Release Notes: Project Not Published

Published: Project Not Published

Coding Instruction Updates:

Sequence #	Element Name
4455	Atrial Flutter Classification
7165	Adjunctive Ablation Lesions
12903	Condition History Name
15510	Condition History Occurrence
15710	Additional Ablation

Section: Demographics **Parent: Root**

Element: 2000 Last Name

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

Target Value: The value on arrival at this facility

Technical Specification

Code:	1000142463
Code System Name:	ACC NCDR
Short Name:	LastName
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	Yes
Data Type:	LN
Precision:	50
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 2010 First Name

Coding Instruction: Indicate the patient's first name.

Target Value: The value on arrival at this facility

Technical Specification

Code:	1000142463
Code System Name:	ACC NCDR
Short Name:	FirstName
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	Yes
Data Type:	FN
Precision:	50
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 2020 Middle Name

Coding Instruction: Indicate the patient's middle name.

Note(s):
It is acceptable to specify the middle initial.

If there is no middle name given, leave field blank.

If there are multiple middle names, enter all of the middle names sequentially.

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

Target Value: The value on arrival at this facility

Technical Specification

Code:	1000142463
Code System Name:	ACC NCDR
Short Name:	MidName
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	Yes
Data Type:	MN
Precision:	50
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Section: Demographics **Parent: Root**

Element: 2050 Birth Date

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

Target Value: The value on arrival at this facility

Technical Specification

Code:	1000142447
Code System Name:	ACC NCDR
Short Name:	DOB
Missing Data:	Illegal
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	Yes
Data Type:	DT
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 2030 SSN

Coding Instruction: Indicate the patient's United States Social Security Number (SSN).

Note(s):
If the patient does not have a US Social Security Number (SSN), leave blank and check 'SSN NA'.

Target Value: The value on arrival at this facility

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

Technical Specification

Code:	2.16.840.1.113883.4.1
Code System Name:	United States Social Security Number (SSN)
Short Name:	SSN
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	Yes
Data Type:	ST
Precision:	9
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 2031 SSN N/A

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

Target Value: The value on arrival at this facility

Technical Specification

Code:	2.16.840.1.113883.4.1
Code System Name:	United States Social Security Number (SSN)
Short Name:	SSNNA
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	Yes
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Section: Demographics **Parent: Root**

Element: 2040 Patient ID

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

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

Target Value: The value on arrival at this facility

Technical Specification

Code:	2.16.840.1.113883.3.3478.4.842
Code System Name:	ACC NCDR
Short Name:	NCDRPatientID
Missing Data:	Illegal
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	Yes
Data Type:	NUM
Precision:	9
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	1 - 999,999,999
Data Source:	Automatic

Element: 2045 Other ID

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

Target Value: N/A

Technical Specification

Code:	2.16.840.1.113883.3.3478.4.843
Code System Name:	ACC NCDR
Short Name:	OtherID
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	Yes
Data Type:	ST
Precision:	50
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 2060 Sex

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

Target Value: The value on arrival at this facility

Technical Specification

Code:	1000142448
Code System Name:	ACC NCDR
Short Name:	Sex
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Person Sex - 1.3.6.1.4.1.19376.1.4.1.6.5.19

Selection	Definition	Source	Code	Code System Name
Male			M	HL7 Administrative Gender
Female			F	HL7 Administrative Gender

Section: Demographics **Parent: Root**

Element: 2065 Patient Zip Code

Coding Instruction: Indicate the patient's United States Postal Service zip code of their primary residence.

Note(s):
If the patient does not have a U.S. residence, or is homeless, leave blank and check 'Zip Code NA'.

Target Value: The value on arrival at this facility

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

Technical Specification

Code:	1000142449
Code System Name:	ACC NCDR
Short Name:	ZipCode
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	Yes
Data Type:	ST
Precision:	5
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 2066 Zip Code N/A

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

Note(s):
This includes patients who do not have a U.S. residence or are homeless.

Target Value: The value on arrival at this facility

Technical Specification

Code:	1000142449
Code System Name:	ACC NCDR
Short Name:	ZipCodeNA
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	Yes
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 2070 Race - White

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

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

Target Value: The value on arrival at this facility

Supporting Definition: **White (race)**

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

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

Technical Specification

Code:	2106-3
Code System Name:	HL7 Race
Short Name:	RaceWhite
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Section: Demographics **Parent: Root**

Element: 2071 Race - Black/African American

Coding Instruction: Indicate if the patient is Black or African American as determined by the patient/family.

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

Target Value: The value on arrival at this facility

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

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

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

Technical Specification

Code:	2054-5
Code System Name:	HL7 Race
Short Name:	RaceBlack
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 2073 Race - American Indian/Alaskan Native

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

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

Target Value: The value on arrival at this facility

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

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

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

Technical Specification

Code:	1002-5
Code System Name:	HL7 Race
Short Name:	RaceAmIndian
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 2072 Race - Asian

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

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

Target Value: The value on arrival at this facility

Supporting Definition: **Asian (race)**

Having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

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

Technical Specification

Code:	2028-9
Code System Name:	HL7 Race
Short Name:	RaceAsian
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Section: Demographics **Parent: Root**

Element: 2074 Race - Native Hawaiian/Pacific Islander

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

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

Target Value: The value on arrival at this facility

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

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

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

Technical Specification

Code:	2076-8
Code System Name:	HL7 Race
Short Name:	RaceNatHaw
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 2076 Hispanic or Latino Ethnicity

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

Target Value: The value on arrival at this facility

Supporting Definition: **Hispanic or Latino Ethnicity**

A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."

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

Technical Specification

Code:	2135-2
Code System Name:	HL7 Ethnicity
Short Name:	HispOrig
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Section: Episode of Care **Parent: Root**

Element: 2999 Episode Unique Key

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

Target Value: N/A

Technical Specification

Code:	2.16.840.1.113883.3.3478.4.855
Code System Name:	ACC NCDR
Short Name:	EpisodeKey
Missing Data:	Illegal
Harvested:	Yes
Is Identifier:	Yes
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	ST
Precision:	50
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	Automatic

Element: 3001 Arrival Date and Time

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

If the arrival date and time are not specified, code the earliest date and time found in the medical record indicating the patient was at this facility.

Target Value: N/A

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

Technical Specification

Code:	1000142450
Code System Name:	ACC NCDR
Short Name:	ArrivalDateTime
Missing Data:	Illegal
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	TS
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Element: 3005 Health Insurance

Coding Instruction: Indicate if the patient has health insurance.

Target Value: The value on arrival at this facility

Technical Specification

Code:	63513-6
Code System Name:	LOINC
Short Name:	HealthIns
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Section: Episode of Care **Parent: Root**

Element: 3010 Health Insurance Payment Source

Coding Instruction: Indicate the patient's health insurance payment type.

Note(s):
If the patient has multiple insurance payors, select all payors.

Target Value: The value on arrival at this facility

Technical Specification

Code:	100001072
Code System Name:	ACC NCDR
Short Name:	HIPS
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Multiple
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 3005 Health Insurance
Operator: Equal
Value: Yes

Payor Category - 1.3.6.1.4.1.19376.1.4.1.6.5.5

Selection	Definition	Source	Code	Code System Name
Private health insurance	Private health insurance is coverage by a health plan provided through an employer or union or purchased by an individual from a private health insurance company. A health maintenance organization (HMO) is considered private health insurance.		5	PHDSC
State-specific plan (non-Medicaid)	State Specific Plans - Some states have their own health insurance programs for low-income uninsured individuals. These health plans may be known by different names in different states.		36	PHDSC
Medicare (Part A or B)	Medicare is a health insurance program for: people age 65 or older; people under age 65 with certain disabilities; and people of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant). Medicare Part A (Hospital Insurance) – Part A helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Medicare Part B (Medical Insurance) – Part B helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.	Medicare Program - General Information | CMS	1	PHDSC
Medicare Advantage (Part C)	Medicare Part C (Medicare Advantage) – Part C is an alternative way to get Medicare coverage through private insurance companies instead of the federal government. Part C provides the same benefits as Medicare Part A and Part B, and may include additional benefits such as dental, vision, prescription drug and wellness programs coverage.	Medicare Advantage Plans (Part C) | MedicareAdvantage.com	112000002025	ACC NCDR
Medicaid	Medicaid is a program administered at the state level, which provides medical assistance to the needy. Families with dependent children, the aged, blind, and disabled who are in financial need are eligible for Medicaid. It may be known by different names.		2	PHDSC
Military health care	Military Health care - Military health care includes TRICARE/CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) and CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), as well as care provided by the Department of Veterans Affairs (VA).		31	PHDSC

Section: Episode of Care	Parent: Root		
Indian Health Service	Indian Health Service (IHS) is a health care program through which the Department of Health and Human Services provides medical assistance to eligible American Indians at IHS facilities. In addition, the IHS helps pay the cost of selected health care services provided at non-IHS facilities.	33	PHDSC
Non-US insurance	Non-US insurance refers to individuals with a payor that does not originate in the United States.	100000812	ACC NCDR

Element: 12846 — Medicare Beneficiary Identifier

Coding Instruction: Indicate the patient's Medicare Beneficiary Identifier (MBI).

Note(s):
Enter the Medicare Beneficiary Identifier (MBI) for those patients insured by Medicare. Patients without Medicare will not have a MBI.

Target Value: The value on arrival at this facility

Supporting Definition: **Medicare Beneficiary Identifier**

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, requires us to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status.

Source: https://www.cms.gov/Medicare/New-Medicare-Card/index.html

Technical Specification

Code:	2.16.840.1.113883.4.927
Code System Name:	Center for medicare and medicaid services, MBI
Short Name:	MBI
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	ST
Precision:	11
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	3010 Health Insurance Payment Source
Operator:	Equal
Value:	Medicare (Part A or B)
Element:	3010 Health Insurance Payment Source
Operator:	Equal
Value:	Medicare Advantage (Part C)

Element: 3020 — Patient Enrolled in Research Study

Coding Instruction: Indicate if the patient is enrolled in an ongoing ACC-NCDR sponsored or associated research study relating to this registry.

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

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

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

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

Technical Specification

Code:	100001095
Code System Name:	ACC NCDR
Short Name:	EnrolledStudy
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Section: Research Study **Parent: Episode of Care**

Element: 3025 Research Study Name

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

Note(s):
If the patient is in more than one research study, list each separately.

Target Value: N/A

Vendor Instruction: Research Study Name (3025) must be a valid study name for the Registry.

Technical Specification

Code:	100001096
Code System Name:	ACC NCDR
Short Name:	StudyName
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	ST
Precision:	50
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	3020	Patient Enrolled in Research Study
Operator:	Equal	
Value:	Yes	

Element: 3030 Research Study Patient ID

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

Note(s):
If the patient is in more than one research study, list each separately.

Target Value: N/A

Technical Specification

Code:	2.16.840.1.113883.3.3478.4.852
Code System Name:	ACC NCDR
Short Name:	StudyPtID
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	ST
Precision:	50
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	3020	Patient Enrolled in Research Study
Operator:	Equal	
Value:	Yes	

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

Element: 4700 — AFEQT Patient Questionnaire Performed

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

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

Technical Specification

Code:	100001145
Code System Name:	ACC NCDR
Short Name:	AFEQTBase
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 4705 — Are you currently in atrial fibrillation?

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

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

Supporting Definition: **Section 1, Q1**

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

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

Technical Specification

Code:	100001146
Code System Name:	ACC NCDR
Short Name:	AFEQTS1Q1
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	4700 AFEQT Patient Questionnaire Performed
Operator:	Equal
Value:	Yes

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

Element: 4710

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

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

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

Supporting Definition: **Section 1, Q2**

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

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

Technical Specification

Code:	100001147
Code System Name:	ACC NCDR
Short Name:	AFEQTS1Q2
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	4705 Are you currently in atrial fibrillation?
Operator:	Equal
Value:	No

AFEQT Response - Timing of Episode of atrial fibrillation - 1.3.6.1.4.1.19376.1.4.1.6.5.234

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

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

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

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

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

Supporting Definition: **Section 2, Q1**

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

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

Technical Specification

Code:	100001154
Code System Name:	ACC NCDR
Short Name:	AFEQTS2Q1
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	4700 AFEQT Patient Questionnaire Performed
Operator:	Equal
Value:	Yes

AFEQT Response - Bothered Scale 1-4 - 1.3.6.1.4.1.19376.1.4.1.6.5.230

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

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

Element: 4720 — Q2: Irregular heart beat

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

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

Supporting Definition: **Section 2, Q2**

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

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

Technical Specification

Code:	100001155
Code System Name:	ACC NCDR
Short Name:	AFEQTS2Q2
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	4700 AFEQT Patient Questionnaire Performed
Operator:	Equal
Value:	Yes

AFEQT Response - Bothered Scale 1-4 - 1.3.6.1.4.1.19376.1.4.1.6.5.230

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

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

Element: 4725 — Q3: Pause in Heart Activity

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

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

Supporting Definition: **Section 2, Q3**

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

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

Technical Specification

Code:	100001156
Code System Name:	ACC NCDR
Short Name:	AFEQTS2Q3
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	4700 AFEQT Patient Questionnaire Performed
Operator:	Equal
Value:	Yes

AFEQT Response - Bothered Scale 1-4 - 1.3.6.1.4.1.19376.1.4.1.6.5.230

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

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

Element: 4730 — Q4: Lightheadedness or dizziness

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

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

Supporting Definition: **Section 2, Q4**

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

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

Technical Specification

Code:	100001157
Code System Name:	ACC NCDR
Short Name:	AFEQTS2Q4
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	4700 AFEQT Patient Questionnaire Performed
Operator:	Equal
Value:	Yes

AFEQT Response - Bothered Scale 1-4 - 1.3.6.1.4.1.19376.1.4.1.6.5.230

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

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

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

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

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

Supporting Definition: **Section 2, Q5**

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

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

Technical Specification

Code:	100001165
Code System Name:	ACC NCDR
Short Name:	AFEQTS2Q5
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	4700 AFEQT Patient Questionnaire Performed
Operator:	Equal
Value:	Yes

AFEQT Response - Limitation Scale - 1.3.6.1.4.1.19376.1.4.1.6.5.231

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

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

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

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

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

Supporting Definition: **Section 2, Q6**

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

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

Technical Specification

Code:	100001166
Code System Name:	ACC NCDR
Short Name:	AFEQTS2Q6
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	4700 AFEQT Patient Questionnaire Performed
Operator:	Equal
Value:	Yes

AFEQT Response - Limitation Scale - 1.3.6.1.4.1.19376.1.4.1.6.5.231

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

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

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

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

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

Supporting Definition: **Section 2, Q7**

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

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

Technical Specification

Code:	100001174
Code System Name:	ACC NCDR
Short Name:	AFEQTS2Q7
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	4700 AFEQT Patient Questionnaire Performed
Operator:	Equal
Value:	Yes

AFEQT Response - Difficulty Scale - 1.3.6.1.4.1.19376.1.4.1.6.5.232

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

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

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

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

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

Supporting Definition: **Section 2, Q8**

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

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

Technical Specification

Code:	100001175
Code System Name:	ACC NCDR
Short Name:	AFEQTS2Q8
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	4700 AFEQT Patient Questionnaire Performed
Operator:	Equal
Value:	Yes

AFEQT Response - Difficulty Scale - 1.3.6.1.4.1.19376.1.4.1.6.5.232

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

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

Element: 4755 — Q9: Difficulty exercising

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

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

Supporting Definition: **Section 2, Q9**

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

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

Technical Specification

Code:	100001176
Code System Name:	ACC NCDR
Short Name:	AFEQTS2Q9
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	4700 AFEQT Patient Questionnaire Performed
Operator:	Equal
Value:	Yes

AFEQT Response - Difficulty Scale - 1.3.6.1.4.1.19376.1.4.1.6.5.232

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

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

Element: 4760 — Q10: Difficulty walking briskly

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

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

Supporting Definition: **Section 2, Q10**

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

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

Technical Specification

Code:	100001177
Code System Name:	ACC NCDR
Short Name:	AFEQTS2Q10
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 4700 AFEQT Patient Questionnaire Performed
Operator: Equal
Value: Yes

AFEQT Response - Difficulty Scale - 1.3.6.1.4.1.19376.1.4.1.6.5.232

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

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

Element: 4765

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

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

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

Supporting Definition: **Section 2, Q11**

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

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

Technical Specification

Code:	100001178
Code System Name:	ACC NCDR
Short Name:	AFEQTS2Q11
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	4700 AFEQT Patient Questionnaire Performed
Operator:	Equal
Value:	Yes

AFEQT Response - Difficulty Scale - 1.3.6.1.4.1.19376.1.4.1.6.5.232

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

Section: Atrial Fibrillation Effect on Quality of Life Parent: Root

Element: 4770

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

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

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

Supporting Definition: **Section 2, Q12**

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

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

Technical Specification

Code:	100001179
Code System Name:	ACC NCDR
Short Name:	AFEQTS2Q12
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	4700 AFEQT Patient Questionnaire Performed
Operator:	Equal
Value:	Yes

AFEQT Response - Difficulty Scale - 1.3.6.1.4.1.19376.1.4.1.6.5.232

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

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

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

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

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

Supporting Definition: **Section 2, Q13**

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

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

Technical Specification

Code:	100001187
Code System Name:	ACC NCDR
Short Name:	AFEQTS2Q13
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 4700 AFEQT Patient Questionnaire Performed
Operator: Equal
Value: Yes

AFEQT Response - Bothered Scale 13-18 - 1.3.6.1.4.1.19376.1.4.1.6.5.246

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

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

Element: 4780

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

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

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

Supporting Definition: **Section 2, Q14**

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

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

Technical Specification

Code:	100001188
Code System Name:	ACC NCDR
Short Name:	AFEQTS2Q14
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	4700 AFEQT Patient Questionnaire Performed
Operator:	Equal
Value:	Yes

AFEQT Response - Bothered Scale 13-18 - 1.3.6.1.4.1.19376.1.4.1.6.5.246

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

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

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

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

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

Supporting Definition: **Section 2, Q15**

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

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

Technical Specification

Code:	100001189
Code System Name:	ACC NCDR
Short Name:	AFEQTS2Q15
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	4700 AFEQT Patient Questionnaire Performed
Operator:	Equal
Value:	Yes

AFEQT Response - Bothered Scale 13-18 - 1.3.6.1.4.1.19376.1.4.1.6.5.246

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

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

Element: 4790

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

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

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

Supporting Definition: **Section 2, Q16**

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

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

Technical Specification

Code:	100001190
Code System Name:	ACC NCDR
Short Name:	AFEQTS2Q16
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	4700 AFEQT Patient Questionnaire Performed
Operator:	Equal
Value:	Yes

AFEQT Response - Bothered Scale 13-18 - 1.3.6.1.4.1.19376.1.4.1.6.5.246

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

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

Element: 4795

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

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

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

Supporting Definition: **Section 2, Q17**

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

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

Technical Specification

Code:	100001191
Code System Name:	ACC NCDR
Short Name:	AFEQTS2Q17
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	4700 AFEQT Patient Questionnaire Performed
Operator:	Equal
Value:	Yes

AFEQT Response - Bothered Scale 13-18 - 1.3.6.1.4.1.19376.1.4.1.6.5.246

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

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

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

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

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

Supporting Definition: **Section 2, Q18**

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

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

Technical Specification

Code:	100001192
Code System Name:	ACC NCDR
Short Name:	AFEQTS2Q18
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	4700 AFEQT Patient Questionnaire Performed
Operator:	Equal
Value:	Yes

AFEQT Response - Bothered Scale 13-18 - 1.3.6.1.4.1.19376.1.4.1.6.5.246

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

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

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

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

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

Supporting Definition: **Section 2, Q19**

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

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

Technical Specification

Code:	100001193
Code System Name:	ACC NCDR
Short Name:	AFEQTS2Q19
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	4700 AFEQT Patient Questionnaire Performed
Operator:	Equal
Value:	Yes

AFEQT Response - Satisfaction Scale - 1.3.6.1.4.1.19376.1.4.1.6.5.233

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

Section: Atrial Fibrillation Effect on Quality of Life — Parent: Root

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

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

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

Supporting Definition: **Section 2, Q20**

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

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

Technical Specification

Code:	100001194
Code System Name:	ACC NCDR
Short Name:	AFEQTS2Q20
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	4700 AFEQT Patient Questionnaire Performed
Operator:	Equal
Value:	Yes

AFEQT Response - Satisfaction Scale - 1.3.6.1.4.1.19376.1.4.1.6.5.233

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

Section: Physical Exam and Labs **Parent: Root**

Element: 6000 Height

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

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

Technical Specification

Code:	8302-2
Code System Name:	LOINC
Short Name:	Height
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	PQ
Precision:	5,2
Selection Type:	Single
Unit of Measure:	cm
Default Value:	Null
Usual Range:	100.00 - 225.00 cm
Valid Range:	20.00 - 260.00 cm
Data Source:	User

Element: 6005 Weight

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

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

Technical Specification

Code:	3141-9
Code System Name:	LOINC
Short Name:	Weight
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	PQ
Precision:	5,2
Selection Type:	Single
Unit of Measure:	kg
Default Value:	Null
Usual Range:	40.00 - 200.00 kg
Valid Range:	10.00 - 700.00 kg
Data Source:	User

Element: 6010 Pulse

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

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

Technical Specification

Code:	8867-4
Code System Name:	LOINC
Short Name:	Pulse
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	PQ
Precision:	3,0
Selection Type:	Single
Unit of Measure:	bpm
Default Value:	Null
Usual Range:	30 - 250 bpm
Valid Range:	0 - 300 bpm
Data Source:	User

Section: Physical Exam and Labs **Parent: Root**

Element: 6015 Systolic BP

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

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

Technical Specification

Code:	8480-6
Code System Name:	LOINC
Short Name:	SystolicBP
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	PQ
Precision:	3,0
Selection Type:	Single
Unit of Measure:	mm[Hg]
Default Value:	Null
Usual Range:	50 - 220 mm[Hg]
Valid Range:	1 - 300 mm[Hg]
Data Source:	User

Element: 6020 Diastolic BP

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

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

Technical Specification

Code:	8462-4
Code System Name:	LOINC
Short Name:	DiastolicBP
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	PQ
Precision:	3,0
Selection Type:	Single
Unit of Measure:	mm[Hg]
Default Value:	Null
Usual Range:	30 - 110 mm[Hg]
Valid Range:	1 - 200 mm[Hg]
Data Source:	User

Element: 6045 International Normalized Ratio (INR)

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

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

Most recent values prior to the start of the procedure.

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

Technical Specification

Code:	34714-6
Code System Name:	LOINC
Short Name:	INR
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	PQ
Precision:	3,1
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	0.9 - 1.3
Valid Range:	0.5 - 30.0
Data Source:	User

Parent/Child Validation

Element:	6046 International Normalized Ratio Not Drawn
Operator:	Equal
Value:	No (or Not Answered)

Section: Physical Exam and Labs **Parent: Root**

Element: 6046 International Normalized Ratio Not Drawn

Coding Instruction: Indicate if INR was not drawn.

Target Value: N/A

Technical Specification

Code:	34714-6
Code System Name:	LOINC
Short Name:	INRND
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 6050 Creatinine

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

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

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

Technical Specification

Code:	2160-0
Code System Name:	LOINC
Short Name:	PreProcCreat
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	PQ
Precision:	4,2
Selection Type:	Single
Unit of Measure:	mg/dL
Default Value:	Null
Usual Range:	0.10 - 5.00 mg/dL
Valid Range:	0.10 - 30.00 mg/dL
Data Source:	User

Parent/Child Validation

Element:	6051 Creatinine Not Drawn
Operator:	Equal
Value:	No (or Not Answered)

Element: 6051 Creatinine Not Drawn

Coding Instruction: Indicate if a creatinine level was not drawn.

Target Value: N/A

Technical Specification

Code:	2160-0
Code System Name:	LOINC
Short Name:	PreProcCreatND
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Section: Physical Exam and Labs **Parent: Root**

Element: 6030 Hemoglobin

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

Note(s):
This may include POC (Point of Care) testing results or results obtained prior to arrival at this facility.

Target Value: The last value within 30 days prior to the first procedure in this admission

Supporting Definition: **Hemoglobin**

Hemoglobin (Hb or Hgb) is the iron-containing oxygen-transport metalloprotein in the red blood cells. It carries oxygen from the lungs to the rest of the body (i.e. the tissues) where it releases the oxygen to burn nutrients and provide energy. Hemoglobin concentration measurement is among the most commonly performed blood tests, usually as part of a complete blood count. If the concentration is below normal, this is called anemia. Anemias are classified by the size of red blood cells: "microcytic" if red cells are small, "macrocytic" if they are large, and "normocytic" if otherwise. Dehydration or hyperhydration can greatly influence measured hemoglobin levels.

Source: http://s.details.loinc.org/LOINC/718-7.html?sections=Simple

Technical Specification

Code:	718-7
Code System Name:	LOINC
Short Name:	HGB
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	PQ
Precision:	4,2
Selection Type:	Single
Unit of Measure:	g/dL
Default Value:	
Usual Range:	5.00 - 20.00 g/dL
Valid Range:	1.00 - 50.00 g/dL
Data Source:	User

Parent/Child Validation

Element:	6031 Hemoglobin Not Drawn
Operator:	Equal
Value:	No (or Not Answered)

Element: 6031 Hemoglobin Not Drawn

Coding Instruction: Indicate if the hemoglobin was not drawn.

Target Value: The last value within 30 days prior to the first procedure in this admission

Supporting Definition: **Hemoglobin**

Hemoglobin (Hb or Hgb) is the iron-containing oxygen-transport metalloprotein in the red blood cells. It carries oxygen from the lungs to the rest of the body (i.e. the tissues) where it releases the oxygen to burn nutrients and provide energy. Hemoglobin concentration measurement is among the most commonly performed blood tests, usually as part of a complete blood count. If the concentration is below normal, this is called anemia. Anemias are classified by the size of red blood cells: "microcytic" if red cells are small, "macrocytic" if they are large, and "normocytic" if otherwise. Dehydration or hyperhydration can greatly influence measured hemoglobin levels.

Source: http://s.details.loinc.org/LOINC/718-7.html?sections=Simple

Technical Specification

Code:	718-7
Code System Name:	LOINC
Short Name:	HGBND
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Section: Physical Exam and Labs **Parent: Root**

Element: 14280 BNP

Coding Instruction: Indicate the B-type natriuretic peptide (BNP) value.

Target Value: The last value between 6 months prior to procedure and the start of the current procedure

Supporting Definition: **Natriuretic peptide B**

Brain natriuretic peptide (BNP) is an active fragment (1-32) of ProBNP which is produced by myocardial cells. It increases in both right-sided and left-sided heart failure as well as in systolic and diastolic heart failure. Thus, it is used to diagnose and manage heart failure. When a patient is taking recombinant PBN (Natricor), BNP will reflect serum levels. NT-ProBNP, an inactive fragment (1-78) of ProBNP is used to assess the degree of failure. Both of these polypeptides have roughly the same predictive power. NT-ProBNP is commonly called ProBNP.

Source: http://s.details.loinc.org/LOINC/42637-9.html?sections=Simple

Vendor Instruction: Either BNP (14280) or N-Terminal Pro B-Type Natriuretic Peptide Value (14279) can have a value, not both

Technical Specification

Code:	42637-9
Code System Name:	LOINC
Short Name:	PreProc_BNPValue
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	PQ
Precision:	5,0
Selection Type:	Single
Unit of Measure:	pg/mL
Default Value:	
Usual Range:	5 - 1,000 pg/mL
Valid Range:	1 - 10,000 pg/mL
Data Source:	User

Parent/Child Validation

Element:	13205 B-Type Natriuretic Peptide Not Drawn
Operator:	Equal
Value:	No (or Not Answered)

Element: 13205 B-Type Natriuretic Peptide Not Drawn

Coding Instruction: Indicate if a pre-procedure B-type natriuretic peptide (BNP) was not collected.

Target Value: N/A

Technical Specification

Code:	42637-9
Code System Name:	LOINC
Short Name:	PreProcBNPNotDrawn
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Section: Physical Exam and Labs **Parent: Root**

Element: 14279 N-Terminal Pro B-Type Natriuretic Peptide Value

Coding Instruction: Indicate the N-Terminal Pro B-Type Natriuretic Peptide (NT-proBNP) Value.

Target Value: The last value between 6 months prior to procedure and the start of the current procedure

Supporting Definition: **N-Terminal Pro B-Type Natriuretic Peptide Value**

ProBNP is the 108 amino acid pro-hormone of BNP (Brain Naturetic Peptide) that is produced mainly in the left ventricle. The prohormone splits into two polypeptides- the biologically active but shorter BNP (77-108) and the longer N terminal (1-76) fragment called NT-proBNP. Commercial assays are available for NT-proBNP because of its usefulness in predicting cardiovascular risk. In one study, it was the single best predictor of survival among patients with the acute coronary syndrome. It also declines with successful treatment of left ventricular dysfunctionand heart failure and is used by some to track the success of such treatment. No commercial assays exist for proBNP (the whole peptide)- though the trade name for one companies NT-proBNP is "proBNP" -- a misnomer. We include proBNP as the a related name for NT-proBNP so that people who call it proBNP will find it in LOINC.
Source: Regenstrief Help

Source: http://s.details.loinc.org/LOINC/33762-6.html?sections=Simple

Vendor Instruction: Either BNP (14280) or N-Terminal Pro B-Type Natriuretic Peptide Value (14279) can have a value, not both

Technical Specification

Code:	33762-6
Code System Name:	LOINC
Short Name:	PreProcedureNTBNP
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	PQ
Precision:	5,0
Selection Type:	Single
Unit of Measure:	pg/mL
Default Value:	
Usual Range:	5 - 30,000 pg/mL
Valid Range:	5 - 30,000 pg/mL
Data Source:	User

Parent/Child Validation

Element:	13206 N-Terminal Pro B-Type Natriuretic Peptide Not Drawn
Operator:	Equal
Value:	No (or Not Answered)

Element: 13206 N-Terminal Pro B-Type Natriuretic Peptide Not Drawn

Coding Instruction: Indicate if a pre-procedure N-terminal pro B-type natriuretic peptide (NT-proBNP) was not collected.

Target Value: N/A

Technical Specification

Code:	33762-6
Code System Name:	LOINC
Short Name:	PreProcNTBNPNotDrawn
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Section: CHA2DS2-VASC Risk Scores **Parent: History and Risk Factors**

Element: 4005 CHA2DS2-VASc Congestive Heart Failure

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

Note(s): A diagnosis of heart failure must be specifically documented in the medical record and not coded by the abstractor based upon patient symptoms.

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

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

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

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

Technical Specification

Code:	100001203
Code System Name:	ACC NCDR
Short Name:	ChadCHF
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 4015 CHA2DS2-VASc LV Dysfunction

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

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

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

Left Ventricular Ejection Fraction < 40%.

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

Technical Specification

Code:	100001204
Code System Name:	ACC NCDR
Short Name:	ChadLVDysf
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 4020 CHA2DS2-VASc Hypertension

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

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

Supporting Definition: **CHA2DS2-VASc Hypertension**

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

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

Technical Specification

Code:	100001205
Code System Name:	ACC NCDR
Short Name:	ChadHypertCont
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Section: CHA2DS2-VASC Risk Scores **Parent: History and Risk Factors**

Element: 4025 CHA2DS2-VASc Diabetes Mellitus

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

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

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

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

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

Technical Specification

Code:	100001206
Code System Name:	ACC NCDR
Short Name:	ChadDM
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 4045 CHA2DS2-VASc Vascular Disease

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

Target Value: Any occurrence between birth and the procedure

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

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

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

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

Technical Specification

Code:	100001210
Code System Name:	ACC NCDR
Short Name:	ChadVascDis
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 4030 CHA2DS2-VASc Stroke

Coding Instruction: Indicate if the patient has been diagnosed with an ischemic stroke, according to the CHA2DS2-VASc definition, or a stroke with undetermined origin.

Note: If the stroke was Hemorrhagic in origin code 'No.'

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **CHA2DS2-VASc Stroke**

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

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

Technical Specification

Code:	100001207
Code System Name:	ACC NCDR
Short Name:	ChadStroke
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Section: CHA2DS2-VASC Risk Scores **Parent: History and Risk Factors**

Element: 4035 CHA2DS2-VASc TIA

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

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **CHA2DS2-VASc TIA**

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

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

Technical Specification

Code:	100001208
Code System Name:	ACC NCDR
Short Name:	ChadTIA
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 4040 CHA2DS2-VASc Thromboembolic Event

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

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **Thromboembolic Events**

Thrombolembolic Event (TE) is defined as either an ischemic stroke, peripheral embolism, or pulmonary embolism. Peripheral embolism is defined as a TE outside the brain, heart, eyes, and lungs. Pulmonary embolism is defined by the responsible physician.

Source:

Technical Specification

Code:	100001209
Code System Name:	ACC NCDR
Short Name:	ChadTE
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

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

Element: 12903 Condition History Name

Coding Instruction: Select from the following list medical conditions based on prior diagnoses (or orders, such as for medication) given to the patient. Additional definitions below for those selections that may need additional clarification.

Target Value: N/A

Technical Specification

Code:	312850006
Code System Name:	SNOMED CT
Short Name:	ConditionHx
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Condition History Name - 1.3.6.1.4.1.19376.1.4.1.6.5.340

Selection	Definition	Source	Code	Code System Name
Symptoms During Afib/Aflutter			418799008+106063007:=195080001	SNOMED CT
Cardiomyopathy			85898001	SNOMED CT
Chronic Lung Disease	Coding requires a documented history or diagnosis of a chronic lung disease. Examples of these are: chronic inhalation reactive disease (asbestosis, mesothelioma, black lung disease or pneumoconiosis), Radiation induced pneumonitis or radiation fibrosis, chronic obstructive pulmonary disease, chronic bronchitis, or emphysema. It can also include a patient who is currently being chronically treated with inhaled or oral pharmacological therapy (e.g., beta-adrenergic agonist, anti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patients not included are: history of a transient condition, for example: atelectasis. Patients with asthma or seasonal allergies are also not considered to have chronic lung disease.		413839001	SNOMED CT
Coronary Artery Disease	Other documentation that can be used to support a history of CAD: 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		53741008	SNOMED CT
Sleep Apnea	Sleep apnea must be diagnosed by a provider or by sleep study. *Do not capture suspected sleep apnea or that reported by family members as sleep apnea. *Both Obstructive and Central Sleep Apnea are captured. *Code "No" if sleep apnea has been surgically corrected. *CPAP or BiPAP therapy is not a requirement to code "Yes" for sleep apnea.		73430006	SNOMED CT
Valvular Atrial Fibrillation	Consider this selection if atrial fibrillation is present in the setting of valvular heart disease and believed to be, at least in part, directly attributable to valvular heart disease		100001118	ACC NCDR

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

*Must be diagnosed by a provider.

Element: 15510 Condition History Occurrence

Coding Instruction: Please indicate whether the patient has or has not had a clinical diagnosis of the respective medical condition.

Please refer to "Condition History 12903" to view a list of selections and definitions.

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

Technical Specification

Code:	312850006
Code System Name:	SNOMED CT
Short Name:	ConditionHxOccurenceArrival
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	12903	Condition History Name
Operator:		
Value:	Any Value	

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

Element: 15723 Symptoms Experienced

Coding Instruction: Indicate the symptoms that are documented in the medical record that are due to atrial fibrillation or atrial flutter.

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

Technical Specification

Code:	418799008+106063007:=195080001
Code System Name:	SNOMED CT
Short Name:	SxExperienced
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Multiple (Dynamic List)
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 12903 Condition History Name
Operator: Equal
Value: Symptoms During Afib/Aflutter

--- AND ---

Element: 15510 Condition History Occurrence
Operator: Equal
Value: Yes

Symptoms Prior to Ablation - 1.3.6.1.4.1.19376.1.4.1.6.5.948

Selection	Definition	Source	Code	Code System Name
Anxiety			48694002	SNOMED CT
Chest pain			29857009	SNOMED CT
Dyspnea at rest			161941007	SNOMED CT
Dyspnea on exertion			60845006	SNOMED CT
Fatigue			84229001	SNOMED CT
Irregular heartbeat			361137007	SNOMED CT
Light-headedness			386705008	SNOMED CT
Palpitations			80313002	SNOMED CT
Other			112000003645	ACC NCDR

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

Element: 4570 Cardiomyopathy Type

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

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

Target Value: Any occurrence between birth and the procedure

Technical Specification

Code:	100000953
Code System Name:	ACC NCDR
Short Name:	PriorCMType
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Multiple
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 12903 Condition History Name
Operator: Equal
Value: Cardiomyopathy

--- AND ---

Element: 15510 Condition History Occurrence
Operator: Equal
Value: Yes

Cardiomyopathy Type - 1.3.6.1.4.1.19376.1.4.1.6.5.193

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

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

Element: 4585 Sleep Apnea Recommended Treatment Followed

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

Target Value: Any occurrence between birth and the procedure

Technical Specification

Code:	100001098
Code System Name:	ACC NCDR
Short Name:	SleepApneaRxFollowed
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 12903 Condition History Name
Operator: Equal
Value: Sleep Apnea

--- AND ---

Element: 15510 Condition History Occurrence
Operator: Equal
Value: Yes

Element: 4390 Mechanical Valve in Mitral Position

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

Target Value: Any occurrence between birth and the procedure

Technical Specification

Code:	431339008
Code System Name:	SNOMED CT
Short Name:	MechValveMitPos
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 12903 Condition History Name
Operator: Equal
Value: Valvular Atrial Fibrillation

--- AND ---

Element: 15510 Condition History Occurrence
Operator: Equal
Value: Yes

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

Element: 4400 Atrial Fibrillation Classification

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

Note: If more than one Atrial Fibrillation Classification is documented, use the most recent classification that prompted the current ablation.

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

Technical Specification

Code:	100000935
Code System Name:	ACC NCDR
Short Name:	AFibClass
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Atrial Fibrillation Classification - 1.3.6.1.4.1.19376.1.4.1.6.5.17

Selection	Definition	Source	Code	Code System Name
Paroxysmal	AF that terminates spontaneously or with intervention within 7 days of onset. Episodes may recur with variable frequency. Classification 3A		26593000	SNOMED CT
Persistent	Continuous AF that is sustained >7 days or with electrical or pharmacological termination. Classification 3B		62459000	SNOMED CT
LS - Persistent	Continuous AF of >12 months duration. Classification 3C		100001029	ACC NCDR

Element: 4455 Atrial Flutter Classification

Coding Instruction: Indicate the presence of, as well as the predominant type of atrial flutter experienced by the patient.

Note:
- In the absence of physician documentation identifying the Aflutter Classification, please select 'Typical / CTI dependent'.
- If both Classifications are documented, please select 'Typical / CTI dependent'

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **Atrial Flutter Type**

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

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

Technical Specification

Code:	100000938
Code System Name:	ACC NCDR
Short Name:	AFlutterType
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Atrial Flutter Classification - 1.3.6.1.4.1.19376.1.4.1.6.5.191

Selection	Definition	Source	Code	Code System Name
No			100013073	ACC NCDR
Yes - Typical/CTI Dependent	Typical atrial flutter is a macro-re-entrant atrial tachycardia that usually proceeds up the atrial septum, down the lateral atrial wall, and through the cavotricuspid (subeustachian) isthmus between the tricuspid valve annulus and inferior vena cava, where it is commonly targeted for ablation.		100000982	ACC NCDR
Yes - Atypical	Atypical flutter, or "noncavotricuspid isthmus-dependent macro-re-entrant atrial tachycardia", describes macro-re-entrant atrial tachycardias that are not one of the typical forms of atrial flutter that use the cavotricuspid isthmus.		112231000	SNOMED CT

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

Element: 12905 Procedure History Name

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

Target Value: N/A

Technical Specification

Code:	416940007
Code System Name:	SNOMED CT
Short Name:	ProcedHxName
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Procedure History Name - 1.3.6.1.4.1.19376.1.4.1.6.5.341

Selection	Definition	Source	Code	Code System Name
AV Node ablation with Pacemaker Implantation			428663009+307280005	SNOMED CT
Left Atrial Appendage Occlusion			112000002070	ACC NCDR
Atrial Fibrillation Termination Attempt	Therapeutic options for conversion of AF to sinus rhythm includes: antiarrhythmic drugs, direct current cardioversion, catheter ablation and surgical ablation.	McNamara RL, Brass LM, Drozda JP, Jr, et al. ACC/AHA key data elements and definitions for measuring the clinical management and outcomes of patients with atrial fibrillation: A report of the American College of Cardiology/American Heart Association Task Force on clinical data standards (writing committee to develop data standards on atrial fibrillation). J Am Coll Cardiol. 2004;44(2):475-495	100000936	ACC NCDR
Atrial Flutter Termination Attempt	Therapeutic options for conversion of atrial flutter to sinus rhythm includes: antiarrhythmic drugs, direct current cardioversion, and catheter ablation.	McNamara RL, Brass LM, Drozda JP, Jr, et al. ACC/AHA key data elements and definitions for measuring the clinical management and outcomes of patients with atrial fibrillation: A report of the American College of Cardiology/American Heart Association Task Force on clinical data standards (writing committee to develop data standards on atrial fibrillation). J Am Coll Cardiol. 2004;44(2):475-495.	100000937	ACC NCDR

Element: 14268 Procedure History Occurrence

Coding Instruction: Indicate if the patient does or does not have a history of the indicated medical procedure.

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

Technical Specification

Code:	416940007
Code System Name:	SNOMED CT
Short Name:	ProcHxOccur
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 12905 Procedure History Name
Operator:
Value: Any Value

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

Element: 4415 Atrial Fibrillation Termination - Pharmacologic Cardioversion

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

These elements will be coded with successful as well as unsuccessful attempts.

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **Pharmacologic Cardioversion**

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

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

Technical Specification

Code:	440142000:363702006=49436004
Code System Name:	SNOMED CT
Short Name:	PrevAFibTermPC
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 12905 Procedure History Name
Operator: Equal
Value: Atrial Fibrillation Termination Attempt

--- AND ---

Element: 14268 Procedure History Occurrence
Operator: Equal
Value: Yes

Element: 4420 Atrial Fibrillation Termination - DC Cardioversion

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

These elements will be coded with successful as well as unsuccessful attempts

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **DC Cardioversion**

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

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

Technical Specification

Code:	180325003:363702006=49436004
Code System Name:	SNOMED CT
Short Name:	PrevAFibTermDC
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 12905 Procedure History Name
Operator: Equal
Value: Atrial Fibrillation Termination Attempt

--- AND ---

Element: 14268 Procedure History Occurrence
Operator: Equal
Value: Yes

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

Element: 4425 Atrial Fibrillation Termination - Catheter Ablation

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

These elements will be coded with successful as well as unsuccessful attempts.

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **Catheter Ablation**

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

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

Technical Specification

Code:	18286008:363702006=49436004
Code System Name:	SNOMED CT
Short Name:	PrevAFibTermCA
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 12905 Procedure History Name
Operator: Equal
Value: Atrial Fibrillation Termination Attempt

--- AND ---

Element: 14268 Procedure History Occurrence
Operator: Equal
Value: Yes

Element: 4430 Atrial Fibrillation Most Recent Catheter Ablation Date

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

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

Target Value: Any occurrence between birth and the procedure

Technical Specification

Code:	18286008:363702006=49436004
Code System Name:	SNOMED CT
Short Name:	AFibCathAblDate
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	DT
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 4425 Atrial Fibrillation Termination - Catheter Ablation
Operator: Equal
Value: Yes

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

Element: 4435 Prior Catheter Ablation Strategy

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

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

Target Value: Any occurrence between birth and the procedure

Technical Specification

Code:	18286008:363702006=49436004
Code System Name:	SNOMED CT
Short Name:	AFibPriorAblStrategyCode
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Multiple (Dynamic List)
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 4425 Atrial Fibrillation Termination - Catheter Ablation
Operator: Equal
Value: Yes

Ablation Strategy - 1.3.6.1.4.1.19376.1.4.1.6.5.211

Selection	Definition	Source	Code	Code System Name
Complex Fractionated Atrial Electrogram	An ablation strategy targeting areas of continuous high -frequency (complex fractionated) atrial electrograms.		100000910	ACC NCDR
Convergent Procedure	The convergent procedure consists of epicardial (Epi) followed by endocardial (Endo) radio-frequency ablation in patients (pts) with atrial fibrillation (AF), deemed at high risk of recurrence with endo ablation only.		100000911	ACC NCDR
Cryoablation	Cryoablation, or freezing technology, involves a coolant being released into the catheter's balloon to freeze and ablate the tissue.		233161001	SNOMED CT
Empiric LA Linear Lesions	An ablation strategy that can include adjunctive linear lesions (such as a roof line or mitral annular line) that may accompany WACA, PVI, or other approaches, with a goal of preventing development of subsequent left atrial flutter.		100000912	ACC NCDR
Focal Ablation	An ablation strategy targeting one or more foci of putative triggers of atrial fibrillation. Ablation may be of a trigger of AF or just of a focal atrial tachycardia that accompanies AF or emerges following previous AF therapies (i.e. is a stand-alone rhythm).		100000913	ACC NCDR
Ganglion Plexus Ablation	An ablation strategy targeting one or more regions of autonomic nerve plexi around the left atrium.		100000914	ACC NCDR
Pulmonary Vein Isolation	An ablation strategy defined as electrical disconnection of atrial myocardium extending into the pulmonary veins from the body of the left atrium.		100000915	ACC NCDR
Pulsed Field Ablation	Pulsed field ablation uses electrical pulses to cause nonthermal irreversible electroporation and induce cardiac cell death.		112000003642	ACC NCDR
Rotor Based Mapping	An ablation strategy guided by mapping software technology employed to identify specific atrial fibrillation rotors.		100000917	ACC NCDR
Segmental PV Ablation	An ablation strategy with the goal of electrical isolation of pulmonary venous atrial tachycardia triggers from the body of the left atrium by ablating segmentally and/or circumferentially within a vein or near the venous ostium.		100000916	ACC NCDR
Wide Area Circumferential Ablation	An ablation strategy that includes placement of large circumferential ablation lesion sets encircling the right and left venous antra with the goal of either substrate modification, isolation of the pulmonary veins, or both. This approach generally implies that formal testing for entrance block and/or exit block is NOT performed.		100000918	ACC NCDR

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

Element: 4440 Atrial Fibrillation Termination - Surgical Ablation

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

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **Surgical Ablation**

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

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

Technical Specification

Code:	233163003:363702006=49436004
Code System Name:	SNOMED CT
Short Name:	PrevAFibTermSA
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 12905 Procedure History Name
Operator: Equal
Value: Atrial Fibrillation Termination Attempt

--- AND ---

Element: 14268 Procedure History Occurrence
Operator: Equal
Value: Yes

Element: 4445 Atrial Fibrillation, Most Recent Surgical Ablation Date

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

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

Target Value: Any occurrence between birth and the procedure

Technical Specification

Code:	233163003:363702006=49436004
Code System Name:	SNOMED CT
Short Name:	AFibSurgAblDate
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	DT
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 4440 Atrial Fibrillation Termination - Surgical Ablation
Operator: Equal
Value: Yes

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

Element: 4465 Atrial Flutter Termination - Pharmacologic Cardioversion

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

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **Pharmacologic Cardioversion**

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

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

Technical Specification

Code:	440142000:363702006=5370000
Code System Name:	SNOMED CT
Short Name:	PrevAFLTermPC
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 12905 Procedure History Name
Operator: Equal
Value: Atrial Flutter Termination Attempt
--- AND ---
Element: 14268 Procedure History Occurrence
Operator: Equal
Value: Yes

Element: 4470 Atrial Flutter Termination - DC Cardioversion

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

Target Value: Any occurrence between birth and the procedure

Supporting Definition: **DC Cardioversion**

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

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

Technical Specification

Code:	180325003:363702006=5370000
Code System Name:	SNOMED CT
Short Name:	PrevAFLTermDC
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 12905 Procedure History Name
Operator: Equal
Value: Atrial Flutter Termination Attempt
--- AND ---
Element: 14268 Procedure History Occurrence
Operator: Equal
Value: Yes

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

Element: 4475 Atrial Flutter Termination - Catheter Ablation

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

Target Value: Any occurrence between birth and the procedure

Technical Specification

Code:	18286008:363702006=5370000
Code System Name:	SNOMED CT
Short Name:	PrevAFLTermCA
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 12905 Procedure History Name
Operator: Equal
Value: Atrial Flutter Termination Attempt

--- AND ---

Element: 14268 Procedure History Occurrence
Operator: Equal
Value: Yes

Element: 4480 Atrial Flutter Most Recent Catheter Ablation Date

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

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

Target Value: Any occurrence between birth and the procedure

Technical Specification

Code:	18286008:363702006=5370000
Code System Name:	SNOMED CT
Short Name:	AFibFlutterCathAblDate
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	DT
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 4475 Atrial Flutter Termination - Catheter Ablation
Operator: Equal
Value: Yes

Section: Diagnostic Studies **Parent: Root**

Element: 5100 Atrial Rhythm

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

Note(s): If the patient has multiple atrial rhythms, select all that apply. In the event that a patient is ventricular paced, indicate the underlying atrial rhythm. Target value applies to the first procedure captured for this registry. If no ECG is available, a pre-procedure 6 inch cardiac rhythm strip or clinician documentation may be utilized to obtain this information.

Target Value: The last value within 90 days of procedure start

Technical Specification

Code:	106068003
Code System Name:	SNOMED CT
Short Name:	AtrialRhythm
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Multiple
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Atrial Rhythm - 1.3.6.1.4.1.19376.1.4.1.6.5.187

Selection	Definition	Source	Code	Code System Name
Atrial fibrillation			49436004	SNOMED CT
Atrial flutter			5370000	SNOMED CT
Atrial paced			251268003	SNOMED CT
Atrial tachycardia			276796006	SNOMED CT
Sinus			106067008	SNOMED CT
Sinus arrest			5609005	SNOMED CT

Element: 5110 LVEF Assessed

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

Note(s):
If the LVEF is measured during the episode of care, and documented in the medical record, it can be used. There is no requirement for the LVEF to be documented in a formal diagnostic report.
LVEF values obtained prior to first medical contact are not used for coding.
Enter a percentage in the range of 1-99.
If a percentage range is reported, code the lowest number in the range (i.e. 50-55%, is reported as 50%).
In cases of conflicting measurements, the clinician should specify which value best represents the LVEF closest to discharge and this should be noted in the medical record to support coding.
If only a descriptive value is reported (i.e. normal), enter the corresponding percentage value from the list below:
Normal = 60%
Good function = 50%
Mildly reduced = 45%
Fair function = 40%
Moderately reduced = 30%
Poor function = 25%
Severely reduced = 20%

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

Technical Specification

Code:	100001027
Code System Name:	ACC NCDR
Short Name:	LVEFAssessed
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Section: Diagnostic Studies **Parent: Root**

Element: 5115 Most Recent LVEF %

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

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

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

Supporting Definition: **Most Recent LVEF %**

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

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

Technical Specification

Code:	10230-1
Code System Name:	LOINC
Short Name:	LVEF
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	PQ
Precision:	2,0
Selection Type:	Single
Unit of Measure:	%
Default Value:	Null
Usual Range:	5 - 70 %
Valid Range:	1 - 99 %
Data Source:	User

Parent/Child Validation

Element:	5110 LVEF Assessed
Operator:	Equal
Value:	Yes

Element: 5120 Transthoracic Echo (TTE) Performed

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

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

Technical Specification

Code:	433236007
Code System Name:	SNOMED CT
Short Name:	TTEPerf
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Section: Diagnostic Studies **Parent: Root**

Element: 5125 Most Recent TTE Date

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

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

Technical Specification

Code:	433236007
Code System Name:	SNOMED CT
Short Name:	TTEDate
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	DT
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	5120 Transthoracic Echo (TTE) Performed
Operator:	Equal
Value:	Yes

Section: Diagnostic Studies **Parent: Root**

Element: 15707 Echocardiogram Results

Coding Instruction: Indicate the echocardiography results that were present during the most recent transthoracic echocardiogram.

Notes: Include any enlargement or hypertrophy of the heart as well as the severity.

Enter "none" if there was no hypertrophy identified.

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

Technical Specification

Code:	40701008
Code System Name:	SNOMED CT
Short Name:	EchocardiogramResults
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Multiple (Dynamic List)
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	5120 Transthoracic Echo (TTE) Performed
Operator:	Equal
Value:	Yes

Echocardiogram Results - 1.3.6.1.4.1.19376.1.4.1.6.5.946

Selection	Definition	Source	Code	Code System Name
Atrial thrombus detected			396339007:123005000=59652004	SNOMED CT
LV hypertrophy - none			100001231	ACC NCDR
Mild LV hypertrophy			255604002	SNOMED CT
Moderate LV hypertrophy			6736007	SNOMED CT
Severe LV hypertrophy			24484000	SNOMED CT
LA Not enlarged			253352002:116676008=442021009,17621005	SNOMED CT
Mild LA Enlargement			253352002:116676008=442021009,255604002	SNOMED CT
Moderate LA enlargement			253352002:116676008=442021009,6736007	SNOMED CT
Severe LA enlargement			253352002:116676008=442021009,24484000	SNOMED CT
RA Not enlarged			253339007:116676008=442021009,17621005	SNOMED CT
Mild RA Enlargement			253339007:116676008=442021009,255604002	SNOMED CT
Moderate RA enlargement			253339007:116676008=442021009,6736007	SNOMED CT
Severe RA Enlargement			253339007:116676008=442021009,24484000	SNOMED CT

Element: 5150 Mitral Stenosis

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

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

Technical Specification

Code:	79619009
Code System Name:	SNOMED CT
Short Name:	MitralStenosis
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Section: Diagnostic Studies **Parent: Root**

Element: 5145 Mitral Regurgitation

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

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

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

Supporting Definition: **Mitral Regurgitation**

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

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

Technical Specification

Code:	48724000
Code System Name:	SNOMED CT
Short Name:	MitralRegurg
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Mitral Regurgitation - 1.3.6.1.4.1.19376.1.4.1.6.5.215

Selection	Definition	Source	Code	Code System Name
None			100001231	ACC NCDR
Trace/Trivial			100001111	ACC NCDR
Mild			255604002	SNOMED CT
Moderate			6736007	SNOMED CT
Moderate-Severe			100001045	ACC NCDR
Severe			24484000	SNOMED CT

Element: 5170 Baseline Imaging Performed

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

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

Technical Specification

Code:	363679005
Code System Name:	SNOMED CT
Short Name:	BaselineImagingPerf
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Section: Diagnostic Studies **Parent: Root**

Element: 5175 Baseline CT Performed

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

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

Technical Specification

Code:	58744-4
Code System Name:	LOINC
Short Name:	CTPerformed
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	5170	Baseline Imaging Performed
Operator:	Equal	
Value:	Yes	

Element: 5185 Baseline MRI Performed

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

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

Technical Specification

Code:	36482-8
Code System Name:	LOINC
Short Name:	MRPerformed
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	5170	Baseline Imaging Performed
Operator:	Equal	
Value:	Yes	

Section: Diagnostic Studies **Parent: Root**

Element: 5155 Transesophageal Echocardiogram (TEE) Performed

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

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

Technical Specification

Code:	105376000
Code System Name:	SNOMED CT
Short Name:	TEEPerf
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	5170 Baseline Imaging Performed
Operator:	Equal
Value:	Yes

Element: 5165 Atrial Thrombus Detected

Coding Instruction: Indicate if an atrial thrombus was detected.

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

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

Supporting Definition: **Atrial Thrombus Detected**

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

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

Technical Specification

Code:	396339007:123005000=59652004
Code System Name:	SNOMED CT
Short Name:	AtrialThromDetect
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	5155 Transesophageal Echocardiogram (TEE) Performed
Operator:	Equal
Value:	Yes

Section: Pre-Procedure Medications **Parent: Root**

Element: 6985 Pre-procedure Medication Code

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

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

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

Vendor Instruction: Pre-procedure Medication Code (6985) should not be duplicated in an episode

Technical Specification

Code: 100013057
Code System Name: ACC NCDR
Short Name: MedID
Missing Data: Report
Harvested: Yes
Is Identifier: No
Is Base Element: Yes
Is Followup Element: No
Data Type: CD
Precision:
Selection Type: Single (Dynamic List)
Unit of Measure:
Default Value: Null
Usual Range:
Valid Range:
Data Source: User

Pre-Procedure Medication - 1.3.6.1.4.1.19376.1.4.1.6.5.216

Selection	Definition	Source	Code	Code System Name
Amiodarone			703	RxNorm
Angiotensin converting enzyme inhibitor (ACE-I) (Any)			41549009	SNOMED CT
Angiotensin receptor blocker (ARB) (Any)			372913009	SNOMED CT
Angiotensin II receptor blocker neprilysin inhibitor (ARNI)			1656341	RxNorm
Apixaban			1364430	RxNorm
Aspirin			1191	RxNorm
Aspirin, Extended-Release Dipyridamole			226718	RxNorm
Beta blocker (Any)			33252009	SNOMED CT
Betrixaban			1927851	RxNorm
Cangrelor			1656052	RxNorm
Clopidogrel			32968	RxNorm
Dabigatran			1546356	RxNorm
Digoxin			3407	RxNorm
Diltiazem			3443	RxNorm
Disopyramide			3541	RxNorm
Dofetilide			49247	RxNorm
Dronedarone			233698	RxNorm
Edoxaban			1599538	RxNorm
Flecainide			4441	RxNorm
GLP-1 agonist			772985004	SNOMED CT
Heparin Derivative			100000921	ACC NCDR
Low Molecular Weight Heparin			373294004	SNOMED CT
Prasugrel			613391	RxNorm
Procainamide			8700	RxNorm
Propafenone			8754	RxNorm
Quinidine			9068	RxNorm
Rivaroxaban			1114195	RxNorm
SGLT inhibitor			112000003634	ACC NCDR
Sotalol			9947	RxNorm
Ticagrelor			1116632	RxNorm
Ticlopidine			10594	RxNorm
Unfractionated Heparin			96382006	SNOMED CT
Verapamil			11170	RxNorm
Vorapaxar			1537034	RxNorm
Warfarin			11289	RxNorm

Section: Pre-Procedure Medications **Parent: Root**

Element: 6990 Pre-procedure Medication Administered

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

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

Vendor Instruction: When Pre-procedure Medication Code (6985) is answered, Pre-procedure Medication Administered (6990) cannot be Null.

Technical Specification

Code:	432102000
Code System Name:	SNOMED CT
Short Name:	MedAdmin
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	6985	Pre-procedure Medication Code
Operator:		
Value:	Any Value	

Pre-procedure Medication Administration - 1.3.6.1.4.1.19376.1.4.1.6.5.44

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

Section: Procedure Information — Parent: Root

Element: 7000 Procedure Start Date and Time

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

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

Target Value: Any occurrence on current procedure

Vendor Instruction: Procedure Start Date and Time (7000) must be Greater than or Equal to Arrival Date and Time (3001)

Procedure Start Date and Time (7000) must be Greater than or Equal to Most Recent TTE Date (5125)

Procedure Start Date and Time (7000) must be unique within an episode of care

Technical Specification

Code:	1000142460
Code System Name:	ACC NCDR
Short Name:	ProcedureStartDateTime
Missing Data:	Illegal
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	TS
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 7025 Procedure Status

Coding Instruction: Indicate the status of the procedure.

Target Value: The value on current procedure

Technical Specification

Code:	100001218
Code System Name:	ACC NCDR
Short Name:	ProcStatus
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Procedure Status - 1.3.6.1.4.1.19376.1.4.1.6.5.226

Selection	Definition	Source	Code	Code System Name
Inpatient	Treatment/Billing status of the patient: Patient has been admitted to the hospital.		416800000	SNOMED CT
Outpatient	Patient/Billing status: Patient is an outpatient admission.		373864002	SNOMED CT

Element: 7005 Procedure End Date and Time

Coding Instruction: Indicate the ending date and time at which the operator completes the procedure and breaks scrub at the end of the procedure.

Note(s):
If more than one operator is involved in the case then use the date and time the last operator breaks scrub for the last time.

Target Value: The value on current procedure

Vendor Instruction: Procedure End Date and Time (7005) and Procedure Start Date and Time (7000) must not overlap on multiple procedures

Procedure End Date and Time (7005) must be Greater than Procedure Start Date and Time (7000)

Procedure End Date and Time (7005) must be Less than or Equal to Discharge Date and Time (10101)

Technical Specification

Code:	1000142459
Code System Name:	ACC NCDR
Short Name:	ProcedureEndDateTime
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	TS
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Section: Procedure Information **Parent: Root**

Element: 7100 Operator Last Name

Coding Instruction: Indicate the last name of operator.

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

Target Value: The value on current procedure

Technical Specification

Code:	112000001853
Code System Name:	ACC NCDR
Short Name:	OperA_LastName
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	LN
Precision:	50
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 7105 Operator First Name

Coding Instruction: Indicate the first name of operator.

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

Target Value: The value on current procedure

Technical Specification

Code:	112000001853
Code System Name:	ACC NCDR
Short Name:	OperA_FirstName
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	FN
Precision:	50
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 7110 Operator Middle Name

Coding Instruction: Indicate the middle name of operator.

Note(s):
It is acceptable to specify the middle initial.

If there is no middle name given, leave field blank.

If there are multiple middle names, enter all of the middle names sequentially.

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

Target Value: The value on current procedure

Technical Specification

Code:	112000001853
Code System Name:	ACC NCDR
Short Name:	OperA_MidName
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	MN
Precision:	50
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Section: Procedure Information **Parent: Root**

Element: 7115 Operator NPI

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

Target Value: The value on current procedure

Technical Specification

Code:	2.16.840.1.113883.4.6
Code System Name:	ACC NCDR
Short Name:	OperA_NPI
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	NUM
Precision:	10
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 15433 Fellow Last Name

Coding Instruction: Indicate the last name of the Fellow-in-Training operator.

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

Target Value: The value on current procedure

Technical Specification

Code:	112000003534
Code System Name:	ACC NCDR
Short Name:	FIT_LastName
Missing Data:	No Action
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	LN
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Element: 15434 Fellow First Name

Coding Instruction: Indicate the first name of the Fellow-in-Training operator.

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

Target Value: The value on current procedure

Technical Specification

Code:	112000003534
Code System Name:	ACC NCDR
Short Name:	FIT_FirstName
Missing Data:	No Action
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	FN
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Section: Procedure Information **Parent: Root**

Element: 15435 Fellow Middle Name

Coding Instruction: Indicate the middle name of the Fellow-in-Training operator.

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

Target Value: The value on current procedure

Technical Specification

Code:	112000003534
Code System Name:	ACC NCDR
Short Name:	FIT_MidName
Missing Data:	No Action
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	MN
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Element: 15436 Fellow NPI

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

Target Value: The value on current procedure

Technical Specification

Code:	112000003534
Code System Name:	ACC NCDR
Short Name:	FIT_NPI
Missing Data:	No Action
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	NUM
Precision:	10
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Element: 15431 Fellowship Program Identification Number

Coding Instruction: Indicate the institution's Accreditation Council for Graduate Medical Education (ACGME) number for the program in which the Fellow is participating.

Target Value: The value on current procedure

Supporting Definition: **Fellowship Program Identification Number**

The institution's Accreditation Council for Graduate Medical Education (ACGME) number for the program in which the Fellow is participating.

ACGME oversees the accreditation of fellowship programs in the US. Each accredited training program is assigned a program ID.

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

Technical Specification

Code:	224873004
Code System Name:	SNOMED CT
Short Name:	FITProgID
Missing Data:	No Action
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	ST
Precision:	15
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	15436 Fellow NPI
Operator:	
Value:	Any Value

Section: Procedure Information **Parent: Root**

Element: 7130 Sedation

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

Target Value: The value on current procedure

Supporting Definition: **Sedation**

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

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

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

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

Source: Committee on Quality Management and Departmental Administration. "Statement on Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia." Last Amended: October 23, 2019 (original approval: October 13, 1999). American Society of Anesthesiologists. "Position on Monitored Anesthesia Care." Last amended on October 17, 2018.

https://www.asahq.org/standards-and-practice-parameters/statement-on-continuum-of-depth-of-sedation-definition-of-general-anesthesia-and-levels-of-sedation-analgesia

Technical Specification

Code: 72641008
Code System Name: SNOMED CT
Short Name: Anesthesia
Missing Data: Report
Harvested: Yes
Is Identifier: No
Is Base Element: Yes
Is Followup Element: No
Data Type: CD
Precision:
Selection Type: Single
Unit of Measure:
Default Value: Null
Usual Range:
Valid Range:
Data Source: User

Sedation Method - 1.3.6.1.4.1.19376.1.4.1.6.5.199

Selection	Definition	Source	Code	Code System Name
Minimal Sedation/Anxiolysis			427255001	SNOMED CT
Moderate Sedation/Analgesia			314271007	SNOMED CT
Deep Sedation/Analgesia			426155000	SNOMED CT
General Anesthesia			420653000	SNOMED CT

Element: 7175 Transseptal Catheterization

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

Target Value: The value on current procedure

Technical Specification

Code: 100001112
Code System Name: ACC NCDR
Short Name: TransseptCath
Missing Data: Report
Harvested: Yes
Is Identifier: No
Is Base Element: Yes
Is Followup Element: No
Data Type: CD
Precision:
Selection Type: Single
Unit of Measure:
Default Value: Null
Usual Range:
Valid Range:
Data Source: User

Transseptal Catheterization - 1.3.6.1.4.1.19376.1.4.1.6.5.196

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

Section: Procedure Information **Parent: Root**

Element: 15726 Intracardiac Echocardiography

Coding Instruction: Indicate if imaging was performed via intracardiac echo (ICE).

Target Value: The value on current procedure

Technical Specification

Code:	448761005
Code System Name:	SNOMED CT
Short Name:	PreProcICEPerf
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Intracardiac Echocardiography Types - 1.3.6.1.4.1.19376.1.4.1.6.5.951

Selection	Definition	Source	Code	Code System Name
No			100013073	ACC NCDR
Yes - 2D			112000003651	ACC NCDR
Yes - 3D			448761005	SNOMED CT
Yes - 4D			112000003652	ACC NCDR

Element: 15714 Pulmonary Vein Isolation

Coding Instruction: Indicate if a pulmonary vein isolation was performed during this procedure.

Target Value: The value on current procedure

Technical Specification

Code:	112000001854
Code System Name:	ACC NCDR
Short Name:	PVI
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Section: Procedure Information **Parent: Root**

Element: 15722 Pulmonary Vein Isolation Energy Source

Coding Instruction: Indicate the energy source used during the pulmonary vein isolation.

Target Value: The value on current procedure

Technical Specification

Code:	100000915
Code System Name:	ACC NCDR
Short Name:	PVIEnergySource
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Multiple (Dynamic List)
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	15714	Pulmonary Vein Isolation
Operator:	Equal	
Value:	Yes	

Ablation Energy Source - 1.3.6.1.4.1.19376.1.4.1.6.5.947

Selection	Definition	Source	Code	Code System Name
Cryoenergy	Cryoablation, or freezing technology, involves a coolant being released into the catheter's balloon to freeze and ablate the tissue.		112000003639	ACC NCDR
Ethanol	Ethanol infusion used during catheter ablation		112000003640	ACC NCDR
Laser	The laser balloon catheter comprises an inflatable balloon mounted on a catheter shaft, an endoscope lumen, and an optical fiber that can deliver laser energy		112000003641	ACC NCDR
Pulsed Field Ablation	Pulsed field ablation uses electrical pulses to cause nonthermal irreversible electroporation and induce cardiac cell death.		112000003642	ACC NCDR
Radiofrequency	Radiofrequency uses heat energy generated by radiofrequency waves to create lesions or scars on the heart tissue, disrupting abnormal electrical signals.		112000003643	ACC NCDR
Other	Any energy used during the procedure that is not listed		112000003644	ACC NCDR

Section: Adjunctive Ablation Lesions **Parent: Procedure Information**

Element: 7165 Adjunctive Ablation Lesions

Coding Instruction: Indicate whether additional lesions were created during the current ablation procedure, regardless of the arrythmia being treated with the additional lesions.

Intent: This element is intended to identify what additional targeted areas are ablated beyond the primary pulmonary vein isolation (PVI). Creating additional lesions are intended to enhance the success of the procedure by addressing other potential sources of arrythmia. Additional lesions may also be associated with longer procedure time and more opportunity for complications to occur.

Target Value: The value on current procedure

Supporting Definition: **Adjunctive Ablation Lesions**

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

Source: NCDR

Technical Specification

Code:	100000926
Code System Name:	ACC NCDR
Short Name:	AblLesion
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Section: Ablation Location **Parent: Adjunctive Ablation Lesions**

Element: 15725 Adjunctive Ablation Location

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

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

Target Value: The value on current procedure

Technical Specification

Code:	112000001854
Code System Name:	ACC NCDR
Short Name:	AblLesionLocSingSel
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	7165 Adjunctive Ablation Lesions
Operator:	Equal
Value:	Yes

Adjunctive Ablation Lesion Location - 1.3.6.1.4.1.19376.1.4.1.6.5.201

Selection	Definition	Source	Code	Code System Name
SVC isolation			48345005	SNOMED CT
Coronary sinus isolation			90219004	SNOMED CT
Cavotricuspid isthmus (CTI)			100000981	ACC NCDR
Ligament/vein of marshall			5208200	SNOMED CT
LA roof line			112000003647	ACC NCDR
Left auricular appendage			112000002380	ACC NCDR
LA floor line			112000003648	ACC NCDR
Mitral isthmus line			112000003650	ACC NCDR
Posterior wall isolation			112000003649	ACC NCDR
Other			100001063	ACC NCDR

Element: 15708 Adjuctive Ablation Lesion Occurrence

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

Target Value: The value on current procedure

Technical Specification

Code:	112000003637
Code System Name:	ACC NCDR
Short Name:	AblLesionOcc
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	15725 Adjunctive Ablation Location
Operator:	
Value:	Any Value

Section: Ablation Location **Parent: Adjunctive Ablation Lesions**

Element: 15709 Adjunctive Ablation Lesion Energy Source

Coding Instruction: Indicate the energy source used to create the lesion.

Target Value: The value on current procedure

Technical Specification

Code:	112000003637
Code System Name:	ACC NCDR
Short Name:	AblLesionEnergy
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Multiple (Dynamic List)
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 15725 Adjunctive Ablation Location
Operator:
Value: Any Value

--- AND ---

Element: 15708 Adjuctive Ablation Lesion Occurrence
Operator: Equal
Value: Yes

Ablation Energy Source - 1.3.6.1.4.1.19376.1.4.1.6.5.947

Selection	Definition	Source	Code	Code System Name
Cryoenergy	Cryoablation, or freezing technology, involves a coolant being released into the catheter's balloon to freeze and ablate the tissue.		112000003639	ACC NCDR
Ethanol	Ethanol infusion used during catheter ablation		112000003640	ACC NCDR
Laser	The laser balloon catheter comprises an inflatable balloon mounted on a catheter shaft, an endoscope lumen, and an optical fiber that can deliver laser energy		112000003641	ACC NCDR
Pulsed Field Ablation	Pulsed field ablation uses electrical pulses to cause nonthermal irreversible electroporation and induce cardiac cell death.		112000003642	ACC NCDR
Radiofrequency	Radiofrequency uses heat energy generated by radiofrequency waves to create lesions or scars on the heart tissue, disrupting abnormal electrical signals.		112000003643	ACC NCDR
Other	Any energy used during the procedure that is not listed		112000003644	ACC NCDR

Section: Additional Ablations Attempted **Parent: Procedure Information**

Element: 15710 Additional Ablation

Coding Instruction: Indicate if additional ablations, other than PVI (pulmonary vein isolation), were performed or attempted during the procedure.

Intent: This element, and the child fields, are meant to capture a comprehensive view of the ablation strategies, approaches, techniques utilized during atrial fibrillation (AF) ablation procedures. While pulmonary vein isolation is the primary and most common approach to AF ablation, additional ablation techniques may be employed depending on the patient's specific condition and the complexity of the AF. Understanding whether additional ablations were performed helps to document procedural variability, assess outcomes, and potentially guide future treatment protocols.

Target Value: The value on current procedure

Technical Specification

Code:	112000003637
Code System Name:	ACC NCDR
Short Name:	AddAbl
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Section: Ablation Approach **Parent: Additional Ablations Attempted**

Element: 15711 Additional Ablation Approach

Coding Instruction: Indicate the technique, strategy or approach used to perform the additional ablation.

Target Value: The value on current procedure

Technical Specification

Code:	112000001854
Code System Name:	ACC NCDR
Short Name:	AddAblTech
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	15710 Additional Ablation
Operator:	Equal
Value:	Yes

Additional Ablation Approach - 1.3.6.1.4.1.19376.1.4.1.6.5.953

Selection	Definition	Source	Code	Code System Name
Complex fractionated electrogram			100000910	ACC NCDR
Focal/trigger ablation			100000913	ACC NCDR
Ganglion plexus ablation			100000914	ACC NCDR
Rotor-based mapping			100000917	ACC NCDR
Temporo-spatial dispersion mapping/ablation			112000003656	ACC NCDR
Other			100000351	ACC NCDR

Element: 15712 Additional Ablation Occurrence

Coding Instruction: Indicate the occurrence of each additional ablation technique.

Target Value: The value on current procedure

Technical Specification

Code:	112000003637
Code System Name:	ACC NCDR
Short Name:	AddAblOcc
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	15711 Additional Ablation Approach
Operator:	
Value:	Any Value

Section: Ablation Approach **Parent: Additional Ablations Attempted**

Element: 15713 Additional Ablation Energy Source

Coding Instruction: Indicate the energy source used during the additional ablation.

Target Value: The value on current procedure

Technical Specification

Code:	112000003637
Code System Name:	ACC NCDR
Short Name:	AddAblEnergy
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Multiple (Dynamic List)
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 15711 Additional Ablation Approach
Operator:
Value: Any Value

--- AND ---

Element: 15712 Additional Ablation Occurrence
Operator: Equal
Value: Yes

Ablation Energy Source - 1.3.6.1.4.1.19376.1.4.1.6.5.947

Selection	Definition	Source	Code	Code System Name
Cryoenergy	Cryoablation, or freezing technology, involves a coolant being released into the catheter's balloon to freeze and ablate the tissue.		112000003639	ACC NCDR
Ethanol	Ethanol infusion used during catheter ablation		112000003640	ACC NCDR
Laser	The laser balloon catheter comprises an inflatable balloon mounted on a catheter shaft, an endoscope lumen, and an optical fiber that can deliver laser energy		112000003641	ACC NCDR
Pulsed Field Ablation	Pulsed field ablation uses electrical pulses to cause nonthermal irreversible electroporation and induce cardiac cell death.		112000003642	ACC NCDR
Radiofrequency	Radiofrequency uses heat energy generated by radiofrequency waves to create lesions or scars on the heart tissue, disrupting abnormal electrical signals.		112000003643	ACC NCDR
Other	Any energy used during the procedure that is not listed		112000003644	ACC NCDR

Section: Procedure Information **Parent: Procedure Information**

Element: 7120 Phrenic Nerve Evaluation

Coding Instruction: Indicate if the phrenic nerve was evaluated.

Target Value: The value on current procedure

Technical Specification

Code:	100001078
Code System Name:	ACC NCDR
Short Name:	PhrenicNerveEval
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 15724 Cardioversion Performed During Procedure and Type

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

Target Value: The value on current procedure

Technical Specification

Code:	250980009
Code System Name:	SNOMED CT
Short Name:	CVandType
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Cardioversion Performed During Procedure and Type - 1.3.6.1.4.1.19376.1.4.1.6.5.950

Selection	Definition	Source	Code	Code System Name
No			100013073	ACC NCDR
Yes - Pharmacologic			440142000	SNOMED CT
Yes - DC			180325003	SNOMED CT
Both			112000003646	ACC NCDR

Section: Procedure Information **Parent: Procedure Information**

Element: 15717 Atrial Flutter Observed During Procedure

Coding Instruction: Indicate if atrial flutter was observed during the procedure.

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

Target Value: The value on current procedure

Supporting Definition: **Atrial Flutter**

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

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

Technical Specification

Code:	5370000
Code System Name:	SNOMED CT
Short Name:	AFObserved
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Ablation Performed After Observations - 1.3.6.1.4.1.19376.1.4.1.6.5.952

Selection	Definition	Source	Code	Code System Name
No			100013073	ACC NCDR
Yes - Ablated			112000003653	ACC NCDR
Yes - Not Ablated			112000003654	ACC NCDR

Element: 15718 Atrial Tachycardia Observed During Procedure

Coding Instruction: Indicate if atrial tachycardia was observed during the procedure.

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

Target Value: The value on current procedure

Technical Specification

Code:	276796006
Code System Name:	SNOMED CT
Short Name:	ATObserved
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Ablation Performed After Observations - 1.3.6.1.4.1.19376.1.4.1.6.5.952

Selection	Definition	Source	Code	Code System Name
No			100013073	ACC NCDR
Yes - Ablated			112000003653	ACC NCDR
Yes - Not Ablated			112000003654	ACC NCDR

Section: Device **Parent: Procedure Information**

Element: 7205 Catheter Manipulation

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

Target Value: The value on current procedure

Technical Specification

Code:	103712006
Code System Name:	SNOMED CT
Short Name:	CathManipulation
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Multiple
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Catheter Manipulation Method - 1.3.6.1.4.1.19376.1.4.1.6.5.200

Selection	Definition	Source	Code	Code System Name
Manual			100000958	ACC NCDR
Magnetic/Robotic			112000003635	ACC NCDR
Other			112000003636	ACC NCDR

Section: Catheter Ablation Devices **Parent: Device**

Element: 7255 Catheter Ablation Device

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

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

Target Value: Any occurrence on current procedure

Technical Specification

Code:	2.16.840.1.113883.3.3478.6.1.22
Code System Name:	ACC NCDR Catheter Ablation Devices
Short Name:	DevID
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single (Dynamic List)
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 7260 Catheter Ablation Unique Device Identifier

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

Target Value: Any occurrence on current procedure

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

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

Source: US FDA

Technical Specification

Code:	2.16.840.1.113883.3.3719
Code System Name:	ACC NCDR
Short Name:	CathAblationUDI
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	ST
Precision:	150
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Section: Electroanatomical Mapping System **Parent: Device**

Element: 15715 Electroanatomic Mapping System

Coding Instruction: Indicate the electroanatomic mapping system used. If no mapping system was used, leave this field blank.

Note(s):

Electroanatomic mapping systems combine information of the anatomy and electrical properties of the cardiac structures under evaluation. These systems create a three-dimensional anatomical map used to help localize critical sites for ablation. To request a mapping system be added to this list please contact NCDR.

Target Value: Any occurrence on current procedure

Technical Specification

Code:	707833003
Code System Name:	SNOMED CT
Short Name:	MappingDevID
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single (Dynamic List)
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Section: Radiation Exposure **Parent: Procedure Information**

Element: 7210 Cumulative Air Kerma

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

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

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

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

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

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

Technical Specification

Code:	228850003
Code System Name:	SNOMED CT
Short Name:	FluoroDoseKerm
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	PQ
Precision:	5,0
Selection Type:	Single
Unit of Measure:	mGy, Gy
Default Value:	Null
Usual Range:	1 - 10 Gy 1 - 10,000 mGy
Valid Range:	1 - 50 Gy 1 - 50,000 mGy
Data Source:	User

Parent/Child Validation

Element: 15719 No Radiation Kerma
Operator: Equal
Value: No (or Not Answered)

Element: 15719 No Radiation Kerma

Coding Instruction: Indicate if no radiation was used during the procedure

Target Value: The value on current procedure

Technical Specification

Code:	228850003
Code System Name:	SNOMED CT
Short Name:	NoRadiationKerm
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Section: Radiation Exposure **Parent: Procedure Information**

Element: 14278 Dose Area Product

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

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

Supporting Definition: **Dose Area Product**

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

Also known as KAP (Kerma Area Product).

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

Technical Specification

Code:	100000994
Code System Name:	ACC NCDR
Short Name:	FluoroDoseDAP2
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	PQ
Precision:	7,0
Selection Type:	Single
Unit of Measure:	Gy·cm², dGy·cm², cGy·cm², mGy·cm², µGy·M²
Default Value:	
Usual Range:	1 - 700 Gy·cm² 10 - 7,000 dGy·cm² 100 - 70,000 cGy·cm² 100 - 70,000 µGy·M² 1,000 - 700,000 mGy·cm²
Valid Range:	1 - 5,000 Gy·cm² 10 - 50,000 dGy·cm² 100 - 500,000 cGy·cm² 100 - 500,000 µGy·M² 1,000 - 5,000,000 mGy·cm²
Data Source:	User

Parent/Child Validation

Element:	15720 No Fluoro Used
Operator:	Equal
Value:	No (or Not Answered)

Element: 15720 No Fluoro Used

Coding Instruction: Indicate if no fluoroscopy was used during the procedure.

Target Value: The value on current procedure

Technical Specification

Code:	53438000
Code System Name:	SNOMED CT
Short Name:	NoFluoroUsed
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Section: Radiation Exposure **Parent: Procedure Information**

Element: 7214 Fluoroscopy Time

Coding Instruction: Indicate the total fluoroscopy time recorded to the nearest 0.1-minute. The time recorded should include the total time for the lab visit.

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

Technical Specification

Code:	100014077
Code System Name:	ACC NCDR
Short Name:	FluoroTime
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	PQ
Precision:	4,1
Selection Type:	Single
Unit of Measure:	min
Default Value:	
Usual Range:	0.1 - 30.0 min
Valid Range:	0.1 - 300.0 min
Data Source:	User

Section: Intraprocedure Anticoagulation Strategy — Parent: Procedure Information

Element: 7225 — Intraprocedure Anticoagulation

Coding Instruction: Indicate if intraprocedure anticoagulation therapy was provided.

Target Value: The value on current procedure

Technical Specification

Code:	81839001
Code System Name:	SNOMED CT
Short Name:	IntraProcAnticoag
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Element: 15775 — Uninterrupted Anticoagulation Therapy

Coding Instruction: Indicate if the patient continued on warfarin, heparin, bivalirudin therapy or another anticoagulation therapy and it was not held for the procedure.

Target Value: The value on current procedure

Technical Specification

Code:	100001238
Code System Name:	ACC NCDR
Short Name:	UnintAnticoagTx
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	7225 Intraprocedure Anticoagulation
Operator:	Equal
Value:	Yes

Section: Intra or Post-Procedure Events **Parent: Intra or Post-Procedure Events**

Element: 9001 Intra/Post-Procedure Events

Coding Instruction: Indicate the event that occurred between the start of the procedure and the next procedure or discharge.

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

Vendor Instruction: Intra/Post-Procedure Events (9001) should not be duplicated in a lab visit

Technical Specification

Code:	1000142478
Code System Name:	ACC NCDR
Short Name:	PostProcEvent
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single (Dynamic List)
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Post-Procedure Events - 2.16.840.1.113883.3.3478.6.3.10

Selection	Definition	Source	Code	Code System Name
Acute kidney injury			14669001	SNOMED CT
A-V fistula requiring intervention			439470001	SNOMED CT
Bleeding - access site (transfusion)			100001237	ACC NCDR
Bradycardia adverse events			48867003	SNOMED CT
Cardiac arrest			410429000	SNOMED CT
Cardiac surgery (unplanned emergent)			64915003	SNOMED CT
Deep vein thrombosis			128053003	SNOMED CT
GU Bleeding			417941003	SNOMED CT
Heart failure			84114007	SNOMED CT
Hematoma at access site			385494008	SNOMED CT
Hemolysis			73320003	SNOMED CT
Hemorrhage (non access site)			50960005	SNOMED CT
Hemothorax			31892009	SNOMED CT
Myocardial infarction			22298006	SNOMED CT
Pericardial effusion requiring intervention			100001073	ACC NCDR
Pericardial effusion resulting in cardiac tamponade			100001074	ACC NCDR
Phrenic nerve damage			100001076	ACC NCDR
Pleural effusion			60046008	SNOMED CT
Pneumonia			233604007	SNOMED CT
Pneumothorax			36118008	SNOMED CT
Pseudoaneurysm requiring intervention			443089001	SNOMED CT
Pulmonary embolism			59282003	SNOMED CT
Pulmonary vein damage/dissection			60366008	SNOMED CT
Respiratory failure			409622000	SNOMED CT
Sepsis			91302008	SNOMED CT
Stroke			230690007	SNOMED CT
Transient ischemic attack (TIA)			266257000	SNOMED CT
Vascular injury requiring surgical intervention			30904006:363702006=57662003	SNOMED CT

Section: Intra or Post-Procedure Events **Parent: Intra or Post-Procedure Events**

Element: 9002 Intra/Post-Procedure Events Occurred

Coding Instruction: Indicate the event that occurred between the procedure and the next procedure or discharge.

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

Vendor Instruction: When Intra/Post-Procedure Events (9001) are provided then Intra/Post-Procedure Events Occurred (9002) cannot be Null

Technical Specification

Code:	1000142479
Code System Name:	ACC NCDR
Short Name:	PostProcOccurred
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	9001 Intra/Post-Procedure Events
Operator:	
Value:	Any Value

Section: Intra or Post-Procedure Event Details **Parent: Intra or Post-Procedure Events**

Element: 9030 Bradycardia Requiring Permanent Pacemaker

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

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

Technical Specification

Code:	233182007:363702006=48867003
Code System Name:	SNOMED CT
Short Name:	ReqPermPacing
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 9001 Intra/Post-Procedure Events
Operator: Equal
Value: Bradycardia adverse events

--- AND ---

Element: 9002 Intra/Post-Procedure Events Occurred
Operator: Equal
Value: Yes

Element: 9210 Hemothorax Requiring Drainage

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

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

Technical Specification

Code:	100001011
Code System Name:	ACC NCDR
Short Name:	HemothoraxReqDrng
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 9001 Intra/Post-Procedure Events
Operator: Equal
Value: Hemothorax

--- AND ---

Element: 9002 Intra/Post-Procedure Events Occurred
Operator: Equal
Value: Yes

Section: Intra or Post-Procedure Event Details **Parent: Intra or Post-Procedure Events**

Element: 9220 Pneumothorax Requiring Drainage

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

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

Technical Specification

Code:	100001079
Code System Name:	ACC NCDR
Short Name:	PneumothoraxReqDrng
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 9001 Intra/Post-Procedure Events
Operator: Equal
Value: Pneumothorax

--- AND ---

Element: 9002 Intra/Post-Procedure Events Occurred
Operator: Equal
Value: Yes

Section: Discharge **Parent: Root**

Element: 10025 Discharge Atrial Rhythm

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

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

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

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

Technical Specification

Code:	106068003
Code System Name:	SNOMED CT
Short Name:	DCAtrialRhythm
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Multiple
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Atrial Rhythm - 1.3.6.1.4.1.19376.1.4.1.6.5.187

Selection	Definition	Source	Code	Code System Name
Atrial fibrillation			49436004	SNOMED CT
Atrial flutter			5370000	SNOMED CT
Atrial paced			251268003	SNOMED CT
Atrial tachycardia			276796006	SNOMED CT
Sinus			106067008	SNOMED CT
Sinus arrest			5609005	SNOMED CT

Element: 14871 Post Procedure Hemoglobin

Coding Instruction: Indicate the lowest hemoglobin (Hgb) value (g/dL), obtained via lab assay or point of care assay, between the end of the procedure and the time of discharge.

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

Supporting Definition: **Hemoglobin**

Hemoglobin (Hb or Hgb) is the iron-containing oxygen-transport metalloprotein in the red blood cells. It carries oxygen from the lungs to the rest of the body (i.e. the tissues) where it releases the oxygen to burn nutrients and provide energy. Hemoglobin concentration measurement is among the most commonly performed blood tests, usually as part of a complete blood count. If the concentration is below normal, this is called anemia. Anemias are classified by the size of red blood cells: "microcytic" if red cells are small, "macrocytic" if they are large, and "normocytic" if otherwise. Dehydration or hyperhydration can greatly influence measured hemoglobin levels.

Source: http://s.details.loinc.org/LOINC/718-7.html?sections=Simple

Technical Specification

Code:	718-7
Code System Name:	LOINC
Short Name:	PostProcHgb2
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	PQ
Precision:	3,1
Selection Type:	Single
Unit of Measure:	g/dL
Default Value:	
Usual Range:	5.0 - 20.0 g/dL
Valid Range:	0.1 - 50.0 g/dL
Data Source:	User

Parent/Child Validation

Element:	14872 Post Procedure Hemoglobin Not Drawn
Operator:	Equal
Value:	No (or Not Answered)

Section: Discharge **Parent: Root**

Element: 14872 Post Procedure Hemoglobin Not Drawn

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

Target Value: N/A

Technical Specification

Code:	718-7
Code System Name:	LOINC
Short Name:	PostProcHgbND2
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Element: 10101 Discharge Date and Time

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

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

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

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

Target Value: The value on discharge

Vendor Instruction: Discharge Date and Time (10101) must be Greater than or Equal to 10/01/2024

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

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

Discharge Date and Time (10101) must be Greater than or Equal to Procedure Start Date and Time (7000)

Technical Specification

Code:	1000142457
Code System Name:	ACC NCDR
Short Name:	DCDateTime
Missing Data:	Illegal
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	TS
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Section: Discharge **Parent: Root**

Element: 10105 Discharge Status

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

Target Value: The value on discharge

Technical Specification

Code:	75527-2
Code System Name:	LOINC
Short Name:	DCStatus
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Discharge Life Status - 1.3.6.1.4.1.19376.1.4.1.6.5.42

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

Element: 10120 Death During the Procedure

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

Target Value: Any occurrence on discharge

Technical Specification

Code:	100000923
Code System Name:	ACC NCDR
Short Name:	DeathProcedure
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	10105 Discharge Status
Operator:	Equal
Value:	Deceased

Section: Discharge **Parent: Root**

Element: 10125 Cause of Death

Coding Instruction: Indicate the primary cause of death, i.e. the first significant abnormal event which ultimately led to death.

Target Value: The value on time of death

Supporting Definition: **Cause of Death**

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

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

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

Technical Specification

Code:	184305005
Code System Name:	SNOMED CT
Short Name:	DeathCause
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	No
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	10105 Discharge Status
Operator:	Equal
Value:	Deceased

Cause of Death Clinical Finding - 1.3.6.1.4.1.19376.1.4.1.6.5.88

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

Section: Discharge Medications **Parent: Discharge**

Element: 10200 Discharge Medication Code

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

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

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

Target Value: N/A

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

Technical Specification

Code: 100013057
Code System Name: ACC NCDR
Short Name: DC_MedID
Missing Data: Report
Harvested: Yes
Is Identifier: No
Is Base Element: Yes
Is Followup Element: No
Data Type: CD
Precision:
Selection Type: Single (Dynamic List)
Unit of Measure:
Default Value: Null
Usual Range:
Valid Range:
Data Source: User

Parent/Child Validation

Element: 10105 Discharge Status
Operator: Equal
Value: Alive

Discharge Medication - 1.3.6.1.4.1.19376.1.4.1.6.5.165

Selection	Definition	Source	Code	Code System Name
Amiodarone			703	RxNorm
Angiotensin converting enzyme inhibitor (ACE-I) (Any)			41549009	SNOMED CT
Angiotensin receptor blocker (ARB) (Any)			372913009	SNOMED CT
Angiotensin II receptor blocker neprilysin inhibitor (ARNI)			1656341	RxNorm
Apixaban			1364430	RxNorm
Aspirin			1191	RxNorm
Aspirin, Extended-Release Dipyridamole			226718	RxNorm
Beta blocker (Any)			33252009	SNOMED CT
Betrixaban			1927851	RxNorm
Cangrelor			1656052	RxNorm
Clopidogrel			32968	RxNorm
Dabigatran			1546356	RxNorm
Digoxin			3407	RxNorm
Diltiazem			3443	RxNorm
Disopyramide			3541	RxNorm
Dofetilide			49247	RxNorm
Dronedarone			233698	RxNorm
Edoxaban			1599538	RxNorm
Flecainide			4441	RxNorm
GLP-1 agonist			772985004	SNOMED CT
Heparin Derivative			100000921	ACC NCDR
Low Molecular Weight Heparin			373294004	SNOMED CT
Prasugrel			613391	RxNorm
Procainamide			8700	RxNorm
Propafenone			8754	RxNorm
Quinidine			9068	RxNorm
Rivaroxaban			1114195	RxNorm
SGLT inhibitor			112000003634	ACC NCDR
Sotalol			9947	RxNorm
Ticagrelor			1116632	RxNorm
Ticlopidine			10594	RxNorm
Unfractionated Heparin			96382006	SNOMED CT
Verapamil			11170	RxNorm
Vorapaxar			1537034	RxNorm
Warfarin			11289	RxNorm

Section: Discharge Medications **Parent: Discharge**

Element: 10205 Discharge Medication Prescribed

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

Target Value: The value on discharge

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

Technical Specification

Code: 432102000
Code System Name: SNOMED CT
Short Name: DC_MedAdmin
Missing Data: Report
Harvested: Yes
Is Identifier: No
Is Base Element: Yes
Is Followup Element: No
Data Type: CD
Precision:
Selection Type: Single
Unit of Measure:
Default Value: Null
Usual Range:
Valid Range:
Data Source: User

Parent/Child Validation

Element: 10200 Discharge Medication Code
Operator:
Value: Any Value

Discharge Medication Administration - 1.3.6.1.4.1.19376.1.4.1.6.5.86

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

Section: Follow-Up **Parent: Root**

Element: 10999 Follow-Up Unique Key

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

Target Value: N/A

Technical Specification

Code:	1000142426
Code System Name:	ACC NCDR
Short Name:	FollowUpKey
Missing Data:	Illegal
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	ST
Precision:	50
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	Automatic

Element: 11000 Follow-Up Assessment Date

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

Target Value: The value on Follow-up

Vendor Instruction: Follow-Up Assessment Date (11000) must be Greater than or Equal to 10/01/2024

Follow-Up Assessment Date (11000) must be Greater than Follow-Up Reference Episode Discharge Date and Time (11015)

Follow-Up Assessment Date (11000) must be Less than that of a previously submitted follow-up assessment with Follow-Up Status (11004) of Deceased

Technical Specification

Code:	1000142364
Code System Name:	ACC NCDR
Short Name:	F_AssessmentDate
Missing Data:	Illegal
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	DT
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Element: 11002 Follow-Up Reference Episode Arrival Date and Time

Coding Instruction: Indicate the date and time of arrival for the episode of care that included the reference procedure.

Target Value: The value on Follow-up

Technical Specification

Code:	1000142436
Code System Name:	ACC NCDR
Short Name:	RefArrivalDateTime
Missing Data:	Illegal
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	TS
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	Automatic

Section: Follow-Up **Parent: Root**

Element: 11001 Follow-Up Reference Procedure Start Date and Time

Coding Instruction: Indicate the reference procedure start date and time on the follow-up assessment date.

Target Value: The value on Follow-up

Technical Specification

Code:	1000142372
Code System Name:	ACC NCDR
Short Name:	RefProcStartDateTime
Missing Data:	Illegal
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	TS
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	Automatic

Element: 11015 Follow-Up Reference Episode Discharge Date and Time

Coding Instruction: Indicate the date and time of discharge for the relevant episode of care.

Target Value: The value on Follow-up

Technical Specification

Code:	1000142437
Code System Name:	ACC NCDR
Short Name:	RefDCDateTime
Missing Data:	Illegal
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	TS
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	Automatic

Section: Follow-Up **Parent: Root**

Element: 11003 Method to Determine Follow-Up Status

Coding Instruction: Indicate the method(s) used to determine the patient's vital status for follow up.

Target Value: The value on Follow-up

Technical Specification

Code:	100014059
Code System Name:	ACC NCDR
Short Name:	F_Method
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Multiple
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Method to Determine Follow-up status - 1.3.6.1.4.1.19376.1.4.1.6.5.370

Selection	Definition	Source	Code	Code System Name
Office visit			183654001	SNOMED CT
Medical records			100014060	ACC NCDR
Letter from medical provider			100014061	ACC NCDR
Video call			448337001	SNOMED CT
Remote Monitoring Tool			88140007	SNOMED CT
Phone call			100014062	ACC NCDR
State Registry / Social Security death master file			419099009	SNOMED CT
Hospitalization			1000142363	ACC NCDR
CMS Linked Data			112000001407	ACC NCDR
Other			100000351	ACC NCDR

Element: 11004 Follow-Up Status

Coding Instruction: Indicate the patient status as of the date on which the follow-up assessment was performed.

Target Value: The value on Follow-up

Vendor Instruction: Follow-Up Status (11004) = Deceased may only be submitted once across the Follow-up Assessment Dates (11000) for the Follow-Up Reference Procedure Start Date and Time (11001)

Technical Specification

Code:	308273005
Code System Name:	SNOMED CT
Short Name:	F_Status
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Follow-Up Status - 1.3.6.1.4.1.19376.1.4.1.6.5.372

Selection	Definition	Source	Code	Code System Name
Alive			438949009	SNOMED CT
Deceased			20	HL7 Discharge disposition
Lost to follow-up			399307001	SNOMED CT

Section: Follow-Up **Parent: Root**

Element: 11007 Cause of Death

Coding Instruction: Indicate the primary cause of death, i.e. the first significant abnormal event which ultimately led to death.

Target Value: The value on Follow-up

Technical Specification

Code:	184305005
Code System Name:	SNOMED CT
Short Name:	F_DeathCause
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	11004 Follow-Up Status
Operator:	Equal
Value:	Deceased

Cause of Death Clinical Finding - 1.3.6.1.4.1.19376.1.4.1.6.5.88

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

Section: Follow-Up **Parent: Root**

Element: 11006 Follow-Up Date of Death

Coding Instruction: Indicate the date of death.

Target Value: The value on Follow-up

Vendor Instruction: Follow-Up Date of Death (11006) must be Greater than or Equal to Follow-Up Reference Discharge Date and Time (11015)

Follow-Up Date of Death (11006) must be Less than or Equal to Follow-Up Assessment Date (11000)

Follow-Up Date of Death (11006) must be Greater than or Equal to the Follow-Up Assessment Date (11000) of a previously submitted follow-up assessment with Follow-Up Status (11004) of Alive

Technical Specification

Code:	1000142373
Code System Name:	ACC NCDR
Short Name:	F_DeathDate
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	DT
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	11004 Follow-Up Status
Operator:	Equal
Value:	Deceased

Element: 15749 Follow-up Atrial Rhythm

Coding Instruction: Indicate the patient's atrial rhythm determined during this follow-up assessment.

Note(s): If the patient has multiple atrial rhythms, select all that apply. In the event that a patient is ventricular paced, indicate the underlying atrial rhythm.

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Technical Specification

Code:	106068003
Code System Name:	SNOMED CT
Short Name:	F_AtrialRhythm
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Multiple
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Atrial Rhythm - 1.3.6.1.4.1.19376.1.4.1.6.5.187

Selection	Definition	Source	Code	Code System Name
Atrial fibrillation			49436004	SNOMED CT
Atrial flutter			5370000	SNOMED CT
Atrial paced			251268003	SNOMED CT
Atrial tachycardia			276796006	SNOMED CT
Sinus			106067008	SNOMED CT
Sinus arrest			5609005	SNOMED CT

Section: Follow-Up **Parent: Root**

Element: 15750 Documented Atrial Arrhythmia Recurrence

Coding Instruction: Indicate if the patient had a documented recurrence of any atrial arrhythmia between discharge (or previous follow-up) and current follow-up assessment.

Acceptable documentation includes provider notes indicating atrial arrhythmia or catheter ablation failure, or provider confirmation of atrial arrhythmia on any of the following: 12-lead ECG (EKG) or rhythm strip, Holter monitor report, smart watch alert, implantable device.

Note(s): Code 'Yes' to any documentation of recurrence of atrial arrhythmia, unless it is documented to last less than 30 seconds. If there is documentation that the atrial arrythmia lasted less than 30 seconds, then code 'No.'

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Documented Atrial Arrhythmia Recurrence**

An AF/flutter/tachycardia episode is present if it is documented by ECG and lasts at least 30 seconds. An episode of AF/flutter/tachycardia detected by monitoring should be considered a recurrence if it has a duration of 30 seconds or more.

Source: Calkins H, Brugada J, Packer DL, Cappato R, Chen S-A, Crijns HJG, Damiano R, Davies WD, Haines DE, Haissaguerre M, Iesaka Y, Jackman WJ, Jais P, Kottkamp H, Kuck KH, Lindsay BD, Marchlinski FE, McCarthy PM, Mont L, Morady F, Nademanee K, Natale A, Pappone C, Prystowsky E, Raviele A, Ruskin JN, Shemin RJ. HRS/EHRA/ECAS expert consensus statement on catheter and surgical ablation of atrial fibrillation: recommendations for personnel, policy, procedures and follow-up. Heart Rhythm. 2007; 4:1–46.

Technical Specification

Code:	17366009
Code System Name:	SNOMED CT
Short Name:	AtrialArrhythmiaRecurrence
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Atrial Arrhythmia - 1.3.6.1.4.1.19376.1.4.1.6.5.954

Selection	Definition	Source	Code	Code System Name
No			100013073	ACC NCDR
Yes - Asymptomatic			84387000	SNOMED CT
Yes - Symptomatic			264931009	SNOMED CT

Section: Follow-Up Symptoms **Parent: Follow-Up**

Element: 15751 Follow-up Symptoms Experienced

Coding Instruction: Indicate which symptom(s), if any, the patient experienced between discharge (or previous follow-up) and current follow-up assessment. If the patient had both symptomatic and asymptomatic episodes, code "yes."

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Technical Specification

Code:	418799008+106063007:=195080001
Code System Name:	SNOMED CT
Short Name:	F_Symptoms
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single (Dynamic List)
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Symptoms Prior to Ablation - 1.3.6.1.4.1.19376.1.4.1.6.5.948

Selection	Definition	Source	Code	Code System Name
Anxiety			48694002	SNOMED CT
Chest pain			29857009	SNOMED CT
Dyspnea at rest			161941007	SNOMED CT
Dyspnea on exertion			60845006	SNOMED CT
Fatigue			84229001	SNOMED CT
Irregular heartbeat			361137007	SNOMED CT
Light-headedness			386705008	SNOMED CT
Palpitations			80313002	SNOMED CT
Other			112000003645	ACC NCDR

Element: 15752 Follow-up Symptom Status

Coding Instruction: Indicate whether a patient experienced symptom(s) between discharge (or previous follow-up) and current follow-up assessment.

If yes there is documentation that the patient experienced symptoms, indicate whether the symptoms are improved, unchanged or worse. If symptoms are documented but no documentation is present about whether symptoms are improved, unchanged, or worse than code "Yes-Unknown." If there is no documentation of symptoms then code "Not Documented."

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Technical Specification

Code:	308273005
Code System Name:	SNOMED CT
Short Name:	F_SymptomStatus
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	15751 Follow-up Symptoms Experienced
Operator:	
Value:	Any Value

Follow-up Symptom Status - 1.3.6.1.4.1.19376.1.4.1.6.5.955

Selection	Definition	Source	Code	Code System Name
No			100013073	ACC NCDR
Yes - Improved			385425000	SNOMED CT
Yes - Unchanged			260388006	SNOMED CT
Yes - Worse			231877006	SNOMED CT
Yes - Unknown			261665006	SNOMED CT
Not Documented			112000001830	ACC NCDR

Section: Follow-Up **Parent: Follow-Up**

Element: 15759 Hospitalization

Coding Instruction: Indicate if the patient was hospitalized (or is currently hospitalized) or has had an emergency department visit between discharge (or previous follow-up) and current follow-up assessment.

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Technical Specification

Code:	1000142363
Code System Name:	ACC NCDR
Short Name:	Hospitalization
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Hospitalization Cardiac Reason - 1.3.6.1.4.1.19376.1.4.1.6.5.958

Selection	Definition	Source	Code	Code System Name
No			100013073	ACC NCDR
Yes - Cardiac			112000000678	ACC NCDR
Yes - Non-cardiac			100014165	ACC NCDR

Element: 15760 Hospitalization Date

Coding Instruction: Indicate the date of the start of the hospitalization.

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Technical Specification

Code:	1000142363
Code System Name:	ACC NCDR
Short Name:	HospitalizationDate
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	DT
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	15759 Hospitalization
Operator:	Equal
Value:	Yes - Cardiac
Element:	15759 Hospitalization
Operator:	Equal
Value:	Yes - Non-cardiac

Section: Follow-Up **Parent: Follow-Up**

Element: 15761 Repeat Ablation

Coding Instruction: Indicate if the patient had a repeat ablation between discharge (or previous follow-up) and current follow-up assessment.
Note: Code 'yes' only if the repeat ablation was for an atrial arrhythmia.

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Technical Specification

Code:	112000003637
Code System Name:	ACC NCDR
Short Name:	RepeatAblation
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Element: 15762 Repeat Ablation Date

Coding Instruction: Indicate the repeat ablation procedure date.

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Technical Specification

Code:	112000003637
Code System Name:	ACC NCDR
Short Name:	RepeatAblationDate
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	DT
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	15761 Repeat Ablation
Operator:	Equal
Value:	Yes

Section: Follow-Up Medications **Parent: Follow-Up**

Element: 15772 Follow-up Medications

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Technical Specification

Code:	513881000000106
Code System Name:	SNOMED CT
Short Name:	F_Medications
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single (Dynamic List)
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Follow-up Medications - 1.3.6.1.4.1.19376.1.4.1.6.5.960

Selection	Definition	Source	Code	Code System Name
Amiodarone			703	RxNorm
Apixaban			1364430	RxNorm
Betrixaban			1927851	RxNorm
Dabigatran			1546356	RxNorm
Dofetilide			49247	RxNorm
Dronedarone			233698	RxNorm
Edoxaban			1599538	RxNorm
Flecainide			4441	RxNorm
Procainamide			8700	RxNorm
Propafenone			8754	RxNorm
Quinidine			9068	RxNorm
Rivaroxaban			1114195	RxNorm
Sotalol			9947	RxNorm
Warfarin			11289	RxNorm

Element: 15773 Follow-up Medication Prescribed

Coding Instruction: Indicate the medication(s) the patient is currently prescribed or the medication(s) that were prescribed at the current follow-up assessment.

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Technical Specification

Code:	33633005
Code System Name:	SNOMED CT
Short Name:	F_MedRx
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	15772 Follow-up Medications
Operator:	
Value:	Any Value

Follow-Up Medication Administration - 1.3.6.1.4.1.19376.1.4.1.6.5.371

Selection	Definition	Source	Code	Code System Name
No			100001048	ACC NCDR
Yes			100001247	ACC NCDR

Section: Follow-Up Medications **Parent: Follow-Up**

Element: 15774 Follow-up Medication Discontinued

Coding Instruction: Indicate if the medication(s) the patient is currently prescribed has been discontinued anytime between discharge (or previous follow-up) and current follow-up assessment.

Code 'Yes' if the medication was discontinued during the follow-up assessment.

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Technical Specification

Code:	513881000000106
Code System Name:	SNOMED CT
Short Name:	F_MedDC
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 15772 Follow-up Medications
Operator:
Value: Any Value

--- AND ---

Element: 15773 Follow-up Medication Prescribed
Operator: Equal
Value: Yes

Section: Follow-Up Events **Parent: Follow-Up**

Element: 11011 Follow-Up Events

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

Target Value: N/A

Vendor Instruction: A Follow-up - combination Events (11011), Occurred (11012) and Dates (11014) - may only be entered/selected once

Technical Specification

Code: 1000142377
Code System Name: ACC NCDR
Short Name: F_EventCode
Missing Data: Report
Harvested: Yes
Is Identifier: No
Is Base Element: No
Is Followup Element: Yes
Data Type: CD
Precision:
Selection Type: Single (Dynamic List)
Unit of Measure:
Default Value:
Usual Range:
Valid Range:
Data Source: User

Follow-up Events - 2.16.840.1.113883.3.3478.6.3.20

Selection	Definition	Source	Code	Code System Name
Pericardial effusion requiring intervention	Indicate if the patient had a pericardial effusion that required intervention of any kind. Code 'no' if the effusion was simply monitored.		100001073	ACC NCDR
Pericardial effusion resulting in cardiac tamponade	Indicate if the patient experienced fluid in the pericardial space compromising cardiac filling and requiring intervention. A perforation of the myocardium, aortic annulus or aorta, with or without tamponade associated with the perforation. If tamponade occurs there would be fluid in the pericardial space compromising cardiac filling, and requiring intervention such as pericardiocentesis or returning to the operating room. This should be documented by either: 1. Echo showing pericardial fluid and signs of tamponade such as right heart compromise, or 2. Systemic hypotension due to pericardial fluid compromising cardiac function.		100001074	ACC NCDR
Phrenic nerve damage	Indicate if the patient experienced phrenic nerve damage. Development of new sensory or motor loss of the phrenic nerve function from external nerve compression (e.g., as a result of positioning during a procedure), or internal compression or direct nerve damage from the procedure, occurring within 72 h of a procedure.		100001076	ACC NCDR
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. Hemorrhage may be a consequence of ischemic stroke. In this situation, the stroke is an ischemic stroke with hemorrhagic transformation and not a hemorrhagic stroke. A hemorrhagic stroke is defined as an acute episode of focal or global cerebral or spinal dysfunction caused by intraparenchymal, intraventricular, or subarachnoid hemorrhage (note: subdural hematomas are intracranial hemorrhagic events and not strokes).		100000977	ACC NCDR
Transient ischemic attack (TIA)	Transient episode of focal neurological dysfunction caused by brain, spinal cord, or retinal ischemia without acute infarction. Persistence of symptoms is an acceptable indicator of acute infarction. If it is used, duration of symptom persistence that will be used to distinguish between transient ischemia and acute infarction should be defined for any clinical trial in which it is used.		266257000	SNOMED CT

Section: Follow-Up Events **Parent: Follow-Up**

Element: 11012 Follow-Up Events Occurred

Coding Instruction: Indicate if the event(s) occurred.

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Vendor Instruction: When a Follow-Up Events (11011) code has been entered/selected more than once, then its Follow-Up Events Occurred (11012) cannot have a response of No.

Technical Specification

Code:	1000142378
Code System Name:	ACC NCDR
Short Name:	F_EventOccurred
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	11011 Follow-Up Events
Operator:	
Value:	Any Value

Element: 11014 Follow-Up Event Dates

Coding Instruction: Indicate the date the event occurred.

Note(s):

If an event occurred more than once on the same date, record only the first event.

If an event occurred multiple times within the target timeframe, but on different dates, record each occurrence with its respective date.

For events that occurred with an unknown date, leave the date field blank.

Target Value: All values between discharge (or previous follow-up) and current follow-up assessment

Technical Specification

Code:	1000142379
Code System Name:	ACC NCDR
Short Name:	F_EventDate
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	DT
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	11011 Follow-Up Events
Operator:	
Value:	Any Value
	--- AND ---
Element:	11012 Follow-Up Events Occurred
Operator:	Equal
Value:	Yes

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15758 — AFEQT Patient Questionnaire Performed Follow-Up

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Technical Specification

Code:	100001145
Code System Name:	ACC NCDR
Short Name:	AFEQTFU
Missing Data:	No Action
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Element: 15727 — Are you currently in atrial fibrillation?

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 1, Q1**

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

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

Technical Specification

Code:	100001146
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS1Q1
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	BL
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator:	Equal
Value:	Yes

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15728

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

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 1, Q2**

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

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

Technical Specification

Code:	100001147
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS1Q2
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	15727 Are you currently in atrial fibrillation?
Operator:	Equal
Value:	No

AFEQT Response - Timing of Episode of atrial fibrillation - 1.3.6.1.4.1.19376.1.4.1.6.5.234

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

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15729 — Q1: Palpitations: Heart fluttering, skipping or racing

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 2, Q1**

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

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

Technical Specification

Code:	100001154
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS2Q1
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator: Equal
Value: Yes

AFEQT Response - Bothered Scale 1-4 - 1.3.6.1.4.1.19376.1.4.1.6.5.230

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

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15730 — Q2: Irregular heartbeat

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 2, Q2**

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

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

Technical Specification

Code:	100001155
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS2Q2
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator: Equal
Value: Yes

AFEQT Response - Bothered Scale 1-4 - 1.3.6.1.4.1.19376.1.4.1.6.5.230

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

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15731 — Q3: Pause in Heart Activity

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 2, Q3**

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

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

Technical Specification

Code:	100001156
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS2Q3
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator: Equal
Value: Yes

AFEQT Response - Bothered Scale 1-4 - 1.3.6.1.4.1.19376.1.4.1.6.5.230

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

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15732 — Q4: Lightheadedness or dizziness

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 2, Q4**

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

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

Technical Specification

Code:	100001157
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS2Q4
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator: Equal
Value: Yes

AFEQT Response - Bothered Scale 1-4 - 1.3.6.1.4.1.19376.1.4.1.6.5.230

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

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15733 — Q5: Ability to have recreational pastimes, sports, and hobbies

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 2, Q5**

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

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

Technical Specification

Code:	100001165
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS2Q5
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator: Equal
Value: Yes

AFEQT Response - Limitation Scale - 1.3.6.1.4.1.19376.1.4.1.6.5.231

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

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15734 — Q6: Ability to have a relationship and do things with friends and family

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 2, Q6**

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

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

Technical Specification

Code:	100001166
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS2Q6
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator: Equal
Value: Yes

AFEQT Response - Limitation Scale - 1.3.6.1.4.1.19376.1.4.1.6.5.231

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

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15735 — Q7: Difficulty doing any activity because you felt tired, fatigued, or low on energy

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 2, Q7**

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

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

Technical Specification

Code:	100001174
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS2Q7
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator: Equal
Value: Yes

AFEQT Response - Difficulty Scale - 1.3.6.1.4.1.19376.1.4.1.6.5.232

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

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15736 — Q8: Difficulty doing physical activity because of shortness of breath

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 2, Q8**

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

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

Technical Specification

Code:	100001175
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS2Q8
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator: Equal
Value: Yes

AFEQT Response - Difficulty Scale - 1.3.6.1.4.1.19376.1.4.1.6.5.232

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

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15737 — Q9: Difficulty exercising

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 2, Q9**

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

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

Technical Specification

Code:	100001176
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS2Q9
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator: Equal
Value: Yes

AFEQT Response - Difficulty Scale - 1.3.6.1.4.1.19376.1.4.1.6.5.232

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

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15738 — Q10: Difficulty walking briskly

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 2, Q10**

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

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

Technical Specification

Code:	100001177
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS2Q10
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator:	Equal
Value:	Yes

AFEQT Response - Difficulty Scale - 1.3.6.1.4.1.19376.1.4.1.6.5.232

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

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15739

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

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 2, Q11**

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

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

Technical Specification

Code:	100001178
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS2Q11
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator:	Equal
Value:	Yes

AFEQT Response - Difficulty Scale - 1.3.6.1.4.1.19376.1.4.1.6.5.232

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

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15740

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

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 2, Q12**

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

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

Technical Specification

Code:	100001179
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS2Q12
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator: Equal
Value: Yes

AFEQT Response - Difficulty Scale - 1.3.6.1.4.1.19376.1.4.1.6.5.232

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

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15741 — Q13: Feeling worried or anxious that atrial fibrillation can start anytime

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 2, Q13**

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

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

Technical Specification

Code:	100001187
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS2Q13
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator: Equal
Value: Yes

AFEQT Response - Bothered Scale 13-18 - 1.3.6.1.4.1.19376.1.4.1.6.5.246

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

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15742

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

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 2, Q14**

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

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

Technical Specification

Code:	100001188
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS2Q14
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator:	Equal
Value:	Yes

AFEQT Response - Bothered Scale 13-18 - 1.3.6.1.4.1.19376.1.4.1.6.5.246

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

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15743 — Q15: Worrying about the treatment side effects from medications

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 2, Q15**

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

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

Technical Specification

Code:	100001189
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS2Q15
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator: Equal
Value: Yes

AFEQT Response - Bothered Scale 13-18 - 1.3.6.1.4.1.19376.1.4.1.6.5.246

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

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15744

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

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 2, Q16**

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

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

Technical Specification

Code:	100001190
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS2Q16
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element:	15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator:	Equal
Value:	Yes

AFEQT Response - Bothered Scale 13-18 - 1.3.6.1.4.1.19376.1.4.1.6.5.246

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

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15745

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

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 2, Q17**

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

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

Technical Specification

Code:	100001191
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS2Q17
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator: Equal
Value: Yes

AFEQT Response - Bothered Scale 13-18 - 1.3.6.1.4.1.19376.1.4.1.6.5.246

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

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15746 — Q18: Worrying or feeling anxious that treatment interferes with daily activities

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 2, Q18**

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

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

Technical Specification

Code:	100001192
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS2Q18
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator: Equal
Value: Yes

AFEQT Response - Bothered Scale 13-18 - 1.3.6.1.4.1.19376.1.4.1.6.5.246

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

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15747 — Q19: How well current treatment controls atrial fibrillation

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 2, Q19**

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

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

Technical Specification

Code:	100001193
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS2Q19
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator: Equal
Value: Yes

AFEQT Response - Satisfaction Scale - 1.3.6.1.4.1.19376.1.4.1.6.5.233

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

Section: Follow-Up Atrial Fibrillation Effect on Quality of Life Parent: Follow-Up

Element: 15748 — Q20: The extent to which treatment has relieved symptoms of atrial fibrillation

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

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition: **Section 2, Q20**

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

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

Technical Specification

Code:	100001194
Code System Name:	ACC NCDR
Short Name:	F_AFEQTS2Q20
Missing Data:	Report
Harvested:	Yes
Is Identifier:	No
Is Base Element:	No
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	User

Parent/Child Validation

Element: 15758 AFEQT Patient Questionnaire Performed Follow-Up
Operator: Equal
Value: Yes

AFEQT Response - Satisfaction Scale - 1.3.6.1.4.1.19376.1.4.1.6.5.233

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

Section: Administration **Parent: Root**

Element: 1000 Participant ID

Coding Instruction: Indicate the participant ID of the submitting facility.

Target Value: N/A

Supporting Definition: **Participant ID**

Participant ID is a unique number assigned to each database participant by NCDR. A database participant is defined as one entity that signs a Participation Agreement with the NCDR, submits one data submission file to the harvest, and receives one report on their data.

Each participant's data if submitted to harvest must be in one data submission file for a quarter. If one participant keeps their data in more than one file (e.g. at two sites), then the data must be combined into a single data submission to the system to file for the harvest. If two or more participants share a single purchased software, and enter cases into one database, then the data must be exported into different data submission files, one for each participant ID.

Source: NCDR

Technical Specification

Code:	2.16.840.1.113883.3.3478.4.836
Code System Name:	ACC NCDR
Short Name:	PartID
Missing Data:	Illegal
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	Yes
Data Type:	NUM
Precision:	8
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	Automatic

Element: 1010 Participant Name

Coding Instruction: Indicate the full name of the facility where the procedure was performed.

Note(s):
Values should be full, official hospital names with no abbreviations or variations in spelling.

Target Value: N/A

Technical Specification

Code:	2.16.840.1.113883.3.3478.4.836
Code System Name:	ACC NCDR
Short Name:	PartName
Missing Data:	Illegal
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	Yes
Data Type:	ST
Precision:	100
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	Automatic

Element: 1020 Time Frame of Data Submission

Coding Instruction: Indicate the time frame of data included in the data submission. Format: YYYYQQ. e.g.,2016Q1

Target Value: N/A

Technical Specification

Code:	1.3.6.1.4.1.19376.1.4.1.6.5.45
Code System Name:	ACC NCDR
Short Name:	Timeframe
Missing Data:	Illegal
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	Yes
Data Type:	ST
Precision:	6
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	Automatic

Section: Administration **Parent: Root**

Element: 1040 Transmission Number

Coding Instruction: This is a unique number created, and automatically inserted by the software into export file. It identifies the number of times the software has created a data submission file. The transmission number should be incremented by one every time the data submission files are exported. The transmission number should never be repeated.

Target Value: N/A

Technical Specification

Code:	1.3.6.1.4.1.19376.1.4.1.6.5.45
Code System Name:	ACC NCDR
Short Name:	XmsnId
Missing Data:	Illegal
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	Yes
Data Type:	NUM
Precision:	9
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	1 - 999,999,999
Data Source:	Automatic

Element: 1050 Vendor Identifier

Coding Instruction: Vendor identification (agreed upon by mutual selection between the vendor and the NCDR) to identify software vendor. This is entered into the schema automatically by vendor software. Vendors must use consistent name identification across sites. Changes to vendor name identification must be approved by the NCDR.

Target Value: N/A

Technical Specification

Code:	2.16.840.1.113883.3.3478.4.840
Code System Name:	ACC NCDR
Short Name:	VendorId
Missing Data:	Illegal
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	Yes
Data Type:	ST
Precision:	15
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	Automatic

Element: 1060 Vendor Software Version

Coding Instruction: Vendor's software product name and version number identifying the software which created this record (assigned by vendor). Vendor controls the value in this field. This is entered into the schema automatically by vendor software.

Target Value: N/A

Technical Specification

Code:	2.16.840.1.113883.3.3478.4.847
Code System Name:	ACC NCDR
Short Name:	VendorVer
Missing Data:	Illegal
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	Yes
Data Type:	ST
Precision:	20
Selection Type:	Single
Unit of Measure:	
Default Value:	Null
Usual Range:	
Valid Range:	
Data Source:	Automatic

Section: Administration **Parent: Root**

Element: 1070 Registry Identifier

Coding Instruction: The NCDR registry identifier describes the data registry to which these records apply. It is implemented in the software at the time the data is collected and records are created. This is entered into the schema automatically by software.

Target Value: N/A

Technical Specification

Code:	2.16.840.1.113883.3.3478.4.841
Code System Name:	ACC NCDR
Short Name:	RegistryId
Missing Data:	Illegal
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	Yes
Data Type:	ST
Precision:	30
Selection Type:	Single
Unit of Measure:	
Default Value:	ACC-NCDR-AFib-2.0
Usual Range:	
Valid Range:	
Data Source:	Automatic

Element: 1071 Registry Schema Version

Coding Instruction: Schema version describes the version number of the Registry Transmission Document (RTD) schema to which each record conforms. It is an attribute that includes a constant value indicating the version of schema file. This is entered into the schema automatically by software.

Target Value: N/A

Technical Specification

Code:	1000142438
Code System Name:	ACC NCDR
Short Name:	SchemaVersion
Missing Data:	Illegal
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	Yes
Data Type:	NUM
Precision:	3,1
Selection Type:	Single
Unit of Measure:	
Default Value:	1
Usual Range:	
Valid Range:	
Data Source:	Automatic

Element: 1085 Submission Type

Coding Instruction: Indicate if the data contained in the harvest/data file contains either standard patient episode of care records (arrival date to discharge only) or if it contains patient follow-up records.

A transmission file with all episode of care records (from Arrival to Discharge only) is considered a 'Base Registry Record'.

A file with patient follow-up records (any follow-up assessments performed during the quarter selected) is considered a 'Follow-Up Record'.

Note(s):
Selecting 'Follow-Up Records Only' will transmit all patient records with Follow-up Assessment Dates (Element Ref# 11000) contained in the selected timeframe, regardless of the procedure or discharge date. For example, if a patient has a procedure on 3/30/2017, is discharged on 3/31/2017, and has a follow-up assessment on 5/6/2017, the patient's episode of care data will be transmitted in the 2017Q1 Base Registry Record file, but the Follow-up data will be transmitted in the 2017Q2 Follow-Up File.

Target Value: N/A

Technical Specification

Code:	1000142423
Code System Name:	ACC NCDR
Short Name:	SubmissionType
Missing Data:	Illegal
Harvested:	Yes
Is Identifier:	No
Is Base Element:	Yes
Is Followup Element:	Yes
Data Type:	CD
Precision:	
Selection Type:	Single
Unit of Measure:	
Default Value:	
Usual Range:	
Valid Range:	
Data Source:	Automatic

Submission Type

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

Section Containment Structure

Container Class	Section	Section Code	Section Type	Cardinality
patientContainer	Demographics	DEMOGRAPHICS	Section	1 .. 1
episodeContainer	Episode of Care	EOC	Section	1 .. 1
episodeContainer	Research Study	RESEARCHSTUDY	Repeater Section	0 .. n
episodeContainer	Atrial Fibrillation Effect on Quality of Life	AFEQT	Section	0 .. 1
episodeContainer	Physical Exam and Labs	PELABS	Section	0 .. 1
episodeContainer	History and Risk Factors	HISTORYANDRISK	Section	0 .. 1
episodeContainer	CHA2DS2-VASC Risk Scores	CHA2DS2	Section	0 .. 1
episodeContainer	Condition History	CONDHX	Repeater Section	0 .. n
episodeContainer	Condition History Details	CONDHXDET	Section	0 .. 1
episodeContainer	History and Risk Factors	HISTORYANDRISK2	Section	0 .. 1
episodeContainer	Procedure History	PROCHX	Repeater Section	0 .. n
episodeContainer	Procedure History Details	PROCHXDET	Section	0 .. 1
episodeContainer	Diagnostic Studies	DIAGSTUDIES	Section	0 .. 1
episodeContainer	Pre-Procedure Medications	PREPROCMEDS	Repeater Section	0 .. n
episodeContainer	Procedure Information	PROCINFO	Repeater Section	1 .. n
episodeContainer	Adjunctive Ablation Lesions	ABLLESIONS	Section	0 .. 1
episodeContainer	Ablation Location	ABLLOC	Repeater Section	0 .. n
episodeContainer	Additional Ablations Attempted	ADDLABLS	Section	0 .. 1
episodeContainer	Ablation Approach	ABLAPPR	Repeater Section	0 .. n
episodeContainer	Procedure Information	PROCINFO2	Section	0 .. 1
episodeContainer	Device	DEVICE	Section	0 .. 1
episodeContainer	Catheter Ablation Devices	CATHABLDEV	Repeater Section	0 .. n
episodeContainer	Electroanatomical Mapping System	ELECTROMAPSYS	Repeater Section	0 .. n
episodeContainer	Radiation Exposure	RADEXP	Section	0 .. 1
episodeContainer	Intraprocedure Anticoagulation Strategy	INTRAPROCANTICOAG	Section	0 .. 1
episodeContainer	Intra or Post-Procedure Events	INTPOSTEVENT	Section	0 .. 1
episodeContainer	Intra or Post-Procedure Events	IPPEVENTS	Repeater Section	0 .. n
episodeContainer	Intra or Post-Procedure Event Details	IPPEVENTDET	Section	0 .. 1
episodeContainer	Discharge	DISCHARGE	Section	1 .. 1
episodeContainer	Discharge Medications	DCMEDS	Repeater Section	0 .. n
followupContainer	Follow-Up	FOLLOWUP	Section	1 .. 1
followupContainer	Follow-Up Symptoms	FUPSX	Repeater Section	0 .. n
followupContainer	Follow-Up	FUP2	Section	0 .. 1
followupContainer	Follow-Up Medications	FUPMEDS	Repeater Section	0 .. n
followupContainer	Follow-Up Events	FUPEVENTS	Repeater Section	0 .. n
followupContainer	Follow-Up Atrial Fibrillation Effect on Quality of Life	FUPAFEQT	Section	0 .. 1
submissionInfoContainer	Administration	ADMIN	Section	1 .. 1

Reference Code System Listing

Code System Name	Code System
ACC NCDR	2.16.840.1.113883.3.3478.6.1
United States Social Security Number (SSN)	2.16.840.1.113883.4.1
HL7 Race	2.16.840.1.113883.5.104
HL7 Ethnicity	2.16.840.1.113883.5.50
SNOMED CT	2.16.840.1.113883.6.96
LOINC	2.16.840.1.113883.6.1
ACC NCDR EP Devices	2.16.840.1.113883.3.3478.6.1.21
ACC NCDR Lead Devices	2.16.840.1.113883.3.3478.6.1.20
ACC NCDR Catheter Ablation Devices	2.16.840.1.113883.3.3478.6.1.22
PHDSC	2.16.840.1.113883.3.221.5
HL7 Administrative Gender	2.16.840.1.113883.5.1
HL7NullFlavor	2.16.840.1.113883.5.1008
HL7 Discharge disposition	2.16.840.1.113883.12.112
RxNorm	2.16.840.1.113883.6.88
USPostalCodes	2.16.840.1.113883.6.231
ACC NCDR Intracoronary Devices	2.16.840.1.113883.3.3478.6.1.101
Center for medicare and medicaid services, MBI	2.16.840.1.113883.4.927
clinicaltrials.gov	2.16.840.1.113883.3.1077