A. Demographics

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

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

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

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

Coding Instructions: Indicate the patient's first name.

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

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

Coding Instructions: Indicate the patient's middle name.

Note(s):

It is acceptable to specify the patient's middle initial.

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

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

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

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

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

Note(s):

If the patient does not have a United States Social Security Number (SSN), leave blank and check 'SSN N/A'.

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

A. Demographics

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

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

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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

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

Note(s):

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

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

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

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

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

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

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

A. Demographics

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

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

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
Male	
Female	

Supporting Definitions: (none)

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

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

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **White (race):**

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

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

---

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

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

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

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

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

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

A. Demographics

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

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

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Asian (race):**

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

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

---

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

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

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

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

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

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

---

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

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

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Native Hawaiian or Pacific Islander (race):**

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

A. Demographics

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

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

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Hispanic or Latino Ethnicity:**

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

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

---

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

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

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Asian Indian:**

Having origins in any of the original peoples of India.

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

---

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

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

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Asian - Chinese:**

Having origins in any of the original peoples of China.

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

A. Demographics

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

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

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Asian - Filipino:**

Having origins in any of the original peoples of the Philippines.
Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

---

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

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

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Asian - Japanese:**

Having origins in any of the original peoples of Japan.
Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

---

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

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

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Asian - Korean:**

Having origins in any of the original peoples of Korea.
Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

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

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

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Asian - Vietnamese:**

Having origins in any of the original peoples of Viet Nam.
Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

---

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

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

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Asian - Other Asian:**

Having origins in any of the original peoples elsewhere in Asia.
Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

---

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

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

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

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

Having origins in any of the original peoples of the islands of Hawaii.
Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

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

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

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

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

Having origins in any of the original peoples of the Mariana Islands or the island of Guam.
Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

---

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

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

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

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

Having origins in any of the original peoples of the island of the Samoa.
Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

---

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

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

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

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

Having origins in any of the original peoples of any other island in the Pacific.
Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

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

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

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

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

Having origins in any of the original peoples of Mexico.

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

---

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

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

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

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

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

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

---

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

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

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Hispanic Ethnicity - Cuban:**

Having origins in any of the original peoples of Cuba.

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

A. Demographics

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

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

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

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

Having origins in any of the originals peoples in other Hispanic, Latino or Spanish territories.
Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

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

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

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

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

B. Episode of Care

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

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3005 **Name:** Patient Zip Code

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

Note(s):

If the patient does not have a US residence, or is homeless, leave blank and check 'Zip Code N/A'.

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3006 **Name:** Zip Code N/A

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

Note(s):

This includes patients who do not have a United States residence or are homeless.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

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

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

Note(s):

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

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Private Health Insurance:**

Private health insurance is coverage by a health plan provided through an employer or union or purchased by an individual from a private health insurance company.

Source: U.S. Census Bureau

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

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

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Medicare:**

Medicare is the Federal program which helps pay health care costs for people 65 and older and for certain people under 65 with long-term disabilities.

Source: U.S. Census Bureau

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

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

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Medicaid:**

Medicaid is a program administered at the state level, which provides medical assistance to the needy. Families with dependent children, the aged, blind, and disabled who are in financial need are eligible for Medicaid. It may be known by different names in different states.

Source: U.S. Census Bureau

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

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

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Military Health Care:

Military health care includes TRICARE/CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) and CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), as well as care provided by the Department of Veterans Affairs (VA).

Source: U.S. Census Bureau

Seq. #: 3024 **Name:** Insurance Payors - State-Specific Plan (Non Medicaid)

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

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

State Specific Plan:

Some states have their own health insurance programs for low-income uninsured individuals. These health plans may be known by different names in different states.

Source: U.S. Census Bureau

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

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

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Indian Health Service:

Indian Health Service (IHS) is a health care program through which the Department of Health and Human Services provides medical assistance to eligible American Indians at IHS facilities. In addition, the IHS helps pay the cost of selected health care services provided at non-IHS facilities.

Source: U.S. Census Bureau

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

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

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Non-US Insurance:

Non-US insurance refers to individuals with a payor that does not originate in the United States.

Source: U.S. Census Bureau

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

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

Note(s):

If the patient is receiving care as a result of charity or similar circumstance, code "Insurance Payor - None".

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

None:

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

Source: NCDR

Seq. #: 3030 **Name:** Health Insurance Claim Number (HIC)

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

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions:

Health Insurance Claim Number (HIC):

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

Source: Center for Medicare and Medicaid Services

Seq. #: 3031 **Name:** Fundamental Diagnosis Code

Coding Instructions: Indicate the fundamental diagnosis code.

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

B. Episode of Care

Seq. #: 3045 **Name:** Prior Cardiac Catheterization

Coding Instructions: Indicate whether the patient had a prior cardiac catheterization.

Note(s):

Timeframe does NOT include cardiac catheterizations performed after arrival.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 3050 **Name:** Number of Prior Cardiac Catheterizations

Coding Instructions: Indicate the number of prior catheterizations that have been performed on the patient.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3055 **Name:** Date of Last Catheterization

Coding Instructions: Indicate the date of the patient's last catheterization.

Note(s):

If month or day are unknown enter 01.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3060 **Name:** Most Recent Catheterization Procedure ID

Coding Instructions: Indicate all applicable procedures which occurred during the patient's most recent cardiac catheterization.

Note(s):

Select from the Procedure list supplied, all applicable procedures which were performed during the most recent cardiac cath.

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

Selections: (none)

Supporting Definitions: (none)

B. Episode of Care

Seq. #: 3065 **Name:** Premature Birth

Coding Instructions: Indicate whether the patient was born prematurely.

Note(s):

Code only for patients who are less than 1 year old at time of arrival.

Target Value: The value on birth

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Premature Birth:

A birth that is at least three weeks before a baby's due date. It is also known as preterm birth (or less than 37 weeks - full term is about 40 weeks).

Source: NCDR

Seq. #: 3070 **Name:** Birth Weight

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

Note(s):

Code only for patients who are less than 30 days old at time of arrival.

Target Value: The value on birth

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3075 **Name:** Gestational Age

Coding Instructions: Indicate the patient's gestational age at time of birth in weeks.

Note(s):

Code only for patients who are less than 1 year old at time of arrival.

Target Value: The value on birth

Selections: (none)

Supporting Definitions:

Gestational Age:

Gestation is the period of time between conception and birth during which the fetus grows and develops inside the mother's womb. The time is measured from the first day of the woman's last menstrual cycle to the current date. It is measured in weeks.

Source: NCDR

B. Episode of Care

Seq. #: 3080 **Name:** Prior Cardiac Surgery

Coding Instructions: Indicate whether the patient had a prior cardiac surgery.

Note(s):

Timeframe does NOT include cardiac surgeries performed after arrival.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 3085 **Name:** Number of Prior Cardiac Surgeries

Coding Instructions: Indicate the number of previous cardiac surgeries that have been performed on the patient.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3090 **Name:** Date of Last Cardiac Surgery

Coding Instructions: Indicate the date of the patient's last cardiac surgery.

Note(s):

If month or day are unknown enter 01.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3095 **Name:** Most Recent Cardiac Surgery ID

Coding Instructions: Indicate the patient's most recent cardiac surgery(s).

Note(s):

Select from the Cardiac Surgery list supplied, all applicable procedures which were performed during the most recent cardiac surgery.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

B. Episode of Care

Seq. #: 3096 **Name:** Patient Enrolled in Research Study

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

Note(s):

Code 'Yes' for those patients enrolled in a research study

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 3097 **Name:** Research Study Name

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

Note(s):

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3098 **Name:** Research Study Patient ID

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

Note(s):

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3099 **Name:** Patient Restriction

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

Note(s):

Documentation must be found in the patient record to support the request of removal of their information.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 3100 **Name:** 22q11 Deletion (DiGeorge Syndrome)

Coding Instructions: Indicate whether the patient has documented 22q11 deletion (DiGeorge Syndrome).

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **22q11 Deletion:**

A deletion of a portion of the twenty-second chromosome that can cause such health problems as heart defects, immune deficiency, cleft palate, developmental delays, learning disabilities and social/emotional issues.

Source: NCDR

Seq. #: 3105 **Name:** Alagille Syndrome

Coding Instructions: Indicate whether the patient has documented Alagille Syndrome.

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Alagille Syndrome:**

Genetic condition evidenced by a mutation or deletion of the JAG1 (20p12) gene.

Source: STS

Seq. #: 3110 **Name:** Congenital Diaphragmatic Hernia

Coding Instructions: Indicate whether the patient has a documented congenital diaphragmatic hernia.

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Congenital Diaphragmatic Hernia:**

The absence of the diaphragm, or a hole in the diaphragm at birth. This can occur on either the left or right side, but is most common on the left.

Source: NCDR

Seq. #: 3115 **Name:** Down Syndrome

Coding Instructions: Indicate whether the patient has documented Down Syndrome (Trisomy 21).

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Down Syndrome:**

Congenital disease evidenced by an extra Chromosome 21 or 22.

Source: STS

Seq. #: 3120 **Name:** Heterotaxy

Coding Instructions: Indicate whether the patient has documented heterotaxy.

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Heterotaxy:**

The abnormal placement of organs due to failure to establish the normal left-right patterning during embryonic development.

Source: NCDR

Seq. #: 3125 **Name:** Marfan Syndrome

Coding Instructions: Indicate whether the patient has documented Marfan Syndrome.

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Marfan Syndrome:**

An inherited disorder of the connective tissue that causes abnormalities of the patient's eyes, cardiovascular system, and musculoskeletal system.

Source: NCDR

Seq. #: 3130 **Name:** Noonan Syndrome

Coding Instructions: Indicate whether the patient has documented Noonan Syndrome.

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Noonan Syndrome:

A relatively common congenital genetic condition which affects both males and females. It used to be referred to as the male version of Turner syndrome. However, the genetic causes of Noonan syndrome and Turner syndrome are distinct. The principal features include congenital heart malformation, short stature, learning problems, indentation of the chest, impaired blood clotting, and a characteristic configuration of facial features.

Source: NCDR

Seq. #: 3135 **Name:** Rubella

Coding Instructions: Indicate whether the patient has documented Rubella.

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Rubella:

A contagious viral disease characterized by fever, symptoms of a mild upper respiratory tract infection, lymph node enlargement, arthralgia, and a diffuse fine red maculopapular rash.

Source: NCDR

Seq. #: 3140 **Name:** Trisomy-13

Coding Instructions: Indicate whether the patient has documented Trisomy 13.

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Trisomy 13:

Trisomy 13 (also called Patau syndrome) is a genetic disorder in which a person has three copies of genetic material from chromosome 13, instead of the usual two copies. Rarely, the extra material may be attached to another chromosome (translocation).

Source: NCDR

Seq. #: 3145 **Name:** Trisomy-18

Coding Instructions: Indicate whether the patient has documented Trisomy 18.

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Trisomy-18:**

Edwards syndrome, or Trisomy 18, is a chromosomal abnormality. Incidence is 1:3000-5000 births. Sporadic cases of Edwards syndrome occur usually in association with advanced maternal age at conception. Affected individuals have an extra (or third) copy of chromosome 18. Approximately 50% of infants with Trisomy 18 die within the first week of life, approximately 40% die within the first month of life, only 5-10% survive beyond the first year. Cardiovascular abnormalities in more than 50% of cases include VSD, ASD and PDA; bicuspid aortic and/or pulmonary valves, nodularity of valve leaflets, pulmonic stenosis, coarctation of the aorta in 10-50% of cases; and anomalous coronary artery, TGA, TOF, dextrocardia and aberrant subclavian artery in less than 10% of cases.

Source: STS

Seq. #: 3150 **Name:** Turner Syndrome

Coding Instructions: Indicate whether the patient has documented Turner syndrome (XO syndrome).

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Turner Syndrome:**

A congenital disease as evidenced by a defect in/or absence of the second female X chromosome.

Source: STS

Seq. #: 3155 **Name:** Williams-Beuren Syndrome

Coding Instructions: Indicate whether the patient has documented Williams-Beuren syndrome.

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Williams-Beuren Syndrome:**

Idiopathic hypercalcemia of infants as evidenced by the deletion of chromosome 7 material.

Source: STS

Seq. #: 3160 **Name:** Arrhythmia

Coding Instructions: Indicate if the patient had a history of an arrhythmia diagnosed prior to or during this episode of care.

Target Value: The value between birth and arrival

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 3161 **Name:** Arrhythmia History

Coding Instructions: Indicate the specific arrhythmia diagnosed.

Target Value: The value between birth and arrival

Selections:

Selection Text	*Definition*
Atrial Fibrillation	
Atrial premature complexes	
AV node re-entry (AVNRT)	
AV conduction disturbance	
AV re-entrant tachycardia (AVRT, non-PJRT)	
Focal atrial tachycardia	
Inappropriate sinus tachycardia	
Isolated ventricular pre-excitation	
Junctional tachycardia	
Macro re-entrant atrial tachycardia (Atrial Flutter, IART)	
Permanent junctional reciprocating tachycardia (PJRT)	
Premature ventricular complexes (PVC)	
Supraventricular tachycardia	
Sinus node dysfunction	
Ventricular tachycardia	
Wolff-Parkinson-White syndrome (WPW)	
Wide complex tachycardia	

Supporting Definitions: (none)

Seq. #: 3170 **Name:** Cardiomyopathy

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

Target Value: The last value between arrival and procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 3175 **Name:** Cardiomyopathy History

Coding Instructions: Indicate the type of cardiomyopathy the patient has been diagnosed with.

Target Value: The last value between arrival and procedure

Selections:

Selection Text	*Definition*
Arrhythmogenic right ventricular cardiomyopathy	
Dilated cardiomyopathy (DCM)	
Hypertrophic cardiomyopathy (HCM)	
Noncompaction of the ventricular myocardium	
Restrictive cardiomyopathy (RCM)	
Tachycardia-induced cardiomyopathy	

Supporting Definitions: (none)

Seq. #: 3200 **Name:** Chronic Lung Disease

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

Note(s):

For bronchodysplasia, code "Yes" for chronic lung disease, even if the patient is under three months of age.

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Chronic Lung Disease:

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

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

Seq. #: 3205 **Name:** Coagulation Disorder

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

Note(s):

Includes excessive clotting or inability to clot.

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 3210 **Name:** Hypercoagulable State

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

Note(s):

The PT/PTT are below normal. The coagulopathy is NOT secondary to medications such as vitamin K.

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 3215 **Name:** Hypocoagulable State

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

Note(s):

The PT/PTT are above normal, Thrombocytopenia <100,000, Fibrinogen split products positive (>10%) and the coagulopathy is NOT secondary to medications such as Heparin or Warfarin.

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 3220 **Name:** Diabetes Mellitus

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

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Diabetes Mellitus:

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

This does not include gestational diabetes.

Source: American Diabetes Association Care. 2011;34 Suppl 1:S4-10.

Seq. #: 3221 **Name:** Endocarditis

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

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 3222 **Name:** Heart Failure

Coding Instructions: Indicate if the patient had heart failure within one month of arrival.

Note(s):

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

Target Value: Any occurrence between 1 month prior to arrival and arrival

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Heart Failure:**

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

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

Seq. #: 3223 **Name:** New York Heart Association (NYHA) Functional Classification

Coding Instructions: Indicate the New York Heart Association (NYHA) functional classification.

Target Value: Any occurrence between 1 month prior to arrival and arrival

Selections:

Selection Text	*Definition*
Class I	Patients with cardiac disease but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.
Class II	Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.
Class III	Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain.
Class IV	Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of heart failure or the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

Supporting Definitions:

NYHA:

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

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

Class I:

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

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

Class II:

Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.

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

Class III:

Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain.

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

Class IV:

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

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

Seq. #: 3224 **Name:** Heart Transplant

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

Target Value: Any occurrence between birth and arrival

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 3225 **Name:** Hepatic Disease

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

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Hepatic Dysfunction:**

Hepatic dysfunction is defined as dysfunction of the liver that results in hypoalbuminemia (<2 grams/dL), coagulopathy (PT > 1.5 x upper limits of normal), and hyperbilirubinemia (> 3.0 x upper limits of normal). Code as "Yes" if the patient develops 2 out of these 3 laboratory abnormalities.

Source: STS

Seq. #: 3226 **Name:** Ischemic Heart Disease

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

Target Value: Any occurrence between birth and arrival

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Ischemic Heart Disease:**

Ischemic heart disease is evidenced by any one of the following:

1. History of myocardial infarction (MI) manifested as
a) Wall motion abnormality felt consistent with MI on echocardiography, nuclear imaging, ventriculography, cardiac MR, or other imaging
b) ECG evidence of prior MI or acute MI
c) Cardiac biomarker elevation and clinical presentation (e.g., chest pain) consistent with MI

2. History of Percutaneous Coronary Angioplasty

3. History of Coronary Artery Bypass Graft Surgery

4. Conventional coronary angiography demonstrates >=70% stenosis in at least one major coronary artery.

5. Stress testing (with or without imaging) diagnostic of coronary artery disease.

Source: NCDR

Seq. #: 3227 **Name:** Kawasaki Disease

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

Target Value: Any occurrence between birth and arrival

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 3230 **Name:** Renal Insufficiency

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

Target Value: Any occurrence between birth and start of procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Renal Insufficiency:

Patient has reduced glomerular filtration rate (GFR) for at least 3 months. Degree of renal insufficiency may be further defined according to degree of depression in GFR:

Mild renal insufficiency: GFR 60 to 89 ml/min/1.73 m2.

Moderate renal insufficiency: GFR 30 to 59 ml/min/1.73 m2.

Severe renal insufficiency: GFR 15 to 29 ml/min/1.73 m2.

Renal failure: GFR 15 ml/min/1.73 m2, or patient requires chronic dialysis treatment.

Source: ACC-AHA Clinical Data Standards

Seq. #: 3231 **Name:** Rheumatic Heart Disease

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

Target Value: Any occurrence between birth and arrival

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 3235 **Name:** Seizure Disorder

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

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Seizure Disorder:**

A seizure disorder is defined as episodes of clinical and/or electroencephalographic recognition of epileptiform activity.
Source: STS

Seq. #: 3240 **Name:** Sickle Cell Anemia

Coding Instructions: Indicate if the patient has a history of sickle cell anemia.

Note(s):

Code "No" if the patient has tested positive for the sickle cell trait, but is not showing any active signs of the disease.

Target Value: Any occurrence between birth and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 3250 **Name:** Stroke

Coding Instructions: Indicate if the patient has a history of stroke prior to arrival.

Note(s):

An intraventricular hemorrhage is not considered a stroke.

Target Value: Any occurrence between birth and arrival

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Stroke:**

Loss of neurological function caused by an ischemic or hemorrhagic event with residual symptoms at least 24 hours after onset or leading to death.
Source: ACC-AHA Clinical Data Standards

Seq. #: 3260 **Name:** Auxiliary 3

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3270 **Name:** Auxiliary 4

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

C. Cath Lab Visit

Seq. #: 4000 **Name:** Pre-Procedure Diagnosis Code

Coding Instructions: Indicate all applicable patient cardiac diagnoses prior to the procedure.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 4005 **Name:** Height

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

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 4010 **Name:** Weight

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

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 4015 **Name:** Pre-Procedure Hemoglobin

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

Note(s):

Value used may be from labs obtained at procedure start.

Target Value: The last value between 1 month prior to arrival at this facility and current procedure

Selections: (none)

Supporting Definitions: (none)

C. Cath Lab Visit

Seq. #: 4016 **Name:** Pre-Procedure Hemoglobin Not Drawn

Coding Instructions: Indicate if the patient's pre-procedure hemoglobin was not collected.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4020 **Name:** Pre-Procedure Creatinine

Coding Instructions: Indicate the patient's most recent creatinine level in mg/dL.

Note(s):

Value used may be from labs obtained at procedure start.

Target Value: The last value between 1 month prior to arrival at this facility and current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 4021 **Name:** Pre-Procedure Creatinine Not Drawn

Coding Instructions: Indicate if the patient's pre-procedure creatinine level was not collected.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4025 **Name:** Pre-Procedure O2 Saturation

Coding Instructions: Indicate the patient's most recent oxygen saturation in %.

Note(s):

The oxygen saturation can be obtained by invasive or non-invasive means (i.e. blood gas or pulse oximetry).

Target Value: The last value between 1 month prior to arrival at this facility and current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 4026 **Name:** Single Ventricle

Coding Instructions: Indicate if the patient has a a single ventricle.

Note(s):

Single ventricle is an umbrella term used to describe several very different complex congenital heart defects that share the same problem: the heart has only one functional ventricle (anatomically right or left or indeterminate) supplying the systemic circulation. These defects include tricuspid atresia, hypoplastic left or right heart syndrome, double outlet right ventricle, double inlet left ventricle, and other forms of single ventricle defects.

Target Value: The last value between arrival and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4030 **Name:** Necrotizing Enterocolitis

Coding Instructions: Indicate if the patient has necrotizing enterocolitis.

Note(s):

Code only if the patient is less than 30 days old on cath lab arrival.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4035 **Name:** Sepsis

Coding Instructions: Indicate if the patient was septic.

Note(s):

Code "Yes" if the patient was septic upon arrival to the cath lab or up to 48 hours prior to arrival to the cath lab.

Target Value: Any occurrence between 48 hours prior to procedure and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Sepsis:

Sepsis is defined as "evidence of serious infection accompanied by a deleterious systemic response". Sepsis may be diagnosed by the presence of a Systemic Inflammatory Response Syndrome (SIRS) resulting from suspected or proven infection. A systemic inflammatory response syndrome (SIRS) is present when at least two of the following criteria are present: hypo- or hyperthermia (>38.5 or <36.0), tachycardia or bradycardia, tachypnea, leukocytosis or leukopenia, and thrombocytopenia.

Source: STS

Seq. #: 4040 **Name:** Pregnant

Coding Instructions: Indicate if the patient is pregnant at the time of the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4041 **Name:** Pre-Procedure Medications

Coding Instructions: Indicate if any pre-procedure medications have been prescribed to the patient.

Target Value: The value between 2 weeks prior to arrival at this facility and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4045 **Name:** Pre-Procedure Antiarrhythmics

Coding Instructions: Indicate if an antiarrhythmic has been prescribed to the patient.

Note(s):

If a medication has multiple potential uses, code the class that was the primary intended use.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4046 **Name:** Pre-Procedure Anticoagulants

Coding Instructions: Indicate if an anticoagulant has been prescribed to the patient.

Note(s):

If a medication has multiple potential uses, code the class that was the primary intended use.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

C. Cath Lab Visit

Seq. #: 4047 **Name:** Pre-Procedure Antihypertensives

Coding Instructions: Indicate if an antihypertensive has been prescribed to the patient.

Note(s):

If a medication has multiple potential uses, code the class that was the primary intended use.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4048 **Name:** Pre-Procedure Antiplatelets

Coding Instructions: Indicate if an antiplatelet has been prescribed to the patient.

Note(s):

If a medication has multiple potential uses, code the class that was the primary intended use.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4049 **Name:** Pre-Procedure Beta Blockers

Coding Instructions: Indicate if a beta blocker has been prescribed to the patient.

Note(s):

If a medication has multiple potential uses, code the class that was the primary intended use.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

C. Cath Lab Visit

Seq. #: 4050 **Name:** Pre-Procedure Diuretics

Coding Instructions: Indicate if a diuretic has been prescribed to the patient.

Note(s):

If a medication has multiple potential uses, code the class that was the primary intended use.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4051 **Name:** Pre-Procedure Prostaglandins

Coding Instructions: Indicate if a prostaglandin has been prescribed to the patient.

Note(s):

If a medication has multiple potential uses, code the class that was the primary intended use.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4053 **Name:** Pre-Procedure Vasodilators

Coding Instructions: Indicate if a vasodilator has been prescribed to the patient.

Note(s):

If a medication has multiple potential uses, code the class that was the primary intended use.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4060 **Name:** Pre-Procedure Sinus Rhythm

Coding Instructions: Indicate if the patient's cardiac rhythm originates from the sinoatrial node.

Note(s):

If the patient is in sinus rhythm with 1st degree heart block, code "Yes".

It is acceptable to code the patient's cardiac rhythm based on cardiac rhythm strips (as opposed to 12 lead ECGs) that are interpreted by a qualified professional. If more than one is available, code the rhythm based on the rhythm strip or ECG closest to the start of the procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4061 **Name:** Pre-Procedure Atrial Ectopic Tachycardia (AET)

Coding Instructions: Indicate if the patient's cardiac rhythm is greater than 100 beats per minute that originates from a nonsinus atrial focus or foci.

Note(s):

Atrial ectopic tachycardia is the most common form of incessant supraventricular tachycardia (SVT) in children. Atrial ectopic tachycardia is believed to be secondary to increased automaticity of nonsinus atrial focus or foci.

It is acceptable to code the patient's cardiac rhythm based on cardiac rhythm strips (as opposed to 12 lead ECGs) that are interpreted by a qualified professional. If more than one is available, code the rhythm based on the rhythm strip or ECG closest to the start of the procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4062 **Name:** Pre-Procedure Supraventricular Tachycardia (SVT)

Coding Instructions: Indicate if the patient's cardiac rhythm is greater than 100 beats per minute that originates from the sinoatrial node.

Note(s):

It is acceptable to code the patient's cardiac rhythm based on cardiac rhythm strips (as opposed to 12 lead ECGs) that are interpreted by a qualified professional. If more than one is available, code the rhythm based on the rhythm strip or ECG closest to the start of the procedure.

If a patient demonstrates SVT originating from a nonsinus focus then code AET.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4063 **Name:** Pre-Procedure AFib/Flutter

Coding Instructions: Indicate if the patient's cardiac rhythm is atrial fibrillation or atrial flutter.

Note(s):

Indicate the patient's cardiac rhythm. It is acceptable to code the patient's cardiac rhythm based on cardiac rhythm strips (as opposed to 12 lead ECGs) that are interpreted by a qualified professional. If more than one is available, code the rhythm based on the rhythm strip or ECG closest to the start of the procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Atrial Fibrillaltion/Atrial Flutter:**

There are no consistent P waves. With atrial flutter, in the place of P waves, there is uncoordinated atrial activity with rapid oscillations or fibrillation waves that vary in amplitude, shape, timing, and are associated with an irregular ventricular response (if atrioventricular conduction is intact). With atrial flutter, there is a sawtooth pattern of regular atrial activation.

Source: NCDR

Seq. #: 4064 **Name:** Pre-Procedure Junctional Rhythm

Coding Instructions: Indicate if the patient's cardiac rhythm arises from the atrioventricular (AV) junction.

Note(s):

It is acceptable to code the patient's cardiac rhythm based on cardiac rhythm strips (as opposed to 12 lead ECGs) that are interpreted by a qualified professional. If more than one is available, code the rhythm based on the rhythm strip or ECG closest to the start of the procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4065 **Name:** Pre-Procedure Idioventricular Rhythm

Coding Instructions: Indicate if the patient's cardiac rhythm originates in the ventricles.

Note(s):

The heart rate is usually regular and ranging between 30-40 beats per minute (the intrinsic ventricular rate), but can be higher or lower. If atrial activity is present, there is usually no relationship between the atrial and ventricular complexes.

It is acceptable to code the patient's cardiac rhythm based on cardiac rhythm strips (as opposed to 12 lead ECGs) that are interpreted by a qualified professional. If more than one is available, code the rhythm based on the rhythm strip or ECG closest to the start of the procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4066 **Name:** Pre-Procedure Second Degree AV Block

Coding Instructions: Indicate if the patient's cardiac rhythm is characterized by one of the following:

Mobitz I: progressive PR prolongation and shortening of RR interval until P wave is blocked. Pause after blocked P wave is less than twice the PP interval. PR following block is shorter than PR immediately preceding block.

Mobitz II: regular sinus/atrial rhythm with intermittent nonconducted P waves. Constant PR interval in the conducted beats.

Note(s):

It is acceptable to code the patient's cardiac rhythm based on cardiac rhythm strips (as opposed to 12 lead ECGs) that are interpreted by a qualified professional. If more than one is available, code the rhythm based on the rhythm strip or ECG closest to the start of the procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4067 **Name:** Pre-Procedure Third Degree AV Block

Coding Instructions: Indicate if the patient's cardiac rhythm is characterized by independent atrial and ventricular complexes with the atrial rate usually exceeding ventricular rate. Also known as complete heart block.

Note(s):

It is acceptable to code the patient's cardiac rhythm based on cardiac rhythm strips (as opposed to 12 lead ECGs) that are interpreted by a qualified professional. If more than one is available, code the rhythm based on the rhythm strip or ECG closest to the start of the procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4068 **Name:** Pre-Procedure Paced

Coding Instructions: Indicate if the patient's cardiac rhythm originates from a pacemaker.

Note(s):

It is acceptable to code the patient's cardiac rhythm based on cardiac rhythm strips (as opposed to 12 lead ECGs) that are interpreted by a qualified professional. If more than one is available, code the rhythm based on the rhythm strip or ECG closest to the start of the procedure.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4100 **Name:** Auxiliary 5

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 4105 **Name:** Auxiliary 6

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

D. Procedure Information

Seq. #: 5000 **Name:** Procedure - Diagnostic Cath

Coding Instructions: Indicate if a diagnostic catheterization procedure was performed in the cath lab.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Diagnostic Catheterzation:

Diagnostic cardiac catheterization is the process of introducing a catheter into veins and/or arteries from which it is advanced to the right and/or left sides of the heart. Once the catheters are positioned the pressure of the blood in various chambers of the heart can be measured, blood samples can be taken, and dye (radiographic contrast material) can be injected (a process called angiography) to allow x-ray visualization.

Source: NCDR

Seq. #: 5001 **Name:** Procedure - Atrial Septal Defect (ASD) Closure

Coding Instructions: Indicate if the intent to perform an ASD closure procedure was made in the cath lab, regardless of if the actual intervention ultimately occurred.

Note(s):

The intent to perform an ASD closure procedure is defined as introducing a device used for correcting the ASD defect into the patient

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Atrial Septal Defect Closure:

Atrial septal defect (ASD) is a congenital heart defect in which the wall that separates the upper heart chambers (atria) does not close completely. During the procedure, a catheter is threaded to the heart's septum. The device is then pushed out of the catheter and positioned so that it plugs the hole between the atria.

Source: NCDR

D. Procedure Information

Seq. #: 5002 **Name:** Procedure - Aortic Coarctation Procedure

Coding Instructions: Indicate if the intent to perform an Aortic Coarctation Procedure was made in the cath lab, regardless of if the actual intervention ultimately occurred.

Note(s):

The intent to perform a Aortic Coarctation procedure is defined as introducing a device used for correcting the aortic coarctation into the patient

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Aortic Coarctation Repair:**

Coarctation of the aorta is a congenital heart defect involving a narrowing of the aorta. To repair the aortic coarctation, a catheter is inserted and balloon inflated through the narrowed section of the aorta to stretch the area open. A stent may also be placed in the narrowed area after the balloon dilation to keep the aorta open.

Source: NCDR

Seq. #: 5003 **Name:** Procedure - Aortic Valvuloplasty

Coding Instructions: Indicate if the intent to perform an Aortic Valvuloplasty procedure was made in the cath lab, regardless of if the actual intervention ultimately occurred.

Note(s):

The intent to perform an Aortic Valvuloplasty procedure is defined as introducing a device used for treating the aortic valve into the patient

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Aortic Valvuloplasty:**

Aortic stenosis is a narrowing of the aortic valve. Aortic valvuloplasty is the repair of a stenotic aortic valve using a balloon catheter inside the valve. The balloon is then inflated in an effort to increase the opening size of the valve and improving blood flow.

Source: NCDR

D. Procedure Information

Seq. #: 5004 **Name:** Procedure - Pulmonary Valvuloplasty

Coding Instructions: Indicate if the intent to perform a Pulmonary Valvuloplasty procedure was made in the cath lab, regardless of if the actual intervention ultimately occurred.

Note(s):

The intent to perform a Pulmonary Valvuloplasty procedure is defined as introducing a device used for treating the pulmonary valve into the patient

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Pulmonary Valvuloplasty:**

Pulmonary stensosis is a narrowing of the pulmonary valve. Pulmonary valvuloplasty is the repair of a stenotic pulmonary valve using a balloon catheter inside the valve. The balloon is then inflated in an effort to increase the opening size of the valve and improving blood flow.

Source: NCDR

Seq. #: 5005 **Name:** Procedure - PDA Closure

Coding Instructions: Indicate if the intent to perform a PDA Closure procedure was made in the cath lab, regardless of if the actual intervention ultimately occurred.

Note(s):

The intent to perform a PDA closure procedure is defined as introducing a device used for treating the PDA defect into the patient

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Patent ductus arteriosus (PDA) Closure:**

Patent ductus arteriosus (PDA) is the persistence of a normal fetal structure between the left pulmonary artery and the descending aorta. Persistence of this fetal structure beyond 10 days of life is considered abnormal. A transcatheter device closure is a minimally invasive procedure where the doctor passes a small metal coil or other blocking device through the catheter to the site of the PDA. This corrects the congenital defect by blocking blood flow through the vessel.

Source: NCDR

D. Procedure Information

Seq. #: 5006 **Name:** Procedure - Proximal PA Stenting

Coding Instructions: Indicate if the intent to perform a Proximal PA Stenting procedure was made in the cath lab, regardless of if the actual intervention ultimately occurred.

Note(s):

The intent to perform a Proximal PA Stenting procedure is defined as introducing a device used for treating the proximal artery into the patient.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Pulmonary Artery Stenting:**

Pulmonary artery stenosis is a narrowing (stenosis) that occurs in the pulmonary artery, a large artery that sends oxygen-poor blood into the lungs to be enriched with oxygen.Pulmonary artery stenting consists of moving a balloon dilation catheter into the narrowed area of the artery. Stent placement is accomplished by positioning the balloon dilatation catheter and stent across the narrowed segment of the artery. The balloon is inflated to its recommended pressure, expanding the stent and anchoring it in place.

Source: NCDR

Seq. #: 5007 **Name:** Procedure - Electrophysiology Cath

Coding Instructions: Indicate if the intent to perform a diagnostic Electrophysiology Cath procedure was made in the cath lab, regardless of if the actual intervention ultimately occurred.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Diagnostic Electrophysiology Cath:**

One or more catheters capable of recording and pacing are placed in one or more of the cardiac chambers. The catheters may be used to measure conduction of the impulse from the sinus node to the ventricle; induce a tachycardia; and/or localize (map) the location where the tachycardia originates.

Source: NCDR

D. Procedure Information

Seq. #: 5008 **Name:** Procedure - Electrophysiology Ablation Procedure

Coding Instructions: Indicate if the intent to perform a Electrophysiology Ablation procedure was made in the cath lab, regardless of if the actual intervention ultimately occurred.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Electrophysiology Ablation:**

Catheter ablation is a minimally invasive procedure in which flexible tubes, called catheters, are placed into superficial blood vessels and advanced into the heart, or into the pericardial space around the heart, where the substrate of heart rhythm disorders can be localized and eradicated using heat or cold energy delivered at the tip of the catheter.
Includes endocardial and epicardial catheter ablation

Source: Buxton AE, JACC 2006

Seq. #: 5009 **Name:** Procedure - Transcatheter Pulmonary Valve Replacement (TPVR)

Coding Instructions: Indicate if the intent to perform a Transcatheter Pulmonary Valve (TPV) Replacement procedure was made in the cath lab, regardless of if the actual intervention ultimately occurred.

Note(s):

The intent to perform a TPVR procedure is defined as introducing a device used for preparing the conduit and/or treating the pulmonary valve into the patient.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Transcatheter Pulmonary Valve Replacement (TPVR):**

Transcatheter pulmonary valve replacement (TPVR) is a percutaneous replacement of a dysfunctional pulmonary valve for pulmonary regurgitation and right ventricular outflow tract obstruction in selected patients. The device is introduced through the femoral vein and advanced into the right side of the heart and put into place at the site of the pulmonary valve.

Source: NCDR

Seq. #: 5010 **Name:** Specific Procedure ID

Coding Instructions: Indicate all procedures that were performed while the patient was in the cath lab.

Note(s):

Select from the Procedure list supplied, all applicable procedures which were performed during the current cath lab visit.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

D. Procedure Information

Seq. #: 5015 **Name:** Hospital Status

Coding Instructions: Indicate the patient's hospital status at the start of the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Outpatient	
Admit to inpatient floor	
Admit to inpatient ICU	
23 Hour obs outpatient	
Return to inpatient floor	
Return to inpatient ICU	

Supporting Definitions: (none)

Seq. #: 5020 **Name:** Procedure Status

Coding Instructions: Indicate the status of the procedure. The status is determined at the time of the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Elective	The procedure can be performed on an outpatient basis or during a subsequent hospitalization without significant risk of death. For stable inpatients, the procedure is being performed during this hospitalization for convenience and ease of scheduling and NOT because the patient's clinical situation demands the procedure prior to discharge.
Urgent	The procedure is being performed on an inpatient basis and prior to discharge because of significant concerns. Patients who are outpatients or in the emergency department at the time that the cardiac catheterization is requested would warrant an admission based on their clinical presentation.
Emergency	The procedure is being performed as soon as possible because of substantial concerns that could lead to death. "As soon as possible" refers to a patient who is of sufficient acuity that you would cancel a scheduled case to perform this procedure immediately in the next available room during business hours, or you would activate the on call team were this to occur during off-hours.
Salvage	The procedure is a last resort. The patient is in cardiogenic shock at the start of the procedure. Within the last ten minutes prior to the start of the procedure the patient has also received chest compressions for a total of at least sixty seconds or has been on unanticipated extracorporeal circulatory support (e.g. extracorporeal membrane oxygenation, cardiopulmonay support).

Supporting Definitions: (none)

D. Procedure Information

Seq. #: 5030 **Name:** Operator Last Name

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

Note(s):

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

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5031 **Name:** Operator First Name

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

Note(s):

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

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5032 **Name:** Operator Middle Name

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

Note(s):

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

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5035 **Name:** Operator NPI

Coding Instructions: Indicate the primary operator's National Provider Identifier (NPI), assigned by the Center for Medicare and Medicaid Services (CMS), which is used to uniquely identify physicians for Medicare billing purposes.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

D. Procedure Information

Seq. #: 5036 **Name:** Trainee participating in the Procedure

Coding Instructions: Indicate if a trainee participated in the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5037 **Name:** Second Attending participating in the Procedure

Coding Instructions: Indicate if a second attending physician participated in the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5047 **Name:** Procedure Start Date

Coding Instructions: Indicate the date the procedure was initiated.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5048 **Name:** Procedure Start Time

Coding Instructions: Indicate the time the procedure started, to the nearest minute. 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 time (hours:minutes) using the military 24-hour clock, beginning at midnight (0000 hours).

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

D. Procedure Information

Seq. #: 5057 **Name:** Procedure End Date

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

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5058 **Name:** Procedure End Time

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

Note(s):

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

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5060 **Name:** Anesthesiologist Present

Coding Instructions: Indicate if an anesthesiologist was present at the start of the procedure.

Note(s):

Code "Yes" if an anesthesiologist (MD) or nurse anesthetist was present at the start of the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5065 **Name:** Anesthesiologist Called In

Coding Instructions: Indicate if an anesthesiologist was called into the cath lab after the start of the procedure, due to a need to escalate care.

Note(s):

Code "Yes" if an anesthesiologist (MD) or nurse anesthetist was called into the procedure for escalation of care.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Procedure Information

Seq. #: 5070 **Name:** Sedation Method

Coding Instructions: Indicate the type of sedation that was used during the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
General Anesthesia	
Epidural	
Caudal	
IV	
IM	
Oral/Intranasal	
None	

Supporting Definitions: (none)

Seq. #: 5071 **Name:** Airway Management

Coding Instructions: Indicate if airway management was provided during the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5076 **Name:** Airway Management - Laryngeal mask airway

Coding Instructions: Indicate if a laryngeal mask airway (LMA) was used for airway management during the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Procedure Information

Seq. #: 5077 **Name:** Airway Management - Tracheostomy

Coding Instructions: Indicate if a tracheostomy was used for airway management during the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5078 **Name:** Airway Management - Bag mask ventilation

Coding Instructions: Indicate if bag mask ventilation was used for airway management during the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5079 **Name:** Airway Management - CPAP (Continuous Positive Airway Pressure)

Coding Instructions: Indicate if continuous positive airway pressure (CPAP) was used for airway management during the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5080 **Name:** Airway Management - Elective Intubation

Coding Instructions: Indicate if the patient was electively intubated for airway management.

Note(s):

If the patient was intubated during the procedure for escalation of care code 'Yes' to Airway Event Requiring Intubation in the Intra and Post-Procedure Events section.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Procedure Information

Seq. #: 5081 **Name:** Airway Management - Previously Intubated

Coding Instructions: Indicate if the patient was intubated for airway management prior to the procedure.

Note(s):

If the patient was intubated during the procedure for escalation of care code 'Yes' to Airway Event Requiring Intubation in the Intra and Post-Procedure Events section.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5085 **Name:** Access Location

Coding Instructions: Indicate the location of the access site.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Venous	
Arterial	
Both	

Supporting Definitions: (none)

Seq. #: 5090 **Name:** Venous Access Site

Coding Instructions: Indicate the venous access site.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Left brachial	
Left femoral	
Left jugular	
Left subclavian	
Hepatic	
Umbilical	
Right brachial	
Right femoral	
Right jugular	
Right subclavian	
Transthoracic	
Other	

Supporting Definitions: (none)

D. Procedure Information

Seq. #: 5095 **Name:** Venous Sheath Size

Coding Instructions: Indicate the largest venous sheath size used during the procedure. Units are in French.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5099 **Name:** Venous Closure Method Counter

Coding Instructions: The venous closure method counter distinguishes an individual closure method when multiple are used during one procedure.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5100 **Name:** Venous Closure Method(s)

Coding Instructions: Indicate all venous closure method(s) used in chronological order regardless of whether or not they provided hemostasis. The same closure method may be repeated.

Note(s):

Select from the Closure Method list supplied, all applicable procedures which were performed during the cardiac cath.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5105 **Name:** Venous Closure Method Not Documented

Coding Instructions: Indicate if the method to close the venous access site was not documented.

Target Value: The value between current procedure and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Procedure Information

Seq. #: 5110 **Name:** Arterial Access Site

Coding Instructions: Indicate the arterial access site.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Left axillary	
Left carotid	
Left femoral	
Left radial	
Umbilical	
Right axillary	
Right carotid	
Right femoral	
Right radial	
Other	

Supporting Definitions: (none)

Seq. #: 5115 **Name:** Arterial Sheath Size

Coding Instructions: Indicate the largest arterial sheath size used during the procedure. Units are in French.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5119 **Name:** Arterial Closure Method Counter

Coding Instructions: The arterial closure method counter distinguishes an individual closure method when multiple are used during one procedure.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

D. Procedure Information

Seq. #: 5120 **Name:** Arterial Closure Method(s)

Coding Instructions: Indicate all arterial closure method(s) used in chronological order regardless of whether or not they provided hemostasis. The same closure method may be repeated.

Note(s):

Select from the Closure Method list supplied, all applicable procedures which were performed during the cardiac cath.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5125 **Name:** Arterial Closure Method Not Documented

Coding Instructions: Indicate if the method to close the arterial access site was not documented.

Target Value: The value between current procedure and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5130 **Name:** Fluoro Time

Coding Instructions: Indicate the total procedural fluoroscopy time in minutes.

Note(s):

It is acceptable to code any one, or all, of: Fluoroscopy Time, Cumulative Air Kerma, or Fluoroscopy Dose Area Product.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5135 **Name:** Contrast Volume

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

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

Selections: (none)

Supporting Definitions: (none)

D. Procedure Information

Seq. #: 5140 **Name:** Systemic Heparinization

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

Note(s):

Systemic heparinzation includes IV and subcutaneous given during the procedure for anticoagluation purposes.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5145 **Name:** Activated Clotting Time Monitored

Coding Instructions: Indicate if an activated clotting time (ACT) was monitored.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5150 **Name:** Activated Clotting Time Peak

Coding Instructions: Indicate the peak activated clotting time (ACT) level.

Target Value: The highest value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5160 **Name:** Inotrope

Coding Instructions: Indicate if an inotrope was used during the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Procedure Information

Seq. #: 5165 **Name:** Inotrope Use

Coding Instructions: Indicate the use of the inotrope in relation to the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
On before start of case, on at the end	
On before start of case, off at the end	
Started during the case, on at the end	
Started during case, off at the end	
Used for measurement purposes only	

Supporting Definitions: (none)

Seq. #: 5170 **Name:** Extracorporeal Membrane Oxygenation (ECMO) Use

Coding Instructions: Indicate the use of extracorporeal membrane oxygenation (ECMO) in relation to the procedure.

Note(s):

If the patient is emergently placed on ECMO during the procedure, code 'Yes' to Event requiring ECMO in the Intra and Post-Procedure Events section.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Not used	
In place at start of procedure	
Electively initiated during procedure	

Supporting Definitions: (none)

D. Procedure Information

Seq. #: 5175 **Name:** Left Ventricular Assist Device (LVAD) Use

Coding Instructions: Indicate the use of a left ventricular assist device (LVAD) in relation to the procedure.

Note(s):

If the patient is emergently placed with an LVAD during the procedure, code 'Yes' to Event requiring LVAD in the Intra and Post-Procedure Events section.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Not used	
In place at start of procedure	
Electively initiated during procedure	

Supporting Definitions: (none)

Seq. #: 5180 **Name:** Intra-aortic Balloon Pump (IABP) Use

Coding Instructions: Indicate the use of a intra-aortic balloon pump (IABP) in relation to the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Not used	
In place at start of procedure	
Electively initiated during procedure	

Supporting Definitions: (none)

Seq. #: 5500 **Name:** X-ray Imaging Plane Used

Coding Instructions: Indicate the X-ray imaging plane used during the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Single Plane	
Biplane	

Supporting Definitions: (none)

D. Procedure Information

Seq. #: 5515 **Name:** Cumulative Air Kerma

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

Note(s):

Cumulative Air Kerma (mGy) = 1 - 10000 (usual range)
Cumulative Air Kerma (Gy) = 1 - 10 (usual range)

It is acceptable to code any one of, or all of, Fluoroscopy Time, Cumulative Air Kerma, and Fluoroscopy Dose Area Product.

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

Selections: (none)

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

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

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

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

Seq. #: 5520 **Name:** Cumulative Air Kerma Units

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

Note(s):

Collect one Cumulative Air Kerma unit based on the equipment used.

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

Selections:

Selection Text	*Definition*
mGy	
Gy	

Supporting Definitions: (none)

D. Procedure Information

Seq. #: 5525 **Name:** Dose Area Product

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

Note(s):

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

It is acceptable to code any one of, or all of, Fluoroscopy Time, Cumulative Air Kerma, and Fluoroscopy Dose Area Product.

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

Selections: (none)

Supporting Definitions: **Dose Area Product:**

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

Also known as KAP (Kerma Air Product).

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

Seq. #: 5530 **Name:** Dose Area Product Units

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

Note(s):

Collect one Dose Area Product unit based on the equipment used.

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

Selections:

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

Supporting Definitions: (none)

E. Hemodynamics

Seq. #: 6000 **Name:** Systemic Arterial Saturation

Coding Instructions: Indicate the systemic arterial saturation obtained during the procedure in %.

Note(s):

The systemic arterial saturation can be obtained by invasive or non-invasive means.

Pulse oximetry saturation may be used if the arterial saturation was not measured with an arterial blood sample.

If the value obtained is outside of the valid range, code the highest or lowest number possible.

Target Value: The first value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6001 **Name:** Systemic Arterial Saturation Not Assessed

Coding Instructions: Indicate whether the systemic arterial saturation was not assessed or not obtained during the procedure in %.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if Systemic Arterial Saturation was not assessed.

Supporting Definitions: (none)

Seq. #: 6005 **Name:** Mixed Venous Saturation

Coding Instructions: Indicate the mixed venous saturation obtained during the procedure in %.

Note(s):

If the value obtained is outside of the valid range, code the highest or lowest number possible.

Target Value: The first value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6006 **Name:** Mixed Venous Saturation Not Assessed

Coding Instructions: Indicate whether the mixed venous saturation was not assessed or not obtained during the procedure in %.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if Mixed Venous Saturation was not assessed or not obtained

Supporting Definitions: (none)

Seq. #: 6010 **Name:** Systemic Ventricular Systolic Pressure

Coding Instructions: Indicate the systemic ventricular systolic pressure obtained during the procedure in millimeters of mercury.

Note(s):

If the value obtained is outside of the valid range, code the highest or lowest number possible.

If the patient has a single ventricle, code the ventricular systolic pressure as the Systemic Ventricular Systolic Pressure only. Do not enter a value in the Pulmonary Ventricular Systolic Pressure.

LV (or systemic ventricular) systolic pressure can be the arterial or non-invasive systolic blood pressure if there is no aortic stenosis or LVOT obstruction.

Target Value: The first value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6011 **Name:** Systemic Ventricular Systolic Pressure Not Assessed

Coding Instructions: Indicate whether the systemic ventricular systolic pressure was not assessed or not obtained during the procedure in millimeters of mercury.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if Systemic Ventricular Systolic Pressure was not assessed or not obtained.

Supporting Definitions: (none)

Seq. #: 6015 **Name:** Systemic Ventricular End Diastolic Pressure

Coding Instructions: Indicate the systemic ventricular end diastolic pressure obtained during the procedure in millimeters of mercury.

Note(s):

If the value obtained is outside of the valid range, code the highest or lowest number possible.

LV (or systemic ventricular) end diastolic pressure can be the pulmonary artery wedge pressure (“a wave”) if the LV is not entered and there is reason to believe that the wedge pressure is a good reflection of left atrial pressure and LVED (no pulmonary vein or mitral stenosis)

Target Value: The first value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6016 **Name:** Systemic Ventricular End Diastolic Pressure Not Assessed

Coding Instructions: Indicate whether the systemic ventricular end diastolic pressure was not assessed or not obtained during the procedure in millimeters of mercury.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if Systemic Ventricular End Diastolic Pressure was not assessed or not obtained.

Supporting Definitions: (none)

Seq. #: 6020 **Name:** Systemic Systolic Blood Pressure

Coding Instructions: Indicate the systemic systolic blood pressure in millimeters of mercury.

Note(s):

The systemic blood pressure can be obtained by invasive or non-invasive means.

Arterial pressure can be obtained by the non-invasive blood pressure if not measured with an arterial catheter.

If the value obtained is outside of the valid range, code the highest or lowest number possible.

Target Value: The first value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6021 **Name:** Systemic Systolic Blood Pressure Not Assessed

Coding Instructions: Indicate whether the systemic systolic blood pressure in millimeters of mercury was not assessed or not obtained.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if Systemic Systolic Blood Pressure was not assessed.

Supporting Definitions: (none)

Seq. #: 6025 **Name:** Systemic Diastolic Blood Pressure

Coding Instructions: Indicate the systemic diastolic blood pressure in millimeters of mercury.

Note(s):

The systemic blood pressure can be obtained by invasive or non-invasive means.

Arterial pressure can be obtained by the non-invasive blood pressure if not measured with an arterial catheter.

If the value obtained is outside of the valid range, code the highest or lowest number possible.

Target Value: The first value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6026 **Name:** Systemic Diastolic Blood Pressure Not Assessed

Coding Instructions: Indicate whether the systemic diastolic blood pressure in millimeters of mercury was not assessed or not obtained.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if Systemic Diastolic Blood Pressure was not assessed or not obtained.

Supporting Definitions: (none)

Seq. #: 6030 **Name:** Systemic Mean Blood Pressure

Coding Instructions: Indicate the systemic mean blood pressure obtained during the procedure in millimeters of mercury.

Note(s):

The systemic blood pressure can be obtained by invasive or non-invasive means.

If the value obtained is outside of the valid range, code the highest or lowest number possible.

Target Value: The first value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6031 **Name:** Systemic Mean Blood Pressure Not Assessed

Coding Instructions: Indicate whether the systemic mean blood pressure was not assessed or not obtained during the procedure in millimeters of mercury.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if Systemic Mean Blood Pressure was not assessed or not obtained.

Supporting Definitions: (none)

Seq. #: 6035 **Name:** Pulmonary Artery Systolic Pressure

Coding Instructions: Indicate the pulmonary artery systolic pressure obtained during the procedure in millimeters of mercury.

Note(s):

If the value obtained is outside of the valid range, code the highest or lowest number possible.

Pulmonary venous wedge pressure may be coded if there is no pulmonary artery pressure available.

Target Value: The first value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6036 **Name:** Pulmonary Artery Systolic Pressure Not Assessed

Coding Instructions: Indicate whether the pulmonary artery systolic pressure was not assessed or not obtained during the procedure in millimeters of mercury.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if Pulmonary Artery Systolic Pressure was not assessed or not obtained.

Supporting Definitions: (none)

Seq. #: 6040 **Name:** Pulmonary Artery Mean Pressure

Coding Instructions: Indicate the pulmonary artery mean pressure obtained during the procedure in millimeters of mercury.

Note(s):

If the value obtained is outside of the valid range, code the highest or lowest number possible.

Target Value: The first value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6041 **Name:** Pulmonary Artery Mean Pressure Not Assessed

Coding Instructions: Indicate whether the pulmonary artery mean pressure was not assessed or not obtained during the procedure in millimeters of mercury.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if Pulmonary Artery Mean Pressure was not assessed.

Supporting Definitions: (none)

Seq. #: 6045 **Name:** Pulmonary Ventricular Systolic Pressure

Coding Instructions: Indicate the pulmonary ventricular systolic pressure obtained during the procedure in millimeters of mercury.

Note(s):

If the value obtained is outside of the valid range, code the highest or lowest number possible.

If the patient has a single ventricle, code the ventricular systolic pressure as the Systemic Ventricular Systolic Pressure only. Do not enter a value in the Pulmonary Ventricular Systolic Pressure.

Target Value: The first value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6046 **Name:** Pulmonary Ventricular Systolic Pressure Not Assessed

Coding Instructions: Indicate whether the pulmonary ventricular systolic pressure was not assessed or not obtained during procedure in millimeters of mercury.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if Pulmonary Ventricular Systolic Pressure was not assessed.

Supporting Definitions: (none)

Seq. #: 6050 **Name:** Pulmonary Vascular Resistance Index

Coding Instructions: Indicate the pulmonary vascular resistance index obtained during procedure in wood units*m^2.

Note(s):

If the value obtained is outside of the valid range, code the highest or lowest number possible.

Target Value: The first value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6051 **Name:** Pulmonary Vascular Resistance Index Not Assessed

Coding Instructions: Indicate whether the pulmonary vascular resistance index was not assessed or not obtained during procedure in wood units*m^2.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if Pulmonary Vascular Resistance Index was not assessed.

Supporting Definitions: (none)

Seq. #: 6055 **Name:** Cardiac Index

Coding Instructions: Indicate the cardiac index obtained during the procedure in L/min/m^2.

Note(s):

If the value obtained is outside of the valid range, code the highest or lowest number possible.

If cardiac index is obtained by multiple methods, document the one that the physician deems most accurate.

Target Value: The first value on current procedure

Selections: (none)

Supporting Definitions: (none)

E. Hemodynamics

Seq. #: 6056 **Name:** Cardiac Index Not Assessed

Coding Instructions: Indicate whether the cardiac index was not assessed or not obtained during the procedure in L/min/m^2.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if Cardiac Index was not assessed.

Supporting Definitions: (none)

Seq. #: 6060 **Name:** Qp/Qs Ratio

Coding Instructions: Indicate the Qp/Qs ratio obtained during the procedure.

Note(s):

The number entered will always be the numerator of the ratio over the denominator of 1.

If the value obtained is outside of the valid range, code the highest or lowest number possible.

Target Value: The first value on current procedure

Selections: (none)

Supporting Definitions: **Qp/Qs ratio:**

The magnitude of the shunt caused by a septal defect as determined by the level of pulmonary vascular resistance relative to the systemic vascular resistance. Qp is the pulmonary resistance and Qs is the systemic resistance

Source: NCDR

Seq. #: 6061 **Name:** Qp/Qs Ratio Not Assessed

Coding Instructions: Indicate whether the Qp/Qs ratio was not assessed or not obtained during the procedure.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if Qp/Qs Ratio was not assessed.

Supporting Definitions: (none)

F. ASD Closure

Seq. #: 7000 **Name:** ASD - Primary Procedure Indication

Coding Instructions: Indicate the primary reason the atrial septal defect (ASD) procedure is being performed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Right ventricular volume overload	
Chronic lung disease	
Failure to thrive	
Recurrent respiratory infections	
Ventilator dependent	
Cyanosis	
Stroke prevention	
Migraines	
Pulmonary hypertension	

Supporting Definitions: (none)

Seq. #: 7005 **Name:** ASD - Total Septal Length

Coding Instructions: Indicate the atrial septal defect (ASD) total septal length in millimeters.

Note(s):

The total septal length is the distance from the crux of the heart to the posterior wall measured in the 4 chamber view (TTE).

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7006 **Name:** ASD - Total Septal Length Not Assessed

Coding Instructions: Indicate whether the atrial septal defect (ASD) total septal length in millimeters was not assessed.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if ASD - Total Septal Length was not assessed.

Supporting Definitions: (none)

F. ASD Closure

Seq. #: 7010 **Name:** ASD - Atrial Septal Aneurysm Present

Coding Instructions: Indicate if an atrial septal aneurysm is present.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7020 **Name:** ASD - Defect Counter

Coding Instructions: The atrial septal defect (ASD) defect counter distinguishes individual defects when multiple are treated during one procedure.

The defect counter number is also used to relate the specific defect which was treated with a particular device.

Note(s):

The software-assigned defect counter should start at one and be incremented by one for each defect. The defect counter is reset back to one for each new lab visit.

At least one defect must be specified for each procedure.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7022 **Name:** ASD - Multi-Fenestrated

Coding Instructions: Indicate if the atrial septal defect (ASD) was multi-fenestrated.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7025 **Name:** ASD - Size

Coding Instructions: Indicate the atrial septal defect (ASD) size in millimeters.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

F. ASD Closure

Seq. #: 7030 **Name:** ASD - Balloon Sizing Performed

Coding Instructions: Indicate if balloon sizing was performed on the atrial septal defect (ASD).

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7035 **Name:** ASD - Stretched Diameter Performed

Coding Instructions: Indicate if stretched diameter balloon sizing was performed on the atrial septal defect (ASD).

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7040 **Name:** ASD - Stretched Diameter Size

Coding Instructions: Indicate the atrial septal defect (ASD) stretched diameter size in millimeters.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7045 **Name:** ASD - Stop Flow Technique Performed

Coding Instructions: Indicate if stop flow technique balloon sizing was performed on the atrial septal defect (ASD).

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

F. ASD Closure

Seq. #: 7050 **Name:** ASD - Stop Flow Technique Size

Coding Instructions: Indicate the Atrial defect (ASD) stretched diameter size in millimeters.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7055 **Name:** ASD - Rim Measurement Performed

Coding Instructions: Indicate if rim measurements were performed on the atrial septal defect (ASD).

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7060 **Name:** ASD - IVC Rim Length

Coding Instructions: Indicate the inferior vena cava rim length in millimeters of the atrial septal defect (ASD).

Note(s):

The IVC rim should be measured in a subcostal short axis view or bicaval TEE or ICE view.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7065 **Name:** ASD - Aortic Rim Length

Coding Instructions: Indicate the aortic rim length in millimeters of the atrial septal defect (ASD).

Note(s):

The aortic rim should be measured in a parasternal short axis view on transthoracic echo or corresponding short axis view by TEE or ICE.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

F. ASD Closure

Seq. #: 7066 **Name:** ASD - Posterior Rim Length

Coding Instructions: Indicate the posterior rim length in millimeters of the atrial septal defect (ASD).

Note(s):

The posterior rim should be measured in the parasternal short axis or corresponding short axis view by TEE or ICE.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7080 **Name:** ASD - Residual Shunt Size

Coding Instructions: Indicate the residual shunt of the atrial septal defect (ASD) immediately after device placement.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
None to trivial (<3 mm)	
Significant (>=3 mm)	

Supporting Definitions: (none)

Seq. #: 7084 **Name:** ASD - Device Counter

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

Note(s):

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7085 **Name:** ASD - Device ID

Coding Instructions: Indicate the device utilized during the current atrial septal defect (ASD) closure procedure.

Note(s):

Code all devices used during the procedure.

If a device was utilized on multiple defects, specify it only once (e.g., if a balloon was used to dilate two separate defects, list it only once). Every treatment and support device utilized during the procedure should be specified.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

F. ASD Closure

Seq. #: 7089 **Name:** ASD - Defect Counter Association

Coding Instructions: Indicate the ASD Defect Counter Number(7020) corresponding to the defect which was treated with this device.

Note(s):

Code all defects that were treated with this one device.

If a second instance of the same device was used, code the second device separately.

At least one defect must be associated to each device.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7090 **Name:** ASD - Device Outcome

Coding Instructions: Indicate the outcome of the device used to close the atrial septal defect (ASD).

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Implanted, not released	
Implanted, released	
Implanted, released and retrieved	

Supporting Definitions: (none)

G. Coarctation Procedure

Seq. #: 7100 **Name:** Coarctation - Primary Procedure Indication

Coding Instructions: Indicate the primary reason the Coarctation procedure is being performed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Abnormal ventricular function	
Congestive heart failure	
Exercise hypertension	
Systemic hypertension	
High resting gradient	
Angiographic appearance	
Pseudoaneurysm	

Supporting Definitions: (none)

Seq. #: 7101 **Name:** Nature of simple discrete coarctation (One site of intervention)

Coding Instructions: Indicate if the coarctation lesion is a native stenosis or recurrent stenosis.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Native	
Post Treatment	

Supporting Definitions: (none)

Seq. #: 7102 **Name:** Most Recent Prior Treatment

Coding Instructions: Indicate if the most recent prior treatment of the coarctation was surgical or catheter based.

Target Value: The last value prior to the current procedure

Selections:

Selection Text	*Definition*
Surgical Repair	
Catheter-based Intervention	

Supporting Definitions: (none)

G. Coarctation Procedure

Seq. #: 7107 **Name:** Coarctation - Pre-Procedure Minimal Diameter

Coding Instructions: Indicate the pre-procedure coarctation diameter in millimeters.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7108 **Name:** Coarctation - Pre-Procedure Minimal Diameter Not Assessed

Coding Instructions: Indicate whether the pre-procedure coarctation diameter was not assessed in millimeters.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if Pre-Procedure Minimal Diameter not assessed.

Supporting Definitions: (none)

Seq. #: 7110 **Name:** Coarctation - Pre-Procedure Peak Systolic Gradient

Coding Instructions: Indicate the pre-procedure coarctation peak systolic gradient in millimeters of mercury.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7111 **Name:** Coarctation - Pre-Procedure Peak Systolic Gradient Not Assessed

Coding Instructions: Indicate whether the pre-procedure coarctation peak systolic gradient was not assessed or not obtained in millimeters of mercury.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if Pre-Procedure Peak Systolic Gradient was not assessed.

Supporting Definitions: (none)

G. Coarctation Procedure

Seq. #: 7120 **Name:** Coarctation - Post-Procedure Minimal Diameter

Coding Instructions: Indicate the post-procedure coarctation diameter in millimeters.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7121 **Name:** Coarctation - Post-Procedure Minimal Diameter Not Assessed

Coding Instructions: Indicate whether the post-procedure coarctation diameter was not assessed in millimeters.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if Post-Procedure Minimal Diameter was not assessed.

Supporting Definitions: (none)

Seq. #: 7124 **Name:** Coarctation - Post-Procedure Peak Systolic Gradient Not Assessed

Coding Instructions: Indicate whether the post-procedure coarctation peak systolic gradient was not assessed in millimeters of mercury.

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if Post-Procedure Peak Systolic Gradient was not assessed

Supporting Definitions: (none)

Seq. #: 7125 **Name:** Coarctation - Post-Procedure Peak Systolic Gradient

Coding Instructions: Indicate the post-procedure coarctation peak systolic gradient in millimeters of mercury.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

G. Coarctation Procedure

Seq. #: 7126 **Name:** Coarctation with Additional Associated Aortic Obstruction

Coding Instructions: Indicate if the coarctation was associated with an additional aortic obstruction.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7127 **Name:** Additional Intervention on Aortic Arch

Coding Instructions: Indicate if there was an additional intervention on the aortic arch.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7128 **Name:** Pre-Procedure Total Ascending to Descending Aortic Systolic Gradient

Coding Instructions: Indicate the pre-procedure total ascending to descending aortic systolic gradient.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7129 **Name:** Post-Procedure Total Ascending to Descending Aortic Systolic Gradient

Coding Instructions: Indicate the post-procedure total ascending to descending aortic systolic gradient.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

G. Coarctation Procedure

Seq. #: 7130 **Name:** Coarctation - Device Counter

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

Note(s):

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7135 **Name:** Coarctation - Device ID

Coding Instructions: Indicate the device utilized during the current Coarctation procedure.

Note(s):

Code all devices used during the procedure.

If a device was utilized on multiple defects, specify it only once (e.g., if a balloon was used to dilate two separate defects, list it only once). Every treatment and support device utilized during the procedure should be specified.

For coarctation procedures, if a balloon and stent comes packaged as one device, treat as a stent device. If the balloon of a balloon/stent device is used for angioplasty or stent redilation then document the balloon as a separate device.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7140 **Name:** Coarctation - Device Type

Coding Instructions: Indicate the type of device used to perform the coarctation procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Balloon	
Stent	

Supporting Definitions: (none)

Seq. #: 7145 **Name:** Coarctation - Balloon Purpose

Coding Instructions: Indicate the purpose of the balloon used in the coarctation procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Compliance testing	
Stent redilation	
Angioplasty	
Stent inplantation	

Supporting Definitions: (none)

G. Coarctation Procedure

Seq. #: 7150 **Name:** Coarctation - Balloon Max Inflation Pressure

Coding Instructions: Indicate the max inflation pressure of the balloon used to perform the coarctation procedure in atm(s).

Note(s):

If a hand inflation technique is used, document a pressure of 0.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7155 **Name:** Coarctation - Balloon Outcome

Coding Instructions: Indicate the outcome of the balloon used during the coarctation procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Inflated with rupture	
Inflated without rupture	

Supporting Definitions: (none)

Seq. #: 7160 **Name:** Coarctation - Stent Outcome

Coding Instructions: Indicate the outcome of the stent used during the coarctation procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Implanted intended site	
Implanted other location	
Not deployed	

Supporting Definitions: (none)

Seq. #: 7164 **Name:** Coarctation - In Stent Minimal Diameter Assessed

Coding Instructions: Indicate whether the minimum stent diameter post procedure was assessed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if In Stent Minimal Diameter was assessed.

Supporting Definitions: (none)

G. Coarctation Procedure

Seq. #: 7165 **Name:** Coarctation - In Stent Minimal Diameter

Coding Instructions: Indicate the minimum stent diameter post procedure in millimeters.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

H. Aortic Valvuloplasty

Seq. #: 7200 **Name:** AV - Primary Procedure Indication

Coding Instructions: Indicate the primary reason the aortic valvuloplasty (AV) procedure is being performed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Aortic stenosis gradient	
Abnormal stress test/EKG	
LV dysfunction	
Symptoms	Can include but is not limited to heart failure, syncope or angina.

Supporting Definitions: (none)

Seq. #: 7205 **Name:** AV - Aortic Valve Morphology

Coding Instructions: Indicate the morphology of the aortic valve.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Unicuspid	
Bicuspid	
Tricuspid	
Quadracuspid	
Uncertain	

Supporting Definitions: (none)

Seq. #: 7210 **Name:** AV - Pre-Procedure Valve Regurgitation

Coding Instructions: Indicate the pre-procedure regurgitation of the aortic valve by grade.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
None	
1+ (mild)	Small amount of contrast enters the left ventricle in diastole.
2+ (moderate)	Faint opacification of the entire chamber occurs.
3+ (moderately severe)	The LV chamber is well opacified and equal in density with the ascending aorta.
4+ (severe)	Characterized by complete, dense opacification of the LV chamber in one beat, and the left ventricle appears more densely opacified than the ascending aorta.

Supporting Definitions: (none)

H. Aortic Valvuloplasty

Seq. #: 7215 **Name:** AV - Aortic Valve Diameter

Coding Instructions: Indicate the diameter of the aortic valve in millimeters that was used to select the balloon for the procedure.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7220 **Name:** AV - Pre-Procedure Peak Systolic Gradient

Coding Instructions: Indicate the pre-procedure peak systolic gradient in millimeters of mercury.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7231 **Name:** AV - Balloon Counter

Coding Instructions: Indicate the balloon utilized during the current aortic valvuloplasty procedure.

Note(s):

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7236 **Name:** AV - Balloon Technique

Coding Instructions: Indicate the type of balloon technique used during the aortic valvuloplasty (AV) procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Single	
Double	

Supporting Definitions: (none)

H. Aortic Valvuloplasty

Seq. #: 7241 **Name:** AV - Device ID Balloon 1

Coding Instructions: Indicate the device ID for the balloon #1 used during the aortic valvuloplasty (AV).

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7242 **Name:** AV - Device ID Balloon 2

Coding Instructions: Indicate the device ID for the balloon #2 used during the aortic valvuloplasty (AV).

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7243 **Name:** AV - Balloon Stabilization

Coding Instructions: Indicate if the balloon was stabilized during the aortic valvuloplasty (AV).

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7244 **Name:** AV - Max Inflation Pressure

Coding Instructions: Indicate the max inflation pressure in atm(s) of the balloon used during the aortic valvuloplasty (AV).

Note(s):

If a hand inflation technique is used, document a pressure of 0.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

H. Aortic Valvuloplasty

Seq. #: 7256 **Name:** AV - Balloon Outcome

Coding Instructions: Indicate the outcome of the device used during the aortic valvuloplasty (AV).

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Inflated with rupture	
Inflated without rupture	

Supporting Definitions: (none)

Seq. #: 7257 **Name:** AV - Post Dilation Peak Systolic Gradient

Coding Instructions: Indicate the peak systolic gradient in millimeters of mercury, after the balloon has been inflated during the aortic valvuloplasty (AV).

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7258 **Name:** AV - Post Dilation Aortic Valve Regurgitation

Coding Instructions: Indicate the aortic valve regurgitation after the balloon has been inflated during the aortic valvuloplasty (AV).

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
None	
1+ (mild)	Small amount of contrast enters the left ventricle in diastole.
2+ (moderate)	Faint opacification of the entire chamber occurs.
3+ (moderately severe)	The LV chamber is well opacified and equal in density with the ascending aorta.
4+ (severe)	Characterized by complete, dense opacification of the LV chamber in one beat, and the left ventricle appears more densely opacified than the ascending aorta.

Supporting Definitions: (none)

I. Pulmonary Valvuloplasty

Seq. #: 7400 **Name:** PV - Primary Procedure Indication

Coding Instructions: Indicate the primary reason the pulmonary valvuloplasty (PV) procedure is being performed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
High resting gradient	
R to L shunting	
RV dysfunction	
Symptoms	Can include but is not limited to cyanosis, tachypnea, fainting or low energy.

Supporting Definitions: (none)

Seq. #: 7405 **Name:** PV - Pulmonary Valve Morphology

Coding Instructions: Indicate the morphology of the pulmonary valve.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Typical	
Dysplastic/Complex	

Supporting Definitions: (none)

Seq. #: 7410 **Name:** PV - Subpulmonary Stenosis Present

Coding Instructions: Indicate if subpulmonary stenosis is present.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7415 **Name:** PV - Pulmonary Valve Diameter

Coding Instructions: Indicate the diameter of the pulmonary valve in millimeters that was used to select the balloon for the procedure.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

I. Pulmonary Valvuloplasty

Seq. #: 7420 **Name:** PV - Pre-Procedure Peak Systolic Gradient

Coding Instructions: Indicate the pre-procedure peak systolic gradient millimeters of mercury.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7421 **Name:** PV - Pre-Procedure Peak Systolic Gradient Not Assessed

Coding Instructions: Indicate whether the pre-procedure peak systolic gradient millimeters of mercury was not assessed..

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if Pre-Procedure Peak Systolic Gradient was not assessed

Supporting Definitions: (none)

Seq. #: 7520 **Name:** PV - Balloon Technique

Coding Instructions: Indicate the FINAL type of technique used for the pulmonary valvuloplasty procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Single	
Double	

Supporting Definitions: (none)

Seq. #: 7525 **Name:** PV - Device ID Balloon 1

Coding Instructions: Indicate the device ID of the balloon #1 used during the pulmonary valvuloplasty (PV).

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

I. Pulmonary Valvuloplasty

Seq. #: 7530 **Name:** PV - Device ID Balloon 2

Coding Instructions: Indicate the device ID of the balloon #2 used during the pulmonary valvuloplasty (PV).

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7535 **Name:** PV - Balloon Stabilization

Coding Instructions: Indicate if the balloon was stabilized during the pulmonary valvuloplasty (PV) procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7540 **Name:** PV - Balloon Max Inflation Pressure

Coding Instructions: Indicate the max inflation pressure in atm(s) of the balloon used during the pulmonary valvuloplasty (PV).

Note(s):

If a hand inflation technique is used, document a pressure of 0.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7545 **Name:** PV - Balloon Device Outcome

Coding Instructions: Indicate the outcome of the device used during the pulmonary valvuloplasty (PV).

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Inflated with rupture	
Inflated without rupture	

Supporting Definitions: (none)

I. Pulmonary Valvuloplasty

Seq. #: 7550 **Name:** PV - Post-Procedure Peak Systolic Gradient

Coding Instructions: Indicate the peak systolic gradient in millimeters of mercury, after the balloon has been inflated to perform the pulmonary valvuloplasty (PV).

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7551 **Name:** PV - Post-Procedure Peak Systolic Gradient Not Assessed

Coding Instructions: Indicate whether the peak systolic gradient was not assessed in millimeters of mercury, after the balloon has been inflated to perform the pulmonary valvuloplasty (PV).

Target Value: N/A

Selections:

Selection Text	*Definition*
No	
Yes	Code "Yes" if Post-Procedure Peak Systolic Gradient was not assessed.

Supporting Definitions: (none)

J. PDA Closure

Seq. #: 7600 **Name:** PDA - Primary Procedure Indication

Coding Instructions: Indicate the primary reason the patent ductus arteriosus (PDA) procedure is being performed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
SBE prevention	
Left ventricular volume overload	
Pulmonary hypertension	

Supporting Definitions: (none)

Seq. #: 7605 **Name:** PDA - Diameter Aortic Side

Coding Instructions: Indicate the patent ductus arteriosus (PDA) diameter on the aortic side in millimeters.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7610 **Name:** PDA - Minimum Luminal Diameter

Coding Instructions: Indicate the patent ductus arteriosus (PDA) minimal luminal diameter in millimeters.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7615 **Name:** PDA - Length

Coding Instructions: Indicate the length of the patent ductus arteriosus (PDA) in millimeters.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

J. PDA Closure

Seq. #: 7620 **Name:** PDA - Classification

Coding Instructions: Indicate the classification of the patent ductus arteriosus (PDA) defect.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Type A (conical)	
Type B (window)	
Type C (tubular)	
Type D (complex)	
Type E (elongated)	

Supporting Definitions: (none)

Seq. #: 7630 **Name:** PDA - Pulmonary Artery Obstruction

Coding Instructions: Indicate if the pulmonary artery was obstructed by the patent ductus arteriosus (PDA) closure device.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	
Not Assessed	

Supporting Definitions: (none)

Seq. #: 7635 **Name:** PDA - Aortic Obstruction

Coding Instructions: Indicate if the aorta was obstructed by the patent ductus arteriosus (PDA) closure device.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	
Not Assessed	

Supporting Definitions: (none)

J. PDA Closure

Seq. #: 7640 **Name:** PDA - Residual Shunt

Coding Instructions: Indicate the residual shunt of the patent ductus arteriosus (PDA) after device placement.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
None to trivial	None and/or contrast extravasations through the device placed.
Significant	Contrast extravasations through and around the device placed.

Supporting Definitions: (none)

Seq. #: 7644 **Name:** PDA - Device Counter

Coding Instructions: The patent ductus arteriosus closure proceduredevice counter distinguishes individual devices when multiple are used during one procedure.

Note(s):

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7645 **Name:** PDA - Device ID

Coding Instructions: Indicate the device utilized during the current patent ductus arteriosus (PDA) closure procedure.

Note(s):

Code all devices used during the procedure.

If a device was utilized on multiple defects, specify it only once (e.g., if a balloon was used to dilate two separate defects, list it only once). Every treatment and support device utilized during the procedure should be specified.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7650 **Name:** PDA - Device Outcome

Coding Instructions: Indicate the outcome of the patent ductus arteriosus (PDA) closure device.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Implanted, not released	
Implanted, released	
Implanted, released and retrieved	

Supporting Definitions: (none)

K. Proximal Pulmonary Artery Stenting Procedure

Seq. #: 7700 **Name:** PA Stenting - Primary Indication

Coding Instructions: Indicate the primary reason the pulmonary artery (PA) stenting procedure is being performed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
PA gradient	
RV hypertension/dysfunction	
Pulmonary insufficiency	
PA flow discrepancy	
Angiographic narrowing	

Supporting Definitions: (none)

Seq. #: 7705 **Name:** PA Stenting - Defect Counter

Coding Instructions: The pulmonary artery (PA) stenting defect counter is used to distinguish individual defects when multiple are treated during one procedure.

The defect counter number is also used to relate the specific defect which was treated with a particular device.

Note(s):

The software-assigned defect counter should start at one and be incremented by one for each defect. The defect counter is reset back to one for each new lab visit.

At least one defect must be specified for each procedure.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7710 **Name:** PA Stenting - Defect Location

Coding Instructions: Indicate the location of the defect(s) in the pulmonary artery (PA).

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Right proximal PA	
Left proximal PA	

Supporting Definitions: (none)

K. Proximal Pulmonary Artery Stenting Procedure

Seq. #: 7720 **Name:** PA Stenting - Distal Obstruction Present

Coding Instructions: Indicate if there was a distal obstruction present in the pulmonary artery (PA).

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7725 **Name:** PA Stenting - Sidebranch Jailing

Coding Instructions: Indicate if there was sidebranch jailing in the pulmonary artery (PA).

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7730 **Name:** PA Stenting - Sidebranch Jailing Intended

Coding Instructions: Indicate if the sidebranch jailing of the pulmonary artery (PA) was intended.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7735 **Name:** PA Stenting - Sidebranch Jailing Artery

Coding Instructions: Indicate the jailed artery if the sidebranch jailing was intended.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Proximal Artery	
Lobar Artery	

Supporting Definitions: (none)

K. Proximal Pulmonary Artery Stenting Procedure

Seq. #: 7740 **Name:** PA Stenting - Sidebranch Jailing Decreased Flow

Coding Instructions: Indicate if there was decreased flow if sidebranch jailing was present.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7745 **Name:** PA Stenting - Pre-Procedure Proximal Systolic Pressure

Coding Instructions: Indicate the pre-procedure proximal systolic pressure in millimeters of mercury, if the patient does not have a single ventricle.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7750 **Name:** PA Stenting - Pre-Procedure Distal Systolic Pressure

Coding Instructions: Indicate the pre-procedure distal systolic pressure in millimeters of mercury, if the patient does not have a single ventricle.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7755 **Name:** PA Stenting - Pre-Procedure Proximal Mean Pressure

Coding Instructions: Indicate the pre-procedure proximal mean pressure in millimeters of mercury, if the patient has a single ventricle.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

K. Proximal Pulmonary Artery Stenting Procedure

Seq. #: 7760 **Name:** PA Stenting - Pre-Procedure Distal Mean Pressure

Coding Instructions: Indicate the pre-procedure distal mean pressure in millimeters of mercury, if the patient has a single ventricle.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7765 **Name:** PA Stenting - Pre-Procedure Proximal Diameter

Coding Instructions: Indicate the pre-procedure proximal diameter of the pulmonary artery (PA) defect in millimeters.

Note(s):

If ostial stenosis is present, code the diameter of the MPA segment.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7770 **Name:** PA Stenting - Pre-Procedure Distal Diameter

Coding Instructions: Indicate the pre-procedure distal diameter of the pulmonary artery (PA) defect in millimeters.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7775 **Name:** PA Stenting - Pre-Procedure PA Vessel Diameter Minimum

Coding Instructions: Indicate the pre-procedure minimum diameter of the pulmonary artery (PA) defect in millimeters.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

K. Proximal Pulmonary Artery Stenting Procedure

Seq. #: 7785 **Name:** PA Stenting - Post-Procedure Proximal Systolic Pressure

Coding Instructions: Indicate the post-procedure proximal systolic pressure in millimeters of mercury, if the patient does not have a single ventricle.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7790 **Name:** PA Stenting - Post-Procedure Distal Systolic Pressure

Coding Instructions: Indicate the post-procedure distal systolic pressure in millimeters of mercury, if the patient does not have a single ventricle.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7795 **Name:** PA Stenting - Post-Procedure Proximal Mean Pressure

Coding Instructions: Indicate the post-procedure proximal mean pressure in millimeters of mercury, if the patient has a single ventricle.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7800 **Name:** PA Stenting - Post-Procedure Distal Mean Pressure

Coding Instructions: Indicate the post-procedure distal mean pressure in millimeters of mercury, if the patient has a single ventricle.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

K. Proximal Pulmonary Artery Stenting Procedure

Seq. #: 7805 **Name:** PA Stenting - Post-Procedure Proximal Diameter

Coding Instructions: Indicate the post-procedure proximal diameter of the pulmonary artery (PA) defect in millimeters.

Note(s):

If ostial stenosis is present, code the diameter of the MPA segment.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7810 **Name:** PA Stenting - Post-Procedure Distal Diameter

Coding Instructions: Indicate the post-procedure distal diameter of the pulmonary artery (PA) defect in millimeters.

Note(s):

The pulmonary artery distal diameter should be obtained at the first branch point to a lobar artery

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7815 **Name:** PA Stenting - Post-Procedure PA Vessel Diameter in Stent Minimum

Coding Instructions: Indicate the post-procedure in stent minimum diameter of the pulmonary artery (PA) defect in millimeters.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7819 **Name:** PA Stenting - Device Counter

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

Note(s):

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

K. Proximal Pulmonary Artery Stenting Procedure

Seq. #: 7820 **Name:** PA Stenting - Device ID

Coding Instructions: Indicate the device utilized during the current pulmonary artery (PA) stenting procedure.

Note(s):

Code all devices used during the procedure.

If a device was utilized on multiple defects, specify it only once (e.g., if a balloon was used to dilate two separate defects, list it only once). Every treatment and support device utilized during the procedure should be specified.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7824 **Name:** PA Stenting - Defect Counter Association

Coding Instructions: Indicate the PA Stenting Defect Counter Number(7705) corresponding to the defect which was treated with this device.

Note(s):

Code all defects that were treated with this one device.

If a second instance of the same device was used, code the second device separately.

At least one defect must be associated to each device.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7825 **Name:** PA Stenting - Device Outcome

Coding Instructions: Indicate the outcome of the pulmonary artery (PA) stenting device.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Stent deployed in intended location	
Stent deployed in unintended location	
Stent not deployed	

Supporting Definitions: (none)

Seq. #: 10000 **Name:** EP - Primary Procedure Indication

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

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Evaluation of specific arrhythmia	
Evaluation of event or symptoms suggesting arrhythmia	
Evaluation of prior antiarrhythmic treatment	
Evaluation of risk for ventricular tachyarrhythmia	
Preoperative evaluation	

Supporting Definitions: (none)

Seq. #: 10005 **Name:** EP - History of Congenital Heart Disease

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

Target Value: The value between birth and current procedure

Selections:

Selection Text	*Definition*
No structural heart disease or trivial, unoperated congenital heart disease	
Repaired functionally two-ventricle congenital heart disease	
Repaired tetralogy of Fallot and tetralogy-like variants	
Transposition of the great arteries following atrial-level (Mustard or Senning) palliation	
Fontan palliation of functionally univentricular heart	
Pre-Fontan palliation of functionally univentricular heart	
Unoperated acyanotic congenital heart disease	
Unoperated cyanotic congenital heart disease	

Supporting Definitions: (none)

Seq. #: 10010 **Name:** EP - Previous EP Therapy Attempted

Coding Instructions: Indicate if an EP therapy was previously attempted with the patient.

Target Value: The value between birth and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

L. Electrophysiology Ablation

Seq. #: 10011 **Name:** Catheter Ablation

Coding Instructions: Indicate if a catheter ablation was previously attempted with the patient.

Target Value: The value between birth and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10012 **Name:** Pharmacologic Therapy

Coding Instructions: Indicate if pharmacologic therapy was previously attempted with the patient.

Target Value: The value between birth and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10013 **Name:** Chemical cardioversion

Coding Instructions: Indicate if a chemical cardioversion was previously attempted with the patient.

Target Value: The value between birth and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10014 **Name:** DC cardioversion

Coding Instructions: Indicate if direct current (DC) cardioversion was previously attempted with the patient.

Target Value: The value between birth and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

L. Electrophysiology Ablation

Seq. #: 10015 **Name:** Pacemaker insertion

Coding Instructions: Indicate if a pacemaker insertion was previously attempted with the patient.

Target Value: The value between birth and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10016 **Name:** ICD insertion

Coding Instructions: Indicate if an intracardiac defibrillator (ICD) insertion was previously attempted with the patient.

Target Value: The value between birth and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10017 **Name:** Arrhythmia surgery

Coding Instructions: Indicate if arrhythmia surgery was previously attempted with the patient.

Target Value: The value between birth and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10018 **Name:** EP - Number of Prior Catheter Ablation procedures

Coding Instructions: Indicate the number of prior catheterization ablation procedures that have been performed on the patient.

Target Value: The value between birth and current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10020 **Name:** Symptom Severity Survey (SSS) Q1

Coding Instructions: SSSQ1: In the past 6 months, what symptom or feeling that comes from the patient's heart rhythm problem bothers her/him most often?

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Palpitations	
Chest pain	
Shortness of breath	
Dizziness	
Fatigue	
Fainting	
No symptoms	

Supporting Definitions: (none)

Seq. #: 10021 **Name:** Symptom Severity Survey (SSS) Q2

Coding Instructions: SSSQ2: If any symptoms present, in the past 6 months how often has patient had this feeling?

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Every day	
At least once per week	
At least once per month	
At least once in the last 6 months	

Supporting Definitions: (none)

Seq. #: 10022 **Name:** Symptom Severity Survey (SSS) Q3

Coding Instructions: SSSQ3: In the past 6 months, what symptom or feeling that comes from the patient's heart rhythm problem was the worst (most severe or unpleasant)?

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Palpitations	
Chest pain	
Shortness of breath	
Dizziness	
Fatigue	
Fainting	
No symptoms	

Supporting Definitions: (none)

Seq. #: 10023 **Name:** Symptom Severity Survey (SSS) Q4

Coding Instructions: SSSQ4: In the past 6 months, for any heart rhythm episodes the patient has had, what is the most intense (severe) treatment that the patient has endured to treat the rhythm problem?

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No rhythm problems during this time	No heart rhythm problems have been experienced during this time frame.
Rhythm is always present and no effort was made to try and relieve it	The heart rhythm issue persists and there has been no effort made to relieve it.
Self-Resolving	The heart rhythm issue resolved without any treatment.
Vagal Maneuvers	The heart rhythm issue resolved with the use of vagal maneuvers performed at home or in a physician's office.
ER visit, symptoms self-resolved or with vagal maneuvers	The heart rhythm issue required a visit to the ER without being admitted where it was relieved via vagal maneuvers or self-resolved after ER arrival.
ER-Treated with medication	The heart rhythm issue required a visit to the ER without being admitted and treatment with medication after ER arrival.
Admitted for >=1 day, treated with medication	The heart rhythm issue required hospital admission for >=1 day and treatment with medication.
Hospital/ER-Cardioversion	The heart rhythm issue required treatment with cardioversion either in the ER or during a hospital admission.

Supporting Definitions: (none)

Seq. #: 10024 **Name:** Symptom Severity Survey (SSS) Q5

Coding Instructions: SSSQ5: In the past 6 months, has the patient taken any of the following medications?

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Amiodarone	
Beta Blocker	
Digoxin	
Diltiazem	
Dofetilide	
Dronedarone	
Flecainide	
Mexiletine	
Propafenone	
Sotalol	
Verapamil	
None	

Supporting Definitions: (none)

Seq. #: 10025 **Name:** Symptom Severity Survey (SSS) Q6

Coding Instructions: SSSQ6: In the past 6 months, does the patient feel that their rhythm problem has interfered with how well they are able to work, go to school or play?

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10026 **Name:** Symptom Severity Survey (SSS) Q7

Coding Instructions: SSSQ7: Indicate who completed the Symptom Severity Survey (SSS)?

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Caregiver	
Parent	
Patient	

Supporting Definitions: (none)

L. Electrophysiology Ablation

Seq. #: 10040 **Name:** EP - Tachyarrhythmias Observed during EP Study

Coding Instructions: Indicate the tachyarrhythmias observed during EP study.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Atrial Fibrillation	
Atrial Flutter - Cavotricuspid isthmus (CTI) - dependent	
Atrial Flutter - Non-Cavotricuspid isthmus (CTI) - dependent	
Atrial premature complexes	
AV node re-entry Typical - (slow/fast)	
AV node re-entry Atypical - (fast/slow)	
AV node re-entry Atypical - (slow/slow)	
AV node re-entry Atypical (unknown)	
AV re-entrant tachycardia (AVRT) - antidromic	
AV re-entry tachycardia (AVRT) - orthodromic	
Ectopic atrial tachycardia	
Inappropriate sinus tachycardia	
Isolated ventricular pre-excitation	
Junctional tachycardia	
Premature ventricular complexes (PVC)	
Ventricular fibrillation	
Ventricular tachycardia, monomorphic	
Ventricular tachycardia, monomorphic, non-sustained	
Ventricular tachycardia, polymorphic	
Ventricular tachycardia, polymorphic, non-sustained	
No tachyarrhythmias or ectopy observed	

Supporting Definitions: (none)

Seq. #: 10065 **Name:** EP - Sedation Medication

Coding Instructions: Indicate the sedation medication(s) that were used during the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Cisatracurium	
Desflurane	
Dexmedetomidine	
Fentanyl	
Isoflurane	
Ketamine	
Midazolam	
Morphine	
Nitrous oxide	
Propofol	
Remifentanil	
Rocuronium	
Sevoflurane	
Succinylcholine	
Vecuronium	

Supporting Definitions: (none)

Seq. #: 10070 **Name:** EP - Imaging System(s) Used

Coding Instructions: Indicate the imaging system used during the EP study.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
CARTO 3	
CARTO XP	
CARTO Sound	
ICE	
Ensite NavX	
Velocity NavX	
EnSite Balloon Array	
Velocity Balloon Array	
TEE	
None	

Supporting Definitions: (none)

L. Electrophysiology Ablation

Seq. #: 10075 **Name:** EP - Ablation Target Counter

Coding Instructions: The electrophysiology ablation target counter is used to distinguish individual targets when multiple targets are treated during one procedure.

Note(s):

The software-assigned target counter should start at one and be incremented by one for each target. The target counter is reset back to one for each new lab visit.

At least one target must be specified for each procedure.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10080 **Name:** EP - Indications for Ablation

Coding Instructions: Indicate the reason for the ablation.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Adverse drug effects	
Cardiomyopathy	
Frequent ICD discharges	
Impending CHD surgery	
Patient choice/desire for a drug-free lifestyle	
Refractory to drug Rx	
Stroke prophylaxis	
Sudden-death prophylaxis	

Supporting Definitions: (none)

Seq. #: 10085 **Name:** EP - Approach to Ablation Target

Coding Instructions: Indicate the approach to the target.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Antegrade approach to right heart from IVC	
Antegrade approach to right heart from SVC	
Trans-foraminal approach to left heart	
Trans-septal approach to left heart	
Retrograde approach to left heart	
Coronary sinus approach to left heart	
Percutaneous approach to the epicardial space	
Trans-hepatic approach to right heart	
Transbaffle approach	
Extracardiac conduit puncture	
Transthoracic cardiac puncture	

Supporting Definitions: (none)

L. Electrophysiology Ablation

Seq. #: 10090 **Name:** EP - Targeted Ablation Substrate

Coding Instructions: Indicate the substrate(s) that were targeted during the EP ablation.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Accessory pathway - concealed	
Accessory pathway - manifest (bidirectional WPW)	
Accessory pathway - manifest (antegrade only WPW)	
Accessory pathway - manifest (unidirectional antegrade decremental pathway - Mahaim)	
AV node	
AV node - fast pathway	
AV node - slow pathway	
His bundle	
Myocardium - atrial	
Myocardium - coronary sinus	
Myocardium - ventricular	
Sinus node	
Congenital Heart Disease Specific Target	
No target identified	

Supporting Definitions: (none)

Seq. #: 10095 **Name:** EP - Ablation Target Location ID

Coding Instructions: Indicate the location ID of the target.

Note(s):

Use the Electrophysiology Targets diagram provided by the NCDR.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Tricuspid annulus - Right anterior	AVRT
Tricuspid annulus - Right lateral	AVRT
Tricuspid annulus - Right posterior	AVRT

Tricuspid annulus - Right posterioseptal	AVRT
Tricuspid annulus - Right intermediate septal	AVRT
Tricuspid annulus - Anteroseptal (paraHisian)	AVRT
Mitral annulus - Left intermediate	AVRT
Mitral annulus - Left posterioseptal	AVRT
Mitral annulus - Left posterior	AVRT
Mitral annulus - Left lateral	AVRT
Mitral annulus - Left anterolateral	AVRT
Coronary sinus - Proximal	AVRT
Coronary sinus - Mid	AVRT
Coronary sinus - Distal	AVRT
Great cardiac vein	AVRT
Right atrium - Triangle of Koch - Posterior	AVNRT
Right atrium - Triangle of Koch - Mid	AVNRT
Right atrium - Triangle of Koch - Anterior	AVNRT
Right atrium - Triangle of Koch - Fast Pathway	AVNRT
Right atrium - Triangle of Koch - His Bundle	AVNRT
Left atrium - Lateral free wall	AET
Left atrium - Left atrial appendage	AET
Left atrium - Left side of interatrial septum	AET
Left atrium - LIPV	AET
Left atrium - LSPV	AET
Left atrium - Posterior free wall	AET
Left atrium - RIPV	AET
Left atrium - RSPV	AET
Left atrium roof isthmus	AET
Right atrium - Crista terminalis	AET
Right atrium - Lateral free wall	AET

Right atrium - Posterior free wall	AET
Right atrium - Right atrial appendage	AET
Right atrium - Right side of interatrial septum	AET
Right atrium - Superior vena cava	AET
Right ventricle - Anterior free wall	VT
Right ventricle - Anterior septum	VT
Right ventricle - Mid-free wall	VT
Right ventricle - Mid-septum	VT
Right ventricle - Posterior free wall	VT
Right ventricle - Posterior septum	VT
Right ventricle - RVOT	VT
Right ventricle - TOF-isthmus between RVOT patch and pulmonary valve	VT
Right ventricle - TOF-isthmus between RVOT patch and tricuspid valve	VT
Right ventricle - TOF-isthmus between VSD patch and pulmonary valve	VT
Right ventricle - TOF-isthmus between VSD patch and tricuspid valve	VT
Left ventricle - Anterior fascicle	VT
Left ventricle - Area of aorto-mitral continuity	VT
Left ventricle - Left coronary cusp	VT
Left ventricle - Posterior fascicle	VT
Left ventricle - Right coronary cusp	VT
Aorta - Non-coronary cusp	VT
Cavotricuspid Isthmus	CTI

Supporting Definitions: (none)

L. Electrophysiology Ablation

Seq. #: 10100 **Name:** EP - Methods to localize target

Coding Instructions: Indicate the methods used to localize the target.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Activation mapping	
Anatomic mapping	
Entrainment mapping	
Signal morphology mapping	
Pace mapping	
Voltage (substrate) mapping	

Supporting Definitions: (none)

Seq. #: 10105 **Name:** EP - Ablation Attempted

Coding Instructions: Indicate if an ablation was attempted.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 10106 **Name:** EP - Reason not attempted

Coding Instructions: Indicate the reason an ablation was not attempted during the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Not clinically indicated	
Proximity to AV node	
Proximity to sinus node	
Insufficient target for mapping and ablation	
Patient/Family choice	

Supporting Definitions: (none)

Seq. #: 10110 **Name:** EP - Outcome of Ablation

Coding Instructions: Indicate the ablation outcome of the targeted substrate.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Elimination of antegrade conduction (Elimination of retrograde conduction)	
Elimination of antegrade conduction (Persistence of retrograde conduction, with SVT)	
Elimination of antegrade conduction (Persistence of retrograde conduction, w/o SVT)	
Persistence of antegrade conduction (Elimination of retrograde conduction, with SVT)	
Persistence of antegrade conduction (Elimination of retrograde conduction, w/o SVT)	
Persistence of antegrade conduction (Persistence of retrograde conduction, with SVT)	
Persistence of antegrade conduction (Persistence of retrograde conduction, w/o SVT)	
Elimination of antegrade AP conduction	
Persistence of antegrade conduction, with SVT	
Persistence of antegrade conduction, without SVT	
Attenuation of AV conduction	
Elimination of AV conduction	
Elimination of ectopic focus/tachycardia (Attenuation of AV conduction)	
Elimination of ectopic focus/tachycardia (Elimination of AV conduction)	

Elimination of ectopic focus/tachycardia (No change in AV conduction)

Persistence of ectopic focus/tachycardia (Attenuation of AV conduction)

Persistence of ectopic focus/tachycardia (Elimination of AV conduction)

Elimination of fast pathway conduction (Attenuation of AV conduction)

Elimination of fast pathway conduction (Elimination of AV conduction)

Elimination of fast pathway conduction (No change in AV conduction)

Persistence of fast pathway conduction (Attenuation of AV conduction)

Persistence of fast pathway conduction (Elimination of AV conduction)

Persistence of fast pathway conduction (No change in AV conduction)

Elimination of retrograde AP conduction

Persistence of retrograde conduction, with SVT

Persistence of retrograde conduction, without SVT

Elimination of slow pathway conduction

Persistence of slow pathway conduction (Persistence of spontaneous or inducible SVT)

Persistence of slow pathway conduction (with single echoes but no SVT)

Persistence of slow pathway conduction (without echoes)

Elimination of spontaneous/inducible VT	
Persistence of spontaneous/inducible VT (with non-sustained VT)	
Persistence of spontaneous/inducible VT (with sustained VT)	
Persistent inappropriate sinus tachycardia	
Normalization of sinus node function	
Sinus bradycardia or arrest	
Substrate attenuated	
Substrate eliminated	
Ablation ineffective	
Unknown or Ambiguous	Target absent or severely attenuated prior to ablation.

Supporting Definitions: (none)

Seq. #: 10115 **Name:** EP - Device Counter

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

Note(s):

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10120 **Name:** EP - Ablation Catheter(s) Device ID

Coding Instructions: Indicate all ablation catheters utilized during the current EP procedure.

Note(s):

Code all devices used during the procedure.

If a device was utilized on multiple defects, specify it only once (e.g., if a balloon was used to dilate two separate defects, list it only once). Every treatment and support device utilized during the procedure should be specified.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

L. Electrophysiology Ablation

Seq. #: 10125 **Name:** EP - Associated Ablation Target(s)

Coding Instructions: Indicate the EP Ablation Target Counter (10075) corresponding to the target which was ablated with this device.

Note(s):

Code all targets that were treated with this one device.

If a second instance of the same device was used, code the second device separately.

At least one target must be associated to each device.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10130 **Name:** EP - Seconds on Ablation Target

Coding Instructions: Indicate the total time, in seconds, that the target was ablated.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10135 **Name:** EP - Number of Ablation Activations

Coding Instructions: Indicate the number of activations used on each target.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

M. Transcatheter Pulmonary Valve Replacement (TPVR)

Seq. #: 11000 **Name:** TPVR - Clinical Indication

Coding Instructions: Indicate the primary clinical reason for the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Symptomatic	
Prevention of symptoms in asymptomatic patient	
Declining ventricular function	
Worsening arrhythmias	
Other	

Supporting Definitions: (none)

Seq. #: 11005 **Name:** TPVR - Hemodynamic Indication

Coding Instructions: Indicate the primary hemodynamic reason for the procedure.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Predominant valve/conduit Obstruction	
Predominant valve/conduit Regurgitation	
Mixed obstruction /regurgitation	

Supporting Definitions: (none)

Seq. #: 11010 **Name:** TPVR - Underlying anatomic reason for RVOT dysfunction

Coding Instructions: Indicate the underlying anatomic ready for the Right Ventricular Outflow Tract (RVOT) dysfunction.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Congenital Heart Disease repaired using RVOT valve/conduit	
s/p Ross Procedure with repair using RVOT valve/conduit	
No Congenital Heart Disease with RVOT valve/conduit	
Native RVOT dysfunction secondary to surgical intervention	
Native RVOT dysfunction secondary to transcatheter intervention	Other than preparation for transcatheter valve.
Native RVOT dysfunction with no prior interventions	

Supporting Definitions: (none)

Seq. #: 11015 **Name:** TPVR - Echocardiogram

Coding Instructions: Indicate if an echocardiogram was performed prior to the procedure.

Target Value: The value between birth and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 11016 **Name:** TPVR - Mean gradient across valve/conduit

Coding Instructions: Indicate the mean gradient across the valve/conduit prior to the procedure by echocardiogram.

Target Value: The value between birth and current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11017 **Name:** TPVR - Maximum gradient across valve/conduit

Coding Instructions: Indicate the maximum gradient across the valve/conduit observed by echocardiogram prior to the procedure.

Target Value: The value between birth and current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11018 **Name:** TPVR - Pulmonary Valve Regurgitation

Coding Instructions: Indicate the amount of pulmonary regurgitation observed by echocardiogram prior to the procedure.

Target Value: The value between birth and current procedure

Selections:

Selection Text	*Definition*
None	
1+ (mild)	
2+ (moderate)	
3+ (moderately severe)	
4+ (severe)	

Supporting Definitions: (none)

Seq. #: 11019 **Name:** TPVR - Echo LVEF

Coding Instructions: Indicate the LVEF obtained by echocardiogram prior to the procedure.

Note(s):

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

If only a descriptive value is reported (e.g. 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 value between birth and current procedure

Selections: (none)

Supporting Definitions: (none)

M. Transcatheter Pulmonary Valve Replacement (TPVR)

Seq. #: 11020 **Name:** TPVR - Tricuspid Regurgitation Severity

Coding Instructions: Indicate the tricuspid regurgitation severity observed by echocardiogram prior to the procedure.

Target Value: The value between birth and current procedure

Selections:

Selection Text	*Definition*
None	
1+ (mild)	
2+ (moderate)	
3+ (moderately severe)	
4+ (severe)	

Supporting Definitions: (none)

Seq. #: 11030 **Name:** TPVR - MRI

Coding Instructions: Indicate if an MRI was performed.

Target Value: The value between birth and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 11031 **Name:** TPVR - MRI RVEF

Coding Instructions: Indicate the right ventricular ejection fraction (RVEF) obtained by MRI.

Target Value: The value between birth and current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11032 **Name:** TPVR - MRI LVEF

Coding Instructions: Indicate the left ventricular ejection fraction (LVEF) obtained by MRI.

Note(s):

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

If only a descriptive value is reported (e.g. 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 value between birth and current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11033 **Name:** TPVR - MRI RVEDV Index

Coding Instructions: Indicate the Right ventricular end diastolic volume

(RVEDV) index obtained by MRI in millimeters per meters squared.

Target Value: The value between birth and current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11034 **Name:** TPVR - MRI RVESV Index

Coding Instructions: Indicate the right ventricular end systolic volume (RVESV) index obtained by MRI in millimeters per meters squared.

Target Value: The value between birth and current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11035 **Name:** TPVR - MRI LVEDV Index

Coding Instructions: Indicate the left ventricular end diastolic volume (LVEDV) index obtained by MRI in millimeters per meters squared.

Target Value: The value between birth and current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11036 **Name:** TPVR - MRI LVESV Index

Coding Instructions: Indicate the left ventricular end systolic volume (LVESV) index obtained by MRI in millimeters per meters squared.

Target Value: The value between birth and current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11037 **Name:** TPVR - MRI PR Fraction

Coding Instructions: Indicate the pulmonary regurgitant fraction obtained by MRI prior to the procedure.

Target Value: The value between birth and procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11040 **Name:** TPVR - Type of RVOT valve/conduit

Coding Instructions: Indicate the type of RVOT valve or conduit.

Note(s):

When a composite conduit is utilized, identify the portion positioned in the valve.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Homograft (aortic)	
Homograft (pulmonary)	
Homograft (unknown)	
Contegra	
Bioprosthetic valve or valved conduit	
Non-valved synthetic tube	
Native/patched RVOT	

Supporting Definitions: (none)

Seq. #: 11041 **Name:** TPVR - Surgically implanted valve/conduit size

Coding Instructions: Indicate the size in millimeters of the implanted valve or conduit.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11045 **Name:** TPVR - Existing stent within valve/conduit

Coding Instructions: Indicate if there is an existing stent within the valve or conduit.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 11050 **Name:** TPVR - Prior TPVR (Valve in Valve)

Coding Instructions: Indicate if there is a prior TPVR in place (valve in valve).

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 11055 **Name:** TPVR - Cath Peak gradient across valve/conduit

Coding Instructions: Indicate the peak gradient across the valve or conduit obtained during the procedure.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11060 **Name:** TPVR - Narrowest angiographic valve/conduit diameter

Coding Instructions: Indicate the narrowest angiographic conduit or valve diameter in millimeters.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11065 **Name:** TPVR - Aortography performed

Coding Instructions: Indicate if an aortography was performed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 11070 **Name:** TPVR - Selective coronary angiography performed

Coding Instructions: Indicate if selective coronary angiography was performed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 11075 **Name:** TPVR - Coronary compression testing performed

Coding Instructions: Indicate if coronary compression testing was performed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 11076 **Name:** TPVR - Maximum Balloon size

Coding Instructions: Indicate the maximum balloon size used during the procedure.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11077 **Name:** TPVR - Coronary compression present

Coding Instructions: Indicate if there is coronary compression present prior to valve insertion.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	
Uncertain	

Supporting Definitions: (none)

Seq. #: 11080 **Name:** TPVR - Pre-dilation performed

Coding Instructions: Indicate if pre-dilation by angioplasty was performed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 11081 **Name:** TPVR - First Balloon size

Coding Instructions: Indicate the size of the first balloon used for the pre-dilation.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

M. Transcatheter Pulmonary Valve Replacement (TPVR)

Seq. #: 11082 **Name:** TPVR - Maximum Balloon size

Coding Instructions: Indicate the maximum angioplasty or stent dilation balloon size used.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11083 **Name:** TPVR - Highest pressure inflation performed

Coding Instructions: Indicate the highest pressure inflation performed during the procedure.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11085 **Name:** TPVR - New Pre-Stent implanted

Coding Instructions: Indicate if any new stents were implanted prior to Transcatheter Pulmonary Valve (TPV) placement.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 11086 **Name:** TPVR - New Stents Number

Coding Instructions: Indicate the number of new stents implanted.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

M. Transcatheter Pulmonary Valve Replacement (TPVR)

Seq. #: 11090 **Name:** TPVR - Access vessel for valve delivery

Coding Instructions: Indicate the vessel used to deliver the Transcatheter Pulmonary Valve (TPV).

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Femoral Vein	
Jugular Vein	
Subclavian Vein	
Per Ventricular	
Other	

Supporting Definitions: (none)

Seq. #: 11095 **Name:** TPVR - Delivery Balloon size

Coding Instructions: Indicate the size of the balloon used for the Transcatheter Pulmonary Valve (TPV) delivery.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11100 **Name:** TPVR - TPV deployed

Coding Instructions: Indicate if a Transcatheter Pulmonary Valve (TPV) was deployed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 11101 **Name:** TPVR - Post-dilation of TPV

Coding Instructions: Indicate if post dilation of the Transcatheter Pulmonary Valve (TPV) was performed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 11102 **Name:** TPVR - Final Balloon size

Coding Instructions: Indicate the final balloon size used for the TPVR replacement in millimeters.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11103 **Name:** TPVR - Final Pressure

Coding Instructions: Indicate the final balloon pressure used for the TPVR replacement in atms.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11105 **Name:** TPVR - Post Procedure Peak RVOT gradient

Coding Instructions: Indicate the post procedure peak Right Ventricle Outflow Tract (RVOT) gradient.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11110 **Name:** TPVR - Post-Procedure Pulmonary Valve Regurgitation

Coding Instructions: Indicate the post-procedure pulmonary valve regurgitation.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
None	
1+ (mild)	
2+ (moderate)	
3+ (moderately severe)	
4+ (severe)	

Supporting Definitions: (none)

Seq. #: 11115 **Name:** TPVR - Final minimal diameter of valve

Coding Instructions: Indicate the final minimal diameter of the valve in millimeters.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11120 **Name:** TPVR - Reason TPV not deployed

Coding Instructions: Indicate the reason the Transcatheter Pulmonary Valve (TPV) was not deployed.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Not indicated based on invasive hemodynamics	
Other treatment performed instead with adequate result	
Coronary artery compression risk	
Valve could not be advanced to implant location	
Complication before deployment	
Pre-stent implanted, planned TPVR at a later date	
Patient unstable	
No treatable landing zone	
Other	

Supporting Definitions: (none)

Seq. #: 11125 **Name:** TPVR - Device Counter

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

Note(s):

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

M. Transcatheter Pulmonary Valve Replacement (TPVR)

Seq. #: 11130 **Name:** TPVR - Device ID

Coding Instructions: Indicate the device utilized during the current Transcatheter Pulmonary Valve Replacement (TPVR) procedure.

Note(s):

Code all devices used during the procedure.

If a device was utilized on multiple defects, specify it only once (e.g., if a balloon was used to dilate two separate defects, list it only once). Every treatment and support device utilized during the procedure should be specified.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11135 **Name:** TPVR - Device Outcome

Coding Instructions: Indicate the outcome of the transcatheter pulmonary valve device.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
Implanted in intended location	
Implanted in unintended location	
Implanted, released and retrieved	
Implanted, not released	

Supporting Definitions: (none)

Seq. #: 11140 **Name:** TPVR - Echocardiogram

Coding Instructions: Indicate if an echocardiogram was performed post Transcatheter Pulmonary Valve (TPV) placement.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 11145 **Name:** TPVR - Mean gradient across valve/conduit

Coding Instructions: Indicate the mean gradient across the valve or conduit post-procedure.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11150 **Name:** TPVR - Maximum gradient across valve/conduit

Coding Instructions: Indicate the maximum valve gradient post-procedure.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11155 **Name:** TPVR - Post-Procedure Pulmonary Valve Regurgitation

Coding Instructions: Indicate the post-procedure pulmonary regurgitation.

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

Selections:

Selection Text	*Definition*
None	
1+ (mild)	
2+ (moderate)	
3+ (moderately severe)	
4+ (severe)	

Supporting Definitions: (none)

N. Intra and Post-Procedure Events

Seq. #: 8000 **Name:** Cardiac Arrest

Coding Instructions: Indicate if there was a cardiac arrest event that required CPR.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Cardiac Arrest:**

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

Source: ACC/AHA/HRS 2006 Key Data Elements and Definitions for Electrophysiological Studies and Procedures

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Seq. #: 8005 **Name:** Arrhythmia

Coding Instructions: Indicate if the patient had an arrhythmia requiring treatment.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8006 **Name:** AV Block

Coding Instructions: Indicate if the patient experienced unintentional mechanical or ablative elimination of signal transduction through the atrioventricular junction.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8007 **Name:** Arrhythmia Spontaneously Resolved

Coding Instructions: Indicate if the patient had an arrhythmia that resolved on its own.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8010 **Name:** Arrhythmia Requiring Antiarrhythmic Medication

Coding Instructions: Indicate if the patient had an arrhythmia requiring an antiarrhythmic medication.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8015 **Name:** Arrhythmia Requiring Cardioversion

Coding Instructions: Indicate if the patient had an arrhythmia requiring cardioversion.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8020 **Name:** Arrhythmia Requiring Temporary Pacemaker

Coding Instructions: Indicate if the patient had an arrhythmia requiring temporary pacing.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8025 **Name:** Arrhythmia Requiring Permanent Pacemaker

Coding Instructions: Indicate if the patient had an arrhythmia requiring permanent pacing.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8030 **Name:** New Heart Valve Regurgitation

Coding Instructions: Indicate if the patient had new heart valve regurgitation.

Code "Yes" if the patient has a new >=3+ regurgitation post procedure.

Note(s):

Includes new significant trisuspid regurgitation after a procedure distal to the tricuspid valve due to a wire or sheath or new MR after an antegrade aortic procedure. Aortic insuffiency or pulmonary insuffiency after aortic or pulmonary valvuloplasty is not included.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8035 **Name:** Tamponade

Coding Instructions: Indicate if the patient experienced fluid in the pericardial space compromising cardiac filling and requiring intervention.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Tamponade:

Tamponade should be documented by either:
1. Echocardiogram showing pericardial fluid and signs of tamponade such as right heart compromise, or
2. Systemic hypotension due to pericardial fluid comprimising cardiac function.

Source: NCDR

Seq. #: 8040 **Name:** Air Embolus

Coding Instructions: Indicate if the patient had an air embolus.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Air Embolus:**

Air introduced into the circulation through a catheter or sheath resulting in a change in clinical condition such as decreased cardiac function from coronary ischemia or permanent damage such as stroke due to a brain embolus.

Source: NCDR

Seq. #: 8045 **Name:** Embolic Stroke

Coding Instructions: Indicate if the patient had an embolic stroke within 72 hours of the procedure.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Stroke:**

A stroke or CVA with loss of neurological function caused by an ischemic or hemorrhagic event with residual symptoms at least 24 hours after onset or leading to death

Source: ACC-AHA Clinical Data Standards

Seq. #: 8050 **Name:** Device Malposition or Thrombus

Coding Instructions: Indicate if the patient had a device malposition or thrombus.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8051 **Name:** Device Malposition or Thrombus Retrieved via Catheterization

Coding Instructions: Indicate if the patient had a device malposition or thrombus where the device had to be retrieved via catheterization.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8052 **Name:** Device Malposition or Thrombus Retrieved via Surgery

Coding Instructions: Indicate if the patient had a device malposition or thrombus where the device had to be retrieved via surgery.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8055 **Name:** Device Embolization (Requiring device retrieval)

Coding Instructions: Indicate if the patient had a device embolization requiring device retrieval.

Note(s):

Code “Yes” for any device that is retrieved including occluders, stents, or coils.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8060 **Name:** Device Embolization Retrieved via Catheterization

Coding Instructions: Indicate if the patient had a device embolization where the device had to be retrieved via catheterization.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8065 **Name:** Device Embolization Retrieved via Surgery

Coding Instructions: Indicate if the patient had a device embolization where the device had to be retrieved via surgery.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8070 **Name:** New Requirement for Dialysis

Coding Instructions: Indicate if the patient experienced acute or worsening renal failure necessitating renal dialysis.

Note(s):

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

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8071 **Name:** Coronary Artery Compression

Coding Instructions: Indicate if the patient incurred coronary compression due to treatment.

Note(s):

A coronary artery compression occuring during testing would not qualify and 'No' would be coded.

Target Value: Any occurrence between start of current procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8072 **Name:** Erosion

Coding Instructions: Indicate if the patient experienced a device erosion.

Target Value: Any occurrence between start of current procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8073 **Name:** Esophageal Fistula

Coding Instructions: Indicate if the patient had an esophageal fistula.

Target Value: Any occurrence between start of current procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8074 **Name:** Left Bundle Branch Block (LBBB)

Coding Instructions: Indicate if the patient had a new left bundle branch block.

Target Value: Any occurrence between start of current procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8075 **Name:** Airway Event Requiring Escalation of Care

Coding Instructions: Indicate if the patient had an airway event requiring escalation of care.

Note(s):

An airway event can include episodes of apnea, hypoxia, or obstruction requiring intubation.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8076 **Name:** Right Bundle Branch Block (RBBB)

Coding Instructions: Indicate if the patient had a new right bundle branch block.

Target Value: The value between start of current procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8080 **Name:** Event Requiring ECMO

Coding Instructions: Indicate if the patient had an event requiring extracorporeal membrane oxygenation (ECMO).

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8085 **Name:** Event Requiring LVAD

Coding Instructions: Indicate if the patient had an event requiring a left ventricular assist device (LVAD).

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8090 **Name:** Bleeding Event

Coding Instructions: Indicate if the patient experienced a suspected or confirmed bleeding event observed and documented in the medical record that was associated with any of the following:

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

Note(s):

A patient who was actively bleeding with coffee ground emesis preprocedure would not qualify as bleeding. However, a patient with peptic ulcer disease with no noted or active bleeding prior to procedure who starts bleeding after the procedure would qualify as a "Yes".

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8095 **Name:** Bleeding Event at Access Site

Coding Instructions: Indicate if the patient experienced significant external bleeding that occurred at the access or percutaneous entry site. To qualify, it must be associated with any of the following:

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

Note(s):

Acute anemia with fall in Hgb >3 g/dL without other obvious source (e.g., GI, GU, operative, or hemolysis) that is attributable to intraprocedural blood loss (e.g., during equipment exchanges) would be considered bleeding at the acess site, even if no hematoma is palpable or documented on imaging studies.

Prolonged pressure does not qualify as an intervention.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8100 **Name:** Hematoma at Access Site

Coding Instructions: Indicate if the patient experienced a hematoma at the percutaneous entry site. To qualify, it must be associated with any of the following:

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

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8110 **Name:** Retroperitoneal Bleeding

Coding Instructions: Indicate if the patient experienced retroperitoneal bleeding. To qualify, it must be associated with any of the following:

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

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8115 **Name:** Gastrointestinal Bleeding

Coding Instructions: Indicate whether the patient experienced gastrointestinal bleeding. To qualify, it must be associated with any of the following:

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

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8120 **Name:** Genitourinary Bleeding

Coding Instructions: Indicate whether genital or urinary bleeding occurred. To qualify, it must be associated with any of the following:

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

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8125 **Name:** Other Bleeding

Coding Instructions: Indicate if other bleeding occurred. Other bleeding includes bleeding from a site not specified, such as pulmonary bleeding. To qualify, it must be associated with any of the following:

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

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8130 **Name:** RBC Transfusion

Coding Instructions: Indicate if there was a transfusion(s) of either whole blood or packed red blood cells.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8131 **Name:** Drop in Hgb

Coding Instructions: Indicate if the patient had a drop in hemoglobin of greater than or equal to 3 g/dL

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8132 **Name:** Anemia prior to Cath Procedure

Coding Instructions: Indicate if the patient had anemia prior to the catheterization procedure.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8133 **Name:** Post-operative Blood Loss

Coding Instructions: Indicate if the patient had post-operative blood loss.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8134 **Name:** ECMO Blood Replacement

Coding Instructions: Indicate if the blood transfusion was given due patient being on ECMO therapy.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8140 **Name:** Other Vascular Complications Requiring Treatment

Coding Instructions: Indicate if the patient experienced any other vascular complications (excluding external bleeding or hematomas) at the percutaneous entry site that required treatment or intervention.

Note(s):

Code "Yes" for patients treated with IV therapy for loss of distal pulse.

Code “Yes” for vascular complications that resulted from any intervention performed during this cath lab visit, including insertion of assist devices.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Vascular Complications Requiring Intervention:**

Vascular complications can include, but are not limited to, access site occlusions, peripheral embolizations, dissections, pseudoaneurysms and/or AV fistulas. Any noted vascular complication must have had an intervention such as a fibrin injection, angioplasty, or surgical repair to qualify. Prolonged pressure does not qualify as an intervention, but ultrasonic guided compression after making a diagnosis of pseudoaneurysm does qualify. A retroperitoneal bleed or hematoma requiring transfusion is not a vascular complication under this data element.

Source: NCDR

Seq. #: 8145 **Name:** Other Events

Coding Instructions: Indicate if the patient had any other intra or post procedure event requiring treatment not otherwise specified.

Note(s):

Select from the Events list supplied, all applicable intra- or post-procedure events which required treatment.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8150 **Name:** Other Events ID

Coding Instructions: Indicate other intra- or post-procedure events.

Note(s):

Select all applicable procedures from the Other Events list supplied which were performed during the most recent prior cardiac cath.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8155 **Name:** Planned Cardiac Surgery

Coding Instructions: Indicate if the patient had planned cardiac surgery.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8160 **Name:** Unplanned Cardiac Surgery

Coding Instructions: Indicate if the patient had unplanned cardiac surgery due to a catheterization complication.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8165 **Name:** Unplanned Vascular Surgery

Coding Instructions: Indicate if the patient had an unplanned vascular surgery due to a catheterization complication.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8170 **Name:** Unplanned Other Surgery

Coding Instructions: Indicate if the patient had an unplanned other (non-cardiac / non-vascular) surgery.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8175 **Name:** Other Surgery Due to Cath Complication

Coding Instructions: Indicate if the unplanned other surgery was due to a catherization complication.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8180 **Name:** Subsequent Cardiac Cath

Coding Instructions: Indicate if the patient had a subsequent catheterization due to a catheterization complication during the first procedure.

Target Value: Any occurrence between start of procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8200 **Name:** Peripheral Nerve Injury

Coding Instructions: Indicate if the patient had a peripheral nerve injury.

Target Value: Any occurrence between start of current procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8205 **Name:** Phrenic Nerve Paralysis

Coding Instructions: Indicate if the patient had a phrenic nerve paralysis.

Target Value: Any occurrence between start of current procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8210 **Name:** Pneumothorax

Coding Instructions: Indicate if the patient had a pneumothorax.

Target Value: Any occurrence between start of current procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8215 **Name:** Pulmonary Embolism

Coding Instructions: Indicate if the patient had a pulmonary embolism.

Target Value: Any occurrence between start of current procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8220 **Name:** Pulmonary Vein Stenosis

Coding Instructions: Indicate if the patient incurred a new pulmonary vein stenosis.

Target Value: Any occurrence between start of current procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8225 **Name:** Radiation Burn to Skin

Coding Instructions: Indicate if the patient had a radiation burn to skin.

Target Value: Any occurrence between start of current procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8230 **Name:** Deep Vein Thrombosis

Coding Instructions: Indicate if the patient had a deep vein thrombosis.

Target Value: Any occurrence between start of current procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8235 **Name:** Conduit Tear

Coding Instructions: Indicate if the patient had a conduit tear.

Target Value: Any occurrence between start of current procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8236 **Name:** Conduit Tear Location

Coding Instructions: Indicate the location of the conduit tear.

Target Value: Any occurrence between start of current procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
Confined or therapeutic tear without hemodynamic change	
Rupture into pericardial or pleural space	
Rupture into bronchus, cardiac chamber, aorta, or other vessel	

Supporting Definitions: (none)

Seq. #: 8237 **Name:** Conduit Tear Treatment

Coding Instructions: Indicate all treatment used for the conduit tear.

Target Value: Any occurrence between start of current procedure and 72 hours post procedure or next procedure/surgery or discharge

Selections:

Selection Text	*Definition*
No specific treatment	
Pericardial or pleural drain	
Covered with TPV	
Other catheter device (covered stent, occluder, coils)	
Surgery	

Supporting Definitions: (none)

O. Discharge

Seq. #: 8305 **Name:** Cardiac Surgery during this admission

Coding Instructions: Indicate if the patient has cardiac surgery during this episode of care.

Target Value: The value on discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8310 **Name:** Cardiac Surgery Date(s)

Coding Instructions: Indicate the date(s) of the cardiac surgery(ies) during this episode of care.

Target Value: The value on discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8315 **Name:** Cardiac Surgery Time(s)

Coding Instructions: Indicate the time(s) of the cardiac surgery(ies) during this episode of care.

Target Value: The value on discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 9000 **Name:** Discharge Date

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

Target Value: The value on discharge

Selections: (none)

Supporting Definitions: (none)

O. Discharge

Seq. #: 9005 **Name:** Discharge Status

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

Target Value: The value on discharge

Selections:

Selection Text	*Definition*
Alive	
Deceased	

Supporting Definitions: (none)

Seq. #: 9010 **Name:** Death in Lab

Coding Instructions: If the patient expired during this hospitalization, indicate if the patient expired while in the cath lab.

Target Value: The value on discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 9015 **Name:** Primary Cause of Death

Coding Instructions: Select the PRIMARY cause of death, i.e. the first significant abnormal event which ultimately led to death.

Target Value: The value on discharge

Selections:

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

Supporting Definitions: (none)

P. Follow-up

Seq. #: 12000 **Name:** Follow-up Assessment Date

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

Note(s):

Collect follow-up from one day to a year post discharge.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12001 **Name:** Reference Procedure Start Date

Coding Instructions: Indicate the procedure start date for which this follow-up is associated.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12002 **Name:** Reference Procedure Start Time

Coding Instructions: Indicate the procedure start time for which this follow-up is associated.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12005 **Name:** Follow-up Status Method - Office Visit

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

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

P. Follow-up

Seq. #: 12006 **Name:** Follow-up Status Method - Medical Records

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

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12007 **Name:** Follow-up Status Method - Letter from Medical Provider

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

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12008 **Name:** Follow-up Status Method - Phone call

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

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12009 **Name:** Follow-up Status Method - Social Security Death Master File

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

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

P. Follow-up

Seq. #: 12010 **Name:** Follow-up Status Method - Hospitalized

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

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12011 **Name:** Follow-up Status Method - Other

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

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12015 **Name:** Follow-up Status

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

Target Value: The value on follow-up

Selections:

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

Supporting Definitions: (none)

Seq. #: 12020 **Name:** Follow-up Date of Death

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

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12025 **Name:** Follow-Up Cause of Death

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

Target Value: The value on follow-up

Selections:

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

P. Follow-up

Supporting Definitions: (none)

Seq. #: 12030 **Name:** Follow-up Readmitted

Coding Instructions: Indicate if the patient was readmitted to an acute care facility during the follow-up period.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12031 **Name:** Follow-up Readmission Length of Stay

Coding Instructions: Indicate the length of stay (LOS) in days, during the follow-up period. If the patient had more than one readmission, code the LOS of the most recent readmission. If the length of stay is less than one day, round up to 1 day.

Note(s):

If LOS is longer than 999, code as 999.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12032 **Name:** Follow-up Readmission Date

Coding Instructions: Indicate the date of readmission during the follow-up period. If the patient had more than one readmission, code the date of the most recent readmission.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12033 **Name:** Follow-up Hospitalized

Coding Instructions: Indicate that the length of stay cannot be calculated because the patient was currently hospitalized during the readmission period.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

P. Follow-up

Seq. #: 12040 **Name:** Follow-up ASD Erosion

Coding Instructions: Indicate if there was erosion of the device.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12045 **Name:** Follow-up ASD Device Embolization

Coding Instructions: Indicate if there was embolization of the device requiring device retrieval.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12046 **Name:** Follow-up ASD Retrieved via Catheterization

Coding Instructions: Indicate if the device embolized, was the device retrieved via catheterization.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12047 **Name:** Follow-up ASD Retrieved via Surgery

Coding Instructions: Indicate if the device embolized, was the device retrieved via surgery.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

P. Follow-up

Seq. #: 12050 **Name:** Follow-up ASD Endocarditis

Coding Instructions: Indicate if the patient experienced endocarditis post ASD procedure.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12051 **Name:** Follow-up ASD Date of Endocarditis Diagnosis

Coding Instructions: Indicate the date that endocarditis was diagnosed.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12052 **Name:** Follow-up ASD Predisposing Factors for Endocarditis

Coding Instructions: Indicate the predisposing factor for endocarditis.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Recent dental work or poor dentition	
History of Endocarditis	
Other implanted foreign bodies	
Other surface injuries/infections	
IV Drug use	

Supporting Definitions: (none)

P. Follow-up

Seq. #: 12053 **Name:** Follow-up ASD Treatment

Coding Instructions: Indicate the treatment for the endocarditis.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Antibiotics	
Surgical Explant	
Transcatheter reintervention	
Other	

Supporting Definitions: (none)

Seq. #: 12055 **Name:** Follow-up ASD Residual Shunt Size

Coding Instructions: Indicate the ASD residual shunt size.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
None to trivial (<3 mm)	
Significant (>=3 mm)	

Supporting Definitions: (none)

Seq. #: 12060 **Name:** Follow-up Symptom Severity Survey (SSS) Q1

Coding Instructions: SSSQ1: In the past 6 months, what symptom or feeling that comes from the patient's heart rhythm problem bothers her/him most often?

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Palpitations	
Chest pain	
Shortness of breath	
Dizziness	
Fatigue	
Fainting	
No symptoms	

Supporting Definitions: (none)

P. Follow-up

Seq. #: 12061 **Name:** Follow-up Symptom Severity Survey (SSS) Q2

Coding Instructions: SSSQ2: If any symptoms present, in the past 6 months how often has patient had this feeling?

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Every day	
At least once per week	
At least once per month	
At least once in the last 6 months	

Supporting Definitions: (none)

Seq. #: 12062 **Name:** Follow-up Symptom Severity Survey (SSS) Q3

Coding Instructions: SSSQ3: In the past 6 months, what symptom or feeling that comes from the patient's heart rhythm problem was the worst (most severe or unpleasant)?

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Palpitations	
Chest pain	
Shortness of breath	
Dizziness	
Fatigue	
Fainting	
No symptoms	

Supporting Definitions: (none)

Seq. #: 12063 **Name:** Follow-up Symptom Severity Survey (SSS) Q4

Coding Instructions: SSSQ4: In the past 6 months, for any heart rhythm episodes the patient has had , what is the most intense (severe) treatment that the patient has endured to treat the rhythm problem?

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No rhythm problems during this time	No heart rhythm problems have been experienced during this time frame.
Rhythm is always present and no effort was made to try and relieve it	The heart rhythm issue persists and there has been no effort made to relieve it.
Self-Resolving	The heart rhythm issue resolved without any treatment.
Vagal Maneuvers	The heart rhythm issue resolved with the use of vagal maneuvers performed at home or in a physician's office.
ER visit, symptoms self-resolved or with vagal maneuvers	The heart rhythm issue required a visit to the ER without being admitted where it was relieved via vagal maneuvers or self-resolved after ER arrival.
ER-Treated with medication	The heart rhythm issue required a visit to the ER without being admitted and treatment with medication after ER arrival.
Admitted for >= 1 day, treated with medication	The heart rhythm issue required hospital admission for >= 1 day and treatment with medication.
Hospital/ER-Cardioversion	The heart rhythm issue required treatment with cardioversion either in the ER or during a hospital admission.

Supporting Definitions: (none)

P. Follow-up

Seq. #: 12064 **Name:** Follow-up Symptom Severity Survey (SSS) Q5

Coding Instructions: SSSQ5: In the past 6 months, has the patient taken any of the following medications?

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Amiodarone	
Beta Blocker	
Digoxin	
Diltiazem	
Dofetilide	
Dronedarone	
Flecainide	
Mexiletine	
Propafenone	
Sotalol	
Verapamil	
None	

Supporting Definitions: (none)

Seq. #: 12065 **Name:** Follow-up Symptom Severity Survey (SSS) Q6

Coding Instructions: SSSQ6: In the past 6 months, does the patient feel that their rhythm problem has interfered with how well they are able to work, go to school or play?

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

P. Follow-up

Seq. #: 12066 **Name:** Follow-up Symptom Severity Survey (SSS) Q7

Coding Instructions: SSSQ7: Indicate fate of ablated substrates

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No Recurrence	No symptoms or signs or ambulatory recordings consistent with recurrence of a previously targeted arrhythmia substrate.
Confirmed No Recurrence	Target ablation success documented by follow-up electrophysiology procedure.
Possible Recurrence	Symptoms or signs consistent with recurrence of previously targeted rhythm but without rhythm documentation.
Probable Recurrence	Ambulatory recording documenting rhythm of like morphology and mechanism when compared with the pre-ablation target rhythm.
Confirmed Recurrence	Target recurrence documented by follow-up electrophysiology procedure.

Supporting Definitions: (none)

Seq. #: 12070 **Name:** Follow-up Transcatheter Pulmonary Valve (TPV) still in place

Coding Instructions: Indicate if the transcatheter pulmonary valve was still in place at follow-up.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12071 **Name:** Follow-up Reason TPV is not still in place

Coding Instructions: Indicate the reason the TPV was not still in place.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Migration	
Embolization	
Explanted	

Supporting Definitions: (none)

P. Follow-up

Seq. #: 12075 **Name:** Follow-up TPV Reintervention

Coding Instructions: Indicate if there was a reintervention since discharge from the index procedure.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12076 **Name:** Follow-up TPV Surgical Reintervention

Coding Instructions: Indicate if there was a surgical reintervention since discharge from the index procedure.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12077 **Name:** Follow-up TPV Surgical Reintervention Date

Coding Instructions: Indicate the date of the surgical reintervention since discharge from the index procedure.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12078 **Name:** Follow-up TPV Catheter Reintervention

Coding Instructions: Indicate if there was a catheter reintervention since discharge from the index procedure.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

P. Follow-up

Seq. #: 12079 **Name:** Follow-up TPV Catheter Reintervention Date

Coding Instructions: Indicate the date of the catheter reintervention since discharge from the index procedure.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12080 **Name:** Follow-up Reason for TPV Reintervention

Coding Instructions: Indicate the reason for the TPV reintervention.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Stenosis	
Pulmonary Regurgitation	
Endocarditis	
Other	

Supporting Definitions: (none)

Seq. #: 12090 **Name:** Follow-up TPV Endocarditis

Coding Instructions: Indicate if the patient experienced endocarditis post TPVR procedure.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 12091 **Name:** Follow-up Endocarditis Diagnosis Date

Coding Instructions: Indicate the date that endocarditis was diagnosed.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

P. Follow-up

Seq. #: 12092 **Name:** Follow-up Predisposing Factors for Endocarditis

Coding Instructions: Indicate the predisposing factor for endocarditis.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Recent dental work or poor dentition	
History of Endocarditis	
Other implanted foreign bodies	
Other surface injuries/infections	
IV Drug use	

Supporting Definitions: (none)

Seq. #: 12093 **Name:** Follow-up Endocarditis Treatment

Coding Instructions: Indicate the treatment for the endocarditis.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
Antibiotics	
Surgical Explant	
Transcatheter reintervention	
Other	

Supporting Definitions: (none)

Seq. #: 12100 **Name:** Follow-up Mean gradient across valve/conduit

Coding Instructions: Indicate the mean pulmonary valve gradient at follow-up.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12105 **Name:** Follow-up Maximum gradient across valve/conduit

Coding Instructions: Indicate the maximum pulmonary valve gradient at follow-up.

Target Value: The value on follow-up

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12110 **Name:** Follow-up Pulmonary Valve Regurgitation

Coding Instructions: Indicate the amount of pulmonary valve regurgitation at follow-up.

Target Value: The value on follow-up

Selections:

Selection Text	*Definition*
None	
1+ (mild)	
2+ (moderate)	
3+ (moderately severe)	
4+ (severe)	

Supporting Definitions: (none)

Seq. #: 1000 **Name:** Participant ID

Coding Instructions: Indicate the participant ID of the submitting facility.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1010 **Name:** Participant Name

Coding Instructions: Indicate the full name of the facility.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1020 **Name:** Time Frame of Data Submission

Coding Instructions: Indicate the time frame of data included in the data submission. Format: YYYYQQ. e.g., 2016Q1

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Z. Administration

Seq. #: 1040 **Name:** Transmission Number

Coding Instructions: This is a unique number created, and automatically inserted by the software into the extract file. It identifies the number of times the software has created data submission files. The transmission number should be incremented by one every time the data submission files are exported. The transmission number should never be repeated.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1050 **Name:** Vendor Identifier

Coding Instructions: Vendor identification (agreed upon by mutual selection between the vendor and the NCDR) used to identify software vendor. This is entered into the schema automatically by vendor software. Vendors must use consistent name identification across sites. Changes to vendor name identification must be approved by the NCDR.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1060 **Name:** Vendor Software Version

Coding Instructions: Vendor's software product name and version number identifying the software which created this record (assigned by vendor). Vendor controls the value in this field. This is entered into the schema automatically by vendor software.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1070 **Name:** Registry Identifier

Coding Instructions: The NCDR registry identifier describes the data registry to which these records apply. It is implemented in the software at the time the data is collected and records are created. This is entered into the schema automatically by software.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Z. Administration

Seq. #: 1080 **Name:** Registry Version

Coding Instructions: Registry version describes the version number of the Data Specifications / Dictionary, to which each record conforms. It identifies which fields should have data, and what are the valid data for each field. It is the version implemented in the software at the time the data is collected and the records are created. This is entered into the schema automatically by software.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1085 **Name:** Submission Type

Coding Instructions: Indicate if the data contained in the harvest/data file contains either standard patient episode of care records (arrival date to discharge only) or if it contains patient follow-up records.

A transmission file with all episode of care records (from Arrival to Discharge only) is considered a "Base Registry Record".

A file with patient follow-up records (any follow-up assessments performed during the quarter selected) is considered a "Follow-Up Record".

Note(s):

'Selecting Follow-Up Records Only' will transmit all patient records with Follow-up Assessment Dates (Seq Num 12000) contained in the selected timeframe, regardless of the procedure or discharge date.

For example, if a patient has a procedure on 3/30/2016, is discharged on 3/31/2016, and has a follow-up assessment on 5/6/2016, the patient's episode of care data will be transmitted in the 2016Q1 Base Registry Record file, but the Follow-up data will be transmitted in the 2016Q2 Follow-Up File.

Target Value: N/A

Selections:

Selection Text	*Definition*
Episode of Care Records Only	Contains all patient and episode of care records with eligible procedures with a Discharge Date (Seq Num 9000) in the selected timeframe. An Episode of Care is defined as a patient's admission/arrival to the facility performing the procedure(s), including any symptoms or medical history prior to arrival, ending at discharge or death.
Follow-Up Records Only	Contains all patient records with at least one Follow-up Assessment performed (Seq Num 12000) in the selected timeframe.

Supporting Definitions: (none)

Seq. #: 1200 **Name:** Auxiliary 0

Coding Instructions: Reserved for future use

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)