treatment of Symptomatic Aneurysm	
Facilitation of other procedure	

Supporting Definitions: (none)

Seq. #: 6041 **Name:** Carotid Intervention Procedure Indication

Coding Instructions: Indicate the primary reason the carotid artery stent or endarterectomy procedure is being performed.

Target Value: The highest value on start of current procedure

Selections:

Selection Text	*Definition*
Asymptomatic	
Restenosis in Target Vessel, prior CEA	
Restenosis in Target Vessel, prior CAS	
Urgent Cardiac Surgery w/in 30 days	
Spontaneous Carotid Artery Dissection	
Symptomatic Lesion w/in 6 months	

Supporting Definitions: (none)

E. Procedure

Seq. #: 6045 **Name:** Target Vessel

Coding Instructions: Indicate the target vessel location for this procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Right Carotid	
Left Carotid	

Supporting Definitions: (none)

Seq. #: 6050 **Name:** Sedation

Coding Instructions: Indicate the type of sedation administered during the procedure.

Target Value: The value on start of current procedure

Selections:

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

Supporting Definitions:

Sedation:

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

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

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

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

Source: American Society of Anesthesiologists House of Delegates on October 13, 1999, and amended on October 21, 2009

E. Procedure

Seq. #: 6055 **Name:** Starting Systolic BP

Coding Instructions: Indicate the patient's (systolic) blood pressure.

Note(s):

Systolic is the pressure exerted on the walls of the arteries when the heart contracts. Systolic blood pressure is represented by the top number in the fraction of a blood pressure reading.

Target Value: The last value on start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6060 **Name:** Starting Diastolic BP

Coding Instructions: Indicate the patient's (diastolic) blood pressure.

Note(s):

Referring to the time when the heart is in a period of relaxation and dilatation (expansion). In a blood pressure reading, the diastolic pressure is typically the second number recorded.

Target Value: The last value on start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6065 **Name:** Dual Antiplatelet Therapy Candidate

Coding Instructions: Indicate if there is documentation in the medical record that an assessment of candidacy for initiation and duration of dual antiplatelet therapy (DAPT) was performed prior to the procedure.

Target Value: The value between arrival at this facility and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Dual Antiplatelet Therapy Candidate:**

Examples of assessment may include consideration of one or more of the following medical and personal issues:
- High risk of bleeding
- Anticipated invasive or surgical procedures requiring early discontinuation of therapy
- Accessibility of medications
- Adherence with medications

Source: NCDR

E. Procedure

Seq. #: 6070 **Name:** Contralateral Carotid Artery Occlusion

Coding Instructions: Indicate if there is known 100% occlusion of the patient's contralateral carotid artery.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6075 **Name:** Fibromuscular Dysplasia of Carotid Artery

Coding Instructions: Indicate if the patient has a known fibromuscular dysplasia of the ipsilateral carotid artery.

Note(s):

Fibromuscular dysplasia, commonly called FMD, is a disease that causes one or more arteries in the body to have abnormal cell development in the artery wall

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6200 **Name:** Access Site Counter

Coding Instructions: The access site counter distinguishes an individual site when multiple are used or attempted during the procedure.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6205 **Name:** Access Side

Coding Instructions: Indicate if the accessed site is on the left or right.

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

Selections:

Selection Text	*Definition*
Right	
Left	

Supporting Definitions: **Arterial Access Site:**

Catheter entry site for percutaneous endovascular procedure (arteriography, intervention).

Source: NCDR

Seq. #: 6210 **Name:** Lower Limb Access Vessel

Coding Instructions: Indicate the location of the access site used for the lower extremity intervention.

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

Selections:

Selection Text	*Definition*
Femoral	
Popliteal	
Dorsalis Pedis	
Posterior Tibial	
Radial	
Brachial	
Other	

Supporting Definitions: **Access Site:**

Catheter entry site for percutaneous endovascular procedure (arteriography, intervention).

Source: NCDR

Seq. #: 6211 **Name:** Carotid Artery Access Vessel

Coding Instructions: Indicate the location of the access site used for the carotid artery stenting procedure.

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

Selections:

Selection Text	*Definition*
Femoral	
Radial	
Brachial/Axillary	
Direct Carotid Puncture	
Carotid Cutdown	
Other	

Supporting Definitions: (none)

Seq. #: 6215 **Name:** Access Directionality

Coding Instructions: Indicate the directionality of the access site.

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

Selections:

Selection Text	*Definition*
Antegrade	Sheath insertion in the same direction of blood flow
Retrograde	Sheath insertion in the opposite direction of the blood flow

Supporting Definitions: (none)

Seq. #: 6220 **Name:** Closure Method Not Documented

Coding Instructions: Indicate if the method to close the arterial access site was not documented.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6225 **Name:** Closure Method Counter

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6230 **Name:** Arterial Access Closure Method

Coding Instructions: Indicate all closure method(s) used in chronological order regardless of whether or not they provided hemostasis. The same closure method may be repeated.

Note(s):

Select all methods performed during the procedure from the Closure Method list supplied.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6235 **Name:** Closure Method 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 to close the access site. This ID is provided by the device manufacturer, and is either a GTIN or HIBBC number.

Note(s):

The direct identifier portion of the UDI (unique device identifier) is provided by the manufacturer, specified at the unit of use. This is not the package barcode. The value should be mapped from your supply chain or inventory management system into this field. Depending on the device and manufacturer, this number could be between 12 to 25 digits.

- GTIN / GS1 standard: numeric, 12 – 14 characters
- HIBCC standard: alphanumeric, 25 characters
- ISBT-128: alphanumeric, 25 characters

If a device was not used, leave blank.

Target Value: N/A

Selections: (none)

Supporting Definitions: **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.

Http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/UniqueDeviceIdentification/default.htm

Source: FDA.gov

Seq. #: 6240 **Name:** Closure Method UDI Lot Number

Coding Instructions: [Reserved for Future Use] Indicate the lot number associated with the device used to close the access site. This lot number is provided by the device manufacturer, and should be available within your supply chain or EHR system. Lot numbers indicate the specific manufacturing source or process.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6245 **Name:** Closure Method UDI Expiration Date

Coding Instructions: [Reserved for Future Use] Indicate the expiration date associated with the device used to close the access site. This expiration date is provided by the device manufacturer, and should be available within your supply chain or EHR system.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6250 **Name:** Aortic Arch Type

Coding Instructions: Indicate the patient's aortic arch type configuration. The three types of aortic arch are based on the relationship of the innominate artery to the aortic arch.

Note(s):

The more inferior the origin of the target artery (i.e., Type II or III aortic arch), the greater the difficulty in gaining access to the carotid artery.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Type I	The Type I aortic arch is characterized by origin of all three great vessels in the same horizontal plane as the outer curvature of the aortic arch.
Type II	In the Type II aortic arch, the innominate artery originates between the horizontal planes of the outer and inner curvatures of the aortic arch.
Type III	In the Type III aortic arch, the innominate artery originates below the horizontal plane of the inner curvature of the aortic arch.
Not Documented	

Supporting Definitions: (none)

Seq. #: 6300 **Name:** Lower Limb Vascular Anatomy Native Vessel Maximum Stenosis - Iliac (Right)

Coding Instructions: Indicate the best estimate of most severe percent stenosis in the right iliac artery as determined by angiography.

Note(s):

If the patient has only a lower extremity procedure it is acceptable to use prior lab visit information, when coding native vessel stenosis, as long as there have been no changes in the vascular anatomy. This includes stenosis determined via peripheral intervention at another facility.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions:

Stenosis:

Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6301 **Name:** Lower Limb Vascular Anatomy Native Vessel CTO - Iliac (Right)

Coding Instructions: Indicate if there is chronic total occlusion of the right iliac artery.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Iliac:

The inner branch of the common iliac artery on either side of the body; divides into several branches that supply blood to the pelvic and gluteal areas

Source: NCDR

Seq. #: 6302 **Name:** Lower Limb Vascular Anatomy Native Vessel Not Available - Iliac (Right)

Coding Instructions: Indicate if the best estimate of most severe percent stenosis in the right iliac artery as determined by angiography is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6305 **Name:** Lower Limb Vascular Anatomy Native Vessel Maximum Stenosis - Common Femoral (Right)

Coding Instructions: Indicate the best estimate of most severe percent stenosis in the right common femoral artery as determined by angiography.

Note(s):

If the patient has only a lower extremity procedure it is acceptable to use prior lab visit information, when coding native vessel stenosis, as long as there have been no changes in the vascular anatomy. This includes stenosis determined via peripheral intervention at another facility.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions:

Stenosis:

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6306 **Name:** Lower Limb Vascular Anatomy Native Vessel CTO - Common Femoral (Right)

Coding Instructions: Indicate if there is chronic total occlusion of the right common femoral artery.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6307 **Name:** Lower Limb Vascular Anatomy Native Vessel Not Available - Common Femoral (Right)

Coding Instructions: Indicate if the best estimate of most severe percent stenosis in the right common femoral artery as determined by angiography is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6310 **Name:** Lower Limb Vascular Anatomy Native Vessel Maximum Stenosis - Profunda (Right)

Coding Instructions: Indicate the presence or absence of blood flow in the right profunda artery.

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

Selections:

Selection Text	*Definition*
Patent	
Occluded	

Supporting Definitions: (none)

Seq. #: 6311 **Name:** Lower Limb Vascular Anatomy Native Vessel Not Available - Profunda (Right)

Coding Instructions: Indicate if the presence or absence of blood flow in the right profunda artery is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6315 **Name:** Lower Limb Vascular Anatomy Native Vessel Maximum Stenosis - Superficial Femoral Artery (Right)

Coding Instructions: Indicate the best estimate of most severe percent stenosis in the right superficial femoral artery as determined by angiography.

Note(s):

If the patient has only a lower extremity procedure it is acceptable to use prior lab visit information, when coding native vessel stenosis, as long as there have been no changes in the vascular anatomy. This includes stenosis determined via peripheral intervention at another facility.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6316 **Name:** Lower Limb Vascular Anatomy Native Vessel CTO - Superficial Femoral Artery (Right)

Coding Instructions: Indicate if there is chronic total occlusion of the right superficial femoral artery.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6317 **Name:** Lower Limb Vascular Anatomy Native Vessel Not Available - Superficial Femoral Artery (Right)

Coding Instructions: Indicate if the best estimate of most severe percent stenosis in the right superficial femoral artery as determined by angiography is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6320 **Name:** Lower Limb Vascular Anatomy Native Vessel Maximum Stenosis - Popliteal (Right)

Coding Instructions: Indicate the best estimate of most severe percent stenosis in the right popliteal artery as determined by angiography.

Note(s):

If the patient has only a lower extremity procedure it is acceptable to use prior lab visit information, when coding native vessel stenosis, as long as there have been no changes in the vascular anatomy. This includes stenosis determined via peripheral intervention at another facility.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6321 **Name:** Lower Limb Vascular Anatomy Native Vessel CTO - Popliteal (Right)

Coding Instructions: Indicate if there is chronic total occlusion of the right popliteal artery.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6322 **Name:** Lower Limb Vascular Anatomy Native Vessel Not Available - Popliteal (Right)

Coding Instructions: Indicate if the best estimate of most severe percent stenosis in the right popliteal artery as determined by angiography is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6325 **Name:** Lower Limb Vascular Anatomy Native Vessel Runoff Vessels (Right)

Coding Instructions: Indicate whether the runoff segment is 1 vessel, 2 vessel, or 3 vessel in the right limb.

Note(s):

Aortography with lower extremity (leg) runoff involves the study of the lower aorta and arteries of the legs.

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

Selections:

Selection Text	*Definition*
3V	3 vessel
2V	2 vessel
1V	1 vessel
None	

Supporting Definitions: **Runoff:**

Runoff refers to the number of tibial vessels (AT, Peroneal and PT) with inline uninterrupted flow to the ankle joint.

Source: NCDR

Seq. #: 6326 **Name:** Lower Limb Vascular Anatomy Native Vessel Runoff Vessels Not Available (Right)

Coding Instructions: Indicate if the runoff segment in the right limb is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6330 **Name:** Carotid Vascular Anatomy Native Vessel Maximum Stenosis - Common Carotid (Right)

Coding Instructions: Indicate the best estimate of most severe percent stenosis in the right common carotid artery as determined by angiography.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6331 **Name:** Carotid Vascular Anatomy Native Vessel CTO - Common Carotid (Right)

Coding Instructions: Indicate if there is chronic total occlusion of the right common carotid artery.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6332 **Name:** Carotid Vascular Anatomy Native Vessel Not Available - Common Carotid (Right)

Coding Instructions: Indicate if the best estimate of most severe percent stenosis in the right common carotid artery as determined by angiography is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6335 **Name:** Carotid Vascular Anatomy Native Vessel Maximum Stenosis - Internal Carotid (Right)

Coding Instructions: Indicate the best estimate of most severe percent stenosis in the right internal carotid artery as determined by angiography.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions:

Stenosis:

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6336 **Name:** Carotid Vascular Anatomy Native Vessel CTO - Internal Carotid (Right)

Coding Instructions: Indicate if there is chronic total occlusion of the native right internal carotid artery.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6337 **Name:** Carotid Vascular Anatomy Native Vessel Not Available - Internal Carotid (Right)

Coding Instructions: Indicate if the best estimate of most severe percent stenosis in the right internal carotid artery as determined by angiography is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6340 **Name:** Carotid Vascular Anatomy Native Vessel Maximum Stenosis - Vertebral (Right)

Coding Instructions: Indicate the best estimate of most severe percent stenosis in the right vertebral artery as determined by angiography.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6341 **Name:** Carotid Vascular Anatomy Native Vessel CTO - Vertebral (Right)

Coding Instructions: Indicate if there is chronic total occlusion of the right vertebral artery.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6342 **Name:** Carotid Vascular Anatomy Native Vessel Not Available - Vertebral (Right)

Coding Instructions: Indicate if the best estimate of most severe percent stenosis in the native right vertebral artery as determined by angiography is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6345 **Name:** Vascular Anatomy Bypass Graft Present (Right)

Coding Instructions: Indicate if a bypass graft of any vessel or vessels is present on the right lower extremity.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6350 **Name:** Vascular Anatomy Graft Maximum Stenosis - Axillo - Femoral (Right)

Coding Instructions: Indicate the best angiographic estimate of the most severe stenosis within the right axillo-femoral bypass graft.

Note(s):

If the patient has only a lower extremity procedure it is acceptable to use prior lab visit information, when coding native vessel stenosis, as long as there have been no changes in the vascular anatomy. This includes stenosis determined via peripheral intervention at another facility.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6351 **Name:** Vascular Anatomy Graft Not Available - Axillo - Femoral (Right)

Coding Instructions: Indicate if the best angiographic estimate of the most severe stenosis within the right axillo-femoral bypass graft is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6355 **Name:** Vascular Anatomy Graft Maximum Stenosis - Aorto - Femoral (Right)

Coding Instructions: Indicate the best angiographic estimate of the most severe stenosis within the right aorto-femoral bypass graft.

Note(s):

If the patient has only a lower extremity procedure it is acceptable to use prior lab visit information, when coding native vessel stenosis, as long as there have been no changes in the vascular anatomy. This includes stenosis determined via peripheral intervention at another facility.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6356 **Name:** Vascular Anatomy Graft Not Available - Aorto - Femoral (Right)

Coding Instructions: Indicate if the best angiographic estimate of the most severe stenosis within the right aorto-femoral bypass graft is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6360 **Name:** Vascular Anatomy Graft Maximum Stenosis - Femoral - Popliteal (Right)

Coding Instructions: Indicate the best angiographic estimate of the most severe stenosis within the right femoral-popliteal bypass graft.

Note(s):

If the patient has only a lower extremity procedure it is acceptable to use prior lab visit information, when coding native vessel stenosis, as long as there have been no changes in the vascular anatomy. This includes stenosis determined via peripheral intervention at another facility.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6361 **Name:** Vascular Anatomy Graft Not Available - Femoral - Popliteal (Right)

Coding Instructions: Indicate if the best angiographic estimate of the most severe stenosis within the right femoral-popliteal bypass graft is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6365 **Name:** Vascular Anatomy Graft Maximum Stenosis - Femoral - Tibial (Right)

Coding Instructions: Indicate the best angiographic estimate of the most severe stenosis within the right femoral-tibial bypass graft.

Note(s):

If the patient has only a lower extremity procedure it is acceptable to use prior lab visit information, when coding native vessel stenosis, as long as there have been no changes in the vascular anatomy. This includes stenosis determined via peripheral intervention at another facility.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6366 **Name:** Vascular Anatomy Graft Not Available - Femoral - Tibial (Right)

Coding Instructions: Indicate if the best angiographic estimate of the most severe stenosis within the right femoral-tibial bypass graft is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6370 **Name:** Vascular Anatomy Graft Maximum Stenosis - Femoral - Femoral (Right)

Coding Instructions: Indicate the best angiographic estimate of the most severe stenosis within the right femoral-femoral bypass graft.

Note(s):

If the patient has only a lower extremity procedure it is acceptable to use prior lab visit information, when coding native vessel stenosis, as long as there have been no changes in the vascular anatomy. This includes stenosis determined via peripheral intervention at another facility.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6371 **Name:** Vascular Anatomy Graft Not available - Femoral - Femoral (Right)

Coding Instructions: Indicate if the best angiographic estimate of the most severe stenosis within the right femoral-femoral bypass graft is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6375 **Name:** Vascular Anatomy Graft Maximum Stenosis - Other (Right)

Coding Instructions: Indicate the best angiographic estimate of the most severe stenosis in other graft within the right lower extremity.

Note(s):

If the patient has only a lower extremity procedure it is acceptable to use prior lab visit information, when coding native vessel stenosis, as long as there have been no changes in the vascular anatomy. This includes stenosis determined via peripheral intervention at another facility.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6376 **Name:** Vascular Anatomy Graft Not Available - Other (Right)

Coding Instructions: Indicate if the best angiographic estimate of the most severe stenosis in other graft on the right lower extremity is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6400 **Name:** Lower Limb Vascular Anatomy Native Vessel Maximum Stenosis - Iliac (Left)

Coding Instructions: Indicate the best estimate of most severe percent stenosis in the left iliac artery as determined by angiography.

Note(s):

If the patient has only a lower extremity procedure it is acceptable to use prior lab visit information, when coding native vessel stenosis, as long as there have been no changes in the vascular anatomy. This includes stenosis determined via peripheral intervention at another facility.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions:

Stenosis:

Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Iliac:

The inner branch of the common iliac artery on either side of the body; divides into several branches that supply blood to the pelvic and gluteal areas

Source: NCDR

Seq. #: 6401 **Name:** Lower Limb Vascular Anatomy Native Vessel CTO - Iliac (Left)

Coding Instructions: Indicate if there is chronic total occlusion of the left iliac artery.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Iliac:

The inner branch of the common iliac artery on either side of the body; divides into several branches that supply blood to the pelvic and gluteal areas

Source: NCDR

Seq. #: 6402 **Name:** Lower Limb Vascular Anatomy Native Vessel Not Available - Iliac (Left)

Coding Instructions: Indicate if the best estimate of most severe percent stenosis in the left iliac artery as determined by angiography is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6405 **Name:** Lower Limb Vascular Anatomy Native Vessel Maximum Stenosis - Common Femoral (Left)

Coding Instructions: Indicate the best estimate of most severe percent stenosis in the left common femoral artery as determined by angiography.

Note(s):

If the patient has only a lower extremity procedure it is acceptable to use prior lab visit information, when coding native vessel stenosis, as long as there have been no changes in the vascular anatomy. This includes stenosis determined via peripheral intervention at another facility.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions:

Femoral Artery:

The main artery of the thigh, supplying blood to the groin and lower extremity.

Source: NCDR

Stenosis:

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6406 **Name:** Lower Limb Vascular Anatomy Native Vessel CTO - Common Femoral (Left)

Coding Instructions: Indicate if there is chronic total occlusion of the left common femoral artery.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6407 **Name:** Lower Limb Vascular Anatomy Native Vessel Not Available - Common Femoral (Left)

Coding Instructions: Indicate if the best estimate of most severe percent stenosis in the left common femoral artery as determined by angiography is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6410 **Name:** Lower Limb Vascular Anatomy Native Vessel Maximum Stenosis - Profunda (Left)

Coding Instructions: Indicate the presence or absence of blood flow in the left profunda artery.

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

Selections:

Selection Text	*Definition*
Patent	
Occluded	

Supporting Definitions: (none)

Seq. #: 6411 **Name:** Lower Limb Vascular Anatomy Native Vessel Not Available - Profunda (Left)

Coding Instructions: Indicate if the presence or absence of blood flow in the left profunda artery is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6415 **Name:** Lower Limb Vascular Anatomy Native Vessel Maximum Stenosis - Superficial Femoral Artery (Left)

Coding Instructions: Indicate the best estimate of most severe percent stenosis in the left superficial femoral artery as determined by angiography.

Note(s):

If the patient has only a lower extremity procedure it is acceptable to use prior lab visit information, when coding native vessel stenosis, as long as there have been no changes in the vascular anatomy. This includes stenosis determined via peripheral intervention at another facility.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6416 **Name:** Lower Limb Vascular Anatomy Native Vessel CTO - Superficial Femoral Artery (Left)

Coding Instructions: Indicate if there is chronic total occlusion of the left superficial femoral artery.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6417 **Name:** Lower Limb Vascular Anatomy Native Vessel Not Available - Superficial Femoral Artery (Left)

Coding Instructions: Indicate if the best estimate of most severe percent stenosis in the left superficial femoral artery as determined by angiography is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6420 **Name:** Lower Limb Vascular Anatomy Native Vessel Maximum Stenosis - Popliteal (Left)

Coding Instructions: Indicate the best estimate of most severe percent stenosis in the left popliteal artery as determined by angiography.

Note(s):

If the patient has only a lower extremity procedure it is acceptable to use prior lab visit information, when coding native vessel stenosis, as long as there have been no changes in the vascular anatomy. This includes stenosis determined via peripheral intervention at another facility.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6421 **Name:** Lower Limb Vascular Anatomy Native Vessel CTO - Popliteal (Left)

Coding Instructions: Indicate if there is chronic total occlusion of the left popliteal artery.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6422 **Name:** Lower Limb Vascular Anatomy Native Vessel Not Available - Popliteal (Left)

Coding Instructions: Indicate if the best estimate of most severe percent stenosis in the left popliteal artery as determined by angiography is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

E. Procedure

Seq. #: 6425 **Name:** Lower Limb Vascular Anatomy Native Vessel Runoff Vessels (Left)

Coding Instructions: Indicate whether the runoff segment is 1 vessel, 2 vessel, or 3 vessel in the left limb.

Note(s):

Aortography with lower extremity (leg) run-off involves the study of the lower aorta and arteries of the legs

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

Selections:

Selection Text	*Definition*
3V	3 vessel
2V	2 vessel
1V	1 vessel
None	

Supporting Definitions: **Runoff:**

Runoff refers to the number of tibial vessels (AT, Peroneal and PT) with inline uninterrupted flow to the ankle joint.
Source: NCDR

Seq. #: 6426 **Name:** Lower Limb Vascular Anatomy Native Vessel Runoff Vessels Not Available (Left)

Coding Instructions: Indicate if the runoff segment in the left limb is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6430 **Name:** Carotid Vascular Anatomy Native Vessel Maximum Stenosis - Common Carotid (Left)

Coding Instructions: Indicate the best estimate of most severe percent stenosis in the left common carotid artery as determined by angiography.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.
Source: NCDR

Seq. #: 6431 **Name:** Carotid Vascular Anatomy Native Vessel CTO - Common Carotid (Left)

Coding Instructions: Indicate if there is chronic total occlusion of the left common carotid artery.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6432 **Name:** Carotid Vascular Anatomy Native Vessel Not Available - Common Carotid (Left)

Coding Instructions: Indicate if the best estimate of most severe percent stenosis in the left common carotid artery as determined by angiography is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6435 **Name:** Carotid Vascular Anatomy Native Vessel Maximum Stenosis - Internal Carotid (Left)

Coding Instructions: Indicate the best estimate of most severe percent stenosis in the left internal carotid artery as determined by angiography.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions:

Stenosis:

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6436 **Name:** Carotid Vascular Anatomy Native Vessel CTO - Internal Carotid (Left)

Coding Instructions: Indicate if there is chronic total occlusion of the native left internal carotid artery.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6437 **Name:** Carotid Vascular Anatomy Native Vessel Not Available - Internal Carotid (Left)

Coding Instructions: Indicate if the best estimate of most severe percent stenosis in the left internal carotid artery as determined by angiography is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6440 **Name:** Carotid Vascular Anatomy Native Vessel Maximum Stenosis - Vertebral (Left)

Coding Instructions: Indicate the best estimate of most severe percent stenosis in the left vertebral artery as determined by angiography.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6441 **Name:** Carotid Vascular Anatomy Native Vessel CTO - Vertebral (Left)

Coding Instructions: Indicate if there is chronic total occlusion of the left vertebral artery.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6442 **Name:** Carotid Vascular Anatomy Native Vessel Not Available -Vertebral (Left)

Coding Instructions: Indicate if the best estimate of most severe percent stenosis in the native left vertebral artery as determined by angiography is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6445 **Name:** Vascular Anatomy Bypass Graft Present (Left)

Coding Instructions: Indicate if a bypass graft of any vessel or vessels is present on the left lower extremity.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6450 **Name:** Vascular Anatomy Graft Maximum Stenosis - Axillo - Femoral (Left)

Coding Instructions: Indicate the best angiographic estimate of the most severe stenosis within the left axillo-femoral bypass graft.

Note(s):

If the patient has only a lower extremity procedure it is acceptable to use prior lab visit information, when coding native vessel stenosis, as long as there have been no changes in the vascular anatomy. This includes stenosis determined via peripheral intervention at another facility.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6451 **Name:** Vascular Anatomy Graft Not Available - Axillo - Femoral (Left)

Coding Instructions: Indicate if the best angiographic estimate of the most severe stenosis within the left axillo-femoral bypass graft is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6455 **Name:** Vascular Anatomy Graft Maximum Stenosis - Aorto - Femoral (Left)

Coding Instructions: Indicate the best angiographic estimate of the most severe stenosis within the left aorto-femoral bypass graft.

Note(s):

If the patient has only a lower extremity procedure it is acceptable to use prior lab visit information, when coding native vessel stenosis, as long as there have been no changes in the vascular anatomy. This includes stenosis determined via peripheral intervention at another facility.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6456 **Name:** Vascular Anatomy Graft Not Available - Aorto - Femoral (Left)

Coding Instructions: Indicate if the best angiographic estimate of the most severe stenosis within the left aorto-femoral bypass graft is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6460 **Name:** Vascular Anatomy Graft Maximum Stenosis - Femoral - Popliteal (Left)

Coding Instructions: Indicate the best angiographic estimate of the most severe stenosis within the left femoral-popliteal bypass graft.

Note(s):

If the patient has only a lower extremity procedure it is acceptable to use prior lab visit information, when coding native vessel stenosis, as long as there have been no changes in the vascular anatomy. This includes stenosis determined via peripheral intervention at another facility.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6461 **Name:** Vascular Anatomy Graft Not Available - Femoral - Popliteal (Left)

Coding Instructions: Indicate if the best angiographic estimate of the most severe stenosis within the left femoral-popliteal bypass graft is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6465 **Name:** Vascular Anatomy Graft Maximum Stenosis - Femoral - Tibial (Left)

Coding Instructions: Indicate the best angiographic estimate of the most severe stenosis within the left femoral-tibial bypass graft.

Note(s):

If the patient has only a lower extremity procedure it is acceptable to use prior lab visit information, when coding native vessel stenosis, as long as there have been no changes in the vascular anatomy. This includes stenosis determined via peripheral intervention at another facility.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6466 **Name:** Vascular Anatomy Graft Not Available - Femoral - Tibial (Left)

Coding Instructions: Indicate if the best angiographic estimate of the most severe stenosis within the left femoral-tibial bypass graft is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6470 **Name:** Vascular Anatomy Graft Maximum Stenosis - Femoral - Femoral (Left)

Coding Instructions: Indicate the best angiographic estimate of the most severe stenosis within the left femoral-femoral bypass graft.

Note(s):

If the patient has only a lower extremity procedure it is acceptable to use prior lab visit information, when coding native vessel stenosis, as long as there have been no changes in the vascular anatomy. This includes stenosis determined via peripheral intervention at another facility.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6471 **Name:** Vascular Anatomy Graft Not available - Femoral - Femoral (Left)

Coding Instructions: Indicate if the best angiographic estimate of the most severe stenosis within the left femoral-femoral bypass graft is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6475 **Name:** Vascular Anatomy Graft Maximum Stenosis - Other (Left)

Coding Instructions: Indicate the best angiographic estimate of the most severe stenosis in other graft within the left lower extremity.

Note(s):

If the patient has only a lower extremity procedure it is acceptable to use prior lab visit information, when coding native vessel stenosis, as long as there have been no changes in the vascular anatomy. This includes stenosis determined via peripheral intervention at another facility.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 6476 **Name:** Vascular Anatomy Graft Not Available - Other (Left)

Coding Instructions: Indicate if the best angiographic estimate of the most severe stenosis in other graft on the left lower extremity is not available.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6700 **Name:** Auxiliary 5

Coding Instructions: Reserved for future use.

Target Value: (None)

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6705 **Name:** Auxiliary 6

Coding Instructions: Reserved for future use.

Target Value: (None)

Selections: (none)

Supporting Definitions: (none)

F. Lower Extremity Catheter-Based Procedure

Seq. #: 7000 **Name:** Lower Extremity Lesion Counter

Coding Instructions: The lesion counter is used to distinguish between multiple lesions on which an intervention is attempted or performed.

Note(s):

The software-assigned lesion counter should start at one and be incremented by one for each lesion. The lesion counter is reset back to one for each new LE lab visit.

At least one lesion must be specified for each LE procedure.

Target Value: N/A

Selections: (none)

Supporting Definitions: **Lesion:**

A target lesion is defined as a stenosis within a peripheral artery or peripheral artery bypass graft on which mechanical revascularization is attempted during the current procedure.

Source: NCDR

Seq. #: 7005 **Name:** Lesion Segment Number

Coding Instructions: Indicate the segment(s) that the current lesion spans (a lesion can span one or more segments).

Use the following numeric reference points to identify segments where procedures were attempted and its proximal reference number.

R01 Right Segment - Common Iliac Artery
R02 Right Segment - External Iliac Artery
R03 Right Segment - Internal Iliac Artery
R04 Right Segment - Common Femoral Artery
R05 Right Segment - Profunda Femoral Artery
R06 Right Segment - Superficial Femoral Artery
R07 Right Segment - Popliteal Artery
R08 Right Segment - Tibioperoneal Trunk
R09 Right Segment - Anterior Tibial Artery
R10 Right Segment - Posterior Tibial Artery
R11 Right Segment - Peroneal Artery
R12 Right Segment - Lateral Plantar Artery
R13 Right Segment - Medial Plantar Artery
R14 Right Segment - Dorsalis Pedis Artery
R15 Right Segment - Metatarsal Branches
R20 Right Graft - Axillo Femoral
R21 Right Graft - Aorto Femoral
R22 Right Graft - Femoral Popliteal
R23 Right Graft - Femoral Tibial
R24 Right Graft - Femoral Femoral
R25 Right Graft - Other
L01 Left Segment - Common Iliac Artery
L02 Left Segment - External Iliac Artery
L03 Left Segment - Internal Iliac Artery
L04 Left Segment - Common Femoral Artery
L05 Left Segment - Profunda Femoral Artery
L06 Left Segment - Superficial Femoral Artery
L07 Left Segment - Popliteal Artery
L08 Left Segment - Tibioperoneal Trunk
L09 Left Segment - Anterior Tibial Artery
L10 Left Segment - Posterior Tibial Artery
L11 Left Segment - Peroneal Artery
L12 Left Segment - Lateral Plantar Artery
L13 Left Segment - Medial Plantar Artery
L14 Left Segment - Dorsalis Pedis Artery
L15 Left Segment - Metatarsal Branches
L20 Left Graft - Axillo Femoral
L21 Left Graft - Aorto Femoral
L22 Left Graft - Femoral Popliteal
L23 Left Graft - Femoral Tibial
L24 Left Graft - Femoral Femoral
L25 Left Graft - Other

Note(s):

A segment is a defined region of a native or graft vessels of the lower limb, as illustrated in the NCDR PVI segment diagram.

If the target lesion is in a bypass graft, indicate the segment location of the first anastomosis distal to the lesion (and if it's above a Y graft, indicate the segment location of the most important distal vessel).

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

F. Lower Extremity Catheter-Based Procedure

Seq. #: 7010 **Name:** Lesion in Graft

Coding Instructions: Indicate if the treated lesion was in a graft.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7015 **Name:** Type of Graft

Coding Instructions: Indicate the type of graft if the treated lesion is within the graft.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
Vein	
Prosthetic	
Other	

Supporting Definitions: (none)

Seq. #: 7020 **Name:** Lesion Location in Graft

Coding Instructions: Indicate the location of the lesion within the graft.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
Ostial	Within first 3 mm of graft origin
Proximal	First 1/3 portion of graft (beyond the ostium)
Mid/Body	Middle 1/3 portion of graft
Distal	Last 1/3 portion of graft (prior to distal anastomosis)
Distal Anastomosis	Within 3 mm of distal attachment of graft to native vessel

Supporting Definitions: (none)

F. Lower Extremity Catheter-Based Procedure

Seq. #: 7025 **Name:** Culprit Lesion

Coding Instructions: Indicate the lesion that is considered to be responsible for the acute limb ischemia.

Note(s):

The physician should use his/her judgment in choosing the primary lesion. In cases in which this is difficult to determine, the lesion supplying the largest territory should be selected.

"No" should be coded if there is no apparent lesion that could be responsible for evidence of ischemia. "Unknown" should be coded if the culprit segment was not known.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	
Unknown	

Supporting Definitions: (none)

Seq. #: 7030 **Name:** Previously Treated Lesion

Coding Instructions: Indicate if this lesion has been treated previously with a peripheral vascular intervention.

Target Value: The value between birth and start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7035 **Name:** Prev Treated Lesion Timeframe

Coding Instructions: Indicate the timeframe of the most recent treatment if the lesion has been previously treated.

Target Value: The last value between birth and start of current procedure

Selections:

Selection Text	*Definition*
< 1 month	
1-5 months	
6-12 months	
1-2 years	
>2 years	
Time unknown	

Supporting Definitions: (none)

F. Lower Extremity Catheter-Based Procedure

Seq. #: 7040 **Name:** Previous Treatment - PTA

Coding Instructions: Indicate if the lesion has been previously treated with percutaneous transluminal angioplasty (PTA).

Target Value: Any occurrence between birth and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7041 **Name:** Previous Treatment - Atherectomy

Coding Instructions: Indicate if the lesion has been previously treated with an atherectomy.

Target Value: Any occurrence between birth and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7042 **Name:** Previous Treatment - Stent

Coding Instructions: Indicate if the lesion has been previously treated with a stent.

Target Value: Any occurrence between birth and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7043 **Name:** Previous Treatment - Drug Eluting Balloon

Coding Instructions: Indicate if the lesion has been previously treated with a drug eluting balloon.

Target Value: Any occurrence between birth and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

F. Lower Extremity Catheter-Based Procedure

Seq. #: 7044 **Name:** Previous Treatment - Unknown

Coding Instructions: Indicate if the lesion has been previously treated with an unknown intervention.

Target Value: Any occurrence between birth and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7045 **Name:** In-Stent Restenosis

Coding Instructions: Indicate if there is in-stent restenosis in the previously treated lesion.

Target Value: Any occurrence between birth and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7050 **Name:** In-Stent Thrombosis

Coding Instructions: Indicate if there is in-stent thrombosis in the previously treated lesion.

Target Value: Any occurrence between birth and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7055 **Name:** Previous Stent Type

Coding Instructions: Indicate the type of stent in the previously treated lesion.

Target Value: Any occurrence between birth and start of current procedure

Selections:

Selection Text	*Definition*
DES	Drug Eluting Stent
BMS	Bare Metal Stent
Covered	Covered Stent
Unknown	The patient has a stent but it is not known whether it was drug eluting or bare metal stent.

Supporting Definitions: (none)

F. Lower Extremity Catheter-Based Procedure

Seq. #: 7060 **Name:** Previous Stent Delivery

Coding Instructions: Indicate if the previously implanted stent was a balloon-expanding or self-expanding stent.

Target Value: Any occurrence between birth and current procedure

Selections:

Selection Text	*Definition*
Balloon Expanded	
Self-expanding	
Unknown	

Supporting Definitions: (none)

Seq. #: 7065 **Name:** Stenosis Immediately Prior to Treatment

Coding Instructions: Indicate the best angiographic estimate of the pre-procedure percent diameter stenosis.

Target Value: The highest value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7070 **Name:** Chronic Total Occlusion

Coding Instructions: Indicate if the segment with 100% pre-procedure stenosis was presumed to be 100% occluded for at least 3 months previous to this procedure AND not related to a clinical event prompting (or leading to) this procedure.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7075 **Name:** Guidewire Across Lesion

Coding Instructions: Indicate if a guidewire successfully crossed the lesion.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

F. Lower Extremity Catheter-Based Procedure

Seq. #: 7080 **Name:** Lesion Length

Coding Instructions: Indicate the length of the treated lesion in millimeters.

Note(s):

Information obtained after the baseline angiogram can be used to help determine lesion length (e.g. for total occlusions where the distal vessel cannot be visualized).

Target Value: Any occurrence on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7085 **Name:** Thrombus Present

Coding Instructions: Indicate if there was angiographic evidence of a thrombus in the target lesion prior to the intervention.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7090 **Name:** Bifurcation Lesion

Coding Instructions: Indicate if the lesion is at a significant bifurcation, trifurcation or more complex branch point.

Note(s):

Code 'Yes' if the current iliac lesion spans to the aorta.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7095 **Name:** Pressure Gradient Performed

Coding Instructions: Indicate if a pressure gradient was performed.

Target Value: Any occurrence between start of current procedure and end of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

F. Lower Extremity Catheter-Based Procedure

Seq. #: 7100 **Name:** Pressure Gradient Rest Pressure Peak to Peak

Coding Instructions: Indicate the peak to peak rest pressure in mmHg.

Target Value: Any occurrence on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7105 **Name:** Pressure Gradient Rest Pressure Mean

Coding Instructions: Indicate the mean rest pressure in mmHg.

Target Value: Any occurrence on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7110 **Name:** Pressure Gradient Hyperemia Pressure Peak to Peak

Coding Instructions: Indicate the peak to peak hyperemia pressure in mmHg.

Target Value: Any occurrence on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7115 **Name:** Pressure Gradient Hyperemia Pressures Mean

Coding Instructions: Indicate the mean hyperemia pressure in mmHg.

Target Value: Any occurrence on current procedure

Selections: (none)

Supporting Definitions: (none)

F. Lower Extremity Catheter-Based Procedure

Seq. #: 7120 **Name:** Aneurysm

Coding Instructions: Indicate if an aneurysm is present at the lesion site.

Target Value: The value on start of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Aneurysm:**

Dilatation of an artery having at least 50% increased diameter compared to the expected normal artery

Source: NCDR

Seq. #: 7125 **Name:** Aneurysm Maximum Diameter

Coding Instructions: Indicate the angiographic maximum diameter of the aneurysm, in mm.

Target Value: The highest value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7130 **Name:** Aneurysm Morphology

Coding Instructions: Indicate if the morphology of the aneurysm is fusiform or saccular.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
Fusiform	Elongated and tapering at both ends
Saccular	Pertaining to a pouch, or shaped like a sac

Supporting Definitions: (none)

Seq. #: 7135 **Name:** Aneurysm Course

Coding Instructions: Indicate if the course of the aneurysm is stable or enlarging.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
Stable	An aneurysm which has not increased in maximal transverse diameter by more than 0.4 cm/year
Enlarging	An aneurysm which has increased in size >0.4 cm in the previous 6-12 months.

Supporting Definitions: (none)

F. Lower Extremity Catheter-Based Procedure

Seq. #: 7140 **Name:** Intentional Subintimal Strategy

Coding Instructions: Indicate if an intentional subintimal strategy was used as defined by the deliberate attempt to cross an occlusion by placing a wire and catheter into the space between the intima and adventitia of an artery.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7145 **Name:** Lower Extremity Lesion Treatment Incomplete or Aborted

Coding Instructions: Indicate if the lesion treatment was incomplete or aborted.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7150 **Name:** Final Stenosis

Coding Instructions: Indicate the final angiographic post-procedure residual stenosis.

Target Value: The highest value on end of current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 7200 **Name:** Lower Extremity Device Counter

Coding Instructions: The software assigned device counter should start at one and be incremented by one for each device implanted, in chronological order, during the lower extremity procedure. The device counter number should be assigned sequentially in ascending order. Do not skip numbers.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

F. Lower Extremity Catheter-Based Procedure

Seq. #: 7205 **Name:** Device ID

Coding Instructions: Indicate the device ID(s) of the interventional device(s) used.

Indicate all devices utilized during the current procedure. If a device was utilized on multiple lesions, specify it only once (e.g., if a balloon was used to dilate two separate lesions, list it only once). Every treatment and support device utilized during the procedure should be specified.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7210 **Name:** Lower Extremity Lesion - Device Association

Coding Instructions: Indicate all Lower Extremity Lesion Counter Numbers (Seq Num. 7000) corresponding to the lesion(s) on which this device was used.

The lesion counter is used to distinguish between multiple lesions on which a lower extremity intervention procedure is attempted or performed.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7215 **Name:** Lower Extremity Device Activation

Coding Instructions: Indicate if the device was activated or deployed on any lesion within the lower extremity target vessel.

Note(s):

Each device must be associated with a lesion unless the device was not activated or deployed.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7220 **Name:** Interventional 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 during the procedure. This ID is provided by the device manufacturer, and is either a GTIN or HIBBC number.

Note(s):

The direct identifier portion of the UDI (unique device identifier) is provided by the manufacturer, specified at the unit of use. This is not the package barcode. The value should be mapped from your supply chain or inventory management system into this field. Depending on the device and manufacturer, this number could be between 12 to 25 digits.

- GTIN / GS1 standard: numeric, 12 – 14 characters
- HIBCC standard: alphanumeric, 25 characters
- ISBT-128: alphanumeric, 25 characters

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7225 **Name:** Interventional Device UDI Lot Number

Coding Instructions: [Reserved for Future Use] Indicate the lot number associated with the device used during the lower extremity procedure. This lot number is provided by the device manufacturer, and should be available within your supply chain or EHR system. Lot numbers indicate the specific manufacturing source or process.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7230 **Name:** Interventional Device UDI Expiration Date

Coding Instructions: [Reserved for Future Use] Indicate the expiration date associated with the interventional device used during the procedure. This expiration date is provided by the device manufacturer, and should be available within your supply chain or EHR system.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

G. Carotid Stent Procedure

Seq. #: 7300 **Name:** Carotid Lesion Counter

Coding Instructions: The carotid lesion counter is used to distinguish between multiple lesions on which an intervention is attempted or performed. When specifying interventional devices, list all treated lesions in which the device was utilized.

Note(s):

The lesion counter is used to distinguish between multiple lesions on which a CAS is attempted or performed. When specifying interventional devices, list all treated lesions in which the device was utilized.

At least one lesion should be counted for one CAS procedure.

Target Value: Any occurrence on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7305 **Name:** Target Vessel Lesion Location

Coding Instructions: Indicate the lesion location for this procedure.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
Isolated CCA	
Isolated ICA	
Bifurcation	

Supporting Definitions: (none)

Seq. #: 7310 **Name:** Lesion Difficult to Access Surgically

Coding Instructions: Indicate if the lesion is difficult to access surgically for Carotid Artery Stenting procedure.

Note(s):

Lesions that are difficult to access include those which are quite high in the neck (e.g. at or above the level of C2), and those that are within the proximal 1/2 or 1/3 of the common carotid artery, at or below the clavicle rendering endarterectomy either difficult or impossible.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

G. Carotid Stent Procedure

Seq. #: 7315 **Name:** Lesion Location - Difficult Surgical Access

Coding Instructions: Indicate if the lesion location is difficult to access surgically.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
High Cervical (C2 or higher)	Lesion that is high (at or above C2) and therefore either difficult to access or inaccessible for surgery.
Low Intrathoracic	A lesion that is low in the carotid artery (generally the common carotid artery [CCA] within the thorax), that makes endarterectomy difficult or impossible.

Supporting Definitions: (none)

Seq. #: 7320 **Name:** Thrombus Present

Coding Instructions: Indicate if a thrombus is detected by angiography within the lesion.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7325 **Name:** Ulceration

Coding Instructions: Indicate if the target lesion is ulcerated as assessed by baseline angiography.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7330 **Name:** Calcification

Coding Instructions: Indicate the degree of calcification in the target lesion as assessed by fluoroscopic inspection.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
None	
Mild to Moderate	
Dense	
Concentric	

Supporting Definitions: (none)

G. Carotid Stent Procedure

Seq. #: 7335 **Name:** Lesion Length

Coding Instructions: Indicate the length of the carotid target lesion in millimeters (mm) as assessed by baseline angiography.

Target Value: Any occurrence on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7340 **Name:** Minimum Luminal Diameter Prior to Treatment

Coding Instructions: Indicate the target lesion's minimum luminal diameter in millimeters (mm) as assessed by baseline angiography.

Note(s):

The Minimal Luminal Diameter (MLD) is defined as the minimum luminal diameter derived from the angiographic view that shows the tightest point of the stenosis.

Target Value: The lowest value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7345 **Name:** Distal (non-tapered) ICA Diameter

Coding Instructions: Indicate the diameter of the non-tapering distal segment of Internal Carotid Artery (ICA) measurement at the intended landing zone of the distal edge of the stent (where the vessel is no longer tapered and the walls become parallel).

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

G. Carotid Stent Procedure

Seq. #: 7350 **Name:** Stenosis Immediately Prior to Treatment

Coding Instructions: Indicate the percent stenosis immediately prior to the procedure, calculated as follows:

1. When the tightest stenosis is in the Internal Carotid Artery or at the carotid bifurcation, use NASCET methodology. Percent Diameter Stenosis is calculated as:

(1- minimum luminal diameter at the lesion site / diameter of non-tapering segment of distal ICA)*100.

"Non-tapering site" is where the walls of the ICA become parallel.

2. Do not use NASCET if the distal lumen collapses from a low-flow situation. In such cases, enter 99%, as the stenosis may be graded as a near occlusion.

3. For stenosis localized to the Common Carotid Artery, Percent Diameter Stenosis is calculated as:

(1- minimum luminal diameter / diameter of the adjacent normal segment of the Common Carotid artery)*100.

Target Value: The highest value on start of current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 7355 **Name:** Embolic Protection Attempted

Coding Instructions: Indicate if the operator attempted to use an embolic protection device (EPD).

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7360 **Name:** Predilation Pre-Embolic

Coding Instructions: Indicate whether balloon dilation was performed on the target lesion before placement of the embolic protection device, but before delivery of the stent.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

G. Carotid Stent Procedure

Seq. #: 7365 **Name:** Pre-Dilation (before any stent)

Coding Instructions: Indicate if there was a pre-dilation of the carotid artery prior to stent placement.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7370 **Name:** Post-Dilation Performed

Coding Instructions: Indicate if there was post-dilation of the stent after stent placement.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7375 **Name:** Lesion Treatment Incomplete or Aborted

Coding Instructions: Indicate if the lesion treatment was incomplete or aborted.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7380 **Name:** Reasons Treatment Aborted - Failure to gain vascular access

Coding Instructions: Indicate if the lesion treatment was incomplete or aborted because of failure to gain vascular access.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

G. Carotid Stent Procedure

Seq. #: 7381 **Name:** Reasons Treatment Aborted - Failure to confirm significant stenosis

Coding Instructions: Indicate if the lesion treatment was incomplete or aborted because of failure to confirm significant stenosis.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7382 **Name:** Reasons Treatment Aborted - Unable to deploy EPD

Coding Instructions: Indicate if the lesion treatment was incomplete or aborted due to inability to deploy EPD.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7383 **Name:** Reasons Treatment Aborted - Unable to place guiding catheter/sheath

Coding Instructions: Indicate if the lesion treatment was incomplete or aborted due to inability to place guiding catheter/sheath.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7384 **Name:** Reasons Treatment Aborted - Unable to deliver stent

Coding Instructions: Indicate if the lesion treatment was incomplete or aborted due to inability to deliver stent.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

G. Carotid Stent Procedure

Seq. #: 7385 **Name:** Reasons Treatment Aborted - Unable to deploy stent

Coding Instructions: Indicate if the lesion treatment was incomplete or aborted due to inability to deploy stent.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7386 **Name:** Reasons Treatment Aborted - Difficult to access due to tortuosity

Coding Instructions: Indicate if the lesion treatment was incomplete or aborted due to difficult to access due to tortuosity.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7387 **Name:** Reasons Treatment Aborted - Unable to cross guidewire

Coding Instructions: Indicate if the lesion treatment was incomplete or aborted due to inability to cross the guidewire.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7388 **Name:** Reasons Treatment Aborted - Hypotension

Coding Instructions: Indicate if the lesion treatment was incomplete or aborted due to hypotension.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

G. Carotid Stent Procedure

Seq. #: 7389 **Name:** Reasons Treatment Aborted - Hypertension

Coding Instructions: Indicate if the lesion treatment was incomplete or aborted due to hypertension.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7390 **Name:** Reasons Treatment Aborted - Arrhythmia

Coding Instructions: Indicate if the lesion treatment was incomplete or aborted due to an arrhythmia.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7391 **Name:** Reasons Treatment Aborted - Unable to cross balloon

Coding Instructions: Indicate if the lesion treatment was incomplete or aborted due to inability to cross the lesion with a balloon.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7392 **Name:** Reasons Treatment Aborted - Cardiac ischemia

Coding Instructions: Indicate if the lesion treatment was incomplete or aborted due to cardiac ischemia.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

G. Carotid Stent Procedure

Seq. #: 7393 **Name:** Reasons Treatment Aborted - Other

Coding Instructions: Indicate if the lesion treatment was incomplete or aborted due to other reason not listed.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7400 **Name:** Final Percent Stenosis

Coding Instructions: Indicate the final percent stenosis of the carotid artery at the end of the procedure.

1. For internal carotid artery site, use NASCET methodology. Percent diameter stenosis is calculated as: (1 - minimum residual luminal diameter within the treated site / diameter of nontapering segment of distal ICD) * 100

- 'Non-tapering site' is where the walls of the ICA become parallel.

2. For lesion and interventional site localized to the common carotid artery, percent diameter stenosis is calculated as: (1 - minimum residual luminal diameter / diameter of the adjacent normal segment of the common carotid artery) * 100

Target Value: The highest value on end of current procedure

Selections: (none)

Supporting Definitions: **Stenosis:**

Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. In instances where multiple lesions are present, enter the single highest percent stenosis noted.

Source: NCDR

Seq. #: 7405 **Name:** Final Minimum Luminal Diameter

Coding Instructions: Indicate the final minimum luminal diameter in millimeters (mm).

Target Value: The lowest value on end of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7410 **Name:** Carotid Device Counter

Coding Instructions: The software assigned stent counter should start at one and be incremented by one for each stent implanted, in chronological order, during the carotid artery stent procedure. The stent counter number should be assigned sequentially in ascending order. Do not skip numbers.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

G. Carotid Stent Procedure

Seq. #: 7415 **Name:** Carotid Device ID

Coding Instructions: Indicate the Device ID used to uniquely identify the device, either a balloon, stent, or embolic protection device.

Note(s):

This section should be used to document all devices utilized during the procedure. Add all devices in the order used/attempted.

If a device (balloon) is used to inflate more than one stent, list the balloon only once.

Target Value: Any occurrence on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7420 **Name:** Carotid Lesion Device Association

Coding Instructions: Indicate all Carotid Artery Lesion Counter Numbers (Seq Num. 7300) corresponding to the lesion on which this device was used.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7425 **Name:** Carotid Device Activation

Coding Instructions: Indicate if the device was activated or deployed on any lesion within the carotid target vessel.

Note(s):

For an Embolic Protection Device, activation equates to successful placement, which is defined as deployment of an embolic protection device distal to the target lesion, prior to stent implantation, which remained in place for the entirety of the procedure.

Code 'No' for this element if the EPD placement was not successful.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

G. Carotid Stent Procedure

Seq. #: 7430 **Name:** Carotid Interventional 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 during the procedure. This ID is provided by the device manufacturer, and is either a GTIN or HIBCC number.

Note(s):

The direct identifier portion of the UDI (unique device identifier) is provided by the manufacturer, specified at the unit of use. This is not the package barcode. The value should be mapped from your supply chain or inventory management system into this field. Depending on the device and manufacturer, this number could be between 12 to 25 digits.

- GTIN / GS1 standard: numeric, 12 – 14 characters
- HIBCC standard: alphanumeric, 25 characters
- ISBT-128: alphanumeric, 25 characters

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7435 **Name:** Carotid Interventional Device UDI Lot Number

Coding Instructions: [Reserved for Future Use] Indicate the lot number associated with the device used during the carotid procedure. This lot number is provided by the device manufacturer, and should be available within your supply chain or EHR system. Lot numbers indicate the specific manufacturing source or process.

Target Value: The first value between start of current procedure and end of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7440 **Name:** Carotid Interventional Device UDI Expiration Date

Coding Instructions: [Reserved for Future Use] Indicate the expiration date associated with the device used during the procedure. This expiration date is provided by the device manufacturer, and should be available within your supply chain or EHR system.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

H. Carotid Endarterectomy Procedure

Seq. #: 7600 **Name:** Arteriotomy Patch Used

Coding Instructions: Indicate if an arteriotomy patch was used during the endarterectomy.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7605 **Name:** Visible Thrombus Present

Coding Instructions: Indicate if there was direct visual evidence of a thrombus in the target lesion at the start of the carotid endarterectomy (CEA) procedure.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7610 **Name:** Shunt Used

Coding Instructions: Indicate if a shunt was used during the carotid endarterectomy.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7615 **Name:** Surgical Procedure Terminated

Coding Instructions: Indicate if the carotid endarterectomy procedure was terminated.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

H. Carotid Endarterectomy Procedure

Seq. #: 7616 **Name:** Surgical Procedure Terminated Reason - Hypertension

Coding Instructions: Indicate if the surgical procedure was terminated early due to hypertension.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7617 **Name:** Surgical Procedure Terminated Reason - Hypotension

Coding Instructions: Indicate if the surgical procedure was terminated early due to hypotension.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7618 **Name:** Surgical Procedure Terminated Reason - Cardiac Instability

Coding Instructions: Indicate if the surgical procedure was terminated early due to cardiac instability.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7619 **Name:** Surgical Procedure Terminated - Nerve Compromise

Coding Instructions: Indicate if the surgical procedure was terminated early due to a compromised nerve.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7620 **Name:** Surgical Procedure Terminated Reason - Difficulty with Anesthesia

Coding Instructions: Indicate if the surgical procedure was terminated early due to difficulty with anesthesia.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7621 **Name:** Surgical Procedure Terminated Reason - Inability to Implement Shunting

Coding Instructions: Indicate if the surgical procedure was terminated early due to inability to implement shunting.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7622 **Name:** Surgical Procedure Terminated Reason - Excessive Scar Tissue

Coding Instructions: Indicate if the surgical procedure was terminated early due to excessive scar tissue.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7623 **Name:** Surgical Procedure Terminated Reason - Difficult Dissection

Coding Instructions: Indicate if the surgical procedure was terminated early due to a difficult dissection.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

H. Carotid Endarterectomy Procedure

Seq. #: 7624 **Name:** Surgical Procedure Terminated Reason - Excessive Bleeding

Coding Instructions: Indicate if the surgical procedure was terminated early due to excessive bleeding.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7625 **Name:** Surgical Procedure Terminated Reason - Carotid Artery Thrombosis

Coding Instructions: Indicate if the surgical procedure was terminated early due to carotid artery thrombosis.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7626 **Name:** Surgical Procedure Terminated Reason - ICA String Sign/Atresia

Coding Instructions: Indicate if the surgical procedure was terminated early due to ICA string sign/atresia.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7627 **Name:** Surgical Procedure Terminated Reason - Inability to Access Lesion due to Anatomy

Coding Instructions: Indicate if the surgical procedure was terminated early due to inability to access lesion due to anatomy.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

H. Carotid Endarterectomy Procedure

Seq. #: 7628 **Name:** Surgical Procedure Terminated Reason - Other

Coding Instructions: Indicate if the surgical procedure was terminated early due to other reason not listed.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

I. Pre and Intra Procedures Medications

Seq. #: 7800 **Name:** Medication ID

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

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. #: 7805 **Name:** Medication Administered

Coding Instructions: Indicate the medications administered within 24 hours prior to and during the procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

J. Procedure Totals

Seq. #: 8000 **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. #: 8005 **Name:** Fluoro Time

Coding Instructions: Indicate the total procedural fluoroscopy time in minutes.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8010 **Name:** Cumulative Air Kerma (mGy)

Coding Instructions: Indicate the total radiation dose (Cumulative Air Kerma, or Reference Air Kerma) recorded to the nearest milligray (mGy). 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.

Note(s):

Collect one Cumulative Air Kerma unit based on the equipment used.

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

Selections: (none)

Supporting Definitions:

Cumulative (Reference) Air kerma:

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

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

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

J. Procedure Totals

Seq. #: 8011 **Name:** Cumulative Air Kerma (Gy)

Coding Instructions: Indicate the total radiation dose (Cumulative Air Kerma, or Reference Air Kerma) recorded to the nearest gray (Gy). The value recorded should include the total dose for the lab visit.

Note(s):

Collect one Cumulative Air Kerma unit based on the equipment used.

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

Selections: (none)

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

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

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

Source: Miller DL, Balter S, Cole PE, et al. Radiation doses in interventional radiology procedures: the RAD-IR study. I. Overall measures of dose. (J Vasc Interv Radiol 2003; 14:711–727.)

Seq. #: 8015 **Name:** Dose Area Product (Gy-cm2)

Coding Instructions: Indicate the total fluoroscopy dose to the nearest integer in gray square centimeter (Gy-cm2). The value recorded should include the total dose for the lab visit.

Note(s):

Collect one Dose Area Product unit based on the equipment used.

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.)

Seq. #: 8016 **Name:** Dose Area Product (cGy-cm2)

Coding Instructions: Indicate the total fluoroscopy dose to the nearest integer in centigray square centimeter (cGy-cm2). The value recorded should include the total dose for the lab visit.

Note(s):

Collect one Dose Area Product unit based on the equipment used.

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.)

J. Procedure Totals

Seq. #: 8017 **Name:** Dose Area Product (mGy-cm2)

Coding Instructions: Indicate the total fluoroscopy dose to the nearest integer in miligray square centimeter (mGy-cm2). The value recorded should include the total dose for the lab visit.

Note(s):

Collect one Dose Area Product unit based on the equipment used.

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.)

Seq. #: 8018 **Name:** Dose Area Product (µGy-m2)

Coding Instructions: Indicate the total fluoroscopy dose to the nearest integer in microgray square meter (uGy-m2). The value recorded should include the total dose for the lab visit.

Note(s):

Collect one Dose Area Product unit based on the equipment used.

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

Selections: (none)

Supporting Definitions: **Dose Air 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.)

K. Labs

Seq. #: 8100 **Name:** Pre-Procedure Creatinine Value

Coding Instructions: Indicate the patient's pre-procedure creatinine value in mg/dL.

Target Value: The last value between 2 weeks prior to current procedure and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8101 **Name:** Pre-Procedure Creatinine Date

Coding Instructions: Indicate the date the patient's pre-procedure creatinine was collected.

Target Value: The last value between 2 weeks prior to current procedure and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8102 **Name:** Pre-Procedure Creatinine Time

Coding Instructions: Indicate the time the patient's pre-procedure creatinine was collected.

Target Value: The last value between 2 weeks prior to current procedure and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8105 **Name:** Pre-Procedure Creatinine Not Drawn

Coding Instructions: Indicate if the patient's pre-procedure creatinine level was not collected.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8110 **Name:** Pre-Procedure Hemoglobin Value

Coding Instructions: Indicate the patient's pre-procedure hemoglobin in g/dL.

Target Value: The last value between 2 weeks prior to current procedure and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8111 **Name:** Pre-Procedure Hemoglobin Date

Coding Instructions: Indicate the date the patient's pre-procedure hemoglobin was collected.

Target Value: The last value between 2 weeks prior to current procedure and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8112 **Name:** Pre-Procedure Hemoglobin Time

Coding Instructions: Indicate the time the patient's pre-procedure hemoglobin was collected.

Target Value: The last value between 2 weeks prior to current procedure and start of current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8115 **Name:** Pre-Procedure Hemoglobin Not Drawn

Coding Instructions: Indicate if the patient's pre-procedure hemoglobin was not collected.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8120 **Name:** LDL Cholesterol Value

Coding Instructions: Indicate the patient's low density lipoprotein (LDL) cholesterol value in mg/dL.

Target Value: The last value between 2 weeks prior to arrival at this facility and discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8121 **Name:** LDL Cholesterol Date

Coding Instructions: Indicate the date the low density lipoprotein (LDL) cholesterol value was collected.

Target Value: The last value between 2 weeks prior to arrival at this facility and discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8122 **Name:** LDL Cholesterol Time

Coding Instructions: Indicate the time the low density lipoprotein (LDL) cholesterol value was collected.

Target Value: The last value between 2 weeks prior to arrival at this facility and discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8125 **Name:** LDL Cholesterol Not Drawn

Coding Instructions: Indicate if the low density lipoprotein (LDL) cholesterol value was not collected.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8130 **Name:** Post-Procedure Creatinine Value

Coding Instructions: Indicate the patient's post-procedure creatinine peak value in mg/dL.

Target Value: The highest value between 6 hours after current procedure and 24 hours after current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8131 **Name:** Post-Procedure Creatinine Date

Coding Instructions: Indicate the date the patient's post-procedure creatinine peak level was collected.

Target Value: The highest value between 6 hours after current procedure and 24 hours after current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8132 **Name:** Post-Procedure Creatinine Time

Coding Instructions: Indicate the time the patient's post-procedure creatinine peak level was collected.

Target Value: The highest value between 6 hours after current procedure and 24 hours after current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8135 **Name:** Post-Procedure Creatinine Not Drawn

Coding Instructions: Indicate if the patient's post-procedure creatinine peak level was not collected.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8140 **Name:** Post-Procedure Hemoglobin Nadir Value

Coding Instructions: Indicate the patient's post-procedure hemoglobin level in g/dL.

Target Value: The lowest value between end of current procedure and 72 hours after current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8141 **Name:** Post-Procedure Hemoglobin Nadir Date

Coding Instructions: Indicate the date the patient's post-procedure hemoglobin level was collected.

Target Value: The lowest value between end of current procedure and 72 hours after currrent procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8142 **Name:** Post-Procedure Hemoglobin Nadir Time

Coding Instructions: Indicate the time the patient's post-procedure hemoglobin level was collected.

Target Value: The lowest value between end of current procedure and 72 hours after current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8145 **Name:** Post-Procedure Hemoglobin Nadir Not Drawn

Coding Instructions: Indicate if the patient's post-procedure hemoglobin was not collected.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

L. Post-Procedure Assessment

Seq. #: 8200 **Name:** Post-Procedure ABI Performed (Right)

Coding Instructions: Indicate if a post-procedure ankle-brachial index (ABI) was performed in the right limb.

Target Value: Any occurrence between end of current procedure and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8205 **Name:** Post-Procedure Ankle-Brachial Index Value (Right)

Coding Instructions: Indicate the post-procedure value of the ankle-brachial index of the right limb.

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

Selections: (none)

Supporting Definitions: **Ankle-Brachial Index:**

Ratio of systolic blood pressure in the ankle (higher of the posterior tibial and dorsal is pedis systolic blood pressures) compared to the higher of the two brachial pressures. Normal ABI 1.0-1.39. Supra-normal >1.40; Borderline 0.91-0.99; Abnormal <0.90.

Source: NCDR

Seq. #: 8210 **Name:** Post-Procedure Ankle-Brachial Index Non-compressible (Right)

Coding Instructions: Indicate if the post-procedure ankle-brachial index of the right limb was performed but was non-compressible.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8215 **Name:** Post-Procedure Exercise ABI Index Performed (Right)

Coding Instructions: Indicate if a post-procedure exercise ankle-brachial index was performed in the right limb.

Target Value: Any occurrence between end of current procedure and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

L. Post-Procedure Assessment

Seq. #: 8220 **Name:** Post-Procedure Exercise ABI Result (Right)

Coding Instructions: Indicate the result of the post-procedure exercise ankle-brachial index of the right limb.

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

Selections:

Selection Text	*Definition*
Negative	Index drop of <= 0.2 or pressure change of <=20mmHg
Positive	Index drop of >0.2 or pressure change of >20mmHg

Supporting Definitions: (none)

Seq. #: 8225 **Name:** Post-Procedure Toe Pressure Performed (Right)

Coding Instructions: Indicate if the post procedure toe pressure was assessed in the right limb.

Target Value: Any occurrence between end of current procedure and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8230 **Name:** Post-Procedure Toe Pressure Value (Right)

Coding Instructions: Indicate the post procedure value of the right limb toe pressure in mmHg.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8235 **Name:** Post-Procedure Duplex Ultrasound Performed (Right)

Coding Instructions: Indicate if a post procedure duplex ultrasound was performed on the right limb.

Target Value: Any occurrence between end of current procedure and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8240 **Name:** Post-Procedure Duplex Ultrasound Maximum Stenosed Segment (Right)

Coding Instructions: Indicate the maximum stenosed segment from the post procedure duplex ultrasound of the right limb.

Note(s):

Use PVI segment diagram provided by the NCDR.

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

Selections:

Selection Text	*Definition*
R01	Right Side Segment - Common Iliac Artery
R02	Right Side Segment - External Iliac Artery
R03	Right Side Segment - Internal Iliac Artery
R04	Right Side Segment - Common Femoral Artery
R05	Right Side Segment - Profunda Femoral Artery
R06	Right Side Segment - Superficial Femoral Artery
R07	Right Side Segment - Popliteal Artery
R08	Right Side Segment - Tibioperoneal Trunk
R09	Right Side Segment - Anterior Tibial Artery
R10	Right Side Segment - Posterior Tibial Artery
R11	Right Side Segment - Peroneal Artery
R12	Right Side Segment - Lateral Plantar Artery
R13	Right Side Segment - Medial Plantar Artery
R14	Right Side Segment - Dorsalis Pedis Artery
R15	Right Side Segment - Metatarsal Branches
R20	Right Side Graft - Axillo Femoral
R21	Right Side Graft - Aorto Femoral
R22	Right Side Graft - Femoral Popliteal
R23	Right Side Graft - Femoral Tibial
R24	Right Side Graft - Femoral Femoral
R25	Right Side Graft - Other

Supporting Definitions: (none)

Seq. #: 8245 **Name:** Post-Procedure Duplex Ultrasound Peak Systolic Velocity in Lesion (Right)

Coding Instructions: Indicate the post procedure duplex ultrasound peak systolic velocity in lesion in the maximum stenosed segment of the right limb, in centimeters per second (cm/sec).

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8250 **Name:** Post-Procedure Duplex Ultrasound Peak Systolic Velocity Proximal To Lesion (Right)

Coding Instructions: Indicate the patient's peak systolic velocity (PSV) proximal to the lesion in the right lower extremity in centimeters per second (cm/sec).

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8255 **Name:** Post-Procedure Duplex Ultrasound Peak Systolic Velocity Ratio (Right)

Coding Instructions: Indicate the post-procedure duplex ultrasound peak systolic velocity ratio of the right limb.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8260 **Name:** Post-Procedure Modified Rankin Score

Coding Instructions: Indicate the Modified Rankin Scale Score administered after the current procedure. The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.

Target Value: The last value between end of current procedure 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: Dead	

Supporting Definitions: (none)

L. Post-Procedure Assessment

Seq. #: 8261 **Name:** Post-Procedure Modified Rankin Score Date Administered

Coding Instructions: Indicate the date the Modified Rankin Scale was administered post-procedure.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8262 **Name:** Post-Procedure Modified Rankin Score Not Administered

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

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8265 **Name:** Post-Procedure NIH Stroke Scale Total Score

Coding Instructions: Indicate the post-procedure NIH Stroke Scale total score.

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

Selections: (none)

Supporting Definitions: **NIH Stroke Scale:**

The National Institute of Health Stroke Scale, or NIH Stroke Scale (NIHSS) is a tool used by healthcare providers to objectively quantify the impairment caused by a stroke. The NIHSS is composed of 11 items, each of which scores a specific ability between a 0 and 4. For each item, a score of 0 typically indicates normal function in that specific ability, while a higher score is indicative of some level of impairment. The individual scores from each item are summed in order to calculate a patient's total NIHSS score. The maximum possible score is 42, with the minimum score being a 0 (zero).

Score	Stroke Severity
0	No Stroke Symptoms
1-4	Minor Stroke
5-15	Moderate Stroke
16-20	Moderate to Severe Stroke
21-42	Severe Stroke

Source: National Institute of Neurological Disorders and Stroke

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Seq. #: 8266 **Name:** Post-Procedure NIH Stroke Scale Date Administered

Coding Instructions: Indicate the date the National Institutes of Health Stroke Scale (NIHSS) was administered post-procedure.

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

Selections: (none)

Supporting Definitions: (none)

L. Post-Procedure Assessment

Seq. #: 8267 **Name:** Post-Procedure NIH Stroke Scale Not Administered

Coding Instructions: Indicate if the National Institutes of Health Stroke Scale (NIHSS) was not administered post-procedure.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8270 **Name:** Post-Procedure NIH Stroke Scale Examiner Last Name

Coding Instructions: Indicate the last name of the NIH Stroke Scale (NIHSS) examiner who administered the post-procedure NIH Stroke Scale.

Note(s):

The Stroke Scale assessment should be conducted by someone other than the operator for this procedure.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8275 **Name:** Post-Procedure NIH Stroke Scale Examiner First Name

Coding Instructions: Indicate the first name of the NIH Stroke Scale (NIHSS) examiner who administered the post-procedure NIH Stroke Scale.

Note(s):

The Stroke Scale assessment should be conducted by someone other than the operator for this procedure.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8280 **Name:** Post-Procedure NIH Stroke Scale Examiner Middle Name

Coding Instructions: Indicate the middle name of the NIH Stroke Scale (NIHSS) examiner who administered the post-procedure NIH Stroke Scale.

Note(s):

The Stroke Scale assessment should be conducted by someone other than the operator for this procedure.

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

Selections: (none)

Supporting Definitions: (none)

L. Post-Procedure Assessment

Seq. #: 8285 **Name:** Post-Procedure NIH Stroke Scale Examiner Certified

Coding Instructions: Indicate if the NIH Stroke Scale (NIHSS) examiner who administered the post-procedure stroke scale is certified to administer the stroke scale exam.

Note(s):

The Stroke Scale assessment should be conducted by someone other than the operator for this procedure.

Target Value: The value on end of current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8300 **Name:** Post-Procedure ABI Performed (Left)

Coding Instructions: Indicate if a post-procedure ankle-brachial index (ABI) was performed in the left limb.

Target Value: Any occurrence between end of current procedure and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8305 **Name:** Post-Procedure Ankle-Brachial Index Value (Left)

Coding Instructions: Indicate the post-procedure value of the ankle-brachial index of the left limb.

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

Selections: (none)

Supporting Definitions:

Ankle-Brachial Index:

Ratio of systolic blood pressure in the ankle (higher of the posterior tibial and dorsal is pedis systolic blood pressures) compared to the higher of the two brachial pressures. Normal ABI 1.0-1.39. Supra-normal >1.40; Borderline 0.91-0.99; Abnormal <0.90.

Source: NCDR

Seq. #: 8310 **Name:** Post-Procedure Ankle-Brachial Index Non-compressible (Left)

Coding Instructions: Indicate if the post-procedure ankle-brachial index of the left limb was performed but was non-compressible.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

L. Post-Procedure Assessment

Seq. #: 8315 **Name:** Post-Procedure Exercise ABI Performed (Left)

Coding Instructions: Indicate if a post-procedure exercise ankle-brachial index was performed in the left limb.

Target Value: Any occurrence between end of current procedure and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8320 **Name:** Post-Procedure Exercise ABI Result (Left)

Coding Instructions: Indicate the result of the post-procedure exercise ankle-brachial index of the left limb.

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

Selections:

Selection Text	*Definition*
Negative	Index drop of <= 0.2 or pressure change of <=20mmHg
Positive	Index drop of >0.2 or pressure change of >20mmHg

Supporting Definitions: (none)

Seq. #: 8325 **Name:** Post-Procedure Toe Pressure Performed (Left)

Coding Instructions: Indicate if the post procedure toe pressure was assessed in the left limb.

Target Value: Any occurrence between end of current procedure and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8330 **Name:** Post-Procedure Toe Pressure Value (Left)

Coding Instructions: Indicate the post-procedure value of the left limb toe pressure in mmHg.

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

Selections: (none)

Supporting Definitions: (none)

L. Post-Procedure Assessment

Seq. #: 8335 **Name:** Post-Procedure Duplex Ultrasound Performed (Left)

Coding Instructions: Indicate if a post-procedure duplex ultrasound was performed on the left limb.

Target Value: Any occurrence between end of current procedure and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8340 **Name:** Post-Procedure Duplex Ultrasound Maximum Stenosed Segment (Left)

Coding Instructions: Indicate the maximum stenosed segment from the post-procedure duplex ultrasound of the left limb.

Note(s):

Use PVI segment diagram provided by the NCDR.

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

Selections:

Selection Text	*Definition*
L01	Left Side Segment - Common Iliac Artery
L02	Left Side Segment - External Iliac Artery
L03	Left Side Segment - Internal Iliac Artery
L04	Left Side Segment - Common Femoral Artery
L05	Left Side Segment - Profunda Femoral Artery
L06	Left Side Segment - Superficial Femoral Artery
L07	Left Side Segment - Popliteal Artery
L08	Left Side Segment - Tibioperoneal Trunk
L09	Left Side Segment - Anterior Tibial Artery
L10	Left Side Segment - Posterior Tibial Artery
L11	Left Side Segment - Peroneal Artery
L12	Left Side Segment - Lateral Plantar Artery
L13	Left Side Segment - Medial Plantar Artery
L14	Left Side Segment - Dorsalis Pedis Artery
L15	Left Side Segment - Metatarsal Branches
L20	Left Side Graft - Axillo Femoral
L21	Left Side Graft - Aorto Femoral
L22	Left Side Graft - Femoral Popliteal
L23	Left Side Graft - Femoral Tibial
L24	Left Side Graft - Femoral Femoral
L25	Left Side Graft - Other

Supporting Definitions: (none)

L. Post-Procedure Assessment

Seq. #: 8345 **Name:** Post-Procedure Duplex Ultrasound Peak Systolic Velocity in Lesion (Left)

Coding Instructions: Indicate the post-procedure duplex ultrasound peak systolic velocity in lesion in the maximum stenosed segment of the left limb, in centimeters per second (cm/sec).

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8350 **Name:** Post-Procedure Duplex Ultrasound Peak Systolic Velocity Proximal To Lesion (Left)

Coding Instructions: Indicate the patient's peak systolic velocity (PSV) proximal to the lesion in the left lower extremity in centimeters per second (cm/sec).

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8355 **Name:** Post-Procedure Duplex Ultrasound Peak Systolic Velocity Ratio (Left)

Coding Instructions: Indicate the post-procedure duplex ultrasound peak systolic velocity ratio of the left limb.

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

Selections: (none)

Supporting Definitions: (none)

M. Intra or Post Procedure Event

Seq. #: 8400 **Name:** Myocardial Infarction

Coding Instructions: Indicate if a myocardial infarction occurred.

Note(s):

Q waves with absent, incomplete or inconclusive biomarkers should be considered evidence of MI and should be coded as yes.

In rare situations, biomarkers may not be obtained in the setting of a post-PCI acute MI (e.g., sudden unexpected cardiac death without symptoms or ECG changes suggestive of ischemia, patient is transferred, or biomarkers were just not ordered). In these situations, the site may choose to report a clinically-diagnosed post-PCI myocardial infarction even in the absence of the usually required biomarker elevations.

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Intra or Post Procedure Myocardial Infarction:

1. Detection of a rise and/or fall of cardiac biomarker values [preferably cardiac troponin (cTn)] with at least one value above the 99th percentile upper reference
limit (URL) and with at least one of the following:

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

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

Source: Expert Consensus Document: Third Universal Definition of Myocardial Infarction (J Am Coll Cardiol. October 16, 2012,60(16):1581-1598 doi:10.1016/j.jacc.2012.08.001)

Seq. #: 8405 **Name:** Cardiogenic Shock

Coding Instructions: Indicate if the patient had a new onset or acute recurrence of cardiogenic shock.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Cardiogenic Shock:**

Cardiogenic shock is defined as
1. a sustained (>30 minutes) episode of systolic blood pressure <90 mm Hg determined to be secondary to cardiac dysfunction, and/or

2. a sustained (>30 minutes) episode of cardiac index <2.2 L/min/m2 determined to be secondary to cardiac dysfunction, and/or

3. the sustained (>30 minutes) requirement for parenteral inotropic or vasopressor agents or mechanical support (e.g., IABP, extracorporeal circulation, ventricular assist devices) to maintain systolic blood pressure >=90 mm Hg, and/or

4. the sustained (>30 minutes) requirement for parenteral inotropic or vasopressor agents or mechanical support (e.g., IABP, extracorporeal circulation, ventricular assist devices) to maintain CI >=2.2 L/min/m2

Source: NCDR

Seq. #: 8410 **Name:** Heart Failure

Coding Instructions: Indicate if the patient had new onset, or acute recurrence of, heart failure which necessitated new or increased pharmacologic therapy.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Heart Failure:**

Heart failure is defined as physician documentation or report of any of the following clinical symptoms of heart failure: unusual dyspnea on light exertion; recurrent dyspnea occurring in the supine position; fluid retention; the description of rales, jugular venous distension, pulmonary edema on physical exam; or pulmonary edema on chest x-ray. A previous hospital admission with principal diagnosis of heart failure is considered evidence of heart failure history. A low ejection fraction without clinical evidence of heart failure does not qualify as heart failure.

Source: ACC Data Standards, The Society of Thoracic Surgeons

M. Intra or Post Procedure Event

Seq. #: 8415 **Name:** Persistent Hypotension >24 hours Requiring Treatment

Coding Instructions: Indicate if the patient had persistent hypotension for more than 24 hours requiring treatment.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8420 **Name:** New Arrhythmia Requiring Treatment

Coding Instructions: Indicate if the patient had a new arrhythmia requiring treatment.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8425 **Name:** Transient Ischemic Attack (TIA)

Coding Instructions: Indicate if the patient experienced a transient ischemic attack (TIA) as defined by a transient episode of focal neurological dysfunction caused by brain, spinal cord, or retinal ischemia, without acute infarction.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Transient Ischemic Attack (TIA):

Transient ischemic attack (TIA) is defined as a transient episode of focal neurological dysfunction caused by brain, spinal cord, or retinal ischemia, without acute infarction.

The symptoms typically last less than 24 hours.

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

M. Intra or Post Procedure Event

Seq. #: 8430 **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.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

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. #: 8435 **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.

Note(s):

Subdural hematomas are intracranial hemorrhagic events and not strokes.

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

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.

Note: Subdural hematomas are intracranial hemorrhagic events and not strokes.

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

M. Intra or Post Procedure Event

Seq. #: 8440 **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.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

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)

Seq. #: 8445 **Name:** CNS Event Location - New Right Hemispheric or Retinal

Coding Instructions: Indicate if the TIA, ischemic stroke, hemorrhagic stroke, or undetermined stroke occurred in the right hemispheric or retinal territory.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
0	
Yes	

Supporting Definitions: (none)

Seq. #: 8446 **Name:** CNS Event Location - Left Hemispheric or Retinal

Coding Instructions: Indicate if the TIA, ischemic stroke, hemorrhagic stroke, or undetermined stroke occurred in the left hemispheric or retinal territory.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

M. Intra or Post Procedure Event

Seq. #: 8447 **Name:** CNS Event Location - Vertebrobasilar

Coding Instructions: Indicate if the TIA, ischemic stroke, hemorrhagic stroke, or undetermined stroke occurred in the vertebrobasilar territory.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8448 **Name:** CNS Event Location - Unknown Location

Coding Instructions: Indicate if the TIA, ischemic stroke, hemorrhagic stroke, or undetermined stroke occurred in an unknown location.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8450 **Name:** New Seizure

Coding Instructions: Indicate if the patient had a new seizure.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

M. Intra or Post Procedure Event

Seq. #: 8455 **Name:** Intracranial Hemorrhage

Coding Instructions: Indicate if the patient had a new intracranial hemorrhage.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8460 **Name:** Emergency CNS Rescue (directly from lab)

Coding Instructions: Indicate if the patient required an emergency central nervous system (CNS) rescue directly from the lab.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8465 **Name:** New Requirement for Dialysis

Coding Instructions: Indicate if there is a new requirement of dialysis.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

M. Intra or Post Procedure Event

Seq. #: 8470 **Name:** Unexpected Intubation or Resuscitation

Coding Instructions: Indicate if the patient required unexpected intubation or resuscitation.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8475 **Name:** Thrombosis

Coding Instructions: Indicate if there is evidence of a thrombus formed.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Thrombosis:

The formation or presence of a blood clot within a blood vessel

Source: NCDR

Seq. #: 8480 **Name:** Embolism

Coding Instructions: Indicate if the patient developed an arterial embolus either intra or post procedure, characterized by coagulated blood, atherosclerotic debris, or a foreign body that has moved through the arterial circulation from one position to another.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Arterial Embolus:

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

Source: NCDR

M. Intra or Post Procedure Event

Seq. #: 8485 **Name:** Significant Dissection

Coding Instructions: Indicate if a significant dissection was observed.

Note(s):

Typically, dissections described as type A or B are not considered significant dissections because there is no impairment of flow. Significant dissections are grade C dissections in the presence of ischemia, or grade D-F dissections, all of which are further described as:
type C: persisting contrast medium extravasations;
type D: spiral filling defect with delayed but complete distal flow;
type E: persistent filling defect with delayed antegrade flow;
type F: filling defect with impaired flow and total occlusion

Although not considered "significant", type A and B are as follows:
Type A dissections represent minor radiolucent areas within the coronary lumen during contrast injection with little or no persistence of contrast after the dye has cleared.

Type B dissections are parallel tracts or a double lumen separated by a radiolucent area during contrast injection, with minimal or no persistence after dye clearance.

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Dissection:

Dissection is defined as the appearance of contrast materials outside of the expected luminal dimensions of the target vessel and extending longitudinally beyond the length of the lesion.

Source: NCDR

Seq. #: 8490 **Name:** Perforation

Coding Instructions: Indicate if vessel perforation was observed.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Perforation:

A perforation occurs when there is angiographic or clinical evidence of a dissection or intimal tear that extends through the full thickness of the arterial wall.

Source: NCDR

M. Intra or Post Procedure Event

Seq. #: 8491 **Name:** Perforation Treatment - Prolonged Balloon Inflation

Coding Instructions: Indicate if the perforation was treated with a prolonged balloon inflation.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8492 **Name:** Perforation Treatment - Coiling

Coding Instructions: Indicate if the perforation was treated with a coil.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8493 **Name:** Perforation Treatment - Covered Stent

Coding Instructions: Indicate if the perforation was treated with a covered stent.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

M. Intra or Post Procedure Event

Seq. #: 8494 **Name:** Perforation Treatment - External Compression

Coding Instructions: Indicate if the perforation was treated with external compression.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8495 **Name:** Perforation Treatment - Surgery

Coding Instructions: Indicate if the perforation was treated with surgery.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8496 **Name:** Perforation Treatment - Other

Coding Instructions: Indicate if the perforation was treated with a treatment not listed.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

M. Intra or Post Procedure Event

Seq. #: 8497 **Name:** Perforation Treatment - No Specific Rx

Coding Instructions: Indicate if the perforation was not treated.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8500 **Name:** Other Vascular Complications Requiring Treatment

Coding Instructions: Indicate if the patient experienced any other vascular complications (excluding external bleeding or hematomas) at the percutaneous entry site that required treatment or intervention.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Vascular Complications:

Vascular complications can include, but are not limited to, access site occlusions, peripheral embolizations, dissections, pseudoaneurysms and/or AV fistulas. Any noted vascular complication must have had an intervention such as a fibrin injection, angioplasty, or surgical repair to qualify. Prolonged pressure does not qualify as an intervention, but ultrasonic guided compression after making a diagnosis of pseudoaneurysm does qualify. A retroperitoneal bleed or hematoma requiring transfusion is not a vascular complication under this data element.

To qualify, this adverse outcome should be attributable to this procedure and not related to a previous or subsequent procedure.

Source: NCDR

Seq. #: 8505 **Name:** Unplanned Vascular Intervention/Surgery

Coding Instructions: Indicate if the patient required unplanned vascular surgery or intervention due to a complication of the procedure.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

M. Intra or Post Procedure Event

Seq. #: 8510 **Name:** Emergency Vascular Surgery (directly from lab)

Coding Instructions: Indicate if the patient needed to go to the operating room emergently from the peripheral lab to prevent loss of major organ, tissue, limb or life.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8515 **Name:** Major Amputation (unplanned)

Coding Instructions: Indicate if a major unplanned amputation occurred.

Note(s):

Amputation WITHOUT retention of a sufficiently functional foot remnant to allow standing and walking without a prosthesis.

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8520 **Name:** Compartment Syndrome

Coding Instructions: Indicate if the patient experienced compartment syndrome.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Compartment Syndrome:

Abnormal increase in pressure in a muscle group that is enclosed in a fascial sheath. If not identified rapidly, may result in loss of motor and sensory neurologic function and limb amputation.

Source: NCDR

M. Intra or Post Procedure Event

Seq. #: 8525 **Name:** Anaphylactoid Contrast Reaction

Coding Instructions: Indicate if the patient experienced an anaphylactic allergic reaction to contrast.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8530 **Name:** Infection Related to Procedure, Requiring Antibiotics

Coding Instructions: Indicate if the procedure had an infection that required treatment.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8535 **Name:** Bleeding Event w/in 72 Hours

Coding Instructions: Indicate if the patient experienced a confirmed bleeding event observed and documented in the medical record that was associated with any of the following:

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

Target Value: Any occurrence between start of current procedure and 72 hours after procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

M. Intra or Post Procedure Event

Seq. #: 8540 **Name:** Bleeding Event - Bleeding at Access Site

Coding Instructions: Indicate if the patient experienced a bleeding event at the access site.

Target Value: Any occurrence between start of current procedure and 72 hours after current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8545 **Name:** Post-Procedure - Access Bleed Site

Coding Instructions: Indicate the access site ID (Location) if the patient had a bleeding event at the access site.

Note(s):

Code all access sites where a significant bleeding event was documented.

Refer to Sequence Number 6200, Access Site Counter, to complete this element.

Target Value: Any occurrence between start of current procedure and 72 hours after current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8550 **Name:** Bleeding Event - Hematoma at Access Site

Coding Instructions: Indicate if the patient experienced a hematoma at the access site.

Target Value: Any occurrence between start of current procedure and 72 hours after procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8555 **Name:** Post-Procedure - Hematoma Site

Coding Instructions: If the patient had a hematoma at an access site, indicate the Access Site Location corresponding to the hematoma.

Note(s):

Code all access sites where a hematoma was documented.

Refer to Sequence Number 6200, Access Site Counter, to complete this element.

Target Value: Any occurrence between start of current procedure and 72 hours after procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8560 **Name:** Post-Procedure - Retroperitoneal Bleeding

Coding Instructions: Indicate if the patient experienced retroperitoneal bleeding.

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

Target Value: Any occurrence between start of current procedure and 72 hours after current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8565 **Name:** Post-Procedure - Gastrointestinal Bleeding

Coding Instructions: Indicate whether the patient experienced gastrointestinal bleeding.

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

Target Value: Any occurrence between start of current procedure and 72 hours after current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8570 **Name:** Post-Procedure - Genital-Urinary Bleeding

Coding Instructions: Indicate whether genital or urinary bleeding occurred.

To qualify, it must be associated with any of the following:

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

Target Value: Any occurrence between start of current procedure and 72 hours after current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

M. Intra or Post Procedure Event

Seq. #: 8575 **Name:** Post-Procedure - Other Bleeding

Coding Instructions: Indicate if other bleeding occurred. Other bleeding includes bleeding from a site not specified, such as pulmonary bleeding.

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

Target Value: Any occurrence between start of current procedure and 72 hours after currrent procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8580 **Name:** RBC/Whole Blood Transfusion

Coding Instructions: Indicate if there was a transfusion(s) of either whole blood or packed red blood cells.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8585 **Name:** Hgb Prior to 1st Transfusion

Coding Instructions: Indicate the patient's hemoglobin value, in g/dL, prior to first transfusion.

Target Value: The lowest value on prior to first transfusion

Selections: (none)

Supporting Definitions: (none)

N. Discharge

Seq. #: 9000 **Name:** Discharge Date

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

Note(s):

A patient's death during the episode of care will be considered the discharge date.

Target Value: The value on discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 9005 **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)

Seq. #: 9010 **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	
Extended care/TCU/Rehab	
Other acute care hospital	
Skilled nursing facility	
Other	
Left against medical advice	The patient was discharged or eloped against medical advice.

Supporting Definitions: (none)

N. Discharge

Seq. #: 9015 **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. #: 9020 **Name:** Cessation Counseling

Coding Instructions: Indicate if there was documentation in the medical record that tobacco cessation advice or counseling was given during this admission. Tobacco cessation counseling can include one-on-one counseling, classes, pharmacotherapy.

Note(s):

Only required if the patient is listed as a current tobacco user, as specified by the "Current - Every Day", "Current - Some Days", and "Current - Frequency Unknown" selections for Tobacco Use (4110).

Target Value: The value on discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 9025 **Name:** Death During Procedure

Coding Instructions: Indicate if the patient expired during the procedure, either in surgery or in the cath lab.

Target Value: The value on discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 9030 **Name:** Cause of Death

Coding Instructions: Select the PRIMARY cause of death, i.e. the first significant abnormal event which ultimately led to death.

Target Value: The value on discharge

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:

Causes of Death:

Causes of Death

Source: 2013 ACCF/AHA key data elements and definitions for measuring the clinical management and outcomes of patients with acute coronary syndromes and coronary artery disease: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Clinical Data Standards (Writing Committee to Develop Acute Coronary Syndromes and Coronary Artery Disease Clinical Data Standards). (J Am Coll Cardiol [E-pub ahead of print 2013 Jan 28]. doi:10.1016/j.jacc.2012.10.005.)

Seq. #: 9500 **Name:** Discharge Medication ID

Coding Instructions: Indicate the NCDR-assigned IDs for the medications the patient was prescribed upon discharge.

Note(s):

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

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

Target Value: The value on discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 9505 **Name:** Discharge Medication Administered

Coding Instructions: Indicate if the medication was administered, not administered, or was not administered for either a medical, system, or patient reason.

Target Value: The value on discharge

Selections:

Selection Text	*Definition*
Yes	Medications was administered or prescribed.
No - No Reason	Medication was not administered or prescribed with no reason documented.
No - Patient Reason	Unable to administer/prescribe due to a patient reason such as patient refusal of medication.
No - Medical Reason	Unable to administer/prescribe due to a medical reason such as an allergy.
No - System Reason	Unable to administer/prescribe due to system reason such as not available in the formulary.

Supporting Definitions: (none)

O. Follow-Up

Seq. #: 10000 **Name:** Follow-Up Assessment Date

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

Note(s):

Collect follow-up from one day to a year post discharge.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10001 **Name:** Reference Procedure Start Date

Coding Instructions: Indicate the procedure start date for which this follow-up is associated.

Note(s):

If the patient had more than one similar procedure during the original episode of care, list all associated procedure dates and times. See Seq. Number 6000/6001.

(For Example, if the patient had a Lower Extremity stent placed in the left leg on 3/1, and a second stent placed in the right leg on 3/4, list both 3/1 and 3/4.)

(For Example, if a carotid artery stent was aborted on 3/1, but successfully performed on 3/4, list both 3/1 and 3/4.)

The reference procedure date/time must be exactly the same as at least one procedure (Seq. Number 6000/6001) listed in the original episode of care record.

If more than one procedure was performed within the episode of care, and were more than 15 days apart, two follow-up records are recommended, one for each procedure.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10002 **Name:** Reference Procedure Start Time

Coding Instructions: Indicate the procedure start time for which this follow-up is associated.

Note(s):

If the patient had more than one similar procedure during the original episode of care, list all associated procedure dates and times. See Seq. Number 6000/6001.

(For Example, if the patient had a Lower Extremity stent placed in the left leg on 3/1, and a second stent placed in the right leg on 3/4, list both 3/1 and 3/4.)

(For Example, if a carotid artery stent was aborted on 3/1, but successfully performed on 3/4, list both 3/1 and 3/4.)

The reference procedure date/time must be exactly the same as at least one procedure (Seq. Number 6000/6001) listed in the original episode of care record.

If more than one procedure was performed within the episode of care, and were more than 15 days apart, two follow-up records are recommended, one for each procedure.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

O. Follow-Up

Seq. #: 10005 **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. #: 10006 **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. #: 10007 **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)

Seq. #: 10008 **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)

O. Follow-Up

Seq. #: 10009 **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. #: 10010 **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. #: 10011 **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)

Seq. #: 10015 **Name:** Follow-Up Status

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

Target Value: The value on follow-up

Selections:

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

Supporting Definitions: (none)

O. Follow-Up

Seq. #: 10020 **Name:** Follow-Up Date of Death

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

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10025 **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

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)

O. Follow-Up

Seq. #: 10030 **Name:** Follow-Up Modified Rankin Score

Coding Instructions: Indicate the Modified Rankin Scale Score administered either at follow-up, or closest to follow-up. The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.

Note(s):

The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.

Target Value: The 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: Dead	

Supporting Definitions: (none)

Seq. #: 10031 **Name:** Follow-Up Modified Rankin Score Date Administered

Coding Instructions: Indicate the date the Modified Rankin Score was administered.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10032 **Name:** Follow-Up Modified Rankin Score Not Administered

Coding Instructions: Indicate if the Modified Rankin Scale was not administered.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

O. Follow-Up

Seq. #: 10035 **Name:** Follow-Up NIH Stroke Scale Total Score

Coding Instructions: Indicate the NIH Stroke Scale total score if it was performed.

Note(s):

The NIHSS is a standardized neurological examination for patients with acute ischemic stroke that quantitatively measures the level of stroke severity.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: **NIHSS:**

The National Institute of Health Stroke Scale, or NIH Stroke Scale (NIHSS) is a tool used by healthcare providers to objectively quantify the impairment caused by a stroke. The NIHSS is composed of 11 items, each of which scores a specific ability between a 0 and 4. For each item, a score of 0 typically indicates normal function in that specific ability, while a higher score is indicative of some level of impairment. The individual scores from each item are summed in order to calculate a patient's total NIHSS score. The maximum possible score is 42, with the minimum score being a 0 (zero).

Score	Stroke Severity
0	No Stroke Symptoms
1-4	Minor Stroke
5-15	Moderate Stroke
16-20	Moderate to Severe Stroke
21-42	Severe Stroke

Source: NIH, National Institute of Neurological Disorders and Stroke. Stroke Scale

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Seq. #: 10036 **Name:** Follow-Up NIH Stroke Scale Date Administered

Coding Instructions: Indicate the date the National Institutes of Health Stroke Scale (NIHSS) was administered.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10037 **Name:** Follow-Up NIH Stroke Scale Not Administered

Coding Instructions: Indicate if the National Institutes of Health Stroke Scale (NIHSS) was not administered.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

O. Follow-Up

Seq. #: 10040 **Name:** Follow-Up NIH Stroke Scale Examiner Last Name

Coding Instructions: Indicate the last name of the NIH Stroke Scale (NIHSS) examiner who administered the follow-up NIH Stroke Scale.

Note(s):

The Stroke Scale assessment should be conducted by someone other than the operator for this procedure.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10045 **Name:** Follow-Up NIH Stroke Scale Examiner First Name

Coding Instructions: Indicate the first name of the NIH Stroke Scale (NIHSS) examiner who administered the follow-up NIH Stroke Scale.

Note(s):

The Stroke Scale assessment should be conducted by someone other than the operator for this procedure.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10050 **Name:** Follow-Up NIH Stroke Scale Examiner Middle Name

Coding Instructions: Indicate the middle name of the NIH Stroke Scale (NIHSS) examiner who administered the follow-up NIH Stroke Scale.

Note(s):

The Stroke Scale assessment should be conducted by someone other than the operator for this procedure.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10055 **Name:** Follow-Up NIH Stroke Scale Examiner Certified

Coding Instructions: Indicate if the NIH Stroke Scale examiner who administered the follow up stroke scale is certified to administer the stroke scale exam.

Note(s):

The Stroke Scale assessment should be conducted by someone other than the operator for this procedure.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

O. Follow-Up

Seq. #: 10060 **Name:** Follow-Up Symptoms

Coding Instructions: Indicate the most significant status or PAD symptoms of the patient at the time the follow-up was performed.

Note(s):

Please complete for the target vessel limb(s) affected, and report the most severe symptom.

If PAD Symptoms are present in the non-treatment limb, or both limbs were treated during the initial episode of care, provide the most severe symptom for both limbs.

Target Value: The highest value on follow-up

Selections:

Selection Text	*Definition*
Asymptomatic	The patient has no symptoms of claudication, no symptoms of ischemic pain, and no limitation in walking distance.
Atypical claudication	Exertional limb discomfort which occurs at variable distances, and does not resolve with stopping and standing.
Claudication - Mild (Rutherford 1)	Indicate claudication as determined by the discomfort that is: - Exertional - Reproducible - Resolves within 10 min of rest
Claudication - Moderate (Rutherford 2)	Indicate claudication as determined by the discomfort that is: -Exertional -Reproducible -Resolves within 20 min of rest
Claudication - Severe (Rutherford 3)	Indicate claudication as determined by the discomfort that is: -Exertional -Reproducible -Resolves within 30 min of rest
Critical Limb Ischemia - Ischemic Pain at Rest (Rutherford 4)	Ischemic pain at rest
Critical Limb Ischemia - Minor Tissue Loss (Rutherford 5)	Minor tissue loss
Critical Limb Ischemia - Major Tissue Loss (Rutherford 6)	Major tissue loss
Acute Limb Ischemia	Acute limb ischemia is characterized by: - Pallor - Pulselessness - Poikilothermia - Paralysis

Supporting Definitions:

O. Follow-Up

Acute Limb Ischemia:

Acute limb ischemia is characterized by pallor, pulselessness, poikilothermia and /or paralysis.

Source: Adapted from: 2012 ACCF/AHA/ACR/SCAI/SIR/STS/SVM/SVN/SVS Key Data Elements and Definitions for Peripheral Atherosclerotic Vascular Disease. (JACC Vol. 59, No. 3, 2012)

Critical Limb Ischemia :

Critical limb ischemia includes ischemic rest pain, ulceration, or gangrene. This results in tissue loss and may or may not lead to amputation.

Source: Adapted from: 2012 ACCF/AHA/ACR/SCAI/SIR/STS/SVM/SVN/SVS Key Data Elements and Definitions for Peripheral Atherosclerotic Vascular Disease. (JACC Vol. 59, No. 3, 2012)

Claudication:

Claudication is defined by reproducible, exertional, discomfort characterized by cramping, aching, fatigue of the buttock, hip, thigh, calf or foot that resolves within ten to thirty minutes of rest.

Source: Adapted from: 2012 ACCF/AHA/ACR/SCAI/SIR/STS/SVM/SVN/SVS Key Data Elements and Definitions for Peripheral Atherosclerotic Vascular Disease. (JACC Vol. 59, No. 3, 2012)

Seq. #: 10065 **Name:** Follow-Up ABI Performed (Right)

Coding Instructions: Indicate if an ankle-brachial index (ABI) was performed in the right limb.

Target Value: Any occurrence between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Ankle-Brachial Index:**

Ratio of systolic blood pressure in the ankle (higher of the posterior tibial and dorsal is pedis systolic blood pressures) compared to the higher of the two brachial pressures. Normal ABI 1.0-1.39. Supra-normal >1.40; Borderline 0.91-0.99; Abnormal <0.90.

Source: NCDR

Seq. #: 10070 **Name:** Follow-Up Ankle-Brachial Index Value (Right)

Coding Instructions: Indicate the value closest to the time of follow-up of the ankle-brachial index of the right limb.

Target Value: The last value between discharge and follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10075 **Name:** Follow-Up ABI Non-compressible (Right)

Coding Instructions: Indicate if the ankle-brachial index of the right limb was performed at the time of follow-up but was non-compressible.

Target Value: The last value between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

O. Follow-Up

Seq. #: 10080 **Name:** Follow-Up Exercise ABI Performed (Right)

Coding Instructions: Indicate if an exercise ankle-brachial index was performed on the right lower limb.

Target Value: Any occurrence between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Exercise ABI:**

A slight drop in your ABI with exercise means that you probably have PAD. This drop may be important, because PAD can be linked to a higher risk of heart attack or stroke. The ABI result can help diagnose peripheral arterial disease (PAD). A lower ABI means you might have PAD. A slight drop in the ABI with exercise, even if you have a normal ABI at rest, means that you probably have PAD.

Source: Rooke TW, et al. (2011). 2011 ACCF/AHA Focused update of the guideline for the management of patients with peripheral artery disease (updating the 2005 guideline): A report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. (Journal of the American College of Cardiology, 58 (19): 2020-2045.)

Seq. #: 10085 **Name:** Follow-Up Exercise ABI Value (Right)

Coding Instructions: Indicate the result of the exercise ankle-brachial index of the right limb at the time of follow-up.

Target Value: The last value between discharge and follow-up

Selections:

Selection Text	*Definition*
Negative	Index drop of <= 0.2 or pressure change of <=20mmHg
Positive	Index drop of >0.2 or pressure change of >20mmHg

Supporting Definitions: (none)

Seq. #: 10090 **Name:** Follow-Up Toe Pressure Performed (Right)

Coding Instructions: Indicate if the toe pressure was assessed in the right limb at the time of follow-up.

Target Value: Any occurrence between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10095 **Name:** Follow-Up Toe Pressure Value (Right)

Coding Instructions: Indicate the value at the time of follow-up of the right limb toe pressure in mmHg.

Target Value: The last value between discharge and follow-up

Selections: (none)

Supporting Definitions: (none)

O. Follow-Up

Seq. #: 10100 **Name:** Follow-Up Duplex Ultrasound Performed (Right)

Coding Instructions: Indicate if a duplex ultrasound was performed on the right limb at the time of follow-up.

Target Value: Any occurrence between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10105 **Name:** Follow-Up Duplex Ultrasound Maximum Stenosed Segment (Right)

Coding Instructions: Indicate the maximum stenosed segment from the duplex ultrasound of the right limb at the time of follow-up.

Note(s):

Use PVI segment diagram provided by the NCDR.

Target Value: The last value between discharge and follow-up

Selections:

Selection Text	*Definition*
R01	Right Side Segment - Common Iliac Artery
R02	Right Side Segment - External Iliac Artery
R03	Right Segment - Internal Iliac Artery
R04	Right Segment - Common Femoral Artery
R05	Right Segment - Profunda Femoral Artery
R06	Right Segment - Superficial Femoral Artery
R07	Right Segment - Popliteal Artery
R08	Right Segment - Tibioperoneal Trunk
R09	Right Segment - Anterior Tibial Artery
R10	Right Segment - Posterior Tibial Artery
R11	Right Segment - Peroneal Artery
R12	Right Segment - Lateral Plantar Artery
R13	Right Segment - Medial Plantar Artery
R14	Right Segment - Dorsalis Pedis Artery
R15	Right Segment - Metatarsal Branches
R20	Right Graft - Axillo Femoral
R21	Right Graft - Aorto Femoral
R22	Right Graft - Femoral Popliteal
R23	Right Graft - Femoral Tibial
R24	Right Graft - Femoral Femoral
R25	Right Graft - Other

Supporting Definitions: (none)

O. Follow-Up

Seq. #: 10110 **Name:** Follow-Up Duplex Ultrasound Peak Systolic Velocity in Lesion (Right)

Coding Instructions: Indicate the duplex ultrasound peak systolic velocity in lesion in the maximum stenosed segment of the right limb, in centimeters per second (cm/sec) at the time of follow-up

Target Value: The last value between discharge and follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10115 **Name:** Follow-Up Duplex Ultrasound Peak Systolic Velocity Proximal To Lesion (Right)

Coding Instructions: Indicate the patient's peak systolic velocity (PSV) proximal to the lesion in the right lower extremity in centimeters per second (cm/sec).

Target Value: The last value between discharge and follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10120 **Name:** Follow-Up Duplex Ultrasound Peak Systolic Velocity Ratio (Right)

Coding Instructions: Indicate the duplex ultrasound peak systolic velocity ratio of the right limb at the time of follow-up.

Target Value: The last value between discharge and follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10265 **Name:** Follow-Up ABI Performed (Left)

Coding Instructions: Indicate if an ankle-brachial index (ABI) was performed in the left limb.

Target Value: Any occurrence between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Ankle-Brachial Index:**

Ratio of systolic blood pressure in the ankle (higher of the posterior tibial and dorsal is pedis systolic blood pressures) compared to the higher of the two brachial pressures. Normal ABI 1.0-1.39. Supra-normal >1.40; Borderline 0.91-0.99; Abnormal <0.90.

Source: NCDR

O. Follow-Up

Seq. #: 10270 **Name:** Follow-Up Ankle-Brachial Index Value (Left)

Coding Instructions: Indicate the value closest to the time of follow-up of the ankle-brachial index of the left limb.

Target Value: The last value between discharge and follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10275 **Name:** Follow-Up ABI Non-compressible (Left)

Coding Instructions: Indicate if the ankle-brachial index of the left limb was performed at the time of follow-up but was non-compressible.

Target Value: The last value between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10280 **Name:** Follow-Up Exercise ABI Performed (Left)

Coding Instructions: Indicate if an exercise ankle-brachial index was performed on the left lower limb.

Target Value: Any occurrence between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Exercise ABI:**

A slight drop in your ABI with exercise means that you probably have PAD. This drop may be important, because PAD can be linked to a higher risk of heart attack or stroke. The ABI result can help diagnose peripheral arterial disease (PAD). A lower ABI means you might have PAD. A slight drop in the ABI with exercise, even if you have a normal
ABI at rest, means that you probably have PAD.

Source: Rooke TW, et al. (2011). 2011 ACCF/AHA Focused update of the guideline for the management of patients with peripheral artery disease (updating the 2005 guideline): A report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. Journal of the American College of Cardiology, 58 (19): 2020-2045.

Seq. #: 10285 **Name:** Follow-Up Exercise ABI Value (Left)

Coding Instructions: Indicate the result of the exercise ankle-brachial index of the left limb at the time of follow-up.

Target Value: The last value between discharge and follow-up

Selections:

Selection Text	*Definition*
Negative	Index drop of <= 0.2 or pressure change of <=20mmHg
Positive	Index drop of >0.2 or pressure change of >20mmHg

Supporting Definitions: (none)

O. Follow-Up

Seq. #: 10290 **Name:** Follow-Up Toe Pressure Performed (Left)

Coding Instructions: Indicate if the toe pressure was assessed in the left limb at the time of follow-up.

Target Value: The last value between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10295 **Name:** Follow-Up Toe Pressure Value (Left)

Coding Instructions: Indicate the value at the time of follow-up of the left limb toe pressure in mmHg.

Target Value: The last value between discharge and follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10300 **Name:** Follow-Up Duplex Ultrasound Performed (Left)

Coding Instructions: Indicate if a duplex ultrasound was performed on the left limb at the time of follow-up.

Target Value: Any occurrence between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

O. Follow-Up

Seq. #: 10305 **Name:** Follow-Up Duplex Ultrasound Maximum Stenosed Segment (Left)

Coding Instructions: Indicate the maximum stenosed segment from the duplex ultrasound of the left limb at the time of follow-up.

Note(s):

Use PVI segment diagram provided by the NCDR.

Target Value: The last value between discharge and follow-up

Selections:

Selection Text	*Definition*
L01	Left Side Segment - Common Iliac Artery
L02	Left Side Segment - External Iliac Artery
L03	Left Segment - Internal Iliac Artery
L04	Left Segment - Common Femoral Artery
L05	Left Segment - Profunda Femoral Artery
L06	Left Segment - Superficial Femoral Artery
L07	Left Segment - Popliteal Artery
L08	Left Segment - Tibioperoneal Trunk
L09	Left Segment - Anterior Tibial Artery
L10	Left Segment - Posterior Tibial Artery
L11	Left Segment - Peroneal Artery
L12	Left Segment - Lateral Plantar Artery
L13	Left Segment - Medial Plantar Artery
L14	Left Segment - Dorsalis Pedis Artery
L15	Left Segment - Metatarsal Branches
L20	Left Graft - Axillo Femoral
L21	Left Graft - Aorto Femoral
L22	Left Graft - Femoral Popliteal
L23	Left Graft - Femoral Tibial
L24	Left Graft - Femoral Femoral
L25	Left Graft - Other

Supporting Definitions: (none)

Seq. #: 10310 **Name:** Follow-Up Duplex Ultrasound Peak Systolic Velocity in Lesion (Left)

Coding Instructions: Indicate the duplex ultrasound peak systolic velocity in lesion in the maximum stenosed segment of the left limb, in centimeters per second (cm/sec) at the time of follow-up

Target Value: The last value between discharge and follow-up

Selections: (none)

Supporting Definitions: (none)

O. Follow-Up

Seq. #: 10315 **Name:** Follow-Up Duplex Ultrasound Peak Systolic Velocity Proximal To Lesion (Left)

Coding Instructions: Indicate the patient's peak systolic velocity (PSV) proximal to the lesion in the left lower extremity in centimeters per second (cm/sec).

Target Value: The last value between discharge and follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10320 **Name:** Follow-Up Duplex Ultrasound Peak Systolic Velocity Ratio (Left)

Coding Instructions: Indicate the duplex ultrasound peak systolic velocity ratio of the left limb at the time of follow-up.

Target Value: The last value between discharge and follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10400 **Name:** Follow-Up Readmitted

Coding Instructions: Indicate if the patient was readmitted to an acute care facility during the follow-up period.

Target Value: Any occurrence between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10405 **Name:** Follow-Up Readmission Length of Stay

Coding Instructions: Indicate the length of stay (LOS) in days, during the follow-up period. If the patient had more than one readmission, code the LOS of the most recent readmission. If the length of stay is less than one day, round up to 1 day.

Note(s):

If LOS is longer than 999, code as 999.

Target Value: The last value between discharge and follow-up

Selections: (none)

Supporting Definitions: (none)

O. Follow-Up

Seq. #: 10410 **Name:** Follow-Up Readmission Date

Coding Instructions: Indicate the date of readmission during the follow-up period. If the patient had more than one readmission, code the Date of the most recent readmission.

Target Value: The last value between discharge and follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10415 **Name:** Follow-Up Currently Hospitalized

Coding Instructions: Indicate that the length of stay cannot be calculated because the patient was currently hospitalized during the readmission period.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

O. Follow-Up

Seq. #: 10420 **Name:** Follow-Up Myocardial Infarction

Coding Instructions: Indicate if the patient had a myocardial infarction during the follow-up period.

Target Value: Any occurrence between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Myocardial Infarction:

A myocardial infarction is evidenced by any of the following:

1. A rise and fall of cardiac biomarkers (preferably troponin) with at least one of the values in the abnormal range for that laboratory [typically above the 99th percentile of the upper reference limit (URL) for normal subjects] together with at least one of the following manifestations of myocardial ischemia:

a. Ischemic symptoms.

b. ECG changes indicative of new ischemia (new ST-T changes, new left bundle branch block, or loss of R wave voltage).

c. Development of pathological Q waves in 2 or more contiguous leads in the ECG (or equivalent findings for true posterior MI).

d. Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

e. Documentation in the medical record of the diagnosis of acute myocardial infarction based on the cardiac biomarker pattern in the absence of any items enumerated in a-d due to conditions that may mask their appearance (e.g., peri-operative infarct when the patient cannot report ischemic symptoms; baseline left bundle branch block or ventricular pacing).

2. ECG changes associated with prior myocardial infarction can include the following (with or without prior symptoms):

a. Any Q-wave in leads V2-V3 >=0.02 seconds or QS complex in leads V2 and V3.

b. Q-wave >=0.03 seconds and >=0.1 mV deep or QS complex in leads I, II, aVL, aVF, or V4-V6 in any two leads of a contiguous lead grouping (I, aVL, V6; V4-V6; II, III, and aVF).

c. R-wave >=0.04 seconds in V1-V2 and R/S >=1 with a concordant positive T-wave in the absence of a conduction defect.

3. Imaging evidence of a region with new loss of viable myocardium at rest in the absence of a non-ischemic cause. This can be manifest as:

a. Echocardiographic, CT, MR, ventriculographic or nuclear imaging evidence of left ventricular thinning or scarring and failure to contract appropriately (i.e., hypokinesis, akinesis, or dyskinesis).

b. Fixed (non-reversible) perfusion defects on nuclear radioisotope imaging (e.g., MIBI, thallium).

4. Medical records documentation of prior myocardial infarction.

Source: Joint ESC-ACC-AHA-WHF 2007 Task Force consensus document "Universal Definition of Myocardial Infarction".

O. Follow-Up

Seq. #: 10425 **Name:** Follow-Up Ischemic Stroke

Coding Instructions: Indicate if the patient experienced 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.

Target Value: Any occurrence between discharge and follow-up

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. #: 10430 **Name:** Follow-Up 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 discharge and follow-up

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.

Note: 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. #: 10435 **Name:** Follow-Up 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 discharge and follow-up

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)

O. Follow-Up

Seq. #: 10440 **Name:** Follow-Up Major Vascular Complication

Coding Instructions: Indicate if the patient had a major vascular complication, requiring treatment, during the follow-up period.

Note(s):

Vascular complications can include, but are not limited to, access site occlusions, peripheral embolization, perforations, rupture, dissections, pseudo aneurysms, infections and/or AV fistulas. This also includes irreversible nerve injury, infection or compartment syndrome. Any noted vascular complication must have had an intervention such as a fibrin injection, angioplasty, transfusion, antibiotics or surgical repair to qualify. Prolonged pressure does not qualify as an intervention, but ultrasonic guided compression after making a diagnosis of pseudo aneurysm does qualify.

Target Value: Any occurrence between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10445 **Name:** Follow-Up Life Threatening Bleeding

Coding Instructions: Indicate if the patient experienced life threatening bleeding during the follow-up period.

Target Value: Any occurrence between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Life Threatening Bleeding:

The patient experienced life threatening or disabling bleeding which is defined as:
1. Fatal bleeding OR
2. Bleeding in a critical area or organ, such as intracranial, intraspinal, intraocular, or pericardial necessitating pericardiocentesis, or intramuscular with compartment syndrome OR
3. Bleeding causing hypovolemic shock or severe hypotension requiring vasopressors or surgery OR
4. Overt source of bleeding with drop in hemoglobin of >=5 g/dl or whole blood or packed red blood cells (RBCs) transfusion >=4 U.

Source: Standardized Endpoint Definitions for Transcatheter Aortic Valve Implantation Clinical Trials (JACC, 2011, vol 57, No 3)

Seq. #: 10450 **Name:** Follow-Up New Requirement for Dialysis

Coding Instructions: Indicate if the patient experienced acute or worsening renal failure necessitating a new requirement for renal dialysis (renal dialysis includes hemodialysis and peritoneal dialysis) during the follow-up period.

Note(s):

If a patient is on receiving continuous veno-venous hemofiltration (CVVH) as a result of renal failure (and not as treatment to remove fluid for heart failure), code 'Yes'.

Target Value: Any occurrence between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

O. Follow-Up

Seq. #: 10455 **Name:** Follow-Up Lower Extremity Peripheral Vascular Catheter-based Intervention

Coding Instructions: Indicate if the patient has had a peripheral vascular intervention for a lower extremity vessel since discharge.

Target Value: Any occurrence between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10460 **Name:** Follow-Up PVI - Target Vessel Revascularization

Coding Instructions: If the patient has had a peripheral vascular intervention for a lower extremity vessel since discharge, indicate if the target vessel of the initial vascular intervention was revascularized.

Target Value: Any occurrence between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10465 **Name:** Follow-Up Surgical Revascularization

Coding Instructions: Indicate if the patient has had a surgical revascularization since discharge.

Target Value: Any occurrence between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10470 **Name:** Follow-Up Carotid Endarterectomy

Coding Instructions: Indicate if the patient had a carotid endarterectomy during the follow-up period.

Target Value: Any occurrence between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

O. Follow-Up

Seq. #: 10475 **Name:** Follow-Up CEA - Target Vessel Revascularization

Coding Instructions: Indicate if the patient had a carotid endarterectomy of the index vessel.

Target Value: Any occurrence between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10480 **Name:** Follow-Up Carotid Artery Stenting

Coding Instructions: Indicate if the patient had a carotid artery stenting procedure during the follow-up period.

Target Value: Any occurrence between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10485 **Name:** Follow-Up CAS - Target Vessel Revascularization

Coding Instructions: Indicate if the patient had a carotid artery stenting procedure of the index vessel.

Target Value: Any occurrence between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10490 **Name:** Follow-Up Amputation

Coding Instructions: Indicate if the patient has had an amputation since discharge.

Target Value: Any occurrence between discharge and follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

O. Follow-Up

Seq. #: 10495 **Name:** Follow-Up Amputation Level (Right)

Coding Instructions: Indicate the level of the amputation on the right limb.

Target Value: The last value between discharge and follow-up

Selections:

Selection Text	*Definition*
Above the knee amputation	
Below the knee amputation	
Minor amputation	

Supporting Definitions: (none)

Seq. #: 10500 **Name:** Follow-Up Amputation Staged (Right)

Coding Instructions: Indicate if the amputation of the right limb was unintended or planned staged.

Target Value: The last value between discharge and follow-up

Selections:

Selection Text	*Definition*
Unplanned/Unintended	
Planned/Staged	

Supporting Definitions: (none)

Seq. #: 10505 **Name:** Follow-Up Amputation Level (Left)

Coding Instructions: Indicate the level of the amputation on the left limb.

Target Value: The last value between discharge and follow-up

Selections:

Selection Text	*Definition*
Above the knee amputation	
Below the knee amputation	
Minor amputation	

Supporting Definitions: (none)

Z. Administration

Seq. #: 10510 **Name:** Follow-Up Amputation Staged (Left)

Coding Instructions: Indicate if the amputation of the left limb was unintended or planned staged.

Target Value: The last value between discharge and follow-up

Selections:

Selection Text	*Definition*
Unplanned/Unintended	
Planned/Staged	

Supporting Definitions: (none)

Seq. #: 10600 **Name:** Auxiliary 7

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10605 **Name:** Auxiliary 8

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

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:

Z. Administration

Seq. #: 1010 **Name:** Participant Name

Coding Instructions: Indicate the full name of the facility.

Target Value: N/A

Selections: (none)

Supporting Definitions: **Participant Name:**

Indicate the full name of the facility where the procedure was performed. Values should be full, official hospital names with no abbreviations or variations in spelling.

Source: NCDR

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., 2014Q4

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

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)

Z. Administration

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)

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)

Z. Administration

Seq. #: 1095 **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 3/30/2013, is discharged on 3/31/2013, and has a follow-up assessment on 5/6/2013, the patient's episode of care data will be transmitted in the 2013Q1 Base Registry Record file, but the Follow-up data will be transmitted in the 2013Q2 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 9100) in the selected timeframe. 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 10000) in the selected timeframe.

Supporting Definitions: (none)

Seq. #: 1200 **Name:** Auxiliary 0

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)