

Section: Demographics

Parent: Root

Element: 2000	Last Name
Coding Instruction:	Indicate the patient's last name. Hyphenated names should be recorded with a hyphen.
Target Value:	The value on arrival at this facility
Element: 2010	First Name
Coding Instruction:	Indicate the patient's first name.
Target Value:	The value on arrival at this facility
Element: 2020	Middle Name
Coding Instruction:	Indicate the patient's middle name.
Note(s):	It is acceptable to specify the middle initial.
	If there is no middle name given, leave field blank.
	If there are multiple middle names, enter all of the middle names sequentially.
	If the name exceeds 50 characters, enter the first 50 letters only.
Target Value:	The value on arrival at this facility
Element: 2050	Birth Date
Coding Instruction:	Indicate the patient's date of birth.
Target Value:	The value on arrival at this facility
Element: 2030	SSN
Coding Instruction:	Indicate the patient's United States Social Security Number (SSN).
Note(s):	If the patient does not have a US Social Security Number (SSN), leave blank and check 'SSN NA'.
Target Value:	The value on arrival at this facility
Vendor Instruction:	SSN (2030) must be 9 numeric characters long
Element: 2031	SSN N/A
Coding Instruction:	Indicate if the patient does not have a United States Social Security Number (SSN).
Target Value:	The value on arrival at this facility
Element: 2040	Patient ID
Coding Instruction:	Indicate the number created and automatically inserted by the software that uniquely identifies this patient.
Note(s):	Once assigned to a patient at the participating facility, this number will never be changed or reassigned to a different patient. If the patient returns to the same participating facility or for follow up, they will receive this same unique patient identifier.
Target Value:	The value on arrival at this facility
Element: 2045	Other ID
Coding Instruction:	Indicate an optional patient identifier, such as medical record number, that can be associated with the patient.
Target Value:	N/A
Element: 2060	Sex
Coding Instruction:	Indicate the patient's sex at birth.
Note:	If sex is ambiguous at birth, update this field once genetic testing is complete and results can be added.
Target Value:	The value on arrival at this facility

Person Sex - 1.3.6.1.4.1.19376.1.4.1.6.5.19

Section: Demographics		Parent: Root		
Selection	Definition	Source	Code	Code System
Male			M	HL7 Administrative Gender
Female			F	HL7 Administrative Gender
Element: 2065	Patient Zip Code			
	Coding Instruction: Indicate the patient's United States Postal Service zip code of their primary residence.			
	Note(s): If the patient does not have a U.S. residence, or is homeless, leave blank and check 'Zip Code NA'.			
	Target Value: The value on arrival at this facility			
	Vendor Instruction: Patient Zip Code (2065) must be 5 numeric characters long			
Element: 2066	Zip Code N/A			
	Coding Instruction: Indicate if the patient does not have a United States Postal Service zip code.			
	Note(s): This includes patients who do not have a U.S. residence or are homeless.			
	Target Value: The value on arrival at this facility			
Element: 2070	Race - White			
	Coding Instruction: Indicate if the patient is White as determined by the patient/family.			
	Note(s): If the patient has multiple race origins, specify them using the other race selections in addition to this one.			
	Target Value: The value on arrival at this facility			
	Supporting Definition: White Individuals with origins in any of the original peoples of Europe, including, for example, English, German, Irish, Italian, Polish, and Scottish.			
	Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity			
Element: 2071	Race - Black/African American			
	Coding Instruction: Indicate if the patient is Black or African American as determined by the patient/family.			
	Target Value: The value on arrival at this facility			
	Supporting Definition: Black or African American Individuals with origins in any of the Black racial groups of Africa, including, for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, and Somali.			
	Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity			
Element: 2073	Race - American Indian/Alaskan Native			
	Coding Instruction: Indicate if the patient is American Indian or Alaskan Native as determined by the patient/family.			
	Note(s): If the patient has multiple race origins, specify them using the other race selections in addition to this one.			
	Target Value: The value on arrival at this facility			
	Supporting Definition: American Indian or Alaska Native Individuals with origins in any of the original peoples of North, Central, and South America, including, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, and Maya.			
	Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity			
Element: 2072	Race - Asian			
	Coding Instruction: Indicate if the patient is Asian as determined by the patient/family.			
	Note(s): If the patient has multiple race origins, specify them using the other race selections in addition to this one.			
	Target Value: The value on arrival at this facility			
	Supporting Definition: Asian Individuals with origins in any of the original peoples of Central or East Asia, Southeast Asia, or South Asia, including, for example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, and Japanese.			
	Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity			

Section: Demographics
Parent: Root
Element: 2074
Race - Native Hawaiian/Pacific Islander

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

Note(s):

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

Target Value: The value on arrival at this facility

Supporting Definition: **Native Hawaiian or Pacific Islander**

Individuals with origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands, including, for example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, and Marshallese.

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

Element: 2075
Race - Middle Eastern/North African

Coding Instruction: Indicate if the patient is Middle Eastern or North African as determined by the patient/family.

Target Value: The value on arrival at this facility

Supporting Definition: **Middle Eastern**

Individuals with origins in any of the original peoples of the Middle East or North Africa, including, for example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, and Israeli.

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

Element: 2076
Hispanic or Latino Ethnicity

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

Note(s):

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

Target Value: The value on arrival at this facility

Supporting Definition: **Hispanic or Latino**

Includes individuals of Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, and other Central or South American or Spanish culture or origin.

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

Section: Episode of Care

Parent: Root

Element: 2999 Episode Unique Key

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

Target Value: N/A

Element: 3001 Arrival Date and Time

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

Note(s):

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

Target Value: N/A

Vendor Instruction: Arrival Date and Time (3001) must be <= Discharge Date and Time (10101)

Element: 3005 Health Insurance

Coding Instruction: Indicate if the patient has health insurance.

Target Value: The value on arrival at this facility

Vendor Instruction: Health Insurance (3005) must not be NULL

Element: 3010 Health Insurance Payment Source

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

Note(s):

If the patient has multiple insurance payors, select all payors.

Target Value: The value on arrival at this facility

Payor Category - 1.3.6.1.4.1.19376.1.4.1.6.5.5

Selection	Definition	Source	Code	Code System
Private health insurance	Private health insurance is coverage by a health plan provided through an employer or union or purchased by an individual from a private health insurance company. A health maintenance organization (HMO) is considered private health insurance.		5	PHDSC
State-specific plan (non-Medicaid)	State Specific Plans - Some states have their own health insurance programs for low-income uninsured individuals. These health plans may be known by different names in different states.		36	PHDSC
Medicare (Part A or B)	Medicare is the Federal program which helps pay health care costs for people 65 and older and for certain people under 65 with long-term disabilities.		1	PHDSC
Medicare Advantage (Part C)	Medicare Part C (Medicare Advantage) – Part C is an alternative way to get Medicare coverage through private insurance companies instead of the federal government. Part C provides the same benefits as Medicare Part A and Part B, and may include additional benefits such as dental, vision, prescription drug and wellness programs coverage.	Medicare Advantage Plans (Part C) MedicareAdvantage.com	112000002025	ACC NCDR
Medicaid	Medicaid is a program administered at the state level, which provides medical assistance to the needy. Families with dependent children, the aged, blind, and disabled who are in financial need are eligible for Medicaid. It may be known by different names.		2	PHDSC
Military health care	Military Health care - Military health care includes TRICARE/CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) and CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), as well as care provided by the Department of Veterans Affairs (VA).		31	PHDSC
Indian Health Service	Indian Health Service (IHS) is a health care program through which the Department of Health and Human Services provides medical assistance to eligible American Indians at IHS facilities. In addition, the IHS helps pay the cost of selected health care services provided at non-IHS facilities.		33	PHDSC
Non-US insurance	Non-US insurance refers to individuals with a payor that does not originate in the United States.		100000812	ACC NCDR

Section: Episode of Care
Parent: Root
Element: 12846
Medicare Beneficiary Identifier
Coding Instruction: Indicate the patient's Medicare Beneficiary Identifier (MBI).

Note(s):

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

Target Value: The value on arrival at this facility

Supporting Definition: Medicare Beneficiary Identifier

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

Source: <https://www.cms.gov/Medicare/New-Medicare-Card/index.html>
Element: 3020
Patient Enrolled in Research Study
Coding Instruction: Indicate if the patient is enrolled in an ongoing ACC - NCDR research study related to this registry.

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

Supporting Definition: Patient Enrolled in Research Study

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

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

Section: Research Study

Parent: Episode of Care

Element: 3025

Research Study Name

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

Note(s):

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

Target Value: N/A

Vendor Instruction: A Research Study Name (3025) may only be entered/selected once

Research Study Name (3025) must be a valid study name for IMPACT v3.0

Element: 3030

Research Study Patient ID

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

Note(s):

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

Intended for future use.

Target Value: N/A

Section: Pathway

Parent: Episode of Care

Element: 15836

IMPACT Registry Pathway

Coding Instruction: Indicate the primary procedure(s) that were attempted or performed during the case, regardless of success. If multiple primary procedure types were performed during this episode of care, select all that apply.

Notes

1. Interventional or diagnostic catheterization: Code if any catheterization was performed
2. Electrophysiology study with and without ablation: Code electrophysiology study if an EP study was performed with or without ablation during this episode of care.
3. Cardiovascular implantable electronic device (CIED): Code CIED if a procedure was performed to implant ICD/CRT generators, leads, pacemaker generators, and/or implantable loop recorders. Do not code CIED if a procedure involves temporary pacing or non-implantable cardiac monitoring devices.

Target Value: The value on current procedure

IMPACT Registry Pathway Value Set - 1.3.6.1.4.1.19376.1.4.1.6.5.984

Selection	Definition	Source	Code	Code System
Diagnostic or interventional catheterization			112000003750	ACC NCDR
Electrophysiology study with or without ablation			252425004	SNOMED CT
Cardiovascular implantable electronic device (CIED)	Cardiovascular Implantable Electronic Devices (CIED) refer to procedures done to implant ICD generators/CRT, leads, pacemaker generators, and implantable loop recorders.		112000003721	ACC NCDR

Section: Primary Diagnosis

Parent: Episode of Care

Element: 15835

Primary Diagnosis

Coding Instruction: Indicate the primary congenital heart defect. Select the diagnosis from the diagnosis master list.

Note: "Status post diagnosis(es)" cannot be used as the primary diagnosis.

The intent of the "Primary diagnosis code" is to capture the singular most pertinent heart defect regardless of whether the condition was treated or still present. In cases where the patient has multiple conditions present, please select the one felt to be the most significant or having the broadest overall effect on the patient's health.

If the patient was not born with a congenital heart defect, or has no history of a congenital heart defect, then please identify the electrical variance from the diagnosis master list if available.

If the patient was not born with a congenital heart defect, has no history of a congenital heart defect, and has no electrical variance, then 'Normal Heart' would be selected.

Target Value: The value on arrival at this facility

Diagnosis Master - 1.3.6.1.4.1.19376.1.4.1.6.5.893

Selection	Definition	Source	Code	Code System
Septal defects - PFO			112000002777	ACC NCDR
Septal defects - ASD - secundum			112000002778	ACC NCDR
Septal defects - ASD - sinus venosus			112000002779	ACC NCDR
Septal defects - ASD - coronary sinus			112000002780	ACC NCDR
Septal defects - ASD - common atrium - single atrium			112000002781	ACC NCDR
Septal defects - VSD - Type 1 subarterial - supracristal - conal septal defect - infundibular			112000002782	ACC NCDR
Septal defects - VSD - Type 2 - perimembranous - paramembranous - conoventricular			112000002783	ACC NCDR
Septal defects - VSD - type 3 - inlet - AV canal type			112000002784	ACC NCDR
Septal defects - VSD - type 4 - muscular			112000002785	ACC NCDR
Septal defects - VSD - type - gerbode type - LV-RA communication			112000002786	ACC NCDR
Septal defects - VSD - multiple			112000002787	ACC NCDR
Septal defects - AVC - AVSD - complete CAVSD			112000002788	ACC NCDR
Septal defects - AVC - AVSD - intermediate -transitional			112000002789	ACC NCDR
Septal defects - AVC - AVSD - partial - incomplete - PAVSD - ASD primum			112000002790	ACC NCDR
Septal defects - AP window - aortopulmonary window			112000002791	ACC NCDR
Septal defects - pulmonary artery origin from ascending aorta - hemitruncus			112000002792	ACC NCDR
Septal defects - truncus arteriosus			112000002793	ACC NCDR
Septal defects - truncal valve insufficiency			112000002794	ACC NCDR
Septal defects - truncus arteriosus and interrupted aortic arch			112000002795	ACC NCDR
Pulmonary venous anomalies - partial anomalous pulmonary venous connection			112000002796	ACC NCDR
Pulmonary venous anomalies - partial anomalous pulmonary venous connection - scimitar			112000002797	ACC NCDR
Pulmonary venous anomalies - total anomalous pulmonary venous connection - Type 1			112000002798	ACC NCDR

Section: Primary Diagnosis	Parent: Episode of Care	
supracardiac		
Pulmonary venous anomalies - total anomalous pulmonary venous connection - Type 2 cardiac	112000002799	ACC NCDR
Pulmonary venous anomalies - total anomalous pulmonary venous connection - Type 3 infracardiac	112000002800	ACC NCDR
Pulmonary venous anomalies - total anomalous pulmonary venous connection - Type 4 mixed	112000002801	ACC NCDR
Cor triatriatum - cor triatriatum	112000002802	ACC NCDR
Pulmonary venous stenosis - Pulmonary venous stenosis	112000002803	ACC NCDR
Systemic venous anomalies - Systemic venous anomaly	112000002804	ACC NCDR
Systemic venous anomalies - systemic venous obstruction	112000002805	ACC NCDR
Right heart lesions - TOF	112000002806	ACC NCDR
Right heart lesions - TOF - pulmonary stenosis	112000002807	ACC NCDR
Right heart lesions - TOF - AVC - AVSD	112000002808	ACC NCDR
Right heart lesions - TOF - absent pulmonary valve	112000002809	ACC NCDR
Right heart lesions - pulmonary atresia	112000002810	ACC NCDR
Right heart lesions - pulmonary atresia - IVS	112000002811	ACC NCDR
Right heart lesions - pulmonary atresia - VSD including TOF-PA	112000002812	ACC NCDR
Right heart lesions - pulmonary atresia - VSD-MAPCA - pseudotruncus	112000002813	ACC NCDR
Right heart lesions - MAPCA - major aortopulmonary collaterals - without PA-VSD	112000002814	ACC NCDR
Right heart lesions - Ebsteins anomaly	112000002815	ACC NCDR
Right heart lesions - tricuspid regurgitation - non-Ebsteins related	112000002816	ACC NCDR
Right heart lesions - tricuspid stenosis	112000002817	ACC NCDR
Right heart lesions - tricuspid regurgitation and tricuspid stenosis	112000002818	ACC NCDR
Right heart lesions - tricuspid valve disease - other	112000002819	ACC NCDR
Right heart lesions - pulmonary stenosis - valvar	112000002820	ACC NCDR
Right heart lesions - pulmonary artery stenosis - hypoplasia - main-trunk	112000002821	ACC NCDR
Right heart lesions - pulmonary artery stenosis - branch - central - within the hilar bifurcation	112000002822	ACC NCDR
Right heart lesions - pulmonary artery stenosis - branch - peripheral - at or beyond the hilar bifurcation	112000002823	ACC NCDR
Right heart lesions - pulmonary artery - discontinuous	112000002824	ACC NCDR
Right heart lesions - pulmonary stenosis - subvalvar	112000002825	ACC NCDR
Right heart lesions - DCRV	112000002826	ACC NCDR
Right heart lesions - pulmonary valve disease - other	112000002827	ACC NCDR

Section: Primary Diagnosis	Parent: Episode of Care	
Right heart lesions - pulmonary insufficiency	112000002828	ACC NCDR
Right heart lesions - pulmonary insufficiency and pulmonary stenosis	112000002829	ACC NCDR
Shunt failure - shunt failure	112000002830	ACC NCDR
Right heart lesions - conduit failure	112000002831	ACC NCDR
Left heart lesions - aortic stenosis - subvalvar	112000002832	ACC NCDR
Left heart lesions - aortic stenosis - valvar	112000002833	ACC NCDR
Left heart lesions - aortic stenosis - supravalvar	112000002834	ACC NCDR
Left heart lesions - aortic valve atresia	112000002835	ACC NCDR
Left heart lesions - aortic insufficiency	112000002836	ACC NCDR
Left heart lesions - aortic insufficiency and aortic stenosis	112000002837	ACC NCDR
Left heart lesions - aortic valve - other	112000002838	ACC NCDR
Left heart lesions - sinus of valsalva aneurysm	112000002839	ACC NCDR
Left heart lesions - LV to aorta tunnel	112000002840	ACC NCDR
Left heart lesions - mitral stenosis - supravalvar mitral ring	112000002841	ACC NCDR
Left heart lesions - mitral stenosis - valvar	112000002842	ACC NCDR
Left heart lesions - mitral stenosis - subvalvar	112000002843	ACC NCDR
Left heart lesions - mitral stenosis - subvalvar-parachute	112000002844	ACC NCDR
Left heart lesions - mitral stenosis	112000002845	ACC NCDR
Left heart lesions - mitral regurgitation and mitral stenosis	112000002846	ACC NCDR
Left heart lesions - mitral regurgitation	112000002847	ACC NCDR
Left heart lesions - mitral valve -other	112000002848	ACC NCDR
Left heart lesions - hypoplastic left heart syndrome	112000002849	ACC NCDR
Left heart lesions - shones syndrome	112000002850	ACC NCDR
Left heart lesions - cardiomyopathy - including dilated - restrictive - and hypertrophic	112000002851	ACC NCDR
Left heart lesions - cardiomyopathy - end-stage congenital heart disease	112000002852	ACC NCDR
Left heart lesions - pericardial effusion	112000002853	ACC NCDR
Left heart lesions - pericarditis	112000002854	ACC NCDR
Left heart lesions - pericardial disease - other	112000002855	ACC NCDR
Single ventricle - single ventricle - DILV	112000002856	ACC NCDR
Single ventricle - single ventricle - DIRV	112000002857	ACC NCDR
Single ventricle - single ventricle - mitral atresia	112000002858	ACC NCDR
Single ventricle - single ventricle - tricuspid atresia	112000002859	ACC NCDR
Single ventricle - single ventricle - unbalanced AV	112000002860	ACC NCDR

Section: Primary Diagnosis	Parent: Episode of Care	
canal		
Single ventricle - single ventricle - heterotaxia syndrome	112000002861	ACC NCDR
Single ventricle - single ventricle - other	112000002862	ACC NCDR
Single ventricle - single ventricle and total anomalous pulmonary venous connection	112000002863	ACC NCDR
Transposition of the great arteries - congenitally corrected TGA	112000002864	ACC NCDR
Transposition of the great arteries - congenitally corrected TGA - IVS	112000002865	ACC NCDR
Transposition of the great arteries - congenitally corrected TGA - IVS-LVOTO	112000002866	ACC NCDR
Transposition of the great arteries - congenitally corrected TGA - VSD	112000002867	ACC NCDR
Transposition of the great arteries - congenitally corrected TGA - VSD-LVOTO	112000002868	ACC NCDR
Transposition of the great arteries - TGA - IVS	112000002869	ACC NCDR
Transposition of the great arteries - TGA - IVS-LVOTO	112000002870	ACC NCDR
Transposition of the great arteries - TGA - VSD	112000002871	ACC NCDR
Transposition of the great arteries - TGA - VSD-LVOTO	112000002872	ACC NCDR
DORV - DORV - VSD type	112000002873	ACC NCDR
DORV - DORV - TOF type	112000002874	ACC NCDR
DORV - DORV - TGA type	112000002875	ACC NCDR
DORV - DORV - remote VSD - uncommitted VSD	112000002876	ACC NCDR
DORV - DORV and AVSD - AV canal	112000002877	ACC NCDR
DORV - DORV - IVS	112000002878	ACC NCDR
DOLV - DOLV	112000002879	ACC NCDR
Thoracic arteries and veins - coarctation of aorta	112000002880	ACC NCDR
Thoracic arteries and veins - aortic arch hypoplasia	112000002881	ACC NCDR
Thoracic arteries and veins - VSD plus aortic arch hypoplasia	112000002882	ACC NCDR
Thoracic arteries and veins - VSD plus coarctation of aorta	112000002883	ACC NCDR
Thoracic arteries and veins - coronary artery anomaly - anomalous aortic origin of coronary artery from aorta	112000002884	ACC NCDR
Thoracic arteries and veins - coronary artery anomaly - Anomalous pulmonary origin - includes ALCAPA	112000002885	ACC NCDR
Thoracic arteries and veins - coronary artery anomaly - fistula	112000002886	ACC NCDR
Thoracic arteries and veins - coronary artery anomaly - aneurysm	112000002887	ACC NCDR
Thoracic arteries and veins - coronary artery anomaly - other	112000002888	ACC NCDR
Thoracic arteries and veins - interrupted aortic arch	112000002889	ACC NCDR
Thoracic arteries and veins - interrupted aortic arch and VSD	112000002890	ACC NCDR

Section: Primary Diagnosis	Parent: Episode of Care
Thoracic arteries and veins - interrupted aortic arch and AP window - aortopulmonary window	112000002891 ACC NCDR
Thoracic arteries and veins - patent ductus arteriosus	112000002892 ACC NCDR
Thoracic arteries and veins - vascular ring	112000002893 ACC NCDR
Thoracic arteries and veins - pulmonary artery sling	112000002894 ACC NCDR
Thoracic arteries and veins - aortic aneurysm - including pseudoaneurysm	112000002895 ACC NCDR
Thoracic arteries and veins - aortic dissection	112000002896 ACC NCDR
Thoracic and mediastinal disease - lung disease - benign	112000002897 ACC NCDR
Thoracic and mediastinal disease - lung disease - malignant	112000002898 ACC NCDR
Thoracic and mediastinal disease - pect	112000002899 ACC NCDR
Thoracic and mediastinal disease - tracheal stenosis	112000002900 ACC NCDR
Thoracic and mediastinal disease - airway disease	112000002901 ACC NCDR
Thoracic and mediastinal disease - pleural disease - benign	112000002902 ACC NCDR
Thoracic and mediastinal disease - pleural disease - malignant	112000002903 ACC NCDR
Thoracic and mediastinal disease - pneumothorax	112000002904 ACC NCDR
Thoracic and mediastinal disease - pleural effusion	112000002905 ACC NCDR
Thoracic and mediastinal disease - chylothorax	112000002906 ACC NCDR
Thoracic and mediastinal disease - empyema	112000002907 ACC NCDR
Thoracic and mediastinal disease - esophageal disease - benign	112000002908 ACC NCDR
Thoracic and mediastinal disease - esophageal disease - malignant	112000002909 ACC NCDR
Thoracic and mediastinal disease - mediastinal disease	112000002910 ACC NCDR
Thoracic and mediastinal disease - mediastinal disease - benign	112000002911 ACC NCDR
Thoracic and mediastinal disease - mediastinal disease - malignant	112000002912 ACC NCDR
Thoracic and mediastinal disease - diaphragm paralysis	112000002913 ACC NCDR
Thoracic and mediastinal disease - diaphragm disease - other	112000002914 ACC NCDR
Electrophysiologic - arrhythmia	112000002915 ACC NCDR
Electrophysiologic - arrhythmia - atrial	112000002916 ACC NCDR
Electrophysiologic - arrhythmia - junctional	112000002917 ACC NCDR
Electrophysiologic - arrhythmia - ventricular	112000002918 ACC NCDR
Electrophysiologic - arrhythmia - heart block	112000002919 ACC NCDR
Electrophysiologic - arrhythmia - heart block - acquired	112000002920 ACC NCDR
Electrophysiologic - arrhythmia	112000002921 ACC NCDR

Section: Primary Diagnosis		Parent: Episode of Care	
- heart block - congenital			
Electrophysiologic - arrhythmia	112000002922	ACC	NCDR
- pacemaker - indication for replacement			
Miscellaneous - atrial isomerism - left	112000002923	ACC	NCDR
Miscellaneous - atrial isomerism - right	112000002924	ACC	NCDR
Miscellaneous - dextrocardia	112000002925	ACC	NCDR
Miscellaneous - levocardia	112000002926	ACC	NCDR
Miscellaneous - mesocardia	112000002927	ACC	NCDR
Miscellaneous - situs inversus	112000002928	ACC	NCDR
Miscellaneous - aneurysm - ventricular - right - including pseudoaneurysm	112000002929	ACC	NCDR
Miscellaneous - aneurysm - ventricular - left - including pseudoaneurysm	112000002930	ACC	NCDR
Miscellaneous - aneurysm - pulmonary artery	112000002931	ACC	NCDR
Miscellaneous - aneurysm - other	112000002932	ACC	NCDR
Miscellaneous - hypoplastic RV	112000002933	ACC	NCDR
Miscellaneous - hypoplastic LV	112000002934	ACC	NCDR
Miscellaneous - postoperative bleeding	112000002935	ACC	NCDR
Miscellaneous - mediastinitis	112000002936	ACC	NCDR
Miscellaneous - endocarditis	112000002937	ACC	NCDR
Miscellaneous - rheumatic heart disease	112000002938	ACC	NCDR
Miscellaneous - prosthetic valve failure	112000002939	ACC	NCDR
Miscellaneous - myocardial infarction	112000002940	ACC	NCDR
Miscellaneous - cardiac tumor	112000002941	ACC	NCDR
Miscellaneous - pulmonary AV fistula	112000002942	ACC	NCDR
Miscellaneous - pulmonary embolism	112000002943	ACC	NCDR
Miscellaneous - pulmonary vascular obstructive disease	112000002944	ACC	NCDR
Miscellaneous - pulmonary vascular obstructive disease - Eisenmengers	112000002945	ACC	NCDR
Miscellaneous - primary pulmonary hypertension	112000002946	ACC	NCDR
Miscellaneous - persistent fetal circulation	112000002947	ACC	NCDR
Miscellaneous - meconium aspiration	112000002948	ACC	NCDR
Miscellaneous - cardiac - other	112000002949	ACC	NCDR
Miscellaneous - thoracic and/or mediastinal - other	112000002950	ACC	NCDR
Miscellaneous - peripheral vascular - other	112000002951	ACC	NCDR
Miscellaneous - status post transplant - heart	112000002952	ACC	NCDR
Miscellaneous - status post transplant - lung	112000002953	ACC	NCDR
Miscellaneous - status post transplant - heart and lung	112000002954	ACC	NCDR
Miscellaneous - normal heart	112000002955	ACC	NCDR
Miscellaneous - other	112000002956	ACC	NCDR

Section: History and Risk Factors

Parent: Root

Element: 15113 Genetic Condition

Coding Instruction: Indicate if the patient does or does not have a genetic condition.

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

Element: 15048 Genetic Condition Name

Coding Instruction: Select the genetic condition(s) from which the patient's history is determined.

Target Value: N/A

Genetic and Congenital Condition History - 1.3.6.1.4.1.19376.1.4.1.6.5.811

Selection	Definition	Source	Code	Code System
22q11.2 deletion (DiGeorge syndrome)	A deletion of a portion of the twenty-second chromosome that can cause such health problems as heart defects, immune deficiency, and cleft palate as well as developmental delays, learning disabilities and social/emotional issues.		737546002	SNOMED CT
Alagille syndrome	Genetic condition evidenced by a mutation or deletion of the JAG1 (20p12) gene.		31742004	SNOMED CT
CHARGE syndrome	A syndrome involving a specific set of birth defects, including coloboma, heart defects, choanal atresia, growth retardation, genital abnormalities, and ear anomalies, typically linked to mutations in the CHD7 gene.		47535005	SNOMED CT
Congenital rubella syndrome	A condition caused by maternal rubella infection during pregnancy, often resulting in cardiac defects, hearing impairment, and other anomalies.		36653000	SNOMED CT
Down syndrome	Congenital disease evidenced by a full or partial extra copy of chromosome 21.		41040004	SNOMED CT
Emanuel syndrome	A chromosomal disorder characterized by developmental delays, heart defects, and craniofacial abnormalities, caused by an extra derivative chromosome 22.		702417004	SNOMED CT
Heterotaxy	The abnormal placement of organs due to failure to establish the normal left-right patterning during embryonic development.		14821001	SNOMED CT
Jacobsen syndrome	A chromosomal disorder resulting from a deletion on chromosome 11, often associated with developmental delays, heart defects, and bleeding disorders.		715438008	SNOMED CT
Kabuki syndrome	A genetic disorder characterized by distinct facial features, developmental delays, and a range of congenital anomalies. The condition is typically caused by mutations in the KMT2D or KDM6A genes, which are involved in chromatin regulation and gene expression.		313426007	SNOMED CT
Loeys-Dietz syndrome	A connective tissue disorder marked by arterial aneurysms, dissections, and skeletal anomalies, often caused by mutations in TGFBR1 or TGFBR2 genes.		446263001	SNOMED CT
Marfan syndrome	An inherited disorder of the connective tissue that causes abnormalities of the patient's eyes, cardiovascular system, and musculoskeletal system.		19346006	SNOMED CT
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.		205824006	SNOMED CT
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).		737540008	SNOMED CT
Trisomy-18	Edwards syndrome, or Trisomy 18, is a chromosomal abnormality where the patient has an extra (or third) copy of chromosome 18. 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		737541007	SNOMED CT

Section: History and Risk Factors		Parent: Root	
	subclavian artery in less than 10% of cases.		
Turner syndrome	A congenital disease as evidenced by a defect in/or absence of the second female X chromosome.	38804009	SNOMED CT
VACTERL syndrome	An acronym describing a group of birth defects that affect the vertebrae, anus, cardiovascular system, trachea, esophagus, renal system, and limbs.	431395004	SNOMED CT
Williams-Beuren syndrome	Idiopathic hypercalcemia of infants as evidenced by the deletion of chromosome 7 material.	63247009	SNOMED CT
Other	N/A	100000351	ACC NCDR

Section: Condition History
Parent: History and Risk Factors
Element: 12903

Condition History Name

Coding Instruction: Select from the following list of medical conditions based on prior clinical diagnosis/documentation. Additional definitions appear below for those selections that may need further clarification.

Target Value: N/A

Condition Histories - 1.3.6.1.4.1.19376.1.4.1.6.5.927

Selection	Definition	Source	Code	Code System
Cardiomyopathy	Select if there is documentation of cardiomyopathy, a disease of the heart muscle, including but not limited to hypertrophic cardiomyopathy, dilated cardiomyopathy, restrictive cardiomyopathy, arrhythmogenic right ventricular dysplasia, or Takotsubo cardiomyopathy.		85898001	SNOMED CT
Chronic Lung Disease	Select if there is documentation of chronic lung disease, such as chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, chronic inhalation reactive diseases (e.g., asbestosis, pneumoconiosis), or radiation-induced lung damage. This includes patients requiring chronic inhaled or oral pharmacologic therapy, such as steroids or beta-agonists. Asthma, seasonal allergies, and transient conditions like atelectasis are not considered chronic lung disease.		413839001	SNOMED CT
Blood Coagulation Disorder	Select if there is documentation of a history of a hypercoagulable state, characterized by an increased tendency to form blood clots. This may be indicated by below-normal prothrombin time (PT) or partial thromboplastin time (PTT). Conditions caused solely by medications, such as vitamin K, do not meet the criteria		64779008	SNOMED CT
Congenital heart disease	Select if there is documentation of congenital heart disease, including but not limited to Tetralogy of Fallot, Ventricular Septal Defect (VSD), Ebstein anomaly, Transposition of Great Vessels, Patent Foramen Ovale (PFO), Atrial Septal Defect (ASD), Holt-Oram syndrome, Heart-Hand syndrome, or Common Ventricle.		13213009	SNOMED CT
Endocarditis	Select if there is documentation of endocarditis.		56819008	SNOMED CT
Heart Failure	Heart failure is a complex clinical syndrome that results from any structural or functional impairment of ventricular filling or ejection of blood. The cardinal manifestations of HF are dyspnea and fatigue, which may limit exercise tolerance, and fluid retention, which may lead to pulmonary and/or splanchnic congestion and/or peripheral edema. Some patients have exercise intolerance but little evidence of fluid retention, whereas others complain primarily of edema, dyspnea, or fatigue. Because some patients present without signs or symptoms of volume overload, the term "heart failure" is preferred over "congestive heart failure." There is no single diagnostic test for HF because it is largely a clinical diagnosis based on a careful history and physical examination.	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	84114007	SNOMED CT
Heart transplant			32413006	SNOMED CT
Stroke	Select if there is documentation/diagnosis of stroke associated with abrupt onset of neurological deficit lasting more than 24 hours.		100000977	ACC NCDR

Element: 15510

Condition History Occurrence

Coding Instruction: Indicate if the patient has or has not had a clinical diagnosis of the indicated medical condition.

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

Vendor Instruction: Condition History Occurrence (15510) cannot be Null when a Condition History Name (12903) is selected

Section: Condition History Details

Parent: History and Risk Factors

Element: 15051 Cardiomyopathy Type

Coding Instruction: Indicate the type(s) of cardiomyopathy the patient has been diagnosed with.

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

Cardiomyopathy Type - 1.3.6.1.4.1.19376.1.4.1.6.5.193

Selection	Definition	Source	Code	Code System
Arrhythmogenic right ventricular cardiomyopathy	A genetic disorder involving fibrofatty replacement of right ventricular myocardium, predisposing to arrhythmias and potential heart failure.		281170005	SNOMED CT
Dilated cardiomyopathy	Select if there is documentation of ventricular dilation with impaired systolic function, commonly defined by a left ventricular ejection fraction (LVEF) less than 40%. Dilated cardiomyopathy can occur with or without symptoms of heart failure and may be primary (idiopathic) or secondary to identifiable causes such as genetic factors, infections, or systemic conditions.		195021004	SNOMED CT
Hypertrophic cardiomyopathy	Select if there is documentation of hypertrophic cardiomyopathy, characterized by a hypertrophied, nondilated left ventricle (LV) in the absence of other systemic or cardiac diseases capable of causing similar wall thickening (e.g., hypertension, aortic valve stenosis). Diagnosis is typically made using echocardiography or cardiac magnetic resonance imaging (CMR) by identifying otherwise unexplained LV wall thickening, often accompanied by a small LV cavity.		233873004	SNOMED CT
Ischemic cardiomyopathy	Considered to be present in patients with HF who have had a myocardial infarction (MI) or have evidence of viable hibernating myocardium or, on angiography, severe coronary disease. The term ischemic cardiomyopathy has been used to describe significantly impaired left ventricular function (left ventricular ejection fraction <=35 to 40 percent) that results from coronary artery disease. Despite the common clinical use of the term ischemic cardiomyopathy, ventricular dysfunction caused by coronary disease is not a cardiomyopathy as defined by the 2006 American Heart Association and 2008 European Society of Cardiology statements.		426856002	SNOMED CT
Noncompaction of the ventricular myocardium	A congenital condition characterized by the presence of trabeculated (spongy) muscle in the ventricles, often resulting in impaired cardiac function and increased risk of arrhythmias.		112000002196	ACC NCDR
Pacemaker induced	Cardiomyopathy that is due to a pacemaker. Commonly this is a reduction in left ventricular function in the setting of right ventricular pacing.		112000001511	ACC NCDR
Restrictive cardiomyopathy	Select if there is documentation of restrictive cardiomyopathy, a rare form of heart muscle disease characterized by impaired ventricular filling due to restrictive physiology. This condition features non-hypertrophied, non-dilated ventricles with normal or decreased volume, biatrial enlargement, and normal (or near-normal) systolic function. Restrictive cardiomyopathy is associated with diastolic dysfunction and can present similarly to constrictive pericarditis.		415295002	SNOMED CT
Tachycardia-induced cardiomyopathy	The patient developed cardiomyopathy caused by prolonged or frequent tachycardia episodes		426300009	SNOMED CT
Other cardiomyopathy type	The term "unclassified cardiomyopathy" was included in the 2008 ESC classification system to describe disorders that do not readily fit into any of the above phenotypic categories [3]. Examples cited include LV noncompaction and stress-induced (takotsubo) cardiomyopathy.		100001065	ACC NCDR

Element: 15393 Congenital Heart Disease Type

Coding Instruction: Indicate the type of congenital heart disease the patient has been diagnosed with.

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

Vendor Instruction: Parent/Child Validation Notes: For the Primary Diagnosis (15835) parent condition, see Diagnosis Master dynamic list. Enable the element when the element reference number is listed under the enableElements column applicable to the Primary Diagnosis (15835) under the dynamic list.

Section: Condition History Details

Parent: History and Risk Factors

Congenital Heart Disease History Type - 1.3.6.1.4.1.19376.1.4.1.6.5.876

Selection	Definition	Source	Code	Code System
Repaired functionally two-ventricle congenital heart disease	The patient has undergone surgical or interventional repair resulting in a functional two-ventricle circulation. Examples include ventricular septal defect (VSD) or atrioventricular canal defect repairs.		112000002330	ACC NCDR
Transposition of the great arteries following atrial-level (Mustard or Senning) palliation	Select if there is documentation of l-looped ventricles, a congenital heart condition characterized by atrioventricular (AV) and ventriculoarterial discordance. This condition is also referred to as congenitally corrected transposition of the great arteries (ccTGA), double discordance, or ventricular inversion. Key features include the morphologic right ventricle supporting systemic circulation and the morphologic left ventricle supporting pulmonary circulation. Documentation may note associated defects such as ventricular septal defects (VSDs), pulmonary stenosis, or arrhythmias, or highlight risks like systemic right ventricular dysfunction leading to heart failure.		26146002	SNOMED CT
Unoperated acyanotic congenital heart disease	Acyanotic congenital heart conditions that have not undergone surgical or interventional repair. Examples include small atrial septal defects (ASD) or mild pulmonary stenosis.		78485007	SNOMED CT
Unoperated cyanotic congenital heart disease	Cyanotic congenital heart conditions that have not been surgically addressed, leading to persistent mixing of oxygenated and deoxygenated blood. Examples include unrepaired tetralogy of Fallot or transposition of the great arteries.		12770006	SNOMED CT
Single ventricle pre-Glenn	Patients with single-ventricle anatomy who have not yet undergone the Glenn procedure, a staged surgery typically performed as part of single-ventricle palliation.		112000004029	ACC NCDR
Single ventricle pre-Fontan	Patients with single-ventricle anatomy who have completed the Glenn procedure but have not yet undergone the Fontan procedure.		112000004030	ACC NCDR
Single ventricle s/p Fontan	Patients with single-ventricle anatomy who have completed the Fontan procedure, resulting in systemic venous return directly routed to the pulmonary arteries without a pumping chamber.		112000004031	ACC NCDR
Other			100000351	ACC NCDR
Ebstein Anomaly	Ebstein's anomaly is a rare congenital heart defect characterized by abnormal development of the tricuspid valve.		204357006	SNOMED CT

Element: 16031 Single ventricle s/p Fontan Type

Coding Instruction: Select the specific type of Fontan procedure performed in patients with a single ventricle heart physiology.

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

Single ventricle s/p Fontan Type - 1.3.6.1.4.1.19376.1.4.1.6.5.1044

Selection	Definition	Source	Code	Code System
RA to PA Fontan	A Fontan procedure where blood flow is routed from the right atrium (RA) directly to the pulmonary arteries (PA) without a pumping ventricle.		112000003876	ACC NCDR
Lateral tunnel Fontan	A Fontan modification that uses a surgically constructed tunnel within the heart to direct blood flow from the inferior vena cava (IVC) to the pulmonary arteries.		112000003877	ACC NCDR
Extracardiac conduit Fontan	A Fontan variation where an external conduit is used to connect the IVC directly to the pulmonary arteries, avoiding blood flow through the heart.		112000003878	ACC NCDR
Other	N/A		100000351	ACC NCDR

Section: Procedure History

Parent: History and Risk Factors

Element: 12905

Procedure History Name

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

Target Value: N/A

Procedure History Names - 1.3.6.1.4.1.19376.1.4.1.6.5.928

Selection	Definition	Source	Code	Code System
Cardiac catheterization			112000003717	ACC NCDR
Cardiac Surgery			64915003	SNOMED CT
EP therapy attempted	An invasive procedure that tests the electrical conduction system of the heart to assess the electrical activity and conduction pathways of the heart.	Source: Thomas KE, Zimetbaum PJ. Electrophysiology study: indications and interpretations. In: Yan G-X, Kowey PR, eds. Management of Cardiac Arrhythmias. 2nd ed. New York, NY: Humana Press (Springer Science+Business Media, LLC); 2011:123-40	252425004	SNOMED CT
Prior cardiovascular implantable electronic device			100000954	ACC NCDR

Element: 15511

Procedure History Occurrence

Coding Instruction: Indicate if the patient has or has not undergone the indicated medical procedure.

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

Vendor Instruction: Procedure History Occurrence (15511) cannot be Null when a Procedure History Name (12905) is selected

Section: Cardiac Catheterization History

Parent: Procedure History Details

Element: 15856

Most Recent Catheterization Procedures Not Documented

Coding Instruction: Indicate if the patient has had a previous cardiac catheterization performed but the specific procedure is not documented or that procedure is beyond 30 days.

Target Value: N/A

Section: Cardiac Catheterization History

Parent: Cardiac Catheterization History

Element: 15038

Most Recent Catheterization Procedures

Coding Instruction: Indicate the primary procedure(s) that occurred during the patient's most recent cardiac catheterization.

Target Value: The last value within 30 days prior to the start of current procedure

Procedure Master - 1.3.6.1.4.1.19376.1.4.1.6.5.892

Selection	Definition	Source	Code	Code System
Balloon dilation - Conduit - Sano modification - RV to PA valveless conduit			112000002462	ACC NCDR
Balloon dilation - Conduit - Sano modification-with valve - RV to PA valved conduit			112000002463	ACC NCDR
Balloon dilation - Conduit - LV to aorta			112000002465	ACC NCDR
Balloon dilation - Conduit - LV to PA			112000002466	ACC NCDR
Balloon dilation - Conduit - Other			112000002467	ACC NCDR
Balloon dilation - Conduit - RV to PA			112000002472	ACC NCDR
Balloon dilation - Conduit - Shunt - systemic-to-pulmonary			112000002473	ACC NCDR
Balloon dilation - Intracardiac-septum - Atrial baffle S-P atrial switch			112000002474	ACC NCDR
Balloon dilation - Intracardiac-septum - Atrial septum - Static balloon dilation without pullback			112000002475	ACC NCDR
Balloon dilation - Intracardiac-septum - Fontan baffle or extracardiac conduit			112000002476	ACC NCDR
Balloon dilation - Intracardiac-septum - Fontan fenestration			112000002477	ACC NCDR
Balloon dilation - Intracardiac-septum - Ventricular septum			112000002478	ACC NCDR
Balloon dilation - Pulmonary artery - Central - Proximal left and-or proximal right pulmonary artery including the pulmonary artery bifurcation			112000002479	ACC NCDR
Balloon dilation - Pulmonary artery - Main - Trunk			112000002480	ACC NCDR
Balloon dilation - Pulmonary artery - Peripheral			112000002481	ACC NCDR
Balloon dilation - Pulmonary vein - Left - Left pulmonary vein			112000002483	ACC NCDR
Balloon dilation - Pulmonary vein - Left lower - Left lower pulmonary vein			112000002484	ACC NCDR
Balloon dilation - Pulmonary vein - Left upper - Left upper pulmonary vein			112000002485	ACC NCDR
Balloon dilation - Pulmonary vein - Lingula - Lingular pulmonary vein			112000002486	ACC NCDR
Balloon dilation - Pulmonary vein - Pulmonary venous confluence			112000002487	ACC NCDR
Balloon dilation - Pulmonary vein - Pulmonary venous confluence with left atrium			112000002488	ACC NCDR
Balloon dilation - Pulmonary vein - Right - Right pulmonary vein			112000002489	ACC NCDR
Balloon dilation - Pulmonary vein - Right lower - Right lower pulmonary vein			112000002490	ACC NCDR
Balloon dilation - Pulmonary			112000002491	ACC NCDR

Section: Cardiac Catheterization History		Parent: Cardiac Catheterization History	
vein - Right middle - Right middle pulmonary vein			
Balloon dilation - Systemic artery - Aorta	112000002493	ACC	NCDR
Balloon dilation - Systemic artery - Systemic artery other than aorta	112000002494	ACC	NCDR
Balloon dilation - Systemic vein - Caval vein	112000002495	ACC	NCDR
Balloon dilation - Systemic vein - Non-Caval vein	112000002496	ACC	NCDR
Balloon dilation - Systemic vein	112000002497	ACC	NCDR
Balloon dilation - Systemic vein - Caval vein - Superior vena cava	112000002498	ACC	NCDR
Balloon dilation - Pulmonary artery - Proximal - Left	112000002509	ACC	NCDR
Balloon dilation - Pulmonary artery - Proximal - Right	112000002510	ACC	NCDR
Balloon dilation - Systemic artery - Aorta - Abdominal aorta - Coarctation	112000002511	ACC	NCDR
Balloon dilation - Systemic artery - Aorta - Abdominal aorta - Native - Primary coarctation	112000002512	ACC	NCDR
Balloon dilation - Systemic artery - Aorta - Abdominal aorta - Recurrent coarctation	112000002513	ACC	NCDR
Balloon dilation - Systemic artery - Systemic artery other than aorta - Coronary artery	112000002519	ACC	NCDR
Balloon dilation - Systemic artery - Systemic artery other than aorta - Femoral artery	112000002520	ACC	NCDR
Balloon dilation - Systemic artery - Systemic artery other than aorta - Iliac artery	112000002521	ACC	NCDR
Balloon dilation - Systemic artery - Systemic artery other than aorta - Innominate artery	112000002522	ACC	NCDR
Balloon dilation - Systemic artery - Systemic artery other than aorta - Renal artery	112000002523	ACC	NCDR
Balloon dilation - Systemic artery - Systemic artery other than aorta - Subclavian artery	112000002524	ACC	NCDR
Balloon dilation - Systemic vein - Non-Caval vein - Femoral vein	112000002525	ACC	NCDR
Balloon dilation - Systemic vein - Non-Caval vein - Iliac vein	112000002526	ACC	NCDR
Balloon dilation - Systemic vein - Non-Caval vein - Innominate - Brachiocephalic	112000002527	ACC	NCDR
Balloon valvotomy - Aortic valve	112000002529	ACC	NCDR
Balloon valvotomy - Mitral valve	112000002530	ACC	NCDR
Balloon valvotomy - Pulmonic valve	112000002531	ACC	NCDR
Balloon valvotomy - Tricuspid valve	112000002532	ACC	NCDR
Biopsy - RV not S-P heart transplant	112000002533	ACC	NCDR
Biopsy - RV post heart transplant	112000002534	ACC	NCDR
Coil implantation - Conduit - Sano modification - RV to PA valveless conduit	112000002538	ACC	NCDR
Coil implantation - Conduit - Sano modification-with valve -	112000002539	ACC	NCDR

Section: Cardiac Catheterization History		Parent: Cardiac Catheterization History	
RV to PA valved conduit			
Coil implantation - Conduit - LA to LV	112000002540	ACC	NCDR
Coil implantation - Conduit - LV to aorta	112000002541	ACC	NCDR
Coil implantation - Conduit - LV to PA	112000002542	ACC	NCDR
Coil implantation - Conduit - RA to PA	112000002544	ACC	NCDR
Coil implantation - Conduit - RA to RV	112000002546	ACC	NCDR
Coil implantation - Coronary artery fistula	112000002550	ACC	NCDR
Coil implantation - Intracardiac baffle leak	112000002552	ACC	NCDR
Coil implantation - Patent ductus arteriosus - PDA	112000002553	ACC	NCDR
Coil implantation - Perivalvar leak	112000002554	ACC	NCDR
Coil implantation - Pulmonary arteriovenous malformation	112000002555	ACC	NCDR
Coil implantation - Systemic arteriovenous malformation	112000002556	ACC	NCDR
Coil implantation - Systemic artery to pulmonary artery collateral	112000002557	ACC	NCDR
Coil implantation - Systemic vein to pulmonary vein collateral	112000002560	ACC	NCDR
Device implantation - Aortopulmonary window - AP window	112000002568	ACC	NCDR
Device implantation - Atrial septal defect - ASD	112000002569	ACC	NCDR
Device implantation - Conduit - Sano modification-with valve - RV to PA valved conduit	112000002571	ACC	NCDR
Device implantation - Conduit - LA to LV	112000002572	ACC	NCDR
Device implantation - Conduit - Shunt - systemic-to-pulmonary	112000002581	ACC	NCDR
Device implantation - Coronary artery fistula	112000002582	ACC	NCDR
Device implantation - Fontan fenestration	112000002583	ACC	NCDR
Device implantation - Intracardiac baffle leak	112000002584	ACC	NCDR
Device implantation - Patent ductus arteriosus - PDA	112000002585	ACC	NCDR
Device implantation - Patent Foramen Ovale - PFO	112000002586	ACC	NCDR
Device implantation - Perivalvar leak	112000002587	ACC	NCDR
Device implantation - Pulmonary arteriovenous malformation	112000002588	ACC	NCDR
Device implantation - Pulmonary artery	112000002589	ACC	NCDR
Device implantation - Systemic artery to pulmonary artery collateral	112000002591	ACC	NCDR
Device implantation - Systemic vein to pulmonary vein collateral	112000002594	ACC	NCDR
Device implantation - Ventricular septal defect - VSD	112000002598	ACC	NCDR
Device implantation - Conduit	112000002599	ACC	NCDR
Hemodynamic alteration - Oxygen-nitric test	112000002607	ACC	NCDR
Hemodynamic alteration - Inotropy test	112000002608	ACC	NCDR

Section: Cardiac Catheterization History		Parent: Cardiac Catheterization History	
Hemodynamic alteration - Fluid bolus challenge	112000002609	ACC	NCDR
Hybrid Approach - Transcardiac balloon dilation	112000002610	ACC	NCDR
Hybrid Approach - Transcardiac transcatheter device placement	112000002611	ACC	NCDR
Hybrid Approach Stage 1 - Application of RPA and LPA bands	112000002612	ACC	NCDR
Hybrid Approach Stage 1 - Stent placement in arterial duct - PDA	112000002613	ACC	NCDR
Hybrid Approach Stage 1 - Stent placement in arterial duct - PDA plus application of RPA and LPA bands	112000002614	ACC	NCDR
Hybrid approach Stage 2 - Aortopulmonary amalgamation plus Superior Cavopulmonary anastomosis- es plus PA Debanding plus Aortic arch repair - Norwood Stage 1 plus Superior Cavopulmonary anastomosis- es plus PA Debanding	112000002615	ACC	NCDR
Hybrid approach Stage 2 - Aortopulmonary amalgamation plus Superior Cavopulmonary anastomosis- es plus PA Debanding + Without aortic arch repair	112000002616	ACC	NCDR
Intravascular foreign body removal - Intravascular foreign body removal	112000002617	ACC	NCDR
Other invasive procedures- interventional techniques - Pericardiocentesis - elective	112000002618	ACC	NCDR
Other invasive procedures- interventional techniques - Pleuracentesis - elective	112000002620	ACC	NCDR
Other invasive procedures- interventional techniques - Snare foreign body	112000002622	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Atrietic aortic valve	112000002623	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Atrietic pulmonary valve	112000002624	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Atrial septum	112000002625	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Conduit - Sano modification - RV to PA valveless conduit	112000002626	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Conduit - Sano modification- with valve - RV to PA valved conduit	112000002627	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Conduit - LA to LV	112000002628	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication -	112000002630	ACC	NCDR

Section: Cardiac Catheterization History		Parent: Cardiac Catheterization History	
Conduit - LV to PA			
Perforation - establishing interchamber and-or intervessel communication - Conduit - Other	112000002631	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Conduit - RA to PA-pulmonary trunk	112000002633	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Conduit - RA to RV	112000002634	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Conduit - RV to aorta	112000002635	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Fontan Baffle	112000002638	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Systemic artery - Systemic artery other than aorta	112000002640	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Ventricular septum	112000002643	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Systemic artery	112000002645	ACC	NCDR
Septostomy - Septostomy by pullback - Rashkind - BAS	112000002652	ACC	NCDR
Septostomy - Blade atrial septostomy	112000002653	ACC	NCDR
Septostomy - Septostomy	112000002654	ACC	NCDR
Stent insertion - Conduit - Sano modification - RV to PA valveless conduit	112000002655	ACC	NCDR
Stent insertion - Conduit - LA to LV	112000002657	ACC	NCDR
Stent insertion - Conduit - LV to PA	112000002659	ACC	NCDR
Stent insertion - Conduit - Other	112000002660	ACC	NCDR
Stent insertion - Conduit - RV to PA	112000002665	ACC	NCDR
Stent insertion - Conduit - Shunt - systemic-to-pulmonary	112000002666	ACC	NCDR
Stent insertion - Intracardiac-septum - Atrial baffle S-P atrial switch	112000002667	ACC	NCDR
Stent insertion - Intracardiac-septum - Atrial septum	112000002668	ACC	NCDR
Stent insertion - Intracardiac-septum - Fontan Baffle	112000002669	ACC	NCDR
Stent insertion - Intracardiac-septum - Fontan fenestration	112000002670	ACC	NCDR
Stent insertion - Intracardiac-septum - Ventricular septum	112000002671	ACC	NCDR
Stent insertion - PDA	112000002672	ACC	NCDR
Stent insertion - Pulmonary artery - Central - Proximal left and-or proximal right pulmonary artery including the pulmonary artery bifurcation	112000002673	ACC	NCDR
Stent insertion - Pulmonary artery - Main - Trunk	112000002674	ACC	NCDR
Stent insertion - Pulmonary	112000002675	ACC	NCDR

Section: Cardiac Catheterization History		Parent: Cardiac Catheterization History	
artery - Peripheral			
Stent insertion - Pulmonary vein - Left - Left pulmonary vein	112000002677	ACC	NCDR
Stent insertion - Pulmonary vein - Left lower - Left lower pulmonary vein	112000002678	ACC	NCDR
Stent insertion - Pulmonary vein - Left upper - Left upper pulmonary vein	112000002679	ACC	NCDR
Stent insertion - Pulmonary vein - Lingula - Lingular pulmonary vein	112000002680	ACC	NCDR
Stent insertion - Pulmonary vein - Pulmonary venous confluence	112000002681	ACC	NCDR
Stent insertion - Pulmonary vein - Right - Right pulmonary vein	112000002683	ACC	NCDR
Stent insertion - Pulmonary vein - Right lower - Right lower pulmonary vein	112000002684	ACC	NCDR
Stent insertion - Pulmonary vein - Right middle - Right middle pulmonary vein	112000002685	ACC	NCDR
Stent insertion - Systemic artery - Aorta	112000002687	ACC	NCDR
Stent insertion - Systemic vein - Caval vein	112000002689	ACC	NCDR
Stent insertion - Systemic vein - Non-Caval vein	112000002690	ACC	NCDR
Stent insertion - Pulmonary artery - Peripheral - Lobar	112000002691	ACC	NCDR
Stent insertion - Pulmonary artery - Peripheral - Lobar - Left	112000002692	ACC	NCDR
Stent insertion - Systemic vein - Caval vein - Superior vena cava	112000002699	ACC	NCDR
Stent insertion - Systemic artery - Aorta - Abdominal aorta	112000002700	ACC	NCDR
Stent insertion - Systemic artery - Aorta - Thoracic aorta - Coarctation - Native - Primary coarctation	112000002706	ACC	NCDR
Stent insertion - Systemic artery - Aorta - Thoracic aorta - Transverse arch	112000002709	ACC	NCDR
Stent insertion - Systemic artery - Aorta - Thoracoabdominal aorta	112000002710	ACC	NCDR
Stent insertion - Systemic artery - Systemic artery other than aorta - Coronary artery	112000002711	ACC	NCDR
Stent insertion - Systemic artery - Systemic artery other than aorta - Femoral artery	112000002712	ACC	NCDR
Stent insertion - Systemic artery - Systemic artery other than aorta - Iliac artery	112000002713	ACC	NCDR
Stent insertion - Systemic artery - Systemic artery other than aorta - Renal artery	112000002714	ACC	NCDR
Stent insertion - Systemic artery - Systemic artery other than aorta - Subclavian artery	112000002715	ACC	NCDR
Stent insertion - Systemic artery - Systemic artery other than aorta - Systemic pulmonary vessel connection	112000002716	ACC	NCDR
Stent re-dilation - Conduit - Sano modification - RV to PA	112000002718	ACC	NCDR

Section: Cardiac Catheterization History		Parent: Cardiac Catheterization History	
valveless conduit			
Stent re-dilation - Conduit - LV to aorta	112000002721	ACC	NCDR
Stent re-dilation - Conduit - LV to PA	112000002722	ACC	NCDR
Stent re-dilation - Conduit - RV to PA	112000002728	ACC	NCDR
Stent re-dilation - Conduit - Shunt - systemic-to-pulmonary	112000002729	ACC	NCDR
Stent re-dilation - Intracardiac-septum - Atrial baffle S-P atrial switch	112000002730	ACC	NCDR
Stent re-dilation - Intracardiac-septum - Atrial septum	112000002731	ACC	NCDR
Stent re-dilation - Intracardiac-septum - Fontan Baffle	112000002732	ACC	NCDR
Stent re-dilation - Intracardiac-septum - Fontan fenestration	112000002733	ACC	NCDR
Stent re-dilation - PDA	112000002735	ACC	NCDR
Stent re-dilation - Pulmonary artery - Central - Proximal left and-or proximal right pulmonary artery including the pulmonary artery bifurcation	112000002736	ACC	NCDR
Stent re-dilation - Pulmonary artery - Main - Trunk	112000002737	ACC	NCDR
Stent re-dilation - Pulmonary artery - Peripheral	112000002738	ACC	NCDR
Stent re-dilation - Pulmonary vein - Left - Left pulmonary vein	112000002740	ACC	NCDR
Stent re-dilation - Pulmonary vein - Left lower - Left lower pulmonary vein	112000002741	ACC	NCDR
Stent re-dilation - Pulmonary vein - Left upper - Left upper pulmonary vein	112000002742	ACC	NCDR
Stent re-dilation - Pulmonary vein - Lingula - Lingular pulmonary vein	112000002743	ACC	NCDR
Stent re-dilation - Pulmonary vein - Right - Right pulmonary vein	112000002746	ACC	NCDR
Stent re-dilation - Pulmonary vein - Right lower - Right lower pulmonary vein	112000002747	ACC	NCDR
Stent re-dilation - Pulmonary vein - Right middle - Right middle pulmonary vein	112000002748	ACC	NCDR
Stent re-dilation - Pulmonary vein - Right upper - Right upper pulmonary vein	112000002749	ACC	NCDR
Stent re-dilation - Systemic artery - Aorta	112000002750	ACC	NCDR
Stent re-dilation - Systemic vein - Caval vein	112000002752	ACC	NCDR
Stent re-dilation - Systemic vein - Non-Caval vein	112000002753	ACC	NCDR
Transcatheter Fontan completion - Completion of total cavopulmonary connection - TCPC using transcatheter covered stent	112000002754	ACC	NCDR
Transcatheter implantation of valve - Pulmonary outflow position	112000002756	ACC	NCDR
Transcatheter implantation of valve - Systemic outflow position	112000002757	ACC	NCDR
Transcatheter implantation of valve - pulmonary ventricular inflow position	112000002758	ACC	NCDR

Section: Cardiac Catheterization History	Parent: Cardiac Catheterization History	
Transcatheter implantation of valve - Systemic ventricular inflow position	112000002759	ACC NCDR
Transluminal test occlusion - Conduit - Sano modification - RV to PA valveless conduit	112000002760	ACC NCDR
Transluminal test occlusion - Conduit - Sano modification - with valve - RV to PA valved conduit	112000002761	ACC NCDR
Balloon dilation - Drug coated balloon	112000004439	ACC NCDR
Balloon dilation - Cutting balloon	112000004440	ACC NCDR
Device implantation - Systemic vein - Caval vein - Superior vena cava - Left	112000004441	ACC NCDR
Device insertion - Insertion of pulmonary artery flow restrictors	112000004442	ACC NCDR
Device insertion - Mitral Transcatheter Edge-Edge Repair - TEER	112000004443	ACC NCDR
Hybrid placement of transcatheter valve	112000004445	ACC NCDR
Hybrid placement of cardiac device or stent	112000004446	ACC NCDR
Hybrid Stage 1 - Stent placement in arterial duct - PDA application of RPA and LPA bands plus septal stent placement	112000004447	ACC NCDR
Hybrid stent dilation or stent placement in pulmonary artery	112000004448	ACC NCDR
Intracardiac echocardiography	112000003746	ACC NCDR
Lymphatic catheterization - Diagnostic	112000004449	ACC NCDR
Lymphatic catheterization - Interventional	112000004450	ACC NCDR
Mechanical thrombolysis or thrombus aspiration	112000004451	ACC NCDR
Perforation - Fontan baffle or extra cardiac conduit	112000004452	ACC NCDR
Pericardiocentesis - With drain placement	112000004453	ACC NCDR
Pleuracentesis - Without drain placement	112000004456	ACC NCDR
Pericardiocentesis - Without drain placement	112000004454	ACC NCDR
Pleuracentesis - With drain placement	112000004455	ACC NCDR
Pressure-volume loops acquisition using intracardiac conductance catheter	112000004457	ACC NCDR
Septostomy - Septostomy static balloon septoplasty	112000004458	ACC NCDR
Stent insertion - Atrial septum	112000004459	ACC NCDR
Stent insertion - Central/proximal branch pulmonary artery- Bilateral	112000004460	ACC NCDR
Stent insertion - Central/proximal branch pulmonary artery- Unilateral	112000004461	ACC NCDR
Stent insertion - Fontan fenestration	112000004463	ACC NCDR
Stent insertion - Inferior vena cava	112000004464	ACC NCDR
Stent insertion - Mid-distal descending thoracic aorta	112000004465	ACC NCDR
Stent insertion - Peripheral/lobar pulmonary artery	112000004466	ACC NCDR

Section: Cardiac Catheterization History	Parent: Cardiac Catheterization History	
Stent insertion - Proximal descending thoracic aorta	112000004467	ACC NCDR
Stent insertion - RV outflow tract - Native RVOT	112000004468	ACC NCDR
Stent insertion - Superior vena cava	112000004469	ACC NCDR
Stent insertion - SVC - Sinus venosus ASD closure	112000004470	ACC NCDR
Stent insertion - Systemic artery - Other	112000004471	ACC NCDR
Stent insertion - Systemic vein - Other	112000004472	ACC NCDR
Stent insertion - Systemic venous baffle S-P atrial switch	112000004473	ACC NCDR
Stent insertion - Systemic-to-pulmonary artery shunt	112000004474	ACC NCDR
Stent insertion - Innominate vein	112000004475	ACC NCDR
Stent insertion - Covered stent from innominate vein to atrium for thoracic duct decompression	112000004476	ACC NCDR
Stent re-dilation - Systemic venous baffle S-P atrial switch	112000004477	ACC NCDR
Stent re-dilation - Abdominal aorta	112000004478	ACC NCDR
Stent re-dilation - Atrial septum	112000004479	ACC NCDR
Stent re-dilation - Central/proximal branch pulmonary artery- Bilateral	112000004480	ACC NCDR
Stent re-dilation - Central/proximal branch pulmonary artery- Unilateral	112000004481	ACC NCDR
Stent re-dilation - Coronary artery	112000004482	ACC NCDR
Stent re-dilation - Fontan baffle or extra cardiac conduit	112000004483	ACC NCDR
Stent re-dilation - Femoral artery	112000004484	ACC NCDR
Stent re-dilation - Fontan fenestration	112000004485	ACC NCDR
Stent re-dilation - Iliac artery	112000004486	ACC NCDR
Stent re-dilation - Inferior vena cava	112000004487	ACC NCDR
Stent re-dilation - Peripheral/lobar pulmonary artery	112000004488	ACC NCDR
Stent re-dilation - Proximal descending thoracic aorta	112000004489	ACC NCDR
Stent re-dilation - Renal artery	112000004490	ACC NCDR
Stent re-dilation - RV outflow tract	112000004491	ACC NCDR
Stent re-dilation - Superior vena cava	112000004492	ACC NCDR
Stent re-dilation - SVC - Sinus venosus ASD closure	112000004493	ACC NCDR
Stent re-dilation - Systemic artery - Other	112000004494	ACC NCDR
Stent re-dilation - Systemic vein - Other	112000004495	ACC NCDR
Stent re-dilation - Systemic-to-pulmonary shunt	112000004496	ACC NCDR
Stent re-dilation - Transverse aortic arch	112000004497	ACC NCDR
Stent re-dilation - Fontan baffle S-P lateral tunnel fontan	112000004498	ACC NCDR
Stent re-dilation - Mid-distal descending thoracic aorta	112000004499	ACC NCDR
Use of IVUS/OCT/FFR during vascular interventions	112000004500	ACC NCDR
Device occlusion -	112000004501	ACC NCDR

Section: Cardiac Catheterization History**Parent: Cardiac Catheterization History**

Transhepatic access tract		
Device insertion - Tricuspid Transcatheter Edge-Edge Repair - TEER	112000004444	ACC NCDR
Endomyocardial biopsy - Not S/P heart transplant	112000004506	ACC NCDR
Balloon dilation - Innominate vein	112000004504	ACC NCDR
Balloon dilation - Transverse aortic arch	112000004505	ACC NCDR
Transhepatic access for diagnostic or intervention	112000004507	ACC NCDR

Section: Cardiac Surgery History

Parent: Procedure History Details

Element: 15857

Most Recent Cardiac Surgery Not Documented

Coding Instruction: Indicate if the patient has had a previous cardiac surgery but the specific surgery is not documented or that procedure is beyond 30 days.

Target Value: N/A

Section: Cardiac Surgery History

Parent: Cardiac Surgery History

Element: 15045

Most Recent Cardiac Surgery Procedures

Coding Instruction: Indicate all applicable procedures which were performed during the patient's most recent cardiac surgery. Select all applicable procedures performed from the surgery master list.

Target Value: The last value within 30 days prior to the start of current procedure

Cardiac Surgery Master - 1.3.6.1.4.1.19376.1.4.1.6.5.894

Selection	Definition	Source	Code	Code System
ASD - ASD Partial closure			112000002963	ACC NCDR
ASD - Atrial Fenestration closure			112000002965	ACC NCDR
VSD - VSD Repair - Patch			112000002967	ACC NCDR
VSD - VSD Creation-enlargement			112000002970	ACC NCDR
AV Canal - AVC - AVSD - repair - Complete - CAVSD			112000002972	ACC NCDR
AV Canal - AVC - AVSD - repair - Intermediate - Transitional			112000002973	ACC NCDR
AV Canal - AVC - AVSD - repair - Partial - Incomplete - PAVSD			112000002974	ACC NCDR
Truncus arteriosus - Truncus arteriosus repair			112000002977	ACC NCDR
Truncus arteriosus - Valve replacement - Truncal valve			112000002979	ACC NCDR
Partial Anomalous Pulmonary Venous Connection - PAPVC repair			112000002980	ACC NCDR
Partial Anomalous Pulmonary Venous Connection - PAPVC repair - Scimitar			112000002981	ACC NCDR
Total Anomalous Pulmonary Venous Connection - TAPVC Repair			112000002982	ACC NCDR
Cor triatriatum - Cor triatriatum repair			112000002983	ACC NCDR
Pulmonary venous stenosis - Pulmonary venous stenosis Repair			112000002984	ACC NCDR
Tetralogy of Fallot - TOF Repair - No ventriculotomy			112000002988	ACC NCDR
Tetralogy of Fallot - TOF Repair - Ventriculotomy - Nontransanular patch			112000002989	ACC NCDR
Tetralogy of Fallot - TOF Repair - Ventriculotomy - Transanular patch			112000002990	ACC NCDR
Tetralogy of Fallot - TOF Repair - RV-PA conduit			112000002991	ACC NCDR
Tetralogy of Fallot - TOF - AVC - AVSD - repair			112000002992	ACC NCDR
Tetralogy of Fallot - TOF - Absent pulmonary valve			112000002993	ACC NCDR
Pulmonary atresia - VSD including TOF-PA - repair			112000002994	ACC NCDR
Pulmonary atresia - VSD - MAPCA - pseudotruncus - repair			112000002995	ACC NCDR
Pulmonary atresia - Unifocalization MAPCA			112000002996	ACC NCDR
Tricuspid Valve Disease and Ebstein's Anomaly - Valvuloplasty - Tricuspid			112000002998	ACC NCDR
Tricuspid Valve Disease and Ebsteins Anomaly - Ebsteins repair			112000002999	ACC NCDR
Tricuspid Valve Disease and Ebsteins Anomaly - Valve replacement - Tricuspid - TVR			112000003000	ACC NCDR
Tricuspid Valve Disease and			112000003001	ACC NCDR

Section: Cardiac Surgery History		Parent: Cardiac Surgery History	
Ebsteins Anomaly - Valve closure - Tricuspid - exclusion - univentricular approach			
RVOT Obstruction- IVS Pulmonary Stenosis - 1 1-2 ventricular repair	112000003005	ACC	NCDR
RVOT Obstruction- IVS Pulmonary Stenosis - Reconstruction - plasty - Main - trunk	112000003006	ACC	NCDR
RVOT Obstruction- IVS Pulmonary Stenosis - Reconstruction - plasty - Branch-Central within the hilar bifurcation	112000003007	ACC	NCDR
RVOT Obstruction- IVS Pulmonary Stenosis - DCRV repair	112000003009	ACC	NCDR
Conduit Stenosis - Insufficiency - Conduit reoperation	112000003010	ACC	NCDR
Pulmonary Valve Disease - Valvuloplasty - Pulmonic	112000003011	ACC	NCDR
Pulmonary Valve Disease - Valve replacement - Pulmonic - PVR	112000003012	ACC	NCDR
Conduit operations - Conduit placement - RV to PA	112000003013	ACC	NCDR
Conduit operations - Conduit placement - LV to PA	112000003014	ACC	NCDR
Pulmonary Valve Disease - Valve surgery - Other - Pulmonic	112000003017	ACC	NCDR
Aortic Valve Disease - Valvuloplasty - Aortic	112000003018	ACC	NCDR
Aortic Valve Disease - Valve replacement - Aortic - AVR - Mechanical	112000003020	ACC	NCDR
Aortic Valve Disease - Valve replacement - Aortic - AVR - Bioprosthetic	112000003021	ACC	NCDR
Aortic Valve Disease - Ross procedure	112000003027	ACC	NCDR
Aortic Valve Disease - Ross-Konno procedure	112000003029	ACC	NCDR
Aortic Valve Disease - Aortic stenosis - Subvalvar - Repair	112000003031	ACC	NCDR
Aortic Valve Disease - Aortic stenosis - Supravalvar Repair	112000003032	ACC	NCDR
Aortic Valve Disease - Valve surgery - Other - Aortic	112000003033	ACC	NCDR
Mitral Valve Disease - Valvuloplasty - Mitral	112000003036	ACC	NCDR
Mitral Valve Disease - Mitral stenosis - Supravalvar mitral ring repair	112000003037	ACC	NCDR
Mitral Valve Disease - Valve replacement - Mitral - MVR	112000003038	ACC	NCDR
Mitral Valve Disease - Valve surgery - Other - Mitral	112000003039	ACC	NCDR
Hypoplastic Left Heart - Norwood procedure	112000003040	ACC	NCDR
Cardiomyopathy - Transplant - Heart	112000003042	ACC	NCDR
Single Ventricle - Fontan - TCPC - Lateral tunnel Fenestrated	112000003050	ACC	NCDR
Single Ventricle - Fontan - TCPC- Lateral tunnel Nonfenestrated	112000003051	ACC	NCDR
Single Ventricle - Fontan - TCPC- External conduit Fenestrated	112000003052	ACC	NCDR

Section: Cardiac Surgery History		Parent: Cardiac Surgery History	
Single Ventricle - Fontan - TCPC- External conduit Nonfenestrated	112000003053	ACC NCDR	
Single Ventricle - Fontan revision or conversion - Re-do Fontan	112000003054	ACC NCDR	
Single Ventricle - Fontan - Other	112000003055	ACC NCDR	
Congenitally corrected TGA repair - Congenitally corrected TGA repair - Atrial switch and ASO - double switch	112000003057	ACC NCDR	
Congenitally corrected TGA repair - Congenitally corrected TGA repair - Atrial switch and Rastelli	112000003058	ACC NCDR	
Congenitally corrected TGA repair - Congenitally corrected TGA repair - VSD closure	112000003059	ACC NCDR	
Congenitally corrected TGA repair - Congenitally corrected TGA repair - VSD closure and LV to PA conduit	112000003060	ACC NCDR	
Transposition of the Great Arteries - Arterial switch operation	112000003062	ACC NCDR	
Transposition of the Great Arteries - Arterial switch operation and VSD repair	112000003063	ACC NCDR	
Transposition of the Great Arteries - Arterial switch procedure and Aortic arch repair	112000003064	ACC NCDR	
Transposition of the Great Arteries - Arterial switch procedure and VSD repair and Aortic arch repair	112000003065	ACC NCDR	
Transposition of the Great Arteries - Senning	112000003066	ACC NCDR	
Transposition of the Great Arteries - Atrial baffle procedure - Mustard or Senning revision	112000003068	ACC NCDR	
Transposition of the Great Arteries - Rastelli	112000003069	ACC NCDR	
Transposition of the Great Arteries - Aortic root translocation over left ventricle - Including Nikaidoh procedure	112000003071	ACC NCDR	
DORV - DORV - Intraventricular tunnel repair	112000003072	ACC NCDR	
Coarctation of Aorta and Aortic arch hypoplasia - Coarctation repair - End to end	112000003074	ACC NCDR	
Coarctation of Aorta and Aortic arch hypoplasia - Coarctation repair - End to end - Extended	112000003075	ACC NCDR	
Coarctation of Aorta and Aortic arch hypoplasia - Coarctation repair - Subclavian flap	112000003076	ACC NCDR	
Coarctation of Aorta and Aortic arch hypoplasia - Coarctation repair - Patch aortoplasty	112000003077	ACC NCDR	
Coarctation of Aorta and Aortic arch hypoplasia - Coarctation repair - Interposition graft	112000003078	ACC NCDR	
Coarctation of Aorta and Aortic arch hypoplasia - Aortic arch repair	112000003081	ACC NCDR	

Section: Cardiac Surgery History	Parent: Cardiac Surgery History	
Coronary Artery Anomalies - Anomalous origin of coronary artery from pulmonary artery repair	112000003084	ACC NCDR
Coronary Artery Anomalies - Coronary artery bypass	112000003085	ACC NCDR
Coronary Artery Anomalies - Anomalous aortic origin of coronary artery from aorta - repair	112000003086	ACC NCDR
Coronary Artery Anomalies - Coronary artery procedure - Other	112000003087	ACC NCDR
Interrupted Arch - Interrupted aortic arch repair	112000003088	ACC NCDR
Patent Ductus Arteriosus - PDA closure - Surgical	112000003089	ACC NCDR
Vascular Rings and Slings - Vascular ring repair	112000003091	ACC NCDR
Vascular Rings and Slings - Pulmonary artery sling repair	112000003093	ACC NCDR
Electrophysiological - Pacemaker implantation - Permanent	112000003101	ACC NCDR
Electrophysiological - Pacemaker procedure	112000003102	ACC NCDR
Electrophysiological - ICD - AICD - implantation	112000003103	ACC NCDR
Electrophysiological - ICD - AICD - procedure	112000003104	ACC NCDR
Electrophysiological - Arrhythmia surgery - Atrial - Surgical Ablation	112000003105	ACC NCDR
Electrophysiological - Arrhythmia surgery - Ventricular- Surgical Ablation	112000003106	ACC NCDR
RF ablation - RF ablation	112000003112	ACC NCDR
Palliative Procedures - Shunt - Systemic to pulmonary - Modified Blalock-Taussig Shunt	112000003114	ACC NCDR
Palliative Procedures - Shunt - Systemic to pulmonary - Central from aorta or to main pulmonary artery	112000003115	ACC NCDR
Palliative Procedures - Shunt - Systemic to pulmonary - Other	112000003116	ACC NCDR
Palliative Procedures - Shunt - Ligation and takedown	112000003117	ACC NCDR
Palliative Procedures - PA banding	112000003118	ACC NCDR
Palliative Procedures - PA debanding	112000003119	ACC NCDR
Palliative Procedures - Damus- Kaye-Stansel procedure - Creation of AP anastomosis without arch reconstruction	112000003120	ACC NCDR
Palliative Procedures - Bidirectional cavopulmonary anastomosis - BDCPA - bidirectional Glenn	112000003121	ACC NCDR
Palliative Procedures - Glenn unidirectional cavopulmonary anastomosis - unidirectional Glenn	112000003122	ACC NCDR
Palliative Procedures - Bilateral bidirectional cavopulmonary anastomosis - bilateral bidirectional Glenn	112000003123	ACC NCDR
Palliative Procedures - Hemifontan	112000003124	ACC NCDR
Miscellaneous Procedures - Aneurysm - Ventricular - Right Repair	112000003126	ACC NCDR

Section: Cardiac Surgery History		Parent: Cardiac Surgery History	
Miscellaneous Procedures - Aneurysm - Pulmonary artery - Repair	112000003128	ACC	NCDR
Miscellaneous Procedures - Ligation - Pulmonary artery	112000003133	ACC	NCDR
Miscellaneous Procedures - Pulmonary embolectomy - Chronic pulmonary embolus	112000003135	ACC	NCDR
Miscellaneous Procedures - Ligation - Thoracic duct	112000003138	ACC	NCDR
Palliative Procedures - Shunt - Reoperation	112000003161	ACC	NCDR
ASD - ASD repair - Patch plus PAPVC repair	112000003163	ACC	NCDR
Partial Anomalous Pulmonary Venous Connection - PAPVC repair - Baffle redirection to left atrium with systemic vein translocation - Warden - SVC sewn to right atrial appendage	112000003164	ACC	NCDR
Palliative Procedures - Superior Cavopulmonary anastomosis and PA reconstruction	112000003165	ACC	NCDR
Hypoplastic Left Heart - Hybrid approach - Stage 2 - Aortopulmonary amalgamation and Superior Cavopulmonary anastomosis and PA Debanding and Aortic arch repair - Norwood Stage 1 and Superior Cavopulmonary anastomosis and PA Debanding	112000003166	ACC	NCDR
Hypoplastic Left Heart - Hybrid Approach Stage 1 - Application of RPA and LPA bands	112000003168	ACC	NCDR
Hypoplastic Left Heart - Hybrid Approach Stage 1 - Stent placement in arterial duct - PDA	112000003169	ACC	NCDR
Truncus arteriosus - Truncus plus Interrupted aortic arch repair	112000003173	ACC	NCDR
AV Canal - Valvuloplasty converted to valve replacement in the same operation- Common atrioventricular valve	112000003176	ACC	NCDR
AV Canal - Valvuloplasty - Common atrioventricular valve	112000003181	ACC	NCDR
Single Ventricle - Fontan and Atrioventricular valvuloplasty	112000003185	ACC	NCDR
Electrophysiological - Explantation of pacing system	112000003186	ACC	NCDR
Mechanical Support - ECMO cannulation	112000003187	ACC	NCDR
Mechanical Support - ECMO decannulation	112000003188	ACC	NCDR
Mechanical Support - VAD implantation	112000003189	ACC	NCDR
Mechanical Support - VAD explantation	112000003190	ACC	NCDR
Interventional Cardiology Procedures - Cardiovascular catheterization procedure - Therapeutic- Adjunctive therapy	112000003213	ACC	NCDR
Aortic Surgery	32907006	SNOMED	CT
Aortic Valve Disease - Root replacement	112000003725	ACC	NCDR
ASD - Secundum ASD Closure	112000003726	ACC	NCDR

Section: EP Therapy History

Parent: Procedure History Details

Element: 15419 History of Electrophysiological Therapy

Coding Instruction: Indicate all electrophysiologic therapies that have been attempted.

Target Value: Any occurrence between birth and current procedure

Electrophysiological Procedure - 1.3.6.1.4.1.19376.1.4.1.6.5.887

Selection	Definition	Source	Code	Code System
Catheter Ablation	A procedure used to remove or terminate a faulty electrical pathway in the heart to treat cardiac arrhythmias		18286008:363702006=49436004	SNOMED CT
Cardiovascular Implantable Electronic Device	Includes prior implantation of devices such as, but not limited to, pacemakers, implantable cardioverter -defibrillators (ICDs), or cardiac resynchronization therapy (CRT) devices.		112000003721	ACC NCDR
Direct Current (DC) Cardioversion	Restores rhythm through the use of synchronized electrical shock.		180325003	SNOMED CT
Pharmacologic therapy	Antiarrhythmic drugs can be administered for attempted conversion of arrhythmias to sinus rhythm or to facilitate electrical cardioversion.		440142000	SNOMED CT
Surgical ablation or arrhythmia surgery	Refers to procedures such as the Maze procedure, surgical pulmonary vein isolation, or other surgical interventions for arrhythmia management.		64915003	SNOMED CT

Element: 16255 Prior EP Therapy(ies) Received Unknown

Coding Instruction: Select if prior electrophysiology therapy(ies) received are unknown.

Target Value: N/A

Section: EP Therapy Catheter Ablation

Parent: EP Therapy History

Element: 16223

Prior Catheter Ablation Counter

Coding Instruction: The prior catheter ablation counter distinguishes individual prior catheter ablations when multiple catheter ablations have been performed
 Note: The software-assigned device counter should start at one and be incremented by one for each device used.

Target Value: Any occurrence between birth and current procedure

Element: 16033

Substrate Treated

Coding Instruction: Select the arrhythmia substrate that was targeted and treated during any previous catheter ablation procedures. This refers to specific areas or pathways in the heart that were ablated to manage arrhythmias in past interventions.

Target Value: Any occurrence between birth and current procedure

Ablation Information - 1.3.6.1.4.1.19376.1.4.1.6.5.1134

Selection	Definition	Source	Code	Code System
Wolff-Parkinson-White (WPW)			74390002	SNOMED CT
Concealed accessory pathway/permanent junctional reciprocating tachycardia			233922008	SNOMED CT
AV nodal reentrant tachycardia (AVNRT)			251166008	SNOMED CT
Focal atrial tachycardia			713424004	SNOMED CT
Macroreentrant atrial tachycardia			735682000	SNOMED CT
Ventricular arrhythmias (PVCs, VT, VF)			44103008	SNOMED CT
Junctional tachycardia			426648003	SNOMED CT
Other	Select only when the substrate is not represented by any existing options. Use this category exclusively when no other selection is appropriate.		100000351	ACC NCDR

Section: EP Therapy Previous Ablation

Parent: EP Therapy Catheter Ablation

Element: 16034

Previous Ablation Location

Coding Instruction: Select the anatomical location(s) within the heart that were targeted during any prior catheter ablation procedures. This refers to the specific areas or regions of the heart where ablation was performed to treat arrhythmias in the past.

Target Value: Any occurrence between birth and current procedure

Electrophysiology Ablation Target - 1.3.6.1.4.1.19376.1.4.1.6.5.885

Selection	Definition	Source	Code	Code System
Tricuspid annulus - right anterior			112000002360	ACC NCDR
Tricuspid annulus - right lateral			112000002361	ACC NCDR
Tricuspid annulus - right posterior			112000002362	ACC NCDR
Tricuspid annulus - right posteroseptal			112000002363	ACC NCDR
Tricuspid annulus - right intermediate septal			112000002364	ACC NCDR
Tricuspid Annulus - Anteroseptal			112000002365	ACC NCDR
Mitral annulus - left intermediate			112000002366	ACC NCDR
Mitral annulus - left posterior			112000002368	ACC NCDR
Mitral annulus - left posteroseptal			112000002367	ACC NCDR
Mitral annulus - left lateral			112000002369	ACC NCDR
Mitral annulus - left anterolateral			112000002370	ACC NCDR
Coronary Sinus - Distal			112000002373	ACC NCDR
Coronary Sinus - Mid			112000002372	ACC NCDR
Coronary Sinus - Proximal			112000002371	ACC NCDR
Great Cardiac Vein Structure			5928000	SNOMED CT
Right Atrium - Triangle of Koch - Anterior			112000002376	ACC NCDR
Right Atrium - Triangle of Koch - Fast Pathway			112000002377	ACC NCDR
Right Atrium - Triangle of Koch - His Bundle			112000002378	ACC NCDR
Right Atrium - Triangle of Koch - Mid			112000002375	ACC NCDR
Right Atrium - Triangle of Koch - Posterior			112000002374	ACC NCDR
Right atrium - crista terminalis			112000002388	ACC NCDR
Right atrium - superior vena cava			112000002393	ACC NCDR
Right atrium - right side of interatrial septum			112000002392	ACC NCDR
Right atrium - right atrial appendage			112000002391	ACC NCDR
Right atrium - posterior free wall			112000002390	ACC NCDR
Right atrium - lateral free wall			112000002389	ACC NCDR
Right Ventricle - TOF-Isthmus Between VSD Patch and Tricuspid Valve			112000002404	ACC NCDR
Right Ventricle - TOF-Isthmus Between VSD Patch and Pulmonary Valve			112000002403	ACC NCDR
Right Ventricle - TOF-Isthmus Between RVOT Patch and Tricuspid Valve			112000002402	ACC NCDR
Right Ventricle - TOF-Isthmus Between RVOT Patch and Pulmonary Valve			112000002401	ACC NCDR
Right Ventricle - RVOT			112000002400	ACC NCDR
Right ventricle - posterior septum			112000002399	ACC NCDR
Right ventricle - posterior free wall			112000002398	ACC NCDR
Right ventricle - mid-septum			112000002397	ACC NCDR

Section: EP Therapy Previous Ablation		Parent: EP Therapy Catheter Ablation	
Right ventricle - mid-free wall	112000002396	ACC NCDR	
Right ventricle - anterior septum	112000002395	ACC NCDR	
Right ventricle - anterior free wall	112000002394	ACC NCDR	
Left ventricle - anterior fascicle	112000002405	ACC NCDR	
Left ventricle - area of aorto-mitral continuity	112000002406	ACC NCDR	
Left ventricle - left coronary cusp	112000002407	ACC NCDR	
Left ventricle - posterior fascicle	112000002408	ACC NCDR	
Left ventricle - right coronary cusp	112000002409	ACC NCDR	
CTI	100000981	ACC NCDR	
Aorta - Non-Coronary Cusp	112000002410	ACC NCDR	
Left atrium - lateral free wall	112000002379	ACC NCDR	
Left atrium - left atrial appendage	112000002380	ACC NCDR	
Left atrium - left side of interatrial septum	112000002381	ACC NCDR	
Left Atrium - LIPV	112000002382	ACC NCDR	
Left Atrium - LSPV	112000002383	ACC NCDR	
Left atrium - posterior free wall	112000002384	ACC NCDR	
Left Atrium - RIPV	112000002385	ACC NCDR	
Left Atrium - RSPV	112000002386	ACC NCDR	
Left Atrium Roof Isthmus	112000002387	ACC NCDR	

Section: EP Therapy Same Target

Parent: EP Therapy Catheter Ablation

Element: 16099

Prior Ablation Same Target as Current Procedure

Coding Instruction: Indicate whether the prior ablation was the same target as a target being ablated during the current procedure.

Target Value: Any occurrence between birth and current procedure

Section: History and Risk Factors

Parent: History and Risk Factors

Element: 15041 Gestational Age

Coding Instruction: Indicate the number of full weeks of the patient's estimated gestational age at birth.

Note(s): Code only for patients who are less than 1 year old at time of arrival. If gestational age is known, enter the number of full weeks gestation completed.

Target Value: The value at birth

Supporting Definition: **Gestational Age at Birth**

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

Element: 15846 Gestational Age Not Documented

Coding Instruction: Indicate whether gestational age was not documented.

Target Value: The value at birth

Element: 15040 Birth Weight

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

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

Target Value: The value at birth

Element: 15845 Birth Weight Not Documented

Coding Instruction: Indicate if birth weight was not documented.

Target Value: The value at birth

Section: Prior Device

Parent: Prior Device History

Element: 16175 Prior Device History Device Counter

Coding Instruction: The device counter distinguishes individual devices when a patient has a history of multiple device implants.
Note: The software-assigned device counter should start at one and be incremented by one for each device used.

Target Value: Any occurrence between birth and current procedure

Element: 16176 Prior Cardiac Implantable Electronic Device Type

Coding Instruction: Select the type of cardiac implantable electronic device (CIED) previously implanted.

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

Prior Cardiac Implantable Electronic Device Type - 1.3.6.1.4.1.19376.1.4.1.6.5.1122

Selection	Definition	Source	Code	Code System
Implantable loop recorder			112000003952	ACC NCDR
ICD generator			112000003836	ACC NCDR
Pacemaker generator			118378005	SNOMED CT
Leads only			112000003835	ACC NCDR

Element: 16174 Prior Device History Unknown

Coding Instruction: Select this field if the patient has had or currently has a prior device but the specifics of the device implant are unknown. Specifics include indication of implant, date of implant, and whether it was a new device or replaced an existing device. This situation may arise if the patient was cared for at a different location or if historical documentation is unavailable. If this field is selected, indicate the type of device previously implanted.

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

Element: 16178 Prior Device Implant Date

Coding Instruction: Record the implant date of the previous implant.

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

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

Element: 16205 Prior Device ID

Coding Instruction: Indicate the prior device ID.

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

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

Element: 16177 Prior Device Serial Number

Coding Instruction: Record the manufacturer's device serial number.

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

Element: 16179 Prior Device Status

Coding Instruction: Indicate whether the prior device was the initial device (not replacing an existing device) or a generator change.

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

PDHx Prior Pacemaker Device Status - 1.3.6.1.4.1.19376.1.4.1.6.5.1123

Selection	Definition	Source	Code	Code System
Initial device implant	The patient received the specific device type (i.e. ILR, PM/ICD generator, or lead) for the first time.		112000003662	ACC NCDR
Device change	The patient already had a device and received a generator that was an upgrade or change from one that was initially implanted.		112000004134	ACC NCDR

Element: 16180 Prior Device In Situ

Coding Instruction: Indicate whether the previously implanted device is in situ at the start of current procedure. Select 'no' if the device has been explanted.

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

Section: Prior Device

Parent: Prior Device History

Element: 16181

Prior Explant Date

Coding Instruction: Record the explant date of the previously explanted device.

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

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

Element: 16182

Prior Explant Reason

Coding Instruction: Select the reason(s) the previously implanted device was explanted.

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

ILRP Indication For Reimplantation of Implantable Loop Recorder - 1.3.6.1.4.1.19376.1.4.1.6.5.1069

Selection	Definition	Source	Code	Code System
Relocation	The device was explanted because it needed to be relocated.		112000003953	ACC NCDR
End of expected battery life	The device was explanted due to its battery reaching the end of its expected lifespan.		100001088	ACC NCDR
Erosion	The device was explanted due to erosion of the device through the skin or surrounding tissue.		100014134	ACC NCDR
Faulty connector/header	The device was explanted due to a defect or malfunction in the connector block of a device, which is the part where the leads are attached to the device. This issue can compromise the electrical connection between the device and the leads, potentially leading to improper pacing or sensing functions.		112000004177	ACC NCDR
Infection	The device was explanted due to infection.		112000002137	ACC NCDR
Malfunction	The device was explanted due to a device malfunction or failure.		112000001504	ACC NCDR
Replacement of device at the time of lead revision	The device was explanted and replaced when the leads were being revised.		112000004175	ACC NCDR
Replacement of device at the time of upgrade	The device was explanted and replaced because an upgrade was being implanted.		112000004176	ACC NCDR
Under manufacturer advisory/recalled	The device was explanted following a manufacturer issued advisory or recall		100001093	ACC NCDR
Other			100000351	ACC NCDR

Element: 16183

Prior Implantable Loop Recorder Indication

Coding Instruction: Select the reason(s) for implantation of the previous implantable loop recorder.

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

ILRP Indications - 1.3.6.1.4.1.19376.1.4.1.6.5.1068

Selection	Definition	Source	Code	Code System
Abnormal ECG or Holter monitor results	The device was implanted due to abnormal findings on prior ECG or Holter monitor studies.		1000142474	ACC NCDR
Palpitations	The device was implanted due to palpitations.		80313002	SNOMED CT
Pre-syncope	The device was implanted to investigate episodes of near-fainting or lightheadedness.		427461000	SNOMED CT
Replacement	The device was implanted as a replacement for a previous device.		384728007	SNOMED CT
Risk of malignant arrhythmia	The device was implanted to monitor for potentially life-threatening arrhythmias.		698247007	SNOMED CT
Syncope	The device was implanted due to syncope.		271594007	SNOMED CT
At Risk Genotype	The device was implanted because of a genetic predisposition to arrhythmias or other cardiac conditions.		112000004230	ACC NCDR
Other			100000351	ACC NCDR

Element: 16184

Prior Implantable Loop Recorder Laterality

Coding Instruction: Indicate the location of the previously implanted implantable loop recorder.

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

ILRP Device Laterality - 1.3.6.1.4.1.19376.1.4.1.6.5.1072

Selection	Definition	Source	Code	Code System
Right chest			112000003956	ACC NCDR
Left chest			112000003957	ACC NCDR

Section: Prior Device

Parent: Prior Device History

Element: 16185 Prior Implantable Loop Recorder Location

Coding Instruction: Select the specific location of the previously implanted implantable loop recorder.

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

ILRP Implantable Loop Recorder Location - 1.3.6.1.4.1.19376.1.4.1.6.5.1073

Selection	Definition	Source	Code	Code System
Parasternal			261149009	SNOMED CT
Intercostal			1197041002	SNOMED CT
Axillary			91470000	SNOMED CT
Other			100000351	ACC NCDR

Element: 16186 Prior Pacemaker Indication

Coding Instruction: Select the reason(s) the previous pacemaker generator was implanted.

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

ICD Pacemaker Generator Indication - 1.3.6.1.4.1.19376.1.4.1.6.5.1089

Selection	Definition	Source	Code	Code System
Sinus node dysfunction	The pacemaker was implanted to treat conditions like sinus bradycardia, sinus arrest, or chronotropic incompetence.		60423000	SNOMED CT
AV junctional rhythm	The pacemaker was implanted to manage a junctional rhythm.		11849007	SNOMED CT
2nd degree or high grade block	The pacemaker was implanted to address any second-degree AV block or high-grade AV block.		195042002	SNOMED CT
Complete heart block	The pacemaker was implanted to treat complete (third-degree) AV block.		27885002	SNOMED CT
Ventricular dysfunction	The pacemaker was implanted to improve ventricular function.		112000004022	ACC NCDR
SVT treatment	The pacemaker was implanted to manage supraventricular tachycardias, such as through overdrive pacing.		6456007	SNOMED CT
Other			100000351	ACC NCDR

Element: 16187 Prior Pacemaker Generator Upgrade

Coding Instruction: Indicate whether the generator change involved an upgrade to a different type or newer model of generator.

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

Element: 16188 Prior Pacemaker Generator Upgrade Type

Coding Instruction: Select the type of generator upgrade for the previously implanted pacemaker.

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

Pacemaker Change Upgrade Type - 1.3.6.1.4.1.19376.1.4.1.6.5.1090

Selection	Definition	Source	Code	Code System
Single to dual chamber	The pacemaker was upgraded from a single-chamber system (either atrial or ventricular) to a dual-chamber system, providing pacing for both the atrium and ventricle.		112000003989	ACC NCDR
Pacemaker to cardiac resynchronization therapy with pacemaker	The system was upgraded to include cardiac resynchronization therapy (CRT-P), adding or reconfiguring leads to synchronize ventricular contractions.		112000004024	ACC NCDR
Pacemaker to conduction system pacing	The pacemaker system was modified to pace the heart through the conduction system, such as His-bundle pacing or left bundle branch area pacing.		112000004025	ACC NCDR

Element: 16189 Prior Implantable Cardioverter Defibrillator Generator Type

Coding Instruction: Select the prior implantable cardioverter defibrillator generator type.

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

Prior Implantation Device Type - Dynamic - 1.3.6.1.4.1.19376.1.4.1.6.5.1141

Selection	Definition	Source	Code	Code System
ICD single chamber	A single-chamber ICD defibrillates the ventricle and paces the ventricle.		100001214	ACC NCDR
ICD dual chamber	A dual-chamber ICD defibrillates the ventricle and paces the atrium and ventricle.		100001215	ACC NCDR

Section: Prior Device		Parent: Prior Device History	
Cardiac resynchronization therapy - defibrillator	A cardiac resynchronization therapy device and defibrillator (CRT-D) has dual capabilities. It is a biventricular pacemaker that sends electrical signals to both ventricles as well as a defibrillator. It may or may not have an atrial pacing wire.	100001216	ACC NCDR
Subcutaneous ICD	A subcutaneous only defibrillator.	100001217	ACC NCDR
Extravascular ICD	The extravascular (EV) ICD system has a lead (thin wire) placed outside the heart and veins, under the sternum (breastbone).	112000003612	ACC NCDR

Element: 16190 Prior Implantable Cardioverter Defibrillator Indication

Coding Instruction: Select the indication for the prior implantable cardioverter defibrillator.

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

Procedure Indication - 1.3.6.1.4.1.19376.1.4.1.6.5.33

Selection	Definition	Source	Code	Code System
Primary prevention	An indication for an ICD to prevent sudden cardiac death. It refers to use of ICDs in individuals who are at risk for but have not yet had an episode of sustained ventricular tachycardia, ventricular fibrillation, or resuscitated cardiac arrest.		315233008	SNOMED CT
Secondary prevention	An indication for ICD exclusively for patients who have survived one or more cardiac arrests or sustained ventricular tachycardia. Patients with cardiac conditions associated with a high risk of sudden death who have unexplained syncope that is likely to be due to ventricular arrhythmias are considered to have a secondary indication.		315234002	SNOMED CT

Element: 16191 Prior Implantable Cardioverter Defibrillator Generator Upgrade

Coding Instruction: Indicate whether the generator change for the prior implantable cardioverter defibrillator was a generator upgrade.

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

Element: 16192 Prior Implantable Cardioverter Defibrillator Generator Change Type

Coding Instruction: Select the type of generator change (upgrade or downgrade) for the prior implantable cardioverter defibrillator.

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

Prior ICD Generator Upgrade Type - 1.3.6.1.4.1.19376.1.4.1.6.5.1125

Selection	Definition	Source	Code	Code System
Single chamber to dual chamber			112000004143	ACC NCDR
Implantable cardioverter defibrillator to cardiac resynchronization therapy with defibrillator			112000003990	ACC NCDR
Pacemaker to implantable cardioverter defibrillator			112000004144	ACC NCDR
Subcutaneous to transvenous implantable cardioverter defibrillator			112000004146	ACC NCDR
Transvenous to subcutaneous implantable cardioverter defibrillator			112000004145	ACC NCDR
ICD to Pacemaker			112000004208	ACC NCDR
Transvenous to EV-ICD			112000004201	ACC NCDR
S-ICD to EV-ICD			112000004202	ACC NCDR

Element: 16193 Specify Prior ICD Change

Coding Instruction: Select the specific type of generator upgrade for the prior implantable cardioverter defibrillator.

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

ICD Upgrade Type Detail - 1.3.6.1.4.1.19376.1.4.1.6.5.1084

Selection	Definition	Source	Code	Code System
Ventricular pacemaker to single chamber ICD			112000003995	ACC NCDR
Ventricular pacemaker to dual chamber ICD			112000003996	ACC NCDR

Section: Prior Device	Parent: Prior Device History
Ventricular pacemaker to cardiac resynchronization therapy defibrillator	112000003997 ACC NCDR
Ventricular pacemaker to conduction system pacing defibrillator	112000003998 ACC NCDR
Atrial pacemaker to dual chamber ICD	112000003999 ACC NCDR
Atrial pacemaker to cardiac resynchronization therapy defibrillator	112000004000 ACC NCDR
Atrial pacemaker to conduction system pacing defibrillator	112000004001 ACC NCDR
Transvenous ICD to subcutaneous ICD	112000004002 ACC NCDR
Cardiac resynchronization therapy pacemaker to cardiac resynchronization therapy defibrillator	112000004003 ACC NCDR
Cardiac resynchronization therapy pacemaker to conduction system pacing defibrillator	112000004004 ACC NCDR
Subcutaneous ICD to transvenous ICD	112000004148 ACC NCDR
Single chamber ICD to single chamber PPM	112000004200 ACC NCDR
Transvenous to EV-ICD	112000004201 ACC NCDR
S-ICD to EV-ICD	112000004202 ACC NCDR
Single/dual chamber to CRT-P	112000004203 ACC NCDR
Dual chamber to conduction system pacing	112000004204 ACC NCDR
Single/dual chamber to leadless	112000004205 ACC NCDR
Dual chamber ICD to dual chamber PPM	112000004206 ACC NCDR
Single chamber to conduction system pacing	112000004207 ACC NCDR

Element: 16194 Prior Implantable Cardioverter Defibrillator Generator Shock History

Coding Instruction: Select the shock history for the prior implantable cardioverter defibrillator.

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

Vendor Instruction: When Prior Implantable Cardioverter Defibrillator Generator Shock History (16194) is [No prior shock(s)], no other selections can be selected

Prior ICD Generator Shock History - 1.3.6.1.4.1.19376.1.4.1.6.5.1126

Selection	Definition	Source	Code	Code System
Appropriate shock(s)	The patient had previously received shocks and the shocks were produced appropriately for ventricular fibrillation or ventricular tachycardia.		112000004150	ACC NCDR
Inappropriate shock(s) (from SVT)	The generator produced inappropriate shocks.		112000004151	ACC NCDR
Inappropriate shock(s) from malfunctions	The generator produced inappropriate shocks due to a malfunctioning lead or oversensing.		112000004152	ACC NCDR
No prior shock(s)	No prior shocks have been documented or reported.		112000004153	ACC NCDR

Element: 16195 Prior Implant Location

Coding Instruction: Select the location of the previously implanted pacemaker or ICD.

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

Pacemaker Implant Location - 1.3.6.1.4.1.19376.1.4.1.6.5.1091

Selection	Definition	Source	Code	Code System
Left axillary			112000004008	ACC NCDR
Left pre-pectoral			112000004006	ACC NCDR
Left sub-pectoral			112000004007	ACC NCDR
Right axillary			112000004013	ACC NCDR
Right pre-pectoral			112000004011	ACC NCDR
Right sub-pectoral			112000004012	ACC NCDR

Section: Prior Device

Parent: Prior Device History

Intrathoracic	112000004026	ACC NCDR
Subrectus	112000004009	ACC NCDR
Other	100000351	ACC NCDR

Element: 16196 Previous Antibiotic Pouch Used

Coding Instruction: Indicate whether an antibiotic pouch was used at the time of implant to reduce the risk of infection.

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

Previous Antibiotic Pouch Used - 1.3.6.1.4.1.19376.1.4.1.6.5.1127

Selection	Definition	Source	Code	Code System
No			100013073	ACC NCDR
Yes			100013072	ACC NCDR
Not documented			100001036	ACC NCDR

Element: 16232 Prior Lead ID

Coding Instruction: Indicate the lead ID for the previously implanted leads or subcutaneous components.

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

Element: 16197 Prior Lead or Subcutaneous Component Type

Coding Instruction: Select the type of lead or component that was previously implanted.

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

CIED Lead Type - 1.3.6.1.4.1.19376.1.4.1.6.5.1119

Selection	Definition	Source	Code	Code System
Atrial pace or sense lead	A lead placed in the atrium to deliver pacing therapy or sense atrial activity.		112000004120	ACC NCDR
Ventricular pace or sense lead	A lead placed in the ventricle to deliver pacing therapy or sense ventricular activity.		112000004121	ACC NCDR
Coronary sinus pace or sense lead	A lead positioned in the coronary sinus, typically used for left ventricular pacing in cardiac resynchronization therapy.		112000004122	ACC NCDR
Implantable cardioverter defibrillator lead	A lead that delivers defibrillation and/or pacing therapy, placed in the right ventricle or another chamber as appropriate.		112000004123	ACC NCDR
Subcutaneous implantable cardioverter defibrillator lead	A lead used with a subcutaneous ICD system.		112000004124	ACC NCDR
Implantable cardioverter defibrillator coil only	A component of the ICD system that functions solely as a defibrillation coil without sensing or pacing capabilities.		112000004125	ACC NCDR
Implantable cardioverter defibrillator patch	A patch electrode used to deliver defibrillation therapy, commonly associated with epicardial or subcutaneous ICD systems.		112000004126	ACC NCDR
Other			100000351	ACC NCDR
Extravascular ICD (EV-ICD) lead	A lead used with the Extravascular ICD (EV-ICD) system.		112000003612	ACC NCDR

Element: 16198 Prior Lead Location

Coding Instruction: Select the location of the previously implanted lead.

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

Prior Lead Location - 1.3.6.1.4.1.19376.1.4.1.6.5.1128

Selection	Definition	Source	Code	Code System
Transvenous or endocardial			112000004162	ACC NCDR
Epicardial			261073003	SNOMED CT
Subcutaneous			764295003	SNOMED CT
Extravascular			112000004199	ACC NCDR
Other			100000351	ACC NCDR

Element: 16199 Prior Transvenous or Endocardial Lead Location

Coding Instruction: Select the location of the previously implanted transvenous/endocardial lead.

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

Prior Transvenous or Endocardial Lead Location - 1.3.6.1.4.1.19376.1.4.1.6.5.1129

Selection	Definition	Source	Code	Code System
Systemic venous atrium			112000004164	ACC NCDR

Section: Prior Device

Parent: Prior Device History

Pulmonary venous atrium	112000004165	ACC NCDR
Subpulmonary ventricle	112000004166	ACC NCDR
Systemic ventricle	112000004167	ACC NCDR
Coronary sinus	90219004	SNOMED CT
Fontan baffle	112000003862	ACC NCDR
Other	100000351	ACC NCDR

Element: 16200 Complications During Past Cardiac Implantable Electronic Device Surgery

Coding Instruction: Indicate whether the patient experienced complications related to the prior cardiac implantable electronic device procedure. This may include an intra- or post-procedure complication that is directly attributable to the prior device implant -acute or chronic.

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

Element: 16201 Date of Complication During Prior Cardiac Implantable Electronic Device Procedure

Coding Instruction: Record the date of the last complication the patient experienced related to the prior cardiac implantable electronic device procedure. This may include an intra- or post-procedure complication that is directly attributable to the prior device implant -acute or chronic.

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

Element: 16202 Complication(s) During Prior Cardiac Implantable Electronic Device Surgery

Coding Instruction: Select the complication(s) the patient experienced related to the prior cardiac implantable electronic device procedure. This may include an intra- or post-procedure complication that is directly attributable to the prior device implant -acute or chronic.

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

Complications Prior CIED Surgery - 1.3.6.1.4.1.19376.1.4.1.6.5.1130

Selection	Definition	Source	Code	Code System
Device erosion	Select if there is documentation that the device was replaced due to erosion through the skin or surrounding tissue.		100014134	ACC NCDR
Endocarditis	Select if there is documentation of endocarditis, an infection of the inner lining of the heart (endocardium).		56819008	SNOMED CT
Exit block	Select if there is documentation of exit block, which refers to the inability of electrical activity in the pulmonary veins (PVs) to reach the left atrium (LA).		100001002	ACC NCDR
Faulty connector or head	Select if there is documentation of a defect or malfunction in the connector block, where leads attach to the device, compromising the electrical connection and potentially affecting pacing or sensing functions.		112000003988	ACC NCDR
Lead dislodgement	Select if there is documentation that the patient experienced lead dislodgement, defined as the unintended movement of a cardiac device lead from its original implantation site within the heart or vascular system.		234233007	SNOMED CT
Pericardial effusion requiring intervention	Select if there is documentation of a pericardial effusion, the accumulation of fluid around the heart, that required medical or surgical intervention.		100001073	ACC NCDR
Pneumothorax requiring intervention	Select if there is documentation of a pneumothorax, the accumulation of air in the pleural space as a complication of lead placement, requiring medical or surgical intervention.		112000002152	ACC NCDR
Sepsis	Select if there is documentation of sepsis, defined as a serious infection with systemic inflammatory response (SIRS). SIRS is present when at least two criteria are met: abnormal temperature, heart rate, respiratory rate, or white blood cell count.		91302008	SNOMED CT
Stroke	Select if there is documentation or diagnosis of a stroke, defined as a disruption in blood flow to the brain causing neurological deficits lasting more than 24 hours.		100000977	ACC NCDR
Lead conductor fracture	Select if there is documentation of a lead conductor fracture, a break in the conductor wires within the lead that impairs signal transmission.		112000004169	ACC NCDR
Lead insulation break	Select if there is documentation of a lead insulation break, involving damage to the protective insulation around a lead, exposing internal wires and affecting performance.		762681007	SNOMED CT
Lead malposition	Select if there is documentation of lead malposition, indicating the lead is incorrectly or unintentionally placed, compromising its function.		112000004170	ACC NCDR
Lead perforation	Select if there is documentation of lead perforation,		112000004171	ACC NCDR

Section: Prior Device		Parent: Prior Device History	
	where the lead has penetrated through the heart or vascular structure, potentially causing complications.		
Phrenic capture requiring lead revisions	Select if there is documentation of phrenic nerve capture, where the device stimulates the phrenic nerve causing diaphragm contractions, requiring lead adjustment or replacement.	112000004172	ACC NCDR
Wound or pocket infection	Select if there is documentation of a wound or pocket infection, where the surgical site or device pocket shows signs of infection such as redness, swelling, or discharge.	112000004173	ACC NCDR

Section: Diagnostic Studies

Parent: Root

Element: 16084 Ventricular Function Assessed

Coding Instruction: Indicate whether ventricular function was assessed.

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

Element: 16085 Ejection Fraction

Coding Instruction: Record the ejection fraction (in percent). The ejection fraction can be assessed via invasive (i.e. LV gram), or non-invasive (i.e. Echo, MR, CT or Nuclear) testing. Enter left ventricle ejection fraction unless single ventricle or 1.5 ventricle circulation is present.

Note(s):

Enter a percentage in the range of 01–99. If a percentage range is reported, report the center number in the range (e.g., 50–55% is 52.5 reported to the next whole number is 53%). For EF measurements reported as "less than" or "greater than," code to the nearest whole number (e.g., <40% is coded as 39%, and >40% is coded as 41%).

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

Element: 16086 Ejection Fraction Not Documented

Coding Instruction: Indicate if the ejection fraction was not documented.

Target Value: N/A

Element: 16087 Shortening Fraction

Coding Instruction: Record the shortening fraction (sometimes called fraction shortening) as an estimate of ventricular function.

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

Element: 16088 Shortening Fraction Not Documented

Coding Instruction: Indicate if the shortening fraction was not documented.

Target Value: N/A

Element: 16089 Qualitative Assessment

Coding Instruction: Select the qualitative assessment assigned to the patient's ventricular function.

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

DS Ventricular Function Qualitative Assessment - 1.3.6.1.4.1.19376.1.4.1.6.5.1075

Selection	Definition	Source	Code	Code System
Normal	Ejection fraction is within the normal range.		17621005	SNOMED CT
Mild	Mild dysfunction		255604002	SNOMED CT
Moderate	Moderate dysfunction		6736007	SNOMED CT
Severe			24484000	SNOMED CT
Not documented	No classification is provided		112000001830	ACC NCDR

Element: 16092 Late Gadolinium Enhancement (LGE) (noted on Cardiac MRI)

Coding Instruction: Indicate if late gadolinium enhancement was noted on a cardiac magnetic resonance imaging study. This refers to areas of myocardial tissue that retain gadolinium longer than normal tissue, often indicating fibrosis or scarring. This would typically be documented on the cardiac MRI imaging interpretation.

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

Element: 16134 Cardiac MRI Not Performed

Coding Instruction: Indicate if a cardiac MRI was not performed within 90 days of procedure start.

Target Value: N/A

Element: 16217 Late Gadolinium Enhanced Tissue Locations

Coding Instruction: Select the locations of late gadolinium enhanced tissues noted on the magnetic resonance imaging study.

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

LGE Tissues - 1.3.6.1.4.1.19376.1.4.1.6.5.1142

Selection	Definition	Source	Code	Code System
Right ventricle			53085002	SNOMED CT

Section: Diagnostic Studies

Parent: Root

Left ventricle	112000004083	ACC NCDR
Both	251267008	SNOMED CT

Element: 16093 Location of Late Gadolinium Enhancement

Coding Instruction: Select the location(s) of late gadolinium enhancement noted on the magnetic resonance imaging study.

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

DS Location of Late Gadolinium Enhancement - 1.3.6.1.4.1.19376.1.4.1.6.5.1077

Selection	Definition	Source	Code	Code System
Apex			112000003978	ACC NCDR
Apical anterior			112000003974	ACC NCDR
Apical inferior			112000003976	ACC NCDR
Apical lateral			112000003977	ACC NCDR
Apical septal			112000003975	ACC NCDR
Basal anteriolateral			112000003967	ACC NCDR
Basal anterior			112000003962	ACC NCDR
Basal anteroseptal			112000003963	ACC NCDR
Basal inferiolateral			112000003966	ACC NCDR
Basal inferior			112000003965	ACC NCDR
Basal inferoseptal			112000003964	ACC NCDR
Basal Superior			112000004227	ACC NCDR
Mid anterior			112000003968	ACC NCDR
Mid anterolateral			112000003973	ACC NCDR
Mid anteroseptal			112000003969	ACC NCDR
Mid inferior			112000003971	ACC NCDR
Mid inferolateral			112000003972	ACC NCDR
Mid inferoseptal			112000003970	ACC NCDR
Midventricular			112000004228	ACC NCDR

Element: 16094 Percentage of Late Gadolinium Enhancement

Coding Instruction: Record the percentage of late gadolinium enhancement, if quantified, noted on the magnetic resonance imaging study.

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

Element: 16095 Percentage of Late Gadolinium Enhancement Not Documented

Coding Instruction: Indicate if a quantified percentage of late gadolinium enhancement was not documented on the magnetic resonance imaging study within 90 days of procedure start.

Target Value: N/A

Element: 5030 Electrocardiogram Performed

Coding Instruction: Indicate if the patient had an electrocardiogram (ECG).

Note: 12-lead ECG only

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

Element: 5035 Electrocardiogram Date

Coding Instruction: Indicate the date in which the most recent electrocardiogram (ECG) was performed.

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

Element: 16096 Rhythm on Electrocardiogram

Coding Instruction: Select the rhythm(s) identified and documented from the interpretation of the electrocardiogram.

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

DS Rhythm on Electrocardiogram - 1.3.6.1.4.1.19376.1.4.1.6.5.1078

Selection	Definition	Source	Code	Code System
Sinus rhythm			64730000	SNOMED CT
Atrial ectopic tachycardia (AET)			233892002	SNOMED CT
Supraventricular tachycardia (SVT)			6456007	SNOMED CT
Atrial fibrillation			49436004	SNOMED CT

Section: Diagnostic Studies		Parent: Root	
Atrial flutter	5370000	SNOMED CT	
AV junctional rhythm	11849007	SNOMED CT	
Idioventricular rhythm	112000003866	ACC NCDR	
Second degree AV block	195042002	SNOMED CT	
Third degree AV block	27885002	SNOMED CT	
Sinus arrest	5609005	SNOMED CT	
Atrial paced	100000941	ACC NCDR	
Ventricular paced	251266004	SNOMED CT	
Ventricular tachycardia	25569003	SNOMED CT	
Other rhythm not listed	100000351	ACC NCDR	

Element: 16245 Rhythm on ECG Not Documented

Coding Instruction: Select if ECG rhythm is not documented

Target Value: N/A

Element: 5045 Only Ventricular Paced QRS Complexes Present

Coding Instruction: Indicate if there were only ventricular paced QRS complexes present.

Note(s):

If the patient has some intrinsic ventricular complexes present, code "No".

If no ECG is available, a pre-procedure 6 inch cardiac rhythm strip or clinician documentation may be utilized to obtain this information.

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

Element: 5050 Ventricular Paced QRS Duration

Coding Instruction: Indicate the duration of the ventricular paced QRS complex in milliseconds.

Note(s): Use the following hierarchy to code:

1. Provider documentation of QRS duration. If not available, then
2. Most recent surface 12-lead ECG. If not available, then
3. 6-inch rhythm strip and/or device interrogation.

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

Element: 16097 Paced QRS Morphology

Coding Instruction: Select the morphology (or morphologies) describing the paced QRS wave pattern.

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

DS Paced QRS Morphology - 1.3.6.1.4.1.19376.1.4.1.6.5.1079

Selection	Definition	Source	Code	Code System
Right bundle branch block			164907000	SNOMED CT
Left bundle branch block			63467002	SNOMED CT
Intraventricular conduction delay			4554005	SNOMED CT

Element: 5055 Non-Ventricular Paced QRS duration

Coding Instruction: Indicate the duration of the non-ventricular paced or intrinsic QRS complex in milliseconds.

Note(s): Use the following hierarchy to code:

1. Provider documentation of QRS duration. If not available, then
2. Most recent surface 12-lead ECG. If not available, then
3. 6-inch rhythm strip and/or device interrogation.

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

Element: 16098 Intrinsic QRS Morphology

Coding Instruction: Select the morphology (or morphologies) describing the intrinsic QRS wave pattern.

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

Section: Diagnostic Studies

Parent: Root

Vendor Instruction: When Intrinsic QRS Morphology (16098) is [Normal], no other selections can be selected

DS Intrinsic Paced QRS Morphology - 1.3.6.1.4.1.19376.1.4.1.6.5.1080

Selection	Definition	Source	Code	Code System
Normal			17621005	SNOMED CT
Left anterior fascicular block			37760005	SNOMED CT
Left posterior fascicular block			62026008	SNOMED CT
Left bundle branch block			63467002	SNOMED CT
Right bundle branch block			164907000	SNOMED CT
Intraventricular conduction delay			4554005	SNOMED CT
Alternating RBBB and LBBB			32758004	SNOMED CT

Section: Lab Visit

Parent: Root

Element: 15081

Procedures Performed

Coding Instruction: Indicate the procedure(s) that were attempted or performed in the cath lab, regardless of whether the procedure actually occurred.

Note: If a cardiac biopsy occurred, code non-module intervention.

Target Value: The value on current procedure

Vendor Instruction: For Procedures Performed (15081), cannot select [Diagnostic catheterization only] with [Coarctation intervention, Proximal PA stenting, Atrial septal defect closure, Transcatheter pulmonary valve replacement, Premature infant patent ductus arteriosus closure, Aortic valvuloplasty, Other intervention (non-module)]

For Procedures Performed (15081), cannot select [EP study without ablation] with [EP study with ablation]

IMPACT Procedure Type - 1.3.6.1.4.1.19376.1.4.1.6.5.813

Selection	Definition	Source	Code	Code System
Coarctation intervention	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.	NCDR	112000002204	ACC NCDR
Proximal PA stenting	Pulmonary artery stenosis is a narrowing (stenosis) that occurs in the pulmonary artery. Pulmonary artery stenting consists of moving a balloon catheter into the narrowed area of the pulmonary artery, then inserting a stent in that segment.	NCDR	112000002205	ACC NCDR
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 an ASD closure procedure, a catheter is threaded to the heart's septum and a device is positioned so that it plugs the hole between the atria.	NCDR	112811009	SNOMED CT
Transcatheter pulmonary valve replacement	Transcatheter pulmonary valve replacement (TPVR) is a percutaneous pulmonary valve replacement procedure to treat pulmonary regurgitation and right ventricular outflow tract obstruction.	NCDR	442525005	SNOMED CT
Premature infant patent ductus arteriosus closure	For the IMPACT Registry, a premature infant is defined as 24-37 weeks pre-term or weighing less than 2500 grams at birth. 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. During a PDA closure procedure a physician passes a small metal coil or other blocking device through a catheter to the site of the PDA. This corrects the congenital defect by blocking blood flow through the vessel.		445089003	SNOMED CT
Aortic valvuloplasty	Aortic valve stenosis is a narrowing of the aortic valve. Aortic valvuloplasty is the repair of a stenotic aortic valve by inserting a balloon catheter inside the valve. The balloon is inflated in an effort to increase the opening size of the valve and improve blood flow.	NCDR	77166000	SNOMED CT
Other intervention (non-module)			100000351	ACC NCDR
Diagnostic catheterization only	There was no therapeutic treatment attempted or completed by the interventional cardiologist during the case.		41976001	SNOMED CT
EP study without ablation			112000003838	ACC NCDR
EP study with ablation			112000003837	ACC NCDR
ICD generator			112000003836	ACC NCDR
Implantable loop recorder			1344962007	SNOMED CT
Leads only			112000003835	ACC NCDR
Pacemaker pulse generator			118378005	SNOMED CT

Element: 15694

Procedure Room Entry Date and Time

Coding Instruction: Indicate the date and time the patient entered the procedure room.

Target Value: The value on current procedure

Section: Lab Visit
Parent: Root

Vendor Instruction: Procedure Room Entry Date and Time (15694) must be >= Arrival Date and Time (3001)
 Procedure Room Entry Date and Time (15694) must be < Procedure Room Exit Date and Time (15695)

Element: 7000 Procedure Start Date and Time

Coding Instruction: Indicate the date and time the procedure started.

Note(s): Indicate the date/time (mm/dd/yyyy hours: minutes) using the military 24-hour clock, beginning at midnight (0000 hours). The time the procedure started is defined as the time of first sheath insertion.

For device implant procedures, the start time is defined as the time at which local anesthetic was first administered for vascular access, or the time of the first attempt at vascular access.

Target Value: Any occurrence on current procedure

Vendor Instruction: Procedure Start Date and Time (7000) must be >= Arrival Date and Time (3001)
 Procedure Start Date and Time (7000) must be <= Procedure End Date and Time (7005)
 Procedure Start Date and Time (7000) must be <= Discharge Date and Time (10101)

Element: 7005 Procedure End Date and Time

Coding Instruction: Indicate the date and time the procedure ended.

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

The time the procedure ended is defined as the time of last sheath removal. If the patient leaves the lab with any sheath in place, then indicate the time the primary operator breaks scrub.

For device implant procedures, the ending date and time is defined as the time at which the operator breaks scrub at the end of the procedure.

Target Value: The value on current procedure

Vendor Instruction: Procedure Start Date and Time (7000) and Procedure End Date and Time (7005) must not overlap on multiple procedures
 Procedure End Date and Time (7005) must be <= Discharge Date and Time (10101)

Element: 15695 Procedure Room Exit Date and Time

Coding Instruction: Indicate the date and time the patient exits the procedure room.

Target Value: The value on current procedure

Vendor Instruction: Procedure Room Entry Date and Time (15694) and Procedure Room Exit Date and Time (15695) must not overlap on multiple procedures

Section: Concurrent Conditions
Parent: Lab Visit
Element: 15885 Non-cardiac Comorbidity

Coding Instruction: Indicate if the patient does or does not have a non-cardiac comorbid condition(s) at the time of procedure. Comorbid conditions that warrant coding 'yes' are:

- Chronic lung disease
- Congenital diaphragmatic hernia
- Known airway problems
- Diabetes mellitus
- Acute renal insufficiency
- Chronic renal insufficiency/end stage renal disease
- Seizure disorder
- Global developmental delay
- Bleeding disorder
- Hypercoagulable state
- Sickle cell anemia

Target Value: The value on start of current procedure

Element: 15888 Cardiac Comorbidity

Coding Instruction: Indicate if the patient does or does not have a cardiac comorbid condition(s) at the time of procedure. Cardiac comorbid conditions that warrant coding 'yes' are:

- Single ventricle
- 1.5 ventricle
- L-looped ventricles
- Dilated cardiomyopathy
- Hypertrophic cardiomyopathy
- Ischemic cardiomyopathy
- Pulmonary hypertension
- Rheumatic heart
- Kawasaki disease
- Heart failure
- Aborted sudden death

Target Value: The value on start of current procedure

Element: 15883 Arrhythmia Past 90 Days

Coding Instruction: Indicate whether the patient has a record of a cardiac arrhythmia within the past 90 days.

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

Element: 15966 Cardiac Arrest w/in 48hrs Prior to Current Procedure

Coding Instruction: Indicate whether the patient experienced cardiac arrest within 48 hrs prior to the current procedure

Target Value: Any occurrence within 48 hours prior to procedure and the first procedure in this admission

Section: Non-cardiac Comorbidity

Parent: Concurrent Conditions

Element: 15886

Non-cardiac Comorbidity Name

Coding Instruction: Select the comorbidities currently associated with the patient, as documented in the medical record.

Target Value: N/A

Non-cardiac Comorbidities - 1.3.6.1.4.1.19376.1.4.1.6.5.989

Selection	Definition	Source	Code	Code System
Chronic lung disease	Select if there is documentation of chronic lung disease, such as chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, chronic inhalation reactive diseases (e.g., asbestosis, pneumoconiosis), or radiation-induced lung damage. This includes patients requiring chronic inhaled or oral pharmacologic therapy, such as steroids or beta-agonists. Asthma, seasonal allergies, and transient conditions like atelectasis are not considered chronic lung disease.		413839001	SNOMED CT
Congenital diaphragmatic hernia	Select if there is documentation of a congenital absence or defect (hole) in the diaphragm, typically occurring on the left side but possible on either side.		17190001	SNOMED CT
Known airway problems	Select if there is documentation of structural or functional airway abnormalities, such as tracheomalacia, laryngomalacia, subglottic stenosis, vocal cord paralysis, or other chronic conditions affecting the airway. Include cases of chronic airway obstruction or external compression impairing airflow.		50043002	SNOMED CT
Diabetes mellitus	Code based on clinical diagnosis of diabetes.		73211009	SNOMED CT
Acute Kidney Injury	Acute kidney injury is a sudden decrease in kidney function. In adult and pediatric patients, acute kidney injury is defined as: Increase in serum creatinine by ≥ 0.3 mg/dL (≥ 26.5 micromol/L) within 48 hours, or Increase in serum creatinine to ≥ 1.5 times baseline, which is known or presumed to have occurred within the prior seven days, or Urine volume < 0.5 mL/kg/hour for six hours	The Kidney Disease: Improving Global Outcomes (KDIGO) In previously healthy children where the baseline serum creatinine is unknown, it is generally recommended to use a presumed baseline of 120 mL/min/1.73 m ²	14669001	SNOMED CT
Chronic renal insufficiency	Select if there is documentation of persistent kidney dysfunction, characterized by impaired ability to filter waste or regulate electrolytes over an extended period. This includes chronically elevated creatinine levels, decreased glomerular filtration rate (GFR), or evidence of kidney damage (e.g., proteinuria) lasting three months or longer. Patients requiring dialysis or meeting criteria for end-stage renal disease (ESRD) are not included.		709044004	SNOMED CT
End stage renal disease	Select if there is documentation of irreversible kidney failure requiring chronic dialysis (hemodialysis or peritoneal dialysis) or kidney transplantation. Include cases where end-stage renal disease is explicitly stated in the medical record or where ongoing renal replacement therapy is documented.		46177005	SNOMED CT
Seizure disorder	Select if there is documentation of episodes characterized by clinical signs or electroencephalographic (EEG) evidence of epileptiform activity. This includes cases requiring ongoing medical management or anticonvulsant therapy. Isolated seizure events or transient conditions, such as febrile seizures, are not considered seizure disorders.		128613002	SNOMED CT
Global developmental delay	Select if there is documentation of significant delays in two or more developmental domains (e.g., motor, cognitive, speech/language, or social/emotional) in children under the age of 5. Global developmental delay (GDD) may result from exogenous factors, genetic (metabolic or non-metabolic) conditions, or other underlying causes. Isolated delays in a single domain or conditions diagnosed after the age of 5 are not considered GDD.		224958001	SNOMED CT
Bleeding disorder	Select if there is documentation of a condition		112000002067	ACC NCDR

Section: Non-cardiac Comorbidity

Parent: Concurrent Conditions

	characterized by abnormal bleeding or impaired clotting. Examples include inherited disorders like hemophilia and von Willebrand disease, as well as acquired coagulation disorders. This does not include conditions caused solely by anticoagulant use or transient bleeding episodes.		
Hypercoagulable state	Select if there is documentation of a history of a hypercoagulable state, characterized by an increased tendency to form blood clots. This may be indicated by below-normal prothrombin time (PT) or partial thromboplastin time (PTT). Conditions caused solely by medications, such as vitamin K, do not meet the criteria.	76612001	SNOMED CT
Sickle cell anemia	Select if there is documentation of a history of sickle cell anemia, a condition involving the production of abnormal hemoglobin S, which may lead to chronic anemia and vaso-occlusive complications. Patients with only a positive test for the sickle cell trait, without active signs of the disease, do not meet the criteria.	127040003	SNOMED CT

Element: 15887

Non-cardiac Comorbidity Occurrence

Coding Instruction: Indicate if the patient has or has not had a clinical diagnosis of the indicated comorbid conditions.

Target Value: The value on start of current procedure

Vendor Instruction: Non-cardiac Comorbidity Occurrence (15887) cannot be Null when a Non-cardiac Comorbidity Name (15886) is selected

Section: Cardiac Comorbidity

Parent: Concurrent Conditions

Element: 15889

Cardiac Comorbidity Name

Coding Instruction: Select the comorbidities currently associated with the patient, as documented in the medical record.

Target Value: The value on current procedure

Cardiac Comorbidities - 1.3.6.1.4.1.19376.1.4.1.6.5.990

Selection	Definition	Source	Code	Code System
Single ventricle	Select if there is documentation of a congenital heart defect where the heart has only one functional ventricle (anatomically right, left, or indeterminate) supplying systemic circulation. This term, synonymous with "functionally univentricular heart," includes conditions such as tricuspid atresia, hypoplastic left or right heart syndrome, double outlet right ventricle, and double inlet left ventricle.		45503006	SNOMED CT
One and half ventricle	Select if there is documentation of a congenital heart condition characterized by one fully functional ventricle and a partially functional second ventricle. This term typically applies to cases where a single ventricle repair is supported by a surgically augmented hypoplastic ventricle or atrium to assist with systemic or pulmonary circulation.		112000003745	ACC NCDR
L-looped ventricles	Select if there is documentation of L-looped ventricles, a congenital heart condition characterized by atrioventricular (AV) and ventriculoarterial discordance. This condition is also referred to as congenitally corrected transposition of the great arteries (ccTGA), double discordance, or ventricular inversion. Key features include the morphologic right ventricle supporting systemic circulation and the morphologic left ventricle supporting pulmonary circulation. Documentation may note associated defects such as ventricular septal defects (VSDs), pulmonary stenosis, or arrhythmias, or highlight risks like systemic right ventricular dysfunction leading to heart failure.		26146002	SNOMED CT
Dilated cardiomyopathy	Select if there is documentation of ventricular dilation with impaired systolic function, commonly defined by a left ventricular ejection fraction (LVEF) less than 40%. Dilated cardiomyopathy can occur with or without symptoms of heart failure and may be primary (idiopathic) or secondary to identifiable causes such as genetic factors, infections, or systemic conditions.		195021004	SNOMED CT
Hypertrophic cardiomyopathy	Select if there is documentation of hypertrophic cardiomyopathy, characterized by a hypertrophied, nondilated left ventricle (LV) in the absence of other systemic or cardiac diseases capable of causing similar wall thickening (e.g., hypertension, aortic valve stenosis). Diagnosis is typically made using echocardiography or cardiac magnetic resonance imaging (CMR) by identifying otherwise unexplained LV wall thickening, often accompanied by a small LV cavity.		233873004	SNOMED CT
Restrictive cardiomyopathy	Select if there is documentation of restrictive cardiomyopathy, a rare form of heart muscle disease characterized by impaired ventricular filling due to restrictive physiology. This condition features non-hypertrophied, non-dilated ventricles with normal or decreased volume, biatrial enlargement, and normal (or near-normal) systolic function. Restrictive cardiomyopathy is associated with diastolic dysfunction and can present similarly to constrictive pericarditis.		415295002	SNOMED CT
Pulmonary hypertension	Select if there is documentation of pulmonary hypertension, defined as a mean pulmonary artery pressure (mPAP) >20 mmHg measured by right heart catheterization, as outlined by the Journal of the American Heart Association. Pulmonary vascular resistance (>2.0 Wood units) is also considered for diagnosis and prognostication.		70995007	SNOMED CT
Rheumatic heart	Select if there is documentation of heart disease, usually involving valve dysfunction (e.g., mitral or aortic valves), secondary to rheumatic fever caused by an immune response to a Group A Streptococcal infection		23685000	SNOMED CT

Section: Cardiac Comorbidity		Parent: Concurrent Conditions	
	of the pharynx. This condition results from inflammation and scarring, leading to permanent damage to the heart valves.		
Kawasaki disease	Select if there is documentation of Kawasaki disease, an acute vasculitis of unknown etiology primarily affecting children under 5 years of age. KD is characterized by high fever, mucocutaneous inflammation, and cervical lymphadenopathy, with a specific focus on coronary artery involvement. Complications include coronary artery dilations and aneurysms, which may lead to long-term cardiovascular sequelae.	75053002	SNOMED CT
Ischemic cardiomyopathy	Select if there is documentation of ischemic cardiomyopathy, defined as significant left ventricular dysfunction (e.g., left ventricular ejection fraction $\leq$ 35-40%) caused by coronary artery disease. This condition is typically associated with a history of myocardial infarction (MI), evidence of viable hibernating myocardium, or severe coronary disease identified on angiography. Ischemic cardiomyopathy may lead to reduced systolic function and/or symptoms of heart failure.	426856002	SNOMED CT
Heart failure	Select if there is documentation of heart failure, a multi-dimensional clinical syndrome characterized by symptoms such as dyspnea, fatigue, exertional intolerance, or fluid retention. Heart failure results from structural or functional impairment in ventricular filling or blood ejection, and may necessitate new or escalated pharmacologic therapy to manage symptoms.	84114007	SNOMED CT

Element: 15890

Cardiac Comorbidity Occurrence

Coding Instruction: Indicate if the patient has or had not had a clinical diagnosis of the indicated cardiac comorbid conditions.

Target Value: The value on start of current procedure

Vendor Instruction: Cardiac Comorbidity Occurrence (15890) cannot be Null when a Cardiac Comorbidity Name (15889) is selected

Section: Arrhythmias

Parent: Concurrent Conditions

Element: 15884

Arrhythmia Type past 90 days

Coding Instruction: Indicate the specific arrhythmia diagnosed.

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

Arrhythmia History Type - 1.3.6.1.4.1.19376.1.4.1.6.5.810

Selection	Definition	Source	Code	Code System
Atrial fibrillation			49436004	SNOMED CT
Atrial flutter			5370000	SNOMED CT
Supraventricular tachycardia			6456007	SNOMED CT
1st degree heart block			270492004	SNOMED CT
2nd degree heart block			195042002	SNOMED CT
Complete heart block			27885002	SNOMED CT
Sinus node dysfunction			60423000	SNOMED CT
Ventricular tachycardia			25569003	SNOMED CT
Wolff-Parkinson-White syndrome			74390002	SNOMED CT
Other			100000351	ACC NCDR

Section: Pre-Procedure

Parent: Lab Visit

Element: 15020

Height

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

Target Value: The value on start of current procedure

Element: 15021

Weight

Coding Instruction: Indicate the patient's weight in kilograms or grams for patients weighing greater than or equal to 2 kilograms (2000 grams). If the patient weighs less than 2 kilograms, leave this field blank.

Target Value: The value on start of current procedure

Section: Pre-Procedure Medications

Parent: Pre-Procedure

Element: 15032

Pre-Procedure Medications

Coding Instruction: Indicate the pre-procedure medication the patient was prescribed or received.

For Antiarrhythmics, select 'Yes' if the target arrhythmia was managed with an antiarrhythmic medication that was held for this procedure.

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

Target Value: Any occurrence between 2 weeks prior to current procedure and current procedure

Vendor Instruction: Pre-Procedure Medications (15032) should not be duplicated in a lab visit

Pre-Procedure Medication - 1.3.6.1.4.1.19376.1.4.1.6.5.216

Selection	Definition	Source	Code	Code System
Angiotensin converting enzyme inhibitor (Any)			41549009	SNOMED CT
Angiotensin II receptor blocker (Any)			372913009	SNOMED CT
Antiarrhythmic (Any)			67507000	SNOMED CT
Anticoagulant - DOAC/NOAC			112000002174	ACC NCDR
Anticoagulant - Low molecular weight heparin			373294004	SNOMED CT
Anticoagulant - Unfractionated heparin			96382006	SNOMED CT
Anticoagulant - Warfarin			11289	RxNorm
Anticoagulant - Other			100001064	ACC NCDR
Antiplatelet (Any)			372560006	SNOMED CT
Beta blocker (Any)			33252009	SNOMED CT
Diuretic (Any)			372695000	SNOMED CT
Pulmonary vasodilator (Any)			112000003722	ACC NCDR
Prostaglandin Infusion			26351002	SNOMED CT

Element: 6991

PreProcedure Medication Administered

Coding Instruction: Indicate if the patient was prescribed or received the medication.

Note(s):

Code 'Yes' if the patient received an oral (long-acting formula) of the medication after admission but prior to this cath lab visit. 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 current procedure and current procedure

Vendor Instruction: Pre-Procedure Medication Administered (6991) cannot be Null when a Pre-Procedure Medication (15032) is answered

Pre-Procedure Y/N/C Medication Administration - 1.3.6.1.4.1.19376.1.4.1.6.5.1004

Selection	Definition	Source	Code	Code System
No			112000000168	ACC NCDR
Yes			100001247	ACC NCDR

Section: Pre-Procedure Medication Details

Parent: Pre-Procedure

Element: 16104	Novel Oral Anticoagulant Or Direct Oral Anticoagulant Stopped Prior To Procedure
Coding Instruction:	Indicate whether Novel Oral Anticoagulants (NOAC) Or Direct Oral Anticoagulants (DOAC) were stopped prior to the procedure.
Target Value:	Any occurrence between 2 weeks prior to current procedure and current procedure
Element: 16105	Number of Days Novel Oral Anticoagulant Or Direct Oral Anticoagulant Stopped
Coding Instruction:	Record the number of days Novel Oral Anticoagulants (NOAC) Or Direct Oral Anticoagulants (DOAC) were stopped prior to the procedure.
Target Value:	Any occurrence between 2 weeks prior to current procedure and current procedure
Element: 16107	Low Molecular Weight Heparin Stopped Prior to the Procedure
Coding Instruction:	Indicate whether low molecular weight heparin was stopped (or held/put on hold) prior to the procedure.
Target Value:	Any occurrence between 2 weeks prior to current procedure and current procedure
Element: 16102	Warfarin Stopped Prior To Procedure
Coding Instruction:	Indicate whether warfarin was stopped prior to the procedure.
Target Value:	Any occurrence between 2 weeks prior to current procedure and current procedure
Element: 16103	Number of Days Warfarin Stopped
Coding Instruction:	Record the number of days warfarin was stopped prior to the procedure.
Target Value:	Any occurrence between 2 weeks prior to current procedure and current procedure
Element: 16100	Antiplatelet Stopped Prior To Procedure
Coding Instruction:	Indicate whether antiplatelet medications were stopped prior to the procedure.
Target Value:	Any occurrence between 2 weeks prior to current procedure and current procedure
Element: 16101	Number of Days Antiplatelet Agent Stopped
Coding Instruction:	Record the number of days that the antiplatelet agent (including aspirin) was stopped prior to the procedure.
Target Value:	Any occurrence between 2 weeks prior to current procedure and current procedure

Section: Pre-Procedure Diagnosis Codes

Parent: Pre-Procedure Diagnosis

Element: 15022

Pre-Procedure Diagnosis Code

Coding Instruction: Indicate all applicable cardiac diagnosis codes that were present prior to the procedure. Select all applicable codes from the diagnosis master list.

Target Value: The value on current procedure

Diagnosis Master - 1.3.6.1.4.1.19376.1.4.1.6.5.893

Selection	Definition	Source	Code	Code System
Septal defects - PFO			112000002777	ACC NCDR
Septal defects - ASD - secundum			112000002778	ACC NCDR
Septal defects - ASD - sinus venosus			112000002779	ACC NCDR
Septal defects - ASD - coronary sinus			112000002780	ACC NCDR
Septal defects - ASD - common atrium - single atrium			112000002781	ACC NCDR
Septal defects - VSD - Type 1 subarterial - supracristal - conal septal defect - infundibular			112000002782	ACC NCDR
Septal defects - VSD - Type 2 - perimembranous - paramembranous - conoventricular			112000002783	ACC NCDR
Septal defects - VSD - type 3 - inlet - AV canal type			112000002784	ACC NCDR
Septal defects - VSD - type 4 - muscular			112000002785	ACC NCDR
Septal defects - VSD - type - gerbode type - LV-RA communication			112000002786	ACC NCDR
Septal defects - VSD - multiple			112000002787	ACC NCDR
Septal defects - AVC - AVSD - complete CAVSD			112000002788	ACC NCDR
Septal defects - AVC - AVSD - intermediate -transitional			112000002789	ACC NCDR
Septal defects - AVC - AVSD - partial - incomplete - PAVSD - ASD primum			112000002790	ACC NCDR
Septal defects - AP window - aortopulmonary window			112000002791	ACC NCDR
Septal defects - pulmonary artery origin from ascending aorta - hemitruncus			112000002792	ACC NCDR
Septal defects - truncus arteriosus			112000002793	ACC NCDR
Septal defects - truncal valve insufficiency			112000002794	ACC NCDR
Septal defects - truncus arteriosus and interrupted aortic arch			112000002795	ACC NCDR
Pulmonary venous anomalies - partial anomalous pulmonary venous connection			112000002796	ACC NCDR
Pulmonary venous anomalies - partial anomalous pulmonary venous connection - scimitar			112000002797	ACC NCDR
Pulmonary venous anomalies - total anomalous pulmonary venous connection - Type 1 supracardiac			112000002798	ACC NCDR
Pulmonary venous anomalies - total anomalous pulmonary venous connection - Type 2 cardiac			112000002799	ACC NCDR
Pulmonary venous anomalies - total anomalous pulmonary venous connection - Type 3 infracardiac			112000002800	ACC NCDR
Pulmonary venous anomalies -			112000002801	ACC NCDR

Section: Pre-Procedure Diagnosis Codes	Parent: Pre-Procedure Diagnosis	
total anomalous pulmonary venous connection - Type 4 mixed		
Cor triatriatum - cor triatriatum	112000002802	ACC NCDR
Pulmonary venous stenosis - Pulmonary venous stenosis	112000002803	ACC NCDR
Systemic venous anomalies - Systemic venous anomaly	112000002804	ACC NCDR
Systemic venous anomalies - systemic venous obstruction	112000002805	ACC NCDR
Right heart lesions - TOF	112000002806	ACC NCDR
Right heart lesions - TOF - pulmonary stenosis	112000002807	ACC NCDR
Right heart lesions - TOF - AVC - AVSD	112000002808	ACC NCDR
Right heart lesions - TOF - absent pulmonary valve	112000002809	ACC NCDR
Right heart lesions - pulmonary atresia	112000002810	ACC NCDR
Right heart lesions - pulmonary atresia - IVS	112000002811	ACC NCDR
Right heart lesions - pulmonary atresia - VSD including TOF-PA	112000002812	ACC NCDR
Right heart lesions - pulmonary atresia - VSD-MAPCA - pseudotruncus	112000002813	ACC NCDR
Right heart lesions - MAPCA - major aortopulmonary collaterals - without PA-VSD	112000002814	ACC NCDR
Right heart lesions - Ebsteins anomaly	112000002815	ACC NCDR
Right heart lesions - tricuspid regurgitation - non-Ebsteins related	112000002816	ACC NCDR
Right heart lesions - tricuspid stenosis	112000002817	ACC NCDR
Right heart lesions - tricuspid regurgitation and tricuspid stenosis	112000002818	ACC NCDR
Right heart lesions - tricuspid valve disease - other	112000002819	ACC NCDR
Right heart lesions - pulmonary stenosis - valvar	112000002820	ACC NCDR
Right heart lesions - pulmonary artery stenosis - hypoplasia - main-trunk	112000002821	ACC NCDR
Right heart lesions - pulmonary artery stenosis - branch - central - within the hilar bifurcation	112000002822	ACC NCDR
Right heart lesions - pulmonary artery stenosis - branch - peripheral - at or beyond the hilar bifurcation	112000002823	ACC NCDR
Right heart lesions - pulmonary artery - discontinuous	112000002824	ACC NCDR
Right heart lesions - pulmonary stenosis - subvalvar	112000002825	ACC NCDR
Right heart lesions - DCRV	112000002826	ACC NCDR
Right heart lesions - pulmonary valve disease - other	112000002827	ACC NCDR
Right heart lesions - pulmonary insufficiency	112000002828	ACC NCDR
Right heart lesions - pulmonary insufficiency and pulmonary stenosis	112000002829	ACC NCDR
Shunt failure - shunt failure	112000002830	ACC NCDR
Right heart lesions - conduit failure	112000002831	ACC NCDR
Left heart lesions - aortic stenosis - subvalvar	112000002832	ACC NCDR

Section: Pre-Procedure Diagnosis Codes	Parent: Pre-Procedure Diagnosis	
Left heart lesions - aortic stenosis - valvar	112000002833	ACC NCDR
Left heart lesions - aortic stenosis - supravalvar	112000002834	ACC NCDR
Left heart lesions - aortic valve atresia	112000002835	ACC NCDR
Left heart lesions - aortic insufficiency	112000002836	ACC NCDR
Left heart lesions - aortic insufficiency and aortic stenosis	112000002837	ACC NCDR
Left heart lesions - aortic valve - other	112000002838	ACC NCDR
Left heart lesions - sinus of valsalva aneurysm	112000002839	ACC NCDR
Left heart lesions - LV to aorta tunnel	112000002840	ACC NCDR
Left heart lesions - mitral stenosis - supravalvar mitral ring	112000002841	ACC NCDR
Left heart lesions - mitral stenosis - valvar	112000002842	ACC NCDR
Left heart lesions - mitral stenosis - subvalvar	112000002843	ACC NCDR
Left heart lesions - mitral stenosis - subvalvar-parachute	112000002844	ACC NCDR
Left heart lesions - mitral stenosis	112000002845	ACC NCDR
Left heart lesions - mitral regurgitation and mitral stenosis	112000002846	ACC NCDR
Left heart lesions - mitral regurgitation	112000002847	ACC NCDR
Left heart lesions - mitral valve -other	112000002848	ACC NCDR
Left heart lesions - hypoplastic left heart syndrome	112000002849	ACC NCDR
Left heart lesions - shones syndrome	112000002850	ACC NCDR
Left heart lesions - cardiomyopathy - including dilated - restrictive - and hypertrophic	112000002851	ACC NCDR
Left heart lesions - cardiomyopathy - end-stage congenital heart disease	112000002852	ACC NCDR
Left heart lesions - pericardial effusion	112000002853	ACC NCDR
Left heart lesions - pericarditis	112000002854	ACC NCDR
Left heart lesions - pericardial disease - other	112000002855	ACC NCDR
Single ventricle - single ventricle - DILV	112000002856	ACC NCDR
Single ventricle - single ventricle - DIRV	112000002857	ACC NCDR
Single ventricle - single ventricle - mitral atresia	112000002858	ACC NCDR
Single ventricle - single ventricle - tricuspid atresia	112000002859	ACC NCDR
Single ventricle - single ventricle - unbalanced AV canal	112000002860	ACC NCDR
Single ventricle - single ventricle - heterotaxia syndrome	112000002861	ACC NCDR
Single ventricle - single ventricle - other	112000002862	ACC NCDR
Single ventricle - single ventricle and total anomalous pulmonary venous connection	112000002863	ACC NCDR

Section: Pre-Procedure Diagnosis Codes	Parent: Pre-Procedure Diagnosis	
Transposition of the great arteries - congenitally corrected TGA	112000002864	ACC NCDR
Transposition of the great arteries - congenitally corrected TGA - IVS	112000002865	ACC NCDR
Transposition of the great arteries - congenitally corrected TGA - IVS-LVOTO	112000002866	ACC NCDR
Transposition of the great arteries - congenitally corrected TGA - VSD	112000002867	ACC NCDR
Transposition of the great arteries - congenitally corrected TGA - VSD-LVOTO	112000002868	ACC NCDR
Transposition of the great arteries - TGA - IVS	112000002869	ACC NCDR
Transposition of the great arteries - TGA - IVS-LVOTO	112000002870	ACC NCDR
Transposition of the great arteries - TGA - VSD	112000002871	ACC NCDR
Transposition of the great arteries - TGA - VSD-LVOTO	112000002872	ACC NCDR
DORV - DORV - VSD type	112000002873	ACC NCDR
DORV - DORV - TOF type	112000002874	ACC NCDR
DORV - DORV - TGA type	112000002875	ACC NCDR
DORV - DORV - remote VSD - uncommitted VSD	112000002876	ACC NCDR
DORV - DORV and AVSD - AV canal	112000002877	ACC NCDR
DORV - DORV - IVS	112000002878	ACC NCDR
DOLV - DOLV	112000002879	ACC NCDR
Thoracic arteries and veins - coarctation of aorta	112000002880	ACC NCDR
Thoracic arteries and veins - aortic arch hypoplasia	112000002881	ACC NCDR
Thoracic arteries and veins - VSD plus aortic arch hypoplasia	112000002882	ACC NCDR
Thoracic arteries and veins - VSD plus coarctation of aorta	112000002883	ACC NCDR
Thoracic arteries and veins - coronary artery anomaly - anomalous aortic origin of coronary artery from aorta	112000002884	ACC NCDR
Thoracic arteries and veins - coronary artery anomaly - Anomalous pulmonary origin - includes ALCAPA	112000002885	ACC NCDR
Thoracic arteries and veins - coronary artery anomaly - fistula	112000002886	ACC NCDR
Thoracic arteries and veins - coronary artery anomaly - aneurysm	112000002887	ACC NCDR
Thoracic arteries and veins - coronary artery anomaly - other	112000002888	ACC NCDR
Thoracic arteries and veins - interrupted aortic arch	112000002889	ACC NCDR
Thoracic arteries and veins - interrupted aortic arch and VSD	112000002890	ACC NCDR
Thoracic arteries and veins - interrupted aortic arch and AP window - aortopulmonary window	112000002891	ACC NCDR
Thoracic arteries and veins - patent ductus arteriosus	112000002892	ACC NCDR
Thoracic arteries and veins - vascular ring	112000002893	ACC NCDR
Thoracic arteries and veins -	112000002894	ACC NCDR

Section: Pre-Procedure Diagnosis Codes	Parent: Pre-Procedure Diagnosis	
pulmonary artery sling		
Thoracic arteries and veins - aortic aneurysm - including pseudoaneurysm	112000002895	ACC NCDR
Thoracic arteries and veins - aortic dissection	112000002896	ACC NCDR
Thoracic and mediastinal disease - lung disease - benign	112000002897	ACC NCDR
Thoracic and mediastinal disease - lung disease - malignant	112000002898	ACC NCDR
Thoracic and mediastinal disease - pect	112000002899	ACC NCDR
Thoracic and mediastinal disease - tracheal stenosis	112000002900	ACC NCDR
Thoracic and mediastinal disease - airway disease	112000002901	ACC NCDR
Thoracic and mediastinal disease - pleural disease - benign	112000002902	ACC NCDR
Thoracic and mediastinal disease - pleural disease - malignant	112000002903	ACC NCDR
Thoracic and mediastinal disease - pneumothorax	112000002904	ACC NCDR
Thoracic and mediastinal disease - pleural effusion	112000002905	ACC NCDR
Thoracic and mediastinal disease - chylothorax	112000002906	ACC NCDR
Thoracic and mediastinal disease - empyema	112000002907	ACC NCDR
Thoracic and mediastinal disease - esophageal disease - benign	112000002908	ACC NCDR
Thoracic and mediastinal disease - esophageal disease - malignant	112000002909	ACC NCDR
Thoracic and mediastinal disease - mediastinal disease	112000002910	ACC NCDR
Thoracic and mediastinal disease - mediastinal disease - benign	112000002911	ACC NCDR
Thoracic and mediastinal disease - mediastinal disease - malignant	112000002912	ACC NCDR
Thoracic and mediastinal disease - diaphragm paralysis	112000002913	ACC NCDR
Thoracic and mediastinal disease - diaphragm disease - other	112000002914	ACC NCDR
Electrophysiologic - arrhythmia	112000002915	ACC NCDR
Electrophysiologic - arrhythmia - atrial	112000002916	ACC NCDR
Electrophysiologic - arrhythmia - junctional	112000002917	ACC NCDR
Electrophysiologic - arrhythmia - ventricular	112000002918	ACC NCDR
Electrophysiologic - arrhythmia - heart block	112000002919	ACC NCDR
Electrophysiologic - arrhythmia - heart block - acquired	112000002920	ACC NCDR
Electrophysiologic - arrhythmia - heart block - congenital	112000002921	ACC NCDR
Electrophysiologic - arrhythmia - pacemaker - indication for replacement	112000002922	ACC NCDR
Miscellaneous - atrial isomerism - left	112000002923	ACC NCDR
Miscellaneous - atrial isomerism - right	112000002924	ACC NCDR
Miscellaneous - dextrocardia	112000002925	ACC NCDR

Section: Pre-Procedure Diagnosis Codes	Parent: Pre-Procedure Diagnosis	
Miscellaneous - levocardia	112000002926	ACC NCDR
Miscellaneous - mesocardia	112000002927	ACC NCDR
Miscellaneous - situs inversus	112000002928	ACC NCDR
Miscellaneous - aneurysm - ventricular - right - including pseudoaneurysm	112000002929	ACC NCDR
Miscellaneous - aneurysm - ventricular - left - including pseudoaneurysm	112000002930	ACC NCDR
Miscellaneous - aneurysm - pulmonary artery	112000002931	ACC NCDR
Miscellaneous - aneurysm - other	112000002932	ACC NCDR
Miscellaneous - hypoplastic RV	112000002933	ACC NCDR
Miscellaneous - hypoplastic LV	112000002934	ACC NCDR
Miscellaneous - postoperative bleeding	112000002935	ACC NCDR
Miscellaneous - mediastinitis	112000002936	ACC NCDR
Miscellaneous - endocarditis	112000002937	ACC NCDR
Miscellaneous - rheumatic heart disease	112000002938	ACC NCDR
Miscellaneous - prosthetic valve failure	112000002939	ACC NCDR
Miscellaneous - myocardial infarction	112000002940	ACC NCDR
Miscellaneous - cardiac tumor	112000002941	ACC NCDR
Miscellaneous - pulmonary AV fistula	112000002942	ACC NCDR
Miscellaneous - pulmonary embolism	112000002943	ACC NCDR
Miscellaneous - pulmonary vascular obstructive disease	112000002944	ACC NCDR
Miscellaneous - pulmonary vascular obstructive disease - eisenmengers	112000002945	ACC NCDR
Miscellaneous - primary pulmonary hypertension	112000002946	ACC NCDR
Miscellaneous - persistent fetal circulation	112000002947	ACC NCDR
Miscellaneous - meconium aspiration	112000002948	ACC NCDR
Miscellaneous - cardiac - other	112000002949	ACC NCDR
Miscellaneous - thoracic and/or mediastinal - other	112000002950	ACC NCDR
Miscellaneous - peripheral vascular - other	112000002951	ACC NCDR
Miscellaneous - status post transplant - heart	112000002952	ACC NCDR
Miscellaneous - status post transplant - lung	112000002953	ACC NCDR
Miscellaneous - status post transplant - heart and lung	112000002954	ACC NCDR
Miscellaneous - normal heart	112000002955	ACC NCDR
Miscellaneous - other	112000002956	ACC NCDR

Section: Pre-Procedure Diagnosis CIED

Parent: Pre-Procedure Diagnosis

Element: 16138 Fundamental Diagnosis

Coding Instruction: Select the primary fundamental diagnosis that is the rationale for the cardiac implantable electronic device (CIED) procedure.

Target Value: The last value between birth and the first procedure in this admission

Hx Diagnosis Category - 1.3.6.1.4.1.19376.1.4.1.6.5.1104

Selection	Definition	Source	Code	Code System
Acquired heart disease	Heart disease that is acquired after birth and is not related to a genetic or congenital condition.		112000004082	ACC NCDR
Cardiomyopathy	The patient has cardiomyopathy, including dilated, hypertrophic, or restrictive types.		85898001	SNOMED CT
Congenital heart disease	Structural or functional abnormalities of the heart present at birth.		112000004033	ACC NCDR
Heart block	The patient has atrioventricular (AV) block or other conduction delays requiring intervention.		233916004	SNOMED CT
Inherited arrhythmia, channelopathy	An inherited condition (in the absence of a structural heart defect) that predisposes a patient to life threatening arrhythmias and may lead to sudden cardiac death. Examples include Long or Short QT Syndrome, Brugada Syndrome, Catecholaminergic Polymorphic Ventricular Tachycardia, and idiopathic ventricular fibrillation.		698271000	SNOMED CT
s/p orthotopic heart transplant	The patient has undergone a full heart transplant and now requires a device implant.		32413006	SNOMED CT
Sinus node dysfunction (Non-CHD)	The patient has sinus node dysfunction, excluding cases associated with congenital heart disease.		60423000	SNOMED CT
Unexplained cardiac arrest	Unexplained cardiac arrest refers to cardiac arrest that does not have identifiable cause after an initial clinical evaluation.		112000004209	ACC NCDR
Other			100000351	ACC NCDR

Element: 16135 Acquired Heart Disease Type

Coding Instruction: Indicate the type of acquired heart disease leading to the cardiac implantable electronic device procedure.

Target Value: The last value between birth and the first procedure in this admission

Hx Acquired Heart Disease Type - 1.3.6.1.4.1.19376.1.4.1.6.5.1101

Selection	Definition	Source	Code	Code System
Endocarditis	An infection of the inner lining of the heart (endocardium) or heart valves.		56819008	SNOMED CT
Kawasaki disease	An acute self-limited vasculitis of childhood that is characterized by fever, bilateral nonexudative conjunctivitis, erythema of the lips and oral mucosa, changes in the extremities, rash, and cervical lymphadenopathy.	Source: A Report of the ACC/AHA TF on CDS JACC Vol 70. No 8, August 22, 2017: 1029-95	75053002	SNOMED CT
Myocarditis	Myocarditis is an inflammatory disease of the myocardium resulting from viral infections and/or post-viral immune-mediated responses.	Kindermann I, Barth C, Mahfoud F, et al. Update on Myocarditis. J Am Coll Cardiol 2012;59:779-792.	50920009	SNOMED CT
Rheumatic heart disease	An inflammatory disorder that follows infection with group A streptococcus. It affects the heart, joints, and subcutaneous tissues. It is manifested with pericarditis, heart murmur, congestive heart failure, polyarthritis, subcutaneous nodules, and erythema marginatum.	Source: A Report of the ACC/AHA TF on CDS JACC Vol 70. No 8, August 22, 2017: 1029-95	23685000	SNOMED CT
Other			100000351	ACC NCDR

Element: 16213 PreprocedureDx Cardiomyopathy Type

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

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

Cardiomyopathy Type - 1.3.6.1.4.1.19376.1.4.1.6.5.193

Selection	Definition	Source	Code	Code System
Arrhythmogenic right ventricular cardiomyopathy	A genetic disorder involving fibrofatty replacement of right ventricular myocardium, predisposing to arrhythmias and potential heart failure.		281170005	SNOMED CT
Dilated cardiomyopathy	Select if there is documentation of ventricular dilation with impaired systolic function, commonly defined by a left ventricular ejection fraction (LVEF) less than 40%. Dilated cardiomyopathy can occur with or without symptoms of heart failure and may be primary (idiopathic) or secondary to identifiable causes such as genetic factors, infections, or systemic conditions.		195021004	SNOMED CT

Section: Pre-Procedure Diagnosis CIED

Parent: Pre-Procedure Diagnosis

Hypertrophic cardiomyopathy	Select if there is documentation of hypertrophic cardiomyopathy, characterized by a hypertrophied, nondilated left ventricle (LV) in the absence of other systemic or cardiac diseases capable of causing similar wall thickening (e.g., hypertension, aortic valve stenosis). Diagnosis is typically made using echocardiography or cardiac magnetic resonance imaging (CMR) by identifying otherwise unexplained LV wall thickening, often accompanied by a small LV cavity.	233873004	SNOMED CT
Ischemic cardiomyopathy	Considered to be present in patients with HF who have had a myocardial infarction (MI) or have evidence of viable hibernating myocardium or, on angiography, severe coronary disease. The term ischemic cardiomyopathy has been used to describe significantly impaired left ventricular function (left ventricular ejection fraction <=35 to 40 percent) that results from coronary artery disease. Despite the common clinical use of the term ischemic cardiomyopathy, ventricular dysfunction caused by coronary disease is not a cardiomyopathy as defined by the 2006 American Heart Association and 2008 European Society of Cardiology statements.	426856002	SNOMED CT
Noncompaction of the ventricular myocardium	A congenital condition characterized by the presence of trabeculated (spongy) muscle in the ventricles, often resulting in impaired cardiac function and increased risk of arrhythmias.	112000002196	ACC NCDR
Pacemaker induced	Cardiomyopathy that is due to a pacemaker. Commonly this is a reduction in left ventricular function in the setting of right ventricular pacing.	112000001511	ACC NCDR
Restrictive cardiomyopathy	Select if there is documentation of restrictive cardiomyopathy, a rare form of heart muscle disease characterized by impaired ventricular filling due to restrictive physiology. This condition features non-hypertrophied, non-dilated ventricles with normal or decreased volume, biatrial enlargement, and normal (or near-normal) systolic function. Restrictive cardiomyopathy is associated with diastolic dysfunction and can present similarly to constrictive pericarditis.	415295002	SNOMED CT
Tachycardia-induced cardiomyopathy	The patient developed cardiomyopathy caused by prolonged or frequent tachycardia episodes	426300009	SNOMED CT
Other cardiomyopathy type	The term "unclassified cardiomyopathy" was included in the 2008 ESC classification system to describe disorders that do not readily fit into any of the above phenotypic categories [3]. Examples cited include LV noncompaction and stress-induced (takotsubo) cardiomyopathy.	100001065	ACC NCDR

Element: 16136 Congenital Heart Disease Rationale for Device

Coding Instruction: Indicate, for the patient with congenital heart disease, the reason leading to the cardiac implantable electronic device implantation device.

Target Value: The last value between birth and the first procedure in this admission

Hx Congenital Heart Disease Reason for Device - 1.3.6.1.4.1.19376.1.4.1.6.5.1102

Selection	Definition	Source	Code	Code System
Sinus node dysfunction	The device is being implanted due to sinus node dysfunction.		60423000	SNOMED CT
Heart block	The device is being implanted to address heart block.		233916004	SNOMED CT

Element: 16137 Primary Congenital Defect Diagnosis

Coding Instruction: Select the primary congenital heart disease diagnosis, leading to the cardiac implantable electronic device implantation implant.

Target Value: The last value between birth and the first procedure in this admission

Hx Primary Congenital Defect Diagnosis - 1.3.6.1.4.1.19376.1.4.1.6.5.1103

Selection	Definition	Source	Code	Code System
Anomalous coronary arteries			112000004076	ACC NCDR
Aortopathy			112000004077	ACC NCDR
Coarctation of Aorta			7305005	SNOMED CT
Patent Ductus Arteriosus			83330001	SNOMED CT
Anomalous pulmonary venous return, Partial (PAPVR)			68237008	SNOMED CT

Section: Pre-Procedure Diagnosis CIED		Parent: Pre-Procedure Diagnosis	
Anomalous pulmonary venous return, Total (TAPVR)	111323005	SNOMED CT	
Pulmonary atresia with intact ventricular septum	253590009	SNOMED CT	
Pulmonary atresia with VSD	112000004078	ACC NCDR	
Pulmonary valve disease (stenosis or regurgitation)	76267008	SNOMED CT	
Atrial septal defect (ASD)	70142008	SNOMED CT	
Atrioventricular septal defect or AV canal	360481003	SNOMED CT	
Ventricular Septal Defect	30288003	SNOMED CT	
Aortic valve disease (stenosis or regurgitation)	8722008	SNOMED CT	
Bicuspid Aortic Valve	72352009	SNOMED CT	
Mitral valve disease (stenosis or regurgitation)	11851006	SNOMED CT	
Mitral valve prolapse	409712001	SNOMED CT	
Tricuspid valve disease (stenosis or regurgitation)	20721001	SNOMED CT	
Double inlet left ventricle (DILV)	253283000	SNOMED CT	
Double outlet right ventricle (DORV)	7484005	SNOMED CT	
Ebstein's anomaly	204357006	SNOMED CT	
Hypoplastic left heart syndrome (HLHS)	62067003	SNOMED CT	
Shone's complex (Mitral stenosis, subaortic and valvar aortic stenosis, coarctation)	41371000119100	SNOMED CT	
Subaortic stenosis	204368006	SNOMED CT	
Tetralogy of Fallot	86299006	SNOMED CT	
Transposition of great arteries (D-TGA)	204296002	SNOMED CT	
Transposition of the Great Arteries (congenitally corrected, CC-TGA)	112000004079	ACC NCDR	
Tricuspid atresia	63042009	SNOMED CT	
Truncus arteriosus	61959006	SNOMED CT	
Other	100000351	ACC NCDR	

Element: 15028

Single Ventricle

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

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

Element: 16139

Single Ventricle Type

Coding Instruction: Select the type of single ventricle based on its dominance (right or left). This classification is determined by which ventricle primarily supports systemic circulation.

Target Value: The first value between birth and the first procedure in this admission

Hx Single Ventricle Type - 1.3.6.1.4.1.19376.1.4.1.6.5.1105

Selection	Definition	Source	Code	Code System
Right ventricle			53085002	SNOMED CT
Left ventricle			112000004083	ACC NCDR
Indeterminant			82334004	SNOMED CT

Element: 16140

Single Ventricle Circulation

Coding Instruction: Select the current ventricular circulation for the patient with single ventricle physiology.

Target Value: The last value between birth and the first procedure in this admission

Hx Single Ventricle Circulation - 1.3.6.1.4.1.19376.1.4.1.6.5.1106

Selection	Definition	Source	Code	Code System
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Section: Pre-Procedure Diagnosis CIED		Parent: Pre-Procedure Diagnosis	
Single ventricle circulation	The patient has a single functional ventricle responsible for systemic or pulmonary circulation, with no significant contribution from a second ventricle.	112000004085	ACC NCDR
1.5 ventricle circulation	The patient has a partially functional second ventricle that contributes to circulation but does not provide a fully developed biventricular physiology.	112000004086	ACC NCDR

Element: 16141 Palliative Stage of Single Ventricle

Coding Instruction: Indicate the palliative stage of the patient with single ventricle physiology. This refers to the step in the series of surgeries designed to manage circulation in patients with single ventricle defects.

Note(s):

Select the highest stage that has been completed at the time of the procedure.

Target Value: The last value between birth and the first procedure in this admission

Hx Palliative Stage of Single Ventricle - 1.3.6.1.4.1.19376.1.4.1.6.5.1107

Selection	Definition	Source	Code	Code System
Stage I	Palliative stage 1 is a Norwood Procedure.		112000003040	ACC NCDR
Stage II	Palliative stage 2 is a Bidirectional Glenn Procedure.		112000004089	ACC NCDR
Stage III	Palliative stage 3 is a Fontan Procedure.		112000004088	ACC NCDR

Element: 16142 Heterotaxy Syndrome

Coding Instruction: Indicate whether Heterotaxy Syndrome was present.

Target Value: The last value between birth and the first procedure in this admission

Supporting Definition: Heterotaxy Syndrome

Heterotaxy syndrome is a birth defect that where the heart and other organs in the chest and abdomen are in the wrong position, missing or abnormal. Heterotaxy means "different arrangement".

Source:

Hx Heterotaxy Syndrome - 1.3.6.1.4.1.19376.1.4.1.6.5.1108

Selection	Definition	Source	Code	Code System
No			100013073	ACC NCDR
Yes			100013072	ACC NCDR
Indeterminant			82334004	SNOMED CT

Element: 16143 Heart Block Etiology

Coding Instruction: Select the etiology (or etiologies) of heart block that serve as the rationale for the cardiac implantable electronic device (CIED) procedure as recorded in the medical record.

Target Value: The value on current procedure

Hx Heart Block Etiology - 1.3.6.1.4.1.19376.1.4.1.6.5.1109

Selection	Definition	Source	Code	Code System
Acquired heart block - post ablation	Etiology of heart block is due to an ablation procedure.		112000004091	ACC NCDR
Acquired heart block - post infectious	Etiology of heart block is due to an infection.		112000004092	ACC NCDR
Acquired heart block - post surgical	Etiology of heart block is related to a surgical procedure.		112000004093	ACC NCDR
Congenital heart disease	Etiology of heart block is due to congenital heart disease.		112000004033	ACC NCDR
Idiopathic heart block	Etiology of heart block is idiopathic or due to other causes.		54690008	SNOMED CT

Section: Operator Information

Parent: Procedure Information

Element: 15072 Operator Last Name

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

Note:

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

Target Value: The value on current procedure

Element: 15073 Operator First Name

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

Note:

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

Target Value: The value on current procedure

Element: 15074 Operator Middle Name

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

Note:

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

Target Value: The value on current procedure

Element: 7115 Operator NPI

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

Target Value: The value on current procedure

Vendor Instruction: Operator NPI (7115) may only be entered/selected once

Operator NPI (7115) cannot be Null

Element: 16237 Operator Role

Coding Instruction: Indicate the role that best describes the operator's function during the procedure. The classification is based on whether the operator was primarily responsible for the intervention or electrophysiology procedure or assisted in a secondary role.

Target Value: The value on current procedure

Vendor Instruction: Operator Role (16237) cannot be Null when Operator NPI (7115) has a value

For Operator Role (16237), only one [Primary Interventionalist] and one [Primary Electrophysiologist] can be selected within the lab visit, i.e., only one primary per operator type

Operator Role - 1.3.6.1.4.1.19376.1.4.1.6.5.1149

Selection	Definition	Source	Code	Code System
Primary Interventionalist			112000004257	ACC NCDR
Secondary Interventionalist			112000004258	ACC NCDR
Primary Electrophysiologist			112000004259	ACC NCDR
Secondary Electrophysiologist			112000004260	ACC NCDR

Section: Fellow Information

Parent: Procedure Information

Element: 15433

Fellow Last Name

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

Note(s):

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

Target Value: The value on current procedure

Element: 15434

Fellow First Name

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

Note(s):

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

Target Value: The value on current procedure

Element: 15435

Fellow Middle Name

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

Note(s):

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

Target Value: The value on current procedure

Element: 15436

Fellow NPI

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

Target Value: The value on current procedure

Vendor Instruction: Operator NPI (7115) and Fellow NPI (15436) cannot be the same for a procedure

Element: 15431

Fellowship Program Identification Number

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

Target Value: The value on current procedure

Supporting Definition: Fellowship Program Identification Number

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

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

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

Vendor Instruction: Fellowship Program Identification Number (15431) must be a valid ACGME ID

Section: Procedure Information

Parent: Procedure Information

Element: 16121 Participating Providers

Coding Instruction: Select the type of providers who participated in the cardiac implantable electronic device procedure.

Target Value: The value on current procedure

Participating Providers - 1.3.6.1.4.1.19376.1.4.1.6.5.1093

Selection	Definition	Source	Code	Code System
Electrophysiologist			112000004035	ACC NCDR
Cardiac surgeon			112000004036	ACC NCDR
Nurse practitioner			112000004037	ACC NCDR
Physician assistant			112000004038	ACC NCDR
Other			100000351	ACC NCDR

Element: 15071 Procedure Status

Coding Instruction: Indicate the clinical status of the patient prior to entering the procedure room.

Target Value: The value on current procedure

Procedure Status - 1.3.6.1.4.1.19376.1.4.1.6.5.226

Selection	Definition	Source	Code	Code System
Elective	The patient's cardiac function has been stable in the days or weeks prior to the operation. The procedure could be deferred without increased risk of compromised cardiac outcome.	71388002:260870009=103390000		SNOMED CT
Urgent	The procedure is being performed on an inpatient basis and prior to discharge because of significant concerns that there is risk of cardiac dysfunction or death. Patients who are outpatients or in the emergency department at the time that the procedure is requested would warrant an admission based on their clinical presentation.	71388002:260870009=103391001		SNOMED CT
Emergent	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 if this occurred during off-hours.	112000000481		ACC NCDR
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, cardiopulmonary support).	112000001279		ACC NCDR

Element: 15855 Visit Location

Coding Instruction: Indicate the patient's visit location immediately prior to the procedure. Select the option that best describes where the patient was at the time they were brought in for the procedure.

Target Value: The value on current procedure

Visit Type and Location - 1.3.6.1.4.1.19376.1.4.1.6.5.986

Selection	Definition	Source	Code	Code System
Outpatient	The patient status was outpatient/observation immediately prior to the procedure	373864002		SNOMED CT
Inpatient non-Critical Care	The patient was already admitted to the hospital but not in a critical care unit immediately prior to the procedure	416800000		SNOMED CT
Inpatient critical care	The patient was already admitted to the hospital and in a critical care unit immediately prior to the procedure	305351004		SNOMED CT

Element: 15080 Patient Disposition

Coding Instruction: Indicate the patient's post-procedure disposition status, as planned or known at the start of the procedure.

Target Value: The value on current procedure

Planned Patient Disposition - 1.3.6.1.4.1.19376.1.4.1.6.5.812

Selection	Definition	Source	Code	Code System
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Section: Procedure Information		Parent: Procedure Information	
Outpatient care	Intent to discharge within 24 hours.	440655000	SNOMED CT
Admission to inpatient ward	Admitted to a general inpatient ward for routine monitoring and recovery following the procedure.	305342007	SNOMED CT
Admission to ICU	Admitted to an intensive care unit (ICU).	305351004	SNOMED CT
Other location	Transferred to a location not covered by the other categories (e.g., rehabilitation facility, observation unit).	100000351	ACC NCDR

Element: 16122

PI Procedure Performed Location

Coding Instruction: Select the type of facility or physical setting used when the procedure was performed.

Target Value: The value on current procedure

Procedure Location - 1.3.6.1.4.1.19376.1.4.1.6.5.327

Selection	Definition	Source	Code	Code System
Cardiac catheterization laboratory	The procedure was conducted in a catheterization laboratory.		112000000616	ACC NCDR
Operating room	The procedure was performed in a traditional operating room, typically within a hospital setting, designed for surgical interventions.		225738002	SNOMED CT
Hybrid operating room suite	The procedure took place in a hybrid operating room.		112000001265	ACC NCDR
Outpatient Office	The procedure was conducted in a medical office or clinic setting, outside of a hospital or specialized surgical center.		257651001	SNOMED CT
ASC/Office based lab	The procedure occurred in a standalone outpatient surgical center or an office-based lab.		405607001	SNOMED CT
Other			100000351	ACC NCDR

Element: 15999

Anesthesia Type

Coding Instruction: Select the type of anesthesia or sedation administered during the procedure, based on the patient's level of responsiveness, need for airway intervention, and adequacy of spontaneous ventilation.

Target Value: The value on current procedure

Anesthesia Type - 1.3.6.1.4.1.19376.1.4.1.6.5.463

Selection	Definition	Source	Code	Code System
General anesthesia	A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to maintain ventilatory function is often impaired, requiring airway intervention and, in some cases, positive pressure ventilation. Cardiovascular function may also be impaired. Responsiveness: No response even with painful stimulus Airway: Intervention often required Spontaneous Ventilation: Frequently inadequate		420653000	SNOMED CT
Moderate sedation	A drug-induced depression of consciousness where patients respond purposefully to verbal commands, either alone or with light tactile stimulation. Reflex withdrawal from pain is NOT considered a purposeful response. Airway intervention may be required, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. Responsiveness: Purposeful response to verbal, tactile, or painful stimulation Airway: Intervention may be required Spontaneous Ventilation: May be inadequate		314271007	SNOMED CT
Minimal sedation/anxiolysis/local only	A drug-induced state where patients respond normally to verbal commands. Cognitive function and physical coordination may be impaired, but airway reflexes, ventilatory function, and cardiovascular function remain unaffected. Responsiveness: Normal response to verbal stimulation Airway: Unaffected Spontaneous Ventilation: Unaffected		427255001	SNOMED CT

Section: Procedure Information

Parent: Procedure Information

Element: 16165

Anesthesia Time

Coding Instruction: Record the elapsed time anesthesia was being administered during the procedure in minutes.

Target Value: The value on current procedure

Element: 16166

Anesthesia Time Not Documented

Coding Instruction: Indicate if the elapsed time for anesthesia administration was not documented.

Target Value: The value on current procedure

Element: 15940

Airway Management Method

Coding Instruction: Select the type(s) of airway management used during the procedure.

Target Value: The value on current procedure

Airway Management Method - 1.3.6.1.4.1.19376.1.4.1.6.5.1000

Selection	Definition	Source	Code	Code System
Mask	Use of a face mask to deliver oxygen or ventilation without invasive airway insertion.		261382003	SNOMED CT
Endotracheal intubation	Placement of a tube into the trachea via the mouth or nose to maintain an open airway and assist with ventilation.		112798008	SNOMED CT
Laryngeal mask airway	A supraglottic airway device placed over the larynx to secure the airway and support ventilation.		424979004	SNOMED CT
Tracheostomy present	A surgically created opening in the neck leading directly to the trachea, used for airway access and ventilation.		302108003	SNOMED CT
Previously intubated	The patient was already intubated before the procedure, and no additional airway management was initiated.		52765003	SNOMED CT

Element: 16241

Airway Management Method Not Documented

Coding Instruction: Indicate if the airway management method used is not documented.

Target Value: N/A

Element: 15089

Access Location

Coding Instruction: Indicate the location(s) of the access site.

Target Value: The value on current procedure

Access Locations - 1.3.6.1.4.1.19376.1.4.1.6.5.814

Selection	Definition	Source	Code	Code System
Venous access site			112000000543	ACC NCDR
Arterial access site			100014079	ACC NCDR

Element: 15853

Access Site

Coding Instruction: Select the access site(s) used in the procedure.

Target Value: The value on current procedure

Supporting Definition: General

Location on the body where access was obtained for the procedure.

Source:

Procedure Access Site Selections - 1.3.6.1.4.1.19376.1.4.1.6.5.985

Selection	Definition	Source	Code	Code System
Brachial vein			20115005	SNOMED CT
Femoral vein			83419000	SNOMED CT
Hepatic vein			8993003	SNOMED CT
Internal jugular vein			12123001	SNOMED CT
Jugular vein			63190004	SNOMED CT
Subclavian vein			9454009	SNOMED CT
Transthoracic			41242001	SNOMED CT
Umbilical vein			367567000	SNOMED CT
Other vein			112000001652	ACC NCDR
Axillary artery			67937003	SNOMED CT
Brachial artery			17137000	SNOMED CT
Carotid artery			69105007	SNOMED CT

Section: Procedure Information

Parent: Procedure Information

Femoral artery	7657000	SNOMED CT
Radial artery	181332001	SNOMED CT
Umbilical artery	50536004	SNOMED CT
Other artery	100013029	ACC NCDR

Element: 7225 Intraprocedure Anticoagulation

Coding Instruction: Indicate if intraprocedure anticoagulation therapy was provided.

Target Value: The value on current procedure

Element: 16001 Anticoagulation Start Time

Coding Instruction: Indicate the time when anticoagulation was initiated in relation to the procedure. This refers to whether anticoagulant medications were administered at the start of the procedure or after the procedure had begun.

Target Value: The value on current procedure

EP Anticoagulation Start Time - 1.3.6.1.4.1.19376.1.4.1.6.5.1118

Selection	Definition	Source	Code	Code System
Beginning of procedure	Anticoagulation was administered before or immediately upon obtaining vascular access, but before any diagnostic or therapeutic catheter manipulation (e.g., mapping, pacing, or ablation).		112000004117	ACC NCDR
After procedure started	Anticoagulation was administered after vascular access was obtained and the procedure had progressed beyond initial catheter positioning, such as during electroanatomic mapping, ablation, or upon identifying a specific clinical need.		112000004118	ACC NCDR

Element: 16002 Anticoagulation After Procedure Started Indication

Coding Instruction: Select the reason why anticoagulation was not initiated until after the start of the procedure.

Target Value: The value on current procedure

IMPACT - Anticoagulation After Procedure Started Indication - 1.3.6.1.4.1.19376.1.4.1.6.5.1029

Selection	Definition	Source	Code	Code System
For any ablation	Anticoagulation was initiated after the start of the procedure as part of standard practice.		112000003847	ACC NCDR
Left-sided or systemic atrium or ventricle	Anticoagulation was initiated after the start of the procedure due to procedural involvement of left-sided or systemic atrium or ventricle access, where the risk of thromboembolic complications is higher.		112000003848	ACC NCDR
For specific equipment (multipole mapping catheter, long sheath)	Anticoagulation was initiated after the start of the procedure, secondary to the use of specific equipment that requires anticoagulation to prevent thrombus formation.		112000003849	ACC NCDR
Other			100000351	ACC NCDR

Element: 16244 Anticoagulation After Procedure Started Indication Not Documented

Coding Instruction: Select if the reason why anticoagulation was not initiated until after the start of the procedure is not documented.

Target Value: N/A

Element: 15102 Systemic Heparinization

Coding Instruction: Indicate if heparin was used during the procedure. This includes intravenous and subcutaneous heparin for the purpose of anticoagulation.

Note: Systemic heparinization is generally achieved with unfractionated heparin. Other forms of heparin are less commonly used for the purposes of ACT monitoring.

Target Value: The value on current procedure

Drug Administered - 1.3.6.1.4.1.19376.1.4.1.6.5.711

Selection	Definition	Source	Code	Code System
No			100014173	ACC NCDR
Yes			112000001851	ACC NCDR

Element: 15104 Activated Clotting Time Peak

Coding Instruction: Indicate the peak (highest value) activated clotting time (ACT) (in sec) during the procedure.

Section: Procedure Information

Parent: Procedure Information

Target Value: The highest value on current procedure

Element: 15851 Activated Clotting Time Not Monitored

Coding Instruction: Indicate if an activated clotting time (ACT) was not monitored.

Target Value: N/A

Element: 15850 Activated Clotting Time Below Target

Coding Instruction: Indicate if the patient's activated clotting time (ACT) was recorded as below the target range. The target ACT range should be defined by the treating provider.

Target Value: The value on current procedure

Element: 15854 Activated Clotting Time Below Target Not Documented

Coding Instruction: Indicate if the patients activated clotting time (ACT) below target was not documented.

Target Value: N/A

Element: 16130 Transfusion

Coding Instruction: Indicate whether a red blood cell transfusion was performed during the procedure. Code "No" if transfusion was performed after the procedure ended.

Target Value: The value on current procedure

INTERV - Transfusion - 1.3.6.1.4.1.19376.1.4.1.6.5.1099

Selection	Definition	Source	Code	Code System
No			100013073	ACC NCDR
Yes - adverse event related	The patient received a transfusion due to an adverse event, such as significant bleeding		112000004070	ACC NCDR
Yes - not adverse event related	The patient received a transfusion, but it was not related to an adverse event. This may include pre-planned transfusions as a result of hemodynamic or physiologic findings prior to the procedure.		112000004071	ACC NCDR

Element: 16206 Echocardiogram Performed

Coding Instruction: Indicate whether echocardiography was used during the procedure and select the type if performed.

Target Value: The value on current procedure

Echocardiogram Type - 1.3.6.1.4.1.19376.1.4.1.6.5.526

Selection	Definition	Source	Code	Code System
No			100013073	ACC NCDR
Yes - Intracardiac (ICE)			112000003746	ACC NCDR
Yes - Transthoracic (TTE)			433236007	SNOMED CT
Yes - Transesophageal (TEE)			105376000	SNOMED CT

Element: 7422 Mechanical Ventricular Support

Coding Instruction: Indicate if the patient required mechanical ventricular support.

Target Value: Any occurrence on current procedure

Element: 7423 Mechanical Ventricular Support Device

Coding Instruction: Indicate the mechanical ventricular support device used.

Note(s):

The device that should be collected in your application are controlled by a Mechanical Ventricular Support Master file. This file is maintained by the NCDR and will be made available on the internet for downloading and importing/updating into your application.

Target Value: Any occurrence on current procedure

Mechanical Ventricular Support Device - 2.16.840.1.113883.3.3478.6.1.24

Selection	Definition	Source	Code	Code System
Cardiopulmonary support (CPS)			1000142428	ACC NCDR
Extracorporeal membrane oxygenation (ECMO)			233573008	SNOMED CT
Impella: left ventricular support			100014011	ACC NCDR

Section: Procedure Information		Parent: Procedure Information	
Impella: right ventricular support	112000000188	ACC NCDR	
Intra-aortic balloon pump (IABP)	442807006	SNOMED CT	
Isolated right ventricular support	112000000546	ACC NCDR	
Left ventricular assist device (LVAD)	232967006	SNOMED CT	
Right ventricular assist device (RVAD)	360065002	SNOMED CT	
Percutaneous heart pump (PHP)	1000142429	ACC NCDR	
TandemHeart	100014010	ACC NCDR	
Biventricular axial flow impella catheters (BiPella)	112000001980	ACC NCDR	
Combined extracorporeal membrane oxygenation and percutaneous left ventricular assist device (ECPELLA)	112000002051	ACC NCDR	
Other	100000351	ACC NCDR	

Element: 7424 Mechanical Ventricular Support Timing

Coding Instruction: Indicate when the mechanical ventricular support device was placed.

Target Value: Any occurrence on current procedure

Mechanical Ventricular Support Timing - 1.3.6.1.4.1.19376.1.4.1.6.5.524

Selection	Definition	Source	Code	Code System
In place at start of procedure			100001280	ACC NCDR
Inserted during procedure and prior to intervention			100001281	ACC NCDR
Inserted after intervention has begun			100013042	ACC NCDR

Element: 16000 ECG Rhythm At Lab Presentation

Coding Instruction: Indicate the patient's ECG rhythm upon presentation to the lab for the procedure. This should be coded based on the provider interpretation of the patient's heart rhythm documented on the ECG.

Target Value: The value on start of current procedure

IMPACT ECG Results - 1.3.6.1.4.1.19376.1.4.1.6.5.1028

Selection	Definition	Source	Code	Code System
Sinus rhythm			64730000	SNOMED CT
Atrial fibrillation or atrial flutter			195080001	SNOMED CT
Second degree AV block			195042002	SNOMED CT
Third degree AV block (Complete)			27885002	SNOMED CT
Ectopic atrial rhythm			112000003846	ACC NCDR
Ectopic atrial tachycardia			233892002	SNOMED CT
Idioventricular rhythm			49260003	SNOMED CT
Junctional tachycardia			251155001	SNOMED CT
Paced rhythm (atrial or ventricular paced)			426453001	SNOMED CT
Premature atrial contraction			284470004	SNOMED CT
Premature ventricular contractions			427172004	SNOMED CT
Ventricular tachycardia			25569003	SNOMED CT
Supraventricular tachycardia			6456007	SNOMED CT
Other			100000351	ACC NCDR

Element: 16247 ECG Rhythm At Lab Presentation Not Documented

Coding Instruction: Select if the ECG rhythm at lab presentation is not documented.

Target Value: N/A

Section: Hemodynamics

Parent: Procedure Information

Element: 15125	Systemic Arterial Saturation
Coding Instruction:	Indicate the arterial oxygen saturation in % measured by arterial blood gas or by an invasive monitoring system (such as an arterial line).
Target Value:	The first value on current procedure
Element: 15107	Systemic Arterial Saturation Not Assessed
Coding Instruction:	Indicate whether the systemic arterial saturation was not assessed.
Target Value:	N/A
Element: 15136	Cardiac Index
Coding Instruction:	Indicate the cardiac index measured during the procedure. Cardiac index is a hemodynamic parameter that relates the cardiac output to body surface area, providing a more accurate assessment of heart function relative to patient size. It is expressed in liters per minute per square meter (L/min/m ²).
Target Value:	The first value on current procedure
Element: 15123	Cardiac Index Not Assessed
Coding Instruction:	Indicate whether the cardiac index was not assessed or not obtained during the procedure in L/min/m ² .
Target Value:	N/A
Element: 15842	RVSP : Systemic Systolic BP Ratio
Coding Instruction:	Record the right ventricle systolic pressure to systemic systolic blood pressure ratio (RVSP: Systemic SBP). This ratio is a hemodynamic parameter used to assess the relationship between right ventricular systolic pressure (RVSP) and systemic systolic blood pressure (SBP). Coding can be done using provider documentation or calculated from the individual components. This ratio is particularly relevant in evaluating the severity of pulmonary hypertension and right ventricular function
Target Value:	The value on start of current procedure
Element: 15843	RVSP : Systemic Systolic BP Ratio Not Assessed
Coding Instruction:	Indicate if the right ventricle systolic pressure to systemic systolic blood pressure ratio is not documented or not assessed.
Target Value:	N/A
Element: 15128	Systemic Ventricular End Diastolic Pressure
Coding Instruction:	Indicate the systemic ventricular end diastolic pressure in millimeters of mercury. Note: Pulmonary artery wedge pressure ("a wave") can be documented if the LV (or systemic ventricular) end diastolic pressure is not available AND there is reason to believe that the wedge pressure is a good reflection of left atrial pressure and LVED (in the absence of pulmonary vein or mitral stenosis).
Target Value:	The first value on current procedure
Element: 15115	Systemic Ventricular End Diastolic Pressure Not Assessed
Coding Instruction:	Indicate whether the systemic ventricular end diastolic pressure was not assessed.
Target Value:	N/A
Element: 15137	Pulmonary to Systemic QpQs Shunt Flow Ratio
Coding Instruction:	Indicate the pulmonary to systemic (also called the Qp:Qs) shunt flow ratio.
Target Value:	The first value on current procedure
Supporting Definition:	Qp/Qs ratio Qp represents the pulmonary resistance and Qs represents the systemic resistance. This measures 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. Source:
Element: 15124	Pulmonary to Systemic QpQs Shunt Flow Ratio Not Assessed
Coding Instruction:	Indicate whether the pulmonary to systemic (also called the Qp:Qs) shunt flow ratio was not assessed or not obtained during the procedure.
Target Value:	N/A

Section: Hemodynamics

Parent: Procedure Information

Supporting Definition: Qp/Qs ratio

Qp represents the pulmonary resistance and Qs represents the systemic resistance. This measures 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.

Source:

Element: 15126 Mixed Venous Saturation

Coding Instruction: Indicate the measured mixed venous saturation value obtained during the procedure in percent (%). Mixed venous saturation is the percentage of oxygen bound to hemoglobin in venous blood, measured from a sample typically taken from the pulmonary artery. It reflects the balance between oxygen delivery and consumption.

Target Value: The first value on current procedure

Element: 15108 Mixed Venous Saturation Not Assessed

Coding Instruction: Indicate whether the mixed venous saturation was not assessed.

Target Value: N/A

Element: 15135 Pulmonary Vascular Resistance Index

Coding Instruction: Indicate the pulmonary vascular resistance index in wood units*m².

It can be calculated using the distal mean pulmonary artery pressure and either the pulmonary artery wedge pressure, left atrial or common atrial pressure.

Target Value: The first value on current procedure

Element: 15122 Pulmonary Vascular Resistance Index Not Assessed

Coding Instruction: Indicate whether the pulmonary vascular resistance index was not assessed or not obtained during procedure in wood units*m².

Target Value: N/A

Element: 15133 Pulmonary Artery Mean Pressure

Coding Instruction: Indicate the pulmonary artery mean pressure in millimeters of mercury.

Note: If the patient has a single functional ventricle, use the highest pulmonary artery mean pressure obtained in the central pulmonary artery.

Target Value: The first value on current procedure

Element: 15120 Pulmonary Artery Mean Pressure Not Assessed

Coding Instruction: Indicate whether the pulmonary artery mean pressure was not assessed.

Target Value: N/A

Section: Imaging, Radiation and Contrast

Parent: Procedure Information

Element: 15838 Contrast Volume

Coding Instruction: Indicate the volume of contrast used in milliliters (ml). The volume recorded should be the total volume for the lab visit.

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

Element: 15892 Contrast Volume Not Documented

Coding Instruction: Indicate whether contrast volume is not documented.

Target Value: The value on current procedure

Element: 15112 X-Ray Imaging Plane Used

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

Target Value: The value on current procedure

X-ray Imaging Plane - 1.3.6.1.4.1.19376.1.4.1.6.5.818

Selection	Definition	Source	Code	Code System
No			100013073	ACC NCDR
Yes - Single Plane	X-ray system that captures images from one angle at a time.		112000002218	ACC NCDR
Yes - Biplane	X-ray system that can capture images simultaneously from two different angles.		112000002219	ACC NCDR
Yes - Rotational	A technique where the X-ray arm rotates around the patient, capturing multiple images from different angles.		262112000	SNOMED CT

Element: 15837 Fluoroscopy Used

Coding Instruction: Indicate whether fluoroscopy was used during the procedure.

Fluoroscopy is commonly used in interventional cardiology procedures to guide catheter placement in real time. If yes is selected, child fields for total fluoroscopy time, dose area product, and cumulative air KERMA will become available for answering.

Note: Documentation may include terms such as "fluoroscopy," "fluoro time," "radiation dose," or references to imaging modalities that align with real-time X-ray use.

Target Value: The value on current procedure

Element: 7214 Fluoroscopy Time

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

Note: Capture the total related to the diagnostic or interventional catheterization procedure.

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

Element: 15225 Cumulative Air Kerma

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

Note: Capture the total related to the diagnostic or interventional catheterization procedure.

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

Supporting Definition: Cumulative (Reference) Air kerma

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

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

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

Element: 15226 Dose Area Product

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

Note: Capture the total related to the diagnostic or interventional catheterization procedure.

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

Supporting Definition: Dose Area Product

Dose Area Product is the integral of air kerma (the energy extracted from an x-ray beam per unit mass of air in a small irradiated air

Section: Imaging, Radiation and Contrast

Parent: Procedure Information

volume; for diagnostic x-rays, the dose delivered to that volume of air) across the entire x-ray beam emitted from the x-ray tube. It is a surrogate measure of the amount of energy delivered to the patient.

Also known as KAP (Kerma Area Product).

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

Section: Imaging, Radiation and Contrast EP

Parent: Imaging, Radiation and Contrast

Element: 16233 Fluoroscopy Time

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

Note: Capture the total related to the EP study (with or without ablation) and cardiovascular implantable electronic device procedure.

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

Element: 16234 Cumulative Air Kerma

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

Note: Capture the total related to the EP study (with or without ablation) and cardiovascular implantable electronic device procedure.

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

Supporting Definition: Cumulative (Reference) Air kerma

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

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

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

Element: 16235 Dose Area Product

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

Note: Capture the total related to the EP study (with or without ablation) and cardiovascular implantable electronic device procedure.

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

Supporting Definition: Dose Area Product

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

Also known as KAP (Kerma Area Product).

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

Element: 16211 3D Electroanatomic Mapping Tools Used

Coding Instruction: Indicate whether 3D electroanatomic mapping tools were used during the cardiac implantable electronic device procedure.

Target Value: Any occurrence between start of procedure and end of procedure

Element: 16254 Intracardiac Echocardiogram Used

Coding Instruction: Indicate whether an intracardiac echocardiogram (ICE) was used during the procedure.

Target Value: The value on current procedure

Element: 16224 Intracardiac Echocardiogram Purpose

Coding Instruction: Indicate the primary purpose for using an intracardiac echocardiogram (ICE).

Target Value: The value on current procedure

Intracardiac echocardiogram use and purpose - 1.3.6.1.4.1.19376.1.4.1.6.5.1145

Selection	Definition	Source	Code	Code System
Electroanatomic mapping system	ICE was used for anatomical visualization to assist with mapping.		707833003	SNOMED CT
Real time catheter manipulation	ICE was used to guide catheter positioning and movement.		103712006	SNOMED CT
Transseptal puncture	ICE was used solely to guide transseptal puncture.		112000004242	ACC NCDR
Other			100000351	ACC NCDR

Element: 16238 Transesophageal Echocardiogram

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

Target Value: The value on current procedure

Section: Electrophysiology Study

Parent: Procedure Information

Element: 15392 Electrophysiology Procedure Primary Procedure Indication

Coding Instruction: Indicate the primary reason(s) the procedure is being performed.

Target Value: The value on current procedure

EP Procedure Primary Procedure Indication - 1.3.6.1.4.1.19376.1.4.1.6.5.1092

Selection	Definition	Source	Code	Code System
Symptom	The procedure was indicated due to patient-reported symptoms.		418799008	SNOMED CT
Documented tachyarrhythmia			112000004244	ACC NCDR
ECG findings with potential for risk	The procedure was indicated due to ECG findings with potential for risk. Examples include, but are not limited to arrhythmias or conduction disturbances, that may pose a significant risk to the patient.		112000001362	ACC NCDR
Assessment of anti-arrhythmic medication treatment	The procedure was indicated to evaluate the effectiveness or appropriateness of anti-arrhythmic drug therapy.		112000004032	ACC NCDR
Pre-operative evaluation	The EP study was part of a preoperative evaluation to assess arrhythmia risk or plan interventions		1000142360	ACC NCDR
Post-operative evaluation	The EP study was conducted postoperatively to assess for arrhythmias.		262061000	SNOMED CT
AV Block	The study was performed due to documented or suspected atrioventricular (AV) block.		233917008	SNOMED CT
Inherited arrhythmia history	The procedure was indicated due to inherited arrhythmias, such as, but not limited to, long QT syndrome or Brugada syndrome.		32895009	SNOMED CT
Congenital heart disease	The procedure was indicated due to congenital heart disease to assess arrhythmias related to structural abnormalities or prior repairs.		112000004033	ACC NCDR
Family history	The procedure was indicated based on a family history of sudden cardiac death, inherited arrhythmias, or other genetic cardiac conditions.		57177007	SNOMED CT
Sudden cardiac arrest - SCA	The EP study was performed following a sudden cardiac arrest,		112000004034	ACC NCDR
Atrial or ventricular ectopy	The procedure was indicated due to ectopy or premature beats originating from the atria or ventricles.		112000004236	ACC NCDR

Element: 16021 Symptoms Experienced

Coding Instruction: Select the specific symptoms that prompted the decision to perform the electrophysiology study.

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

EP Symptoms - 1.3.6.1.4.1.19376.1.4.1.6.5.1037

Selection	Definition	Source	Code	Code System
Palpitations	An unpleasant sensation of irregular and/or forceful beating of the heart		80313002	SNOMED CT
Syncope or near syncope	Sudden loss of consciousness with loss of postural tone, not related to anesthesia with spontaneous recovery as reported by patient or observer. Patient may experience syncope when supine.	Ref: ACC/AHA/HRS 2006 Key Data Elements and Definitions for Electrophysiological Studies and Procedures	271594007	SNOMED CT
Other			100000351	ACC NCDR

Element: 16022 ECG Finding with Potential Risk

Coding Instruction: Select the ECG finding with potential risk identified as the procedure indication. Risk refers to specific ECG findings that are associated with an increased likelihood of serious cardiac events or complications. These findings may indicate underlying conditions or predispositions that put the patient at higher risk of adverse outcomes, such as sudden cardiac arrest, arrhythmias, or heart failure.

Target Value: The value on current procedure

EP ECG Finding with Potential Risk - 1.3.6.1.4.1.19376.1.4.1.6.5.1038

Selection	Definition	Source	Code	Code System
AV block	Evidence of atrioventricular (AV) conduction delay or block, including first-degree, second-degree (Mobitz I or II), or complete heart block, identified on the ECG.		233917008	SNOMED CT
Brugada pattern	Polymorphic ventricular tachycardia in the absence of structural heart disease, associated with a baseline ECG pattern during sinus rhythm showing right bundle branch block with ST segment elevation in leads V1 through V3. It can also be characterized by documentation of ECG patterns associated with		418818005	SNOMED CT

Section: Electrophysiology Study

Parent: Procedure Information

Brugada Syndrome, some of which may be unmasked when provoked with drugs.

The most common genetic mutations identified for Brugada syndrome are in a sodium channel gene (SCN5A). Sodium channel blocking drugs, therefore, may exacerbate the electrocardiographic features and clinical presentation. Brugada syndrome typically presents before the age of 50 years.

Complex ventricular ectopy/arrhythmia	Frequent or multifocal premature ventricular contractions (PVCs), couplets, non-sustained ventricular tachycardia, or other complex ventricular arrhythmias noted on the ECG not originating from the right or left ventricular outflow tract	112000003868	ACC NCDR
Pre-excitation	The presence of an accessory pathway resulting in abnormal conduction, such as a delta wave on the ECG, indicative of Wolff-Parkinson-White (WPW) syndrome or similar conditions.	112000003869	ACC NCDR
Prolonged QT interval	An abnormally long QT interval corrected for heart rate (QTc), which may predispose the patient to torsades de pointes or other life-threatening arrhythmias.	112000003870	ACC NCDR
Other		100000351	ACC NCDR

Element: 16020

Final Arrhythmia Diagnosis

Coding Instruction: Select the final arrhythmia diagnosis/diagnoses made after the electrophysiology (EP) study. This refers to the confirmed diagnosis based on the results of the EP study, including any arrhythmias identified during the procedure.

Target Value: The value on current procedure

EP Final Arrhythmia Diagnosis - 1.3.6.1.4.1.19376.1.4.1.6.5.1036

Selection	Definition	Source	Code	Code System
Atrial ectopic tachycardia			233892002	SNOMED CT
Atrial fibrillation			49436004	SNOMED CT
Atrial flutter			5370000	SNOMED CT
Atrial paced			100000941	ACC NCDR
AV junctional rhythm			11849007	SNOMED CT
Complete heart block			27885002	SNOMED CT
Idioventricular rhythm			112000003866	ACC NCDR
Normal sinus rhythm			64730000	SNOMED CT
Second degree atrioventricular block			195042002	SNOMED CT
Sinus arrest			5609005	SNOMED CT
Supraventricular tachycardia			6456007	SNOMED CT
Ventricular paced			251266004	SNOMED CT
Ventricular tachycardia			25569003	SNOMED CT

Element: 16249

Final Arrhythmia Diagnosis Not Documented

Coding Instruction: Select if the final arrhythmia diagnosis is not documented.

Target Value: N/A

Element: 15413

Reason for Electrophysiology Ablation Not Attempted

Coding Instruction: Indicate the reason an ablation was not attempted during the procedure.

Target Value: The value on current procedure

Reason an Electrophysiology Ablation not Attempted - 1.3.6.1.4.1.19376.1.4.1.6.5.884

Selection	Definition	Source	Code	Code System
Diagnostic only	The electrophysiology study was conducted solely for diagnostic purposes, with no plan for ablation during the procedure.		112000004028	ACC NCDR
Pre-op or post-op	The electrophysiology study was performed as part of a preoperative evaluation or postoperative assessment.		112000003879	ACC NCDR
Insufficient target for mapping and ablation or no inducible arrhythmia	The arrhythmia could not be adequately induced or sustained for mapping purposes.		423437008	SNOMED CT
Low risk substrate	The arrhythmia substrate was deemed low risk and did not warrant ablation at the time of the study.		112000003880	ACC NCDR
High risk of collateral damage or complication	The ablation was not attempted due to concerns about potential collateral damage to critical structures or a		112000003881	ACC NCDR

Section: Electrophysiology Study

Parent: Procedure Information

high risk of procedural complications.			
Other	N/A	100000351	ACC NCDR

Element: 16023 Number of Diagnostic Catheters Used

Coding Instruction: Record the number of diagnostic catheters used during the EP study.

Note: Enter the maximum number of diagnostic catheters used at any one point during the procedure, not to including mapping or ablation catheters.

Target Value: The value on current procedure

Element: 16024 Drug for Provocation or Diagnostic Purpose

Coding Instruction: Indicate whether drug provocation was used during the procedure. This refers to the administration of medications to provoke arrhythmias.

Target Value: The value on current procedure

Element: 16025 EP Drug Used for Provocation

Coding Instruction: Select the drug(s) used for drug provocation.

Target Value: The value on current procedure

EP Drug Used for Provocation - 1.3.6.1.4.1.19376.1.4.1.6.5.1039

Selection	Definition	Source	Code	Code System
Isoproterenol			112000003819	ACC NCDR
Adenosine			296	RxNorm
Epinephrine			387362001	SNOMED CT
Other			100000351	ACC NCDR

Element: 16026 Inducible Arrhythmia

Coding Instruction: Indicate whether an arrhythmia was successfully induced during the procedure.

Target Value: The value on current procedure

Section: EP Inducible Arrhythmia

Parent: Electrophysiology Study

Element: 16222 Inducible Arrhythmia Counter

Coding Instruction: The inducible arrhythmia counter distinguishes individual arrhythmias when multiple arrhythmias were induced during the procedure. Note: The software-assigned device counter should start at one and be incremented by one for each device used.

Target Value: The value on current procedure

Element: 16027 Induced Arrhythmia Type

Coding Instruction: Indicate whether the arrhythmia was sustained or non-sustained.

Target Value: The value on current procedure

EP Induced Arrhythmia Type - 1.3.6.1.4.1.19376.1.4.1.6.5.1040

Selection	Definition	Source	Code	Code System
Sustained arrhythmia	The arrhythmia persisted for greater than 30 seconds or required intervention to stop.		112000003871	ACC NCDR
Non-sustained arrhythmia	The arrhythmia spontaneously terminated without requiring intervention.		112000003872	ACC NCDR

Element: 16028 Induced Arrhythmia Location

Coding Instruction: Select the location(s) of the induced arrhythmia.

Target Value: The value on current procedure

EP Induced Arrhythmia Location - 1.3.6.1.4.1.19376.1.4.1.6.5.1041

Selection	Definition	Source	Code	Code System
Supraventricular			112000003874	ACC NCDR
Ventricular			112000003875	ACC NCDR

Element: 16029 Supraventricular Arrhythmia Type

Coding Instruction: Select the type(s) of supraventricular arrhythmia induced.

Target Value: The value on current procedure

EP Supraventricular Arrhythmia Type - 1.3.6.1.4.1.19376.1.4.1.6.5.1042

Selection	Definition	Source	Code	Code System
Atrial fibrillation			49436004	SNOMED CT
Atrial flutter			5370000	SNOMED CT
Focal atrial tachycardia			276796006	SNOMED CT
Antidromic reciprocating tachycardia			233899006	SNOMED CT
AV nodal reentrant tachycardia			251166008	SNOMED CT
Junctional tachycardia			426648003	SNOMED CT
Orthodromic reciprocating tachycardia (ORT)			233897008	SNOMED CT
Premature atrial contraction			284470004	SNOMED CT
Indeterminate or other			82334004	SNOMED CT

Element: 16030 Ventricular Arrhythmia Type

Coding Instruction: Select the type(s) of ventricular arrhythmia induced.

Target Value: The value on current procedure

EP Ventricular Arrhythmia Type - 1.3.6.1.4.1.19376.1.4.1.6.5.1043

Selection	Definition	Source	Code	Code System
Monomorphic VT			251158004	SNOMED CT
Polymorphic VT			251159007	SNOMED CT
Ventricular fibrillation			71908006	SNOMED CT
Premature ventricular contractions (PVCs)			427172004	SNOMED CT

Section: EP Ablation Information

Parent: Electrophysiology Study

Element: 15409 Targeted Electrophysiology Ablation Substrate

Coding Instruction: Indicate the substrate(s) that were targeted during the electrophysiology (EP) ablation.

Target Value: The value on current procedure

Ablation Information - 1.3.6.1.4.1.19376.1.4.1.6.5.1134

Selection	Definition	Source	Code	Code System
Wolff-Parkinson-White (WPW)			74390002	SNOMED CT
Concealed accessory pathway/permanent junctional reciprocating tachycardia			233922008	SNOMED CT
AV nodal reentrant tachycardia (AVNRT)			251166008	SNOMED CT
Focal atrial tachycardia			713424004	SNOMED CT
Macroreentrant atrial tachycardia			735682000	SNOMED CT
Ventricular arrhythmias (PVCs, VT, VF)			44103008	SNOMED CT
Junctional tachycardia			426648003	SNOMED CT
Other	Select only when the substrate is not represented by any existing options. Use this category exclusively when no other selection is appropriate.		100000351	ACC NCDR

Section: Coarctation of the Aorta Intervention

Parent: Procedure Information

Element: 15255 Aortic Coarctation Primary Procedure Indication

Coding Instruction: Indicate the primary reason the coarctation procedure is being performed.

Target Value: The value on start of current procedure

Aortic Coarctation Indications - 1.3.6.1.4.1.19376.1.4.1.6.5.839

Selection	Definition	Source	Code	Code System
Non-invasive gradient	A pressure gradient across the aortic coarctation is documented through non-invasive testing methods, such as echocardiography or Doppler ultrasound.		112000003730	ACC NCDR
Systemic hypertension	Persistent elevated blood pressure is noted at rest, which may or may not be associated with a documented gradient or imaging findings.		38341003	SNOMED CT
Exertional hypertension only	Elevated blood pressure is observed during physical activity or exercise testing, with normal blood pressure at rest.		112000003731	ACC NCDR
Stenosis by imaging	Imaging studies (e.g., MRI, CT, or angiography) reveal significant narrowing at the coarctation site, irrespective of pressure gradients or blood pressure findings.		112000003732	ACC NCDR
Systolic ventricular dysfunction	Impaired systolic function of the left ventricle is noted, often due to increased afterload from the coarctation, as documented by echocardiography or other imaging modalities.		112000003733	ACC NCDR

Element: 15869 Prior Intervention At Lesion Site

Coding Instruction: Indicate if a surgery or catheterization intervention has previously been performed at the lesion site.

Target Value: The value on current procedure

Intervention Type - 1.3.6.1.4.1.19376.1.4.1.6.5.797

Selection	Definition	Source	Code	Code System
No	No prior surgery or catheterization intervention has been previously performed at the lesion site.		100013073	ACC NCDR
Yes - Catheterization	A prior catheterization intervention has been previously performed at the lesion site.		276272002	SNOMED CT
Yes - Surgical	A prior surgery has been previously performed at the lesion site.		387713003	SNOMED CT
Yes - Both	A prior surgery AND catheterization intervention has been previously performed at the lesion site.		112000003646	ACC NCDR

Section: Coarctation Pre-intervention

Parent: Coarctation of the Aorta Intervention

Element: 15263	Pre-Intervention Coarctation Peak Systolic Gradient
Coding Instruction:	Indicate the pre-intervention coarctation peak systolic gradient in millimeters of mercury.
Target Value:	The highest value at start of current procedure
Element: 15264	Pre-Intervention Coarctation Peak Systolic Gradient Not Assessed
Coding Instruction:	Indicate whether the pre-intervention coarctation peak systolic gradient was not assessed.
Target Value:	N/A
Element: 15261	Pre-Intervention Minimal Lumen Coarctation Diameter
Coding Instruction:	Indicate the pre-intervention minimum diameter of the aortic coarctation (in millimeters).
Target Value:	The value on start of current procedure
Element: 15262	Pre-Intervention Minimal Lumen Coarctation Diameter Not Assessed
Coding Instruction:	Indicate whether the pre-intervention minimal diameter of the coarctation was not assessed.
Target Value:	N/A
Element: 15875	Distal Transverse Aortic Arch Diameter
Coding Instruction:	Indicate the pre-intervention diameter of the distal transverse aortic arch in millimeters. The distal transverse aortic arch is considered the portion of the aortic arch between the left carotid artery and the left subclavian artery. The diameter of this site is used as a form of measurement of the aorta and serves diagnostic and interventional purposes. The diameter of the distal transverse aortic arch is used to estimate ideal balloon inflation.
	Note: Enter the largest value if multiple values are documented.
Target Value:	The value on start of current procedure
Element: 15876	Distal Transverse Aortic Arch Diameter Not Documented
Coding Instruction:	Indicate if the pre-intervention diameter of the distal transverse aortic arch is not documented.
Target Value:	N/A

Section: Coarctation Post-intervention
Parent: Coarctation of the Aorta Intervention

Element: 15267 Post-Intervention Coarctation Peak Systolic Gradient

Coding Instruction: Indicate the post-intervention coarctation peak systolic gradient in millimeters of mercury.

Target Value: The highest value at end of current procedure

Element: 15268 Post-Intervention Coarctation Peak Systolic Gradient Not Assessed

Coding Instruction: Indicate whether the post-intervention coarctation peak systolic gradient was not assessed.

Target Value: N/A

Element: 15265 Post-Intervention Minimal Lumen Coarctation Diameter

Coding Instruction: Indicate the post-Intervention minimal diameter of the coarctation in millimeters.

Target Value: The lowest value on current procedure

Element: 15266 Post-Intervention Minimal Coarctation Diameter Not Assessed

Coding Instruction: Indicate whether the post-intervention coarctation diameter was not assessed.

Target Value: N/A

Element: 15871 Gradient Attributable to Intervened Site

Coding Instruction: Indicate the pressure gradient across the segment of the aorta that was treated during the procedure for coarctation of the aorta. This gradient is an important indicator of the effectiveness of the intervention as it refers to the difference in blood pressure (or flow) measured across the segment of the aorta that was treated during the procedure. Enter the gradient in millimeters of mercury (mmHg).
Gradient: This is the difference in pressure across the narrowed segment of the aorta. It's typically measured using invasive methods during catheterization.
Attributable to Intervened Site: This means the gradient being discussed specifically relates to the segment of the aorta that was targeted for intervention (e.g., balloon dilation or stent placement). It assesses how effectively the procedure has addressed the coarctation.

Target Value: The value on end of current procedure

Element: 15872 Gradient Attributable to Intervened Site Not Documented

Coding Instruction: Indicate if the pressure gradient across the segment of the aorta that was treated was not documented.

Target Value: N/A

Section: Coarctation Balloon Dilation

Parent: Coarctation of the Aorta Intervention

Element: 15870

Balloon Dilation Only

Coding Instruction: Indicate whether the procedure involved balloon dilation without the placement of a stent. This refers to a minimally invasive intervention aimed at expanding the narrowed segment of the aorta in patients with coarctation of the aorta.

Select "Yes" if the procedure performed was exclusively a balloon dilation without stent placement.

Select "No" if the procedure involved other interventions, such as stent placement, or if no balloon dilation was performed at all.

Note: Other terms like "indentation resolved," "narrowing corrected," "waist disappeared," or "balloon expanded fully" may be appear in the reports. Confirmation of the intent with the provider is recommended.

Target Value: The value on current procedure

Section: Coarctation Balloon Dilation Only

Parent: Coarctation Balloon Dilation

Element: 15873 Initial Balloon Diameter

Coding Instruction: Indicate the diameter of the balloon used at the start of the balloon dilation procedure for coarctation of the aorta. Enter the diameter of the balloon (in millimeters) as documented at the initial stage of the procedure.

Target Value: The value on current procedure

Element: 15874 Final Balloon Diameter

Coding Instruction: Indicate the diameter of the balloon used at the conclusion of the balloon dilation procedure. Enter the final balloon diameter (in millimeters) used at the end of the procedure, as documented in the catheterization report. Ensure that this represents the largest diameter achieved during the procedure.

Target Value: The value on current procedure

Element: 15878 Waist On Any Balloon - Balloon Dilation Only

Coding Instruction: Indicate whether a "waist" was observed during the balloon dilation procedure. A waist typically suggests resistance at the site of coarctation.

Note: The term "waist" may be described using synonyms or phrases such as Indentation, Narrowing, Constriction, Balloon waist formation or sign. It is recommended to confirm the intent with the provider if any of these are documented.

Target Value: The value on current procedure

Supporting Definition: General Definition

A visible narrowing or indentation on the balloon found during a balloon procedure.

Source:

Element: 15879 Waist Resolved - Balloon Dilation Only

Coding Instruction: Indicate whether the waist (narrowing or indentation) observed on the balloon during the dilation procedure was resolved after inflation. Resolution suggests the balloon successfully expanded the narrowed segment of the aorta.

Note: Other terms like "indentation resolved," "narrowing corrected," "waist disappeared," or "balloon expanded fully" may be appear in the reports. Confirmation of the intent with the provider is recommended.

Target Value: The value on current procedure

Supporting Definition: General Definition

A visible narrowing or indentation on the balloon found during a balloon procedure.

Source:

Section: Coarctation Stent Implantation

Parent: Coarctation Balloon Dilation

Element: 15858 Indication For Stent Placement

Coding Instruction: Indicate the primary reason for stent placement during the procedure for coarctation of the aorta. Stents may be placed either as part of the planned therapy or in response to issues encountered during balloon dilation.

Note: Code only the indication for the first stent.

Target Value: The value on current procedure

Indication For Stent Placement - 1.3.6.1.4.1.19376.1.4.1.6.5.987

Selection	Definition	Source	Code	Code System
Primary therapy	Select this option if stent placement was planned as the primary treatment method for the coarctation, regardless of the balloon dilation outcome. This indicates the stent was part of the initial treatment strategy.		112000003735	ACC NCDR
Insufficient gradient relief after balloon dilation	Select this option if the stent was placed because balloon dilation did not sufficiently relieve the pressure gradient across the coarctation site. This suggests the dilation alone was not enough to resolve the coarctation.		112000003736	ACC NCDR
Treatment/stabilization of injury after balloon dilation	Select this option if the stent was placed to treat or stabilize any injury (e.g., dissection, tear) caused by the balloon dilation. This implies that the stent was used as a corrective measure following a complication.		112000003737	ACC NCDR

Element: 15880 Balloon Diameter Immediately Preceding Stent Placement

Coding Instruction: Record the diameter of the balloon used immediately before stent placement during the procedure for coarctation of the aorta. Enter the balloon diameter in millimeters (mm) to one decimal place (e.g., 9.0 mm, 13.5 mm).

Target Value: The value on current procedure

Element: 15881 Balloon Diameter Immediately Preceding Stent Placement Not Assessed

Coding Instruction: Indicate if the diameter of the balloon used immediately prior to the stent is not documented. Select this option if no balloon was used (stent only).

Target Value: N/A

Element: 15859 Waist On Any Balloon

Coding Instruction: Indicate whether a "waist" was observed during the balloon dilation procedure. A waist typically suggests resistance at the site of coarctation.
Select "Yes" if a waist was observed on any balloon during the procedure.
Select "No" if no waist was observed on any balloon used during the procedure.
Note: The term "waist" may be described using synonyms or phrases such as Indentation, Narrowing, Constriction, Balloon waist formation or sign. It is recommended to confirm the intent with the provider if any of these are documented.

Target Value: The value on current procedure

Supporting Definition: General Definition

A visible narrowing or indentation on the balloon found during a balloon procedure.

Source:

Element: 15861 Waist on Any Balloon Not Assessed

Coding Instruction: Indicate if waist on any balloon was not assessed.

Target Value: N/A

Element: 15860 Waist Resolved

Coding Instruction: Indicate whether the waist (narrowing or indentation) observed on the balloon during the dilation procedure was resolved after inflation. Resolution suggests the balloon successfully expanded the narrowed segment of the aorta.

Note:

Select "Yes" if the waist was observed initially but fully resolved after balloon inflation.

Select "No" if the waist persisted, either partially or fully, even after balloon inflation.

Other terms like "indentation resolved," "narrowing corrected," "waist disappeared," or "balloon expanded fully" may be appear in the reports. Confirmation of the intent with the provider is recommended.

Target Value: The value on current procedure

Supporting Definition: General Definition

A visible narrowing or indentation on the balloon found during a balloon procedure.

Section: Coarctation Stent Implantation

Parent: Coarctation Balloon Dilation

Source:

Section: Coarctation Device

Parent: Coarctation Stent Implantation

Element: 15273 Aortic Coarctation Device Counter

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

Note: The software-assigned device counter should start at one and be incremented by one for each device used. If more than two stents are used, only the first two stents are expected to be entered. Entering beyond two stents is at the discretion of the facility.

Target Value: N/A

Element: 15274 Aortic Coarctation Device ID

Coding Instruction: Indicate the device utilized during the coarctation procedure.

Note: For coarctation procedures, if a balloon and stent comes packaged as one device, treat as a stent device.

The device(s) collected in this field are controlled by the Master file. This file is maintained by the NCDR and will be made available on the internet for downloading and importing/updating into your application.

Target Value: The value on current procedure

Vendor Instruction: Aortic Coarctation Device ID (15274) cannot be Null when Aortic Coarctation Device Counter (15273) has a value

Element: 15864 Unique Device Identifier - Coarctation Stent

Coding Instruction: Indicate the unique device identifier (UDI) of the device. Enter all characters including the parenthesis. Leave blank if the UDI is unknown or unable to be collected due to state/local privacy laws.

Target Value: The value on current procedure

Supporting Definition: General Definition

The UDI identifies the specific individual device; no two devices have the same UDI. Refer to the FDA website for detailed explanation of UDIs.

The UDI is made up of five different identifiers and each identifier is preceded by a number in parentheses.

Example UDI below: Device Identifier (01), Expiration Date (17), Manufacturing date (11), Lot Number (10), and Serial Number (21)

Source:

Element: 15863 Coarctation of the Aorta Stent Length

Coding Instruction: Record the length of the stent used during the procedure for coarctation of the aorta. Enter the stent length in centimeters (cm) or millimeters (mm) to one decimal place (e.g., 5.0 mm, 7.5 mm).

Target Value: The value on current procedure

Element: 15882 Stent Diameter

Coding Instruction: Record the diameter of the stent used during the procedure for coarctation of the aorta. Enter the value to one decimal place in millimeters (mm) or centimeters (cm) (e.g., 5.0 mm, 7.5 mm, or 0.5 cm, 0.75 cm).

Target Value: The value on current procedure

Element: 15862 Stent Type Used

Coding Instruction: Indicate the type of stent used during the procedure for coarctation of the aorta.

Target Value: The value on current procedure

Stent Device Type - 1.3.6.1.4.1.19376.1.4.1.6.5.307

Selection	Definition	Source	Code	Code System
Bare metal	Select this option if a stent with no coating or medication was used. Bare metal stents are designed solely to provide structural support without additional therapeutic agents.		464052002	SNOMED CT
Covered	Select this option if a stent covered with a material was used. Covered stents are designed to prevent blood leakage through the stent struts and may be used in specific anatomical situations.		440271000124109	SNOMED CT

Element: 15865 Implanting Balloon Diameter

Coding Instruction: Record the diameter of the balloon used during the implantation of the stent in the coarctation of the aorta procedure in millimeters (mm) to one decimal place.

Target Value: The value on current procedure

Section: Coarctation Device

Parent: Coarctation Stent Implantation

Element: 15866 Post Dilation

Coding Instruction: Indicate whether a post-dilation was performed after stent placement during the coarctation of the aorta procedure.

Target Value: The value on current procedure

Supporting Definition: **General Definition**

Post-dilation refers to additional balloon inflation after the stent is deployed to optimize stent expansion.

Source:

Element: 15867 Post Dilation Balloon Diameter

Coding Instruction: Indicate the diameter of the balloon used during post-dilation after the stent was placed in the coarctation of the aorta procedure.

Target Value: The highest value on current procedure

Supporting Definition: **General Definition**

Post-dilation refers to additional balloon inflation after the stent is deployed to optimize stent expansion.

Source:

Element: 15877 Reason for Second Stent

Coding Instruction: Select the reason why a second stent was placed during the coarctation of the aorta procedure.

Target Value: The value on current procedure

Reason for Second Stent - 1.3.6.1.4.1.19376.1.4.1.6.5.988

Selection	Definition	Source	Code	Code System
Initial stent malposition	Select if the first stent was not properly positioned and a second stent was placed to correct its location.		112000001325	ACC NCDR
Initial stent too short	Select if the first stent was too short to adequately cover the coarctation site and a second stent was required.		410667008	SNOMED CT
Initial stent recoil	Select if the first stent recoiled (partially collapsed or did not maintain its full expansion), and a second stent was needed to stabilize the area.		112000003741	ACC NCDR
Vascular injury	Select if a second stent was placed to treat or stabilize an injury to the vessel, such as a tear or dissection, caused by the first stent.		112000003742	ACC NCDR

Section: Proximal Pulmonary Artery Stenting

Parent: Procedure Information

Element: 15227 Proximal Pulmonary Artery Stenting Primary Procedure Indication

Coding Instruction: Indicate the reason(s) the pulmonary artery stenting procedure is being performed.

Target Value: The value on start of current procedure

Proximal Pulmonary Artery Stenting Indications - 1.3.6.1.4.1.19376.1.4.1.6.5.835

Selection	Definition	Source	Code	Code System
Angiographic narrowing	Imaging studies (e.g., angiography or CT) demonstrate a narrowing in the proximal pulmonary artery.		708528005	SNOMED CT
Right ventricular hypertension	Elevated pressure within the right ventricle is documented.		461321006	SNOMED CT
Pulmonary artery pressure gradient	A pressure gradient greater than 20 mmHg is measured across the pulmonary artery, indicating significant resistance to blood flow.		250767002	SNOMED CT
Right ventricular dysfunction	Impaired function of the right ventricle is noted, as evidenced by imaging, hemodynamic measurements, or clinical assessment.		473365008	SNOMED CT
Differential blood flow	There is less than 35% of total pulmonary blood flow directed to the lung supplied by the targeted vessel		21762000	SNOMED CT
Pulmonic valve regurgitation	Regurgitation (backflow) of blood into the pulmonary artery is documented, potentially contributing to hemodynamic inefficiency or symptoms.		91434003	SNOMED CT

Element: 16132 Ostial Stenosis Present

Coding Instruction: Indicate whether ostial stenosis is present in the proximal pulmonary artery. Ostial stenosis refers to a narrowing or obstruction at the opening (ostium) where the pulmonary artery originates.

Target Value: The value on current procedure

Section: Proximal PAS Pre-intervention**Parent: Proximal Pulmonary Artery Stenting****Element:** 15239 Proximal Pulmonary Artery Defect Diameter**Coding Instruction:** Indicate the pre-intervention proximal diameter of the pulmonary artery defect in millimeters.**Target Value:** The value between start of procedure and prior to the intervention**Element:** 15240 Distal Pulmonary Artery Defect Diameter**Coding Instruction:** Indicate the pre-intervention distal diameter of the pulmonary artery defect in millimeters.

Note: The pulmonary artery distal diameter should be obtained at the first branch point to a lobar artery.

Target Value: The value between start of procedure and prior to the intervention**Element:** 15241 Pulmonary Artery Vessel Defect Diameter Minimum**Coding Instruction:** Indicate the pre-intervention minimum diameter of the pulmonary artery defect in millimeters.**Target Value:** The value between start of procedure and prior to the intervention

Section: Proximal PAS Post-intervention

Parent: Proximal Pulmonary Artery Stenting

Element: 15247 Post-Intervention Proximal Pulmonary Artery Diameter

Coding Instruction: Indicate the post-intervention proximal diameter of the pulmonary artery defect in millimeters.

Target Value: The value on end of current procedure

Element: 15248 Post-Intervention Distal Pulmonary Artery Diameter

Coding Instruction: Indicate the post-intervention distal diameter of the pulmonary artery defect in millimeters.

Note: The pulmonary artery distal diameter should be obtained at the first branch point to a lobar artery

Target Value: The value on end of current procedure

Element: 15250 Post-Intervention Pulmonary Artery Vessel Diameter Minimum

Coding Instruction: Indicate the post-intervention in stent minimum diameter of the pulmonary artery defect in millimeters.

Target Value: The value on end of current procedure

Section: Proximal PAS Device

Parent: Proximal Pulmonary Artery Stenting

Element: 15251 Pulmonary Artery Stenting Device Counter

Coding Instruction: The pulmonary artery stenting device counter distinguishes individual devices when multiple are used during one procedure.

Note: The software-assigned device counter should start at one and be incremented by one for each device used. If more than two stents are used, only the first stents are expected to be entered. Entering beyond two stents is at the discretion of the facility.

Target Value: The value on current procedure

Element: 15253 Device ID

Coding Instruction: Indicate the device utilized during the current pulmonary artery stenting procedure.

Note:

The device(s) collected in this field are controlled by the master file. This file is maintained by the NCDR and will be made available on the internet for downloading and importing/updating into your application.

Target Value: The value on current procedure

Vendor Instruction: Device ID (15253) cannot be Null when Pulmonary Artery Stenting Device Counter (15251) has a value

Element: 15913 Unique Device Identifier - PPAS Device

Coding Instruction: Indicate the unique device identifier (UDI) of the device. Enter all characters including the parenthesis. Leave blank if the UDI is unknown or unable to be collected due to state/local privacy laws.

Target Value: The value on current procedure

Supporting Definition: General Definition

The UDI identifies the specific individual device; no two devices have the same UDI. Refer to the FDA website for detailed explanation of UDIs.

The UDI is made up of five different identifiers and each identifier is preceded by a number in parentheses.

Example UDI below: Device Identifier (01), Expiration Date (17), Manufacturing date (11), Lot Number (10), and Serial Number (21)

Source:

Element: 15911 Proximal Pulmonary Artery Stent Length

Coding Instruction: Indicate the stent length in millimeters or centimeters.

Target Value: The value on current procedure

Element: 15912 Proximal Pulmonary Artery Stenting Stent Diameter

Coding Instruction: Indicate the stent diameter in millimeters or centimeters.

Target Value: The value on current procedure

Element: 15229 Pulmonary Artery Stenting Defect Location

Coding Instruction: Indicate the location of the defect in the pulmonary artery.

Target Value: The value on current procedure

Pulmonary Artery Location - 1.3.6.1.4.1.19376.1.4.1.6.5.836

Selection	Definition	Source	Code	Code System
Left Proximal Pulmonary Artery			50408007	SNOMED CT
Right Proximal Pulmonary Artery			78480002	SNOMED CT

Element: 15941 PPAS Successful Treatment

Coding Instruction: Indicate whether the proximal pulmonary artery stenting procedure was successful.

Success is defined as achieving a post-procedure diameter of the narrowest portion of the stented segment that is $\geq 75\%$ of the original (pre-procedure) target vessel diameter.

Target Value: The value on current procedure

Element: 15942 PPAS Stent Embolization

Coding Instruction: Indicate whether stent embolization occurred during the proximal pulmonary artery stenting procedure.

This refers to the unintended displacement or migration of the stent from its original placement site, moving entirely to a different

Section: Proximal PAS Device

Parent: Proximal Pulmonary Artery Stenting

anatomical location.

Target Value: The value on current procedure

Element: 15943

PPAS Stent Malposition

Coding Instruction: Indicate whether stent malposition occurred during the proximal pulmonary artery stenting procedure.

This refers to incomplete stent apposition, characterized by at least one stent strut being separated from the arterial wall with evidence of blood flow behind the strut, but without displacement to another site or involvement of side branches.

Target Value: The value on current procedure

Element: 15914

Stent Overhang (Compromising Access to Contralateral Pulmonary Artery)

Coding Instruction: Indicate if access to the contralateral pulmonary artery was obstructed due to a stent overhang.

Target Value: The value on current procedure

Element: 15944

Jailed Side Branch (with Compromised Flow)

Coding Instruction: Indicate whether a jailed side branch with compromised flow occurred during the proximal pulmonary artery stenting procedure. This refers to a situation where a smaller artery (side branch) is blocked, or its blood flow is reduced due to the placement of a stent over its opening.

Target Value: The value on current procedure

Section: Atrial Septal Defect Closure

Parent: Procedure Information

Element: 15893

Atrial Septal Defect Classification

Coding Instruction: Select the atrial septal defect (ASD) descriptor used to describe this procedure.

Note(s):

If multiple classifications are present, choose one based on the following priority:

1. ASD with Congenital Heart Disease,
2. ASD with Pulmonary Hypertension,
3. ASD with Pulmonary Stenosis,
4. ASD - Multiple,
5. ASD - Simple

Target Value: The value on start of current procedure

Atrial Septal Defect Classification - 1.3.6.1.4.1.19376.1.4.1.6.5.991

Selection	Definition	Source	Code	Code System
Atrial septal defect - simple	An isolated defect in the atrial septum with no additional congenital heart abnormalities.		70142008	SNOMED CT
Atrial septal defects - multiple	A general classification for multiple atrial septal defects or when the specific type is not detailed in the records.		112000003748	ACC NCDR
Atrial septal defect with pulmonary artery hypertension	An atrial septal defect associated with increased pressure in the pulmonary arteries, often indicative of significant left-to-right shunting or long-standing defect. Pulmonary hypertension is explicitly noted as a result of the defect.		70995007	SNOMED CT
Atrial septal defect with pulmonary stenosis	Atrial septal defect in a patient who also has pulmonary stenosis, which is a narrowing of the pulmonary valve or pulmonary artery that restricts blood flow from the right ventricle to the lungs.		112000003732	ACC NCDR
Atrial septal defect - with congenital heart disease	An atrial septal defect occurring in conjunction with other forms of congenital heart disease.		112000003749	ACC NCDR

Element: 15141

ASD Primary Procedure Indication

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

Target Value: The value on current procedure

Supporting Definition: Procedure Indication

The primary reason the procedure is being performed

Source:

ASD Closure Indications - 1.3.6.1.4.1.19376.1.4.1.6.5.821

Selection	Definition	Source	Code	Code System
Failure to thrive	The patient exhibits poor growth and development compared to age-based norms, often due to chronic heart failure or inadequate systemic circulation caused by the ASD.		54840006	SNOMED CT
Need for respiratory support	The patient requires mechanical or supplemental respiratory support (e.g., oxygen therapy, ventilator support) due to complications related to the ASD, such as pulmonary overcirculation or pulmonary hypertension.		112000003747	ACC NCDR
Recurrent respiratory infections	The patient has a history of frequent respiratory tract infections (e.g., pneumonia or bronchitis) that may be linked to increased pulmonary blood flow caused by the ASD.		112000002227	ACC NCDR
Right to left cardiac shunt	Hemodynamic evaluation indicates that blood is shunting from the right atrium to the left atrium through the ASD.		441826000	SNOMED CT
Right ventricular volume overload	Imaging or diagnostic studies (e.g., echocardiography) reveal significant enlargement of the right ventricle caused by increased blood flow from a left-to-right shunt, indicating hemodynamic burden.		112000002226	ACC NCDR

Section: ASD Imaging View 1

Parent: Atrial Septal Defect Closure

Element: 15900 ASD Dimension - View 1

Coding Instruction: Record the largest dimension of the atrial septal defect (ASD) as visualized from the first imaging view used during the procedure. View 1 refers to initial imaging plane or angle used to assess the defect.

Target Value: The highest value on current procedure

Element: 15901 ASD Dimension - View 1 Not Documented

Coding Instruction: Indicate whether the pre or post intervention dimension of the atrial septal defect (in mm) in view one was not documented.

Target Value: N/A

Section: ASD Imaging View 2

Parent: Atrial Septal Defect Closure

Element: 15902 ASD Dimension - View 2

Coding Instruction: Record the largest dimension of the atrial septal defect (ASD) as visualized from the second imaging view used during the procedure. View 2 refers to the measurement of the atrial septal defect diameter from a secondary imaging plane.

Target Value: The highest value on current procedure

Element: 15903 ASD Dimension - View 2 Not Documented

Coding Instruction: Indicate whether the pre or post intervention dimension of the atrial septal defect (in mm) in view two was not documented.

Target Value: N/A

Section: ASD Imaging

Parent: Atrial Septal Defect Closure

Element: 15156	Total Septal Length			
Coding Instruction:	Indicate the total septal length in millimeters. Note: 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 start of current procedure			
Element: 15157	Total Septal Length Not Assessed			
Coding Instruction:	Indicate whether the total septal length was not assessed.			
Target Value:	N/A			
Element: 15894	Deficient Rim			
Coding Instruction:	Indicate whether a deficient rim was present during the atrial septal defect (ASD) closure procedure. A deficient rim refers to an inadequate or insufficient amount of surrounding tissue or structure needed to securely place the closure device.			
Target Value:	The value on current procedure			
Element: 15895	Deficient Rim Length			
Coding Instruction:	Indicate the length of the deficient rim if it was present during the atrial septal defect (ASD) closure procedure. This measurement reflects the extent of the rim deficiency. Enter the length of the deficient rim in millimeters (mm).			
Target Value:	The value on current procedure			
Element: 15898	Deficient Rim Length Not Documented			
Coding Instruction:	Indicate if the length of the deficient rim of the atrial septal defect was not documented.			
Target Value:	N/A			
Element: 16133	ASD Deficient Rim Location			
Coding Instruction:	Indicate the area around the atrial septal defect where there is an inadequate amount of tissue (rim) to provide structural support for closure devices or surgical repair.			
Target Value:	The value on current procedure			
ASD Deficient Rim Location - 1.3.6.1.4.1.19376.1.4.1.6.5.1100				
Selection	Definition	Source	Code	Code System
Retroaortic	The rim located anteriorly, between the ASD and the aorta, is insufficient or absent.		112000004073	ACC NCDR
SVC (Superior Vena Cava)	The rim located superiorly, between the ASD and the superior vena cava (SVC), is insufficient or absent.		48345005	SNOMED CT
Posterior	The rim located at the back (posterior) of the ASD, near the pulmonary veins, is insufficient or absent.		255551008	SNOMED CT
Inferior	The rim located below the ASD, adjacent to the inferior vena cava (IVC), is insufficient or absent.		261089000	SNOMED CT
Element: 15896	Second Deficient Rim			
Coding Instruction:	Indicate whether a second deficient rim was present during the atrial septal defect (ASD) closure procedure. A second deficient rim refers to an additional area of inadequate tissue or structure beyond the primary deficient rim.			
Target Value:	The value on current procedure			
Element: 15897	Second Deficient Rim Length			
Coding Instruction:	Indicate the length of the second deficient rim if it was present during the atrial septal defect (ASD) closure procedure. This measurement reflects the extent of the rim deficiency. Enter the length of the deficient rim in millimeters (mm).			
Target Value:	The value on current procedure			
Element: 15899	Second Deficient Rim Length Not Documented			
Coding Instruction:	Indicate if the length of the second deficient rim in the atrial septal defect was not documented.			
Target Value:	N/A			
Element: 15158	Atrial Septal Aneurysm Present			

Section: ASD Imaging
Parent: Atrial Septal Defect Closure

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

Target Value: The value on current procedure

Element: 15162 Atrial Septal Defect Balloon Sizing Performed

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

Target Value: The value on current procedure

Element: 15908 Atrial Septal Defect Balloon Sizing Method

Coding Instruction: Indicate the method used for balloon sizing during the atrial septal defect (ASD) closure procedure. Balloon sizing is employed to determine the appropriate size of the closure device by inflating a balloon within the ASD to measure the defect's dimensions.

Target Value: The value on start of current procedure

Atrial Septal Defect Balloon Sizing Methods - 1.3.6.1.4.1.19376.1.4.1.6.5.992

Selection	Definition	Source	Code	Code System
Waist	Indicates that balloon sizing was performed using the "waist" method. This involves inflating the balloon until a constriction or "waist" is observed, which helps determine the appropriate size of the closure device.		112000003738	ACC NCDR
Stop flow	Indicates that balloon sizing was performed using the "stop flow" method. This involves inflating the balloon until the blood flow across the ASD is stopped, which helps to gauge the defect size.		112000002234	ACC NCDR

Section: ASD Device

Parent: Atrial Septal Defect Closure

Element: 14842 Device Counter

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

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

Target Value: The value on current procedure

Element: 15203 Atrial Septal Defect Device ID

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

Note: 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 dilated two separate defects, list the balloon only once). Every treatment and support device utilized during the procedure should be specified.

The device(s) collected in this field are controlled by the master file. This file is maintained by the NCDR and will be made available on the internet for downloading and importing/updating into your application

Target Value: The value on current procedure

Vendor Instruction: Atrial Septal Defect Device ID (15203) cannot be Null when Device Counter (14842) has a value

Element: 15910 Unique Device Identifier - ASD Device

Coding Instruction: Indicate the unique device identifier (UDI) of the device. Enter all characters including the parenthesis. Leave blank if the UDI is unknown or unable to be collected due to state/local privacy laws.

Target Value: The value on current procedure

Supporting Definition: General Definition

The UDI identifies the specific individual device; no two devices have the same UDI. Refer to the FDA website for detailed explanation of UDIs.

The UDI is made up of five different identifiers and each identifier is preceded by a number in parentheses.

Example UDI below: Device Identifier (01), Expiration Date (17), Manufacturing date (11), Lot Number (10), and Serial Number (21)

Source:

Element: 15909 Atrial Septal Defect Second Device Indication

Coding Instruction: Indicate the reason(s) that a second device was attempted or deployed.

Target Value: The value on current procedure

Atrial Septal Defect Second Device Indication - 1.3.6.1.4.1.19376.1.4.1.6.5.993

Selection	Definition	Source	Code	Code System
Change Size	Select if the second device was deployed because the size of the first device was inadequate, requiring a different size for proper ASD closure.		246115007	SNOMED CT
Unanticipated device problem	Select if the second device was used due to an issue with the first device, such as malfunction or improper deployment.		55607006	SNOMED CT
Other			100000351	ACC NCDR

Section: ASD Closure
Parent: Atrial Septal Defect Closure
Element: 15202

Residual Shunt Size

Coding Instruction: Indicate the residual shunt size of the atrial septal defect.

Target Value: The value on end of current procedure

Residual Shunt Size - 1.3.6.1.4.1.19376.1.4.1.6.5.830

Selection	Definition	Source	Code	Code System
No shunt	The absence of any residual flow through the defect. The closure is complete.		100013073	ACC NCDR
Trivial shunt (less than 3 mm)	A small residual shunt is present, with a measured size less than 3 mm, often considered clinically insignificant.		112000002238	ACC NCDR
Significant shunt (greater or equal to 3 mm)	A residual shunt is detected with a measured size of 3 mm or larger, indicating substantial residual flow through the defect.		112000002239	ACC NCDR

Section: Aortic Valvuloplasty

Parent: Procedure Information

Element: 15204 Aortic Valvuloplasty Primary Procedure Indication

Coding Instruction: Indicate the primary reason the aortic valvuloplasty procedure is being performed.

Target Value: The value on start of current procedure

Aortic Valvuloplasty Indications - 1.3.6.1.4.1.19376.1.4.1.6.5.831

Selection	Definition	Source	Code	Code System
Abnormal stress test/ECG	The procedure was prompted by findings on a stress test or electrocardiogram (ECG).		100000854	ACC NCDR
Aortic valve gradient	The procedure was performed due to elevated pressure gradients across the aortic valve		251088005	SNOMED CT
Left ventricular dysfunction	The procedure was indicated due to impaired left ventricular function, such as reduced ejection fraction, for example.		134401001	SNOMED CT
Symptoms	Symptoms can include, but are not limited to, heart failure, syncope or angina.		418799008	SNOMED CT

Element: 15209 Aortic Valve Morphology

Coding Instruction: Indicate the morphology of the aortic valve.

Target Value: The value on start of current procedure

Aortic Valve Disease Morphology - 1.3.6.1.4.1.19376.1.4.1.6.5.495

Selection	Definition	Source	Code	Code System
Unicuspid	An aortic valve with only one leaflet		253610004	SNOMED CT
Bicuspid	A congenital anomaly in which the aortic valve has two NCI Thesaurus leaflets.		72352009	SNOMED CT
Tricuspid	The normal anatomical structure of the aortic valve, characterized by the presence of three distinct leaflets or cusps		46030003	SNOMED CT
Quadricuspid	A four-cusps aortic valve of various size possibilities		253611000	SNOMED CT
Uncertain	Aortic valve morphology is uncertain.		100012985	ACC NCDR

Element: 15212 Aortic Valve Diameter

Coding Instruction: Indicate the diameter of the aortic valve in millimeters that was used to select the balloon used for the procedure.

Target Value: The value on start of current procedure

Element: 15211 Aortic Valvuloplasty Pre-Intervention Aortic Valve Regurgitation

Coding Instruction: Indicate the pre-intervention regurgitation of the aortic valve. If 'trivial, trace, or physiologic' is documented, select 'none'.

Target Value: The value on start of current procedure

Aortic Valve Regurgitation Severity - 1.3.6.1.4.1.19376.1.4.1.6.5.862

Selection	Definition	Source	Code	Code System
None			112000001910	ACC NCDR
1+ (mild)			112000000380	ACC NCDR
2+ (moderate)			112000000381	ACC NCDR
3+ (moderate to severe)			1000142345	ACC NCDR
4+ (severe)			112000000382	ACC NCDR

Element: 15224 Aortic Valvuloplasty Pre-Intervention Aortic Valve Peak Systolic Gradient

Coding Instruction: Indicate the pre-intervention aortic valve peak systolic gradient in millimeters of mercury.

Target Value: The value on start of current procedure

Element: 15840 Pre-Intervention Aortic Valve Peak Systolic Gradient Not Documented

Coding Instruction: Indicate if the pre-intervention aortic valve peak systolic gradient is not documented.

Target Value: N/A

Element: 15222 Aortic Valvuloplasty Post-Intervention Aortic Valve Regurgitation

Coding Instruction: Indicate the aortic valve regurgitation after the balloon has been inflated during the aortic valvuloplasty.

Note:
If 'trivial, trace, or physiologic' is documented, select 'none'.
Code the highest value or most severe regurgitation when a range is reported.

Section: Aortic Valvuloplasty

Parent: Procedure Information

Target Value: The value on end of current procedure

Aortic Valve Regurgitation Severity - 1.3.6.1.4.1.19376.1.4.1.6.5.862

Selection	Definition	Source	Code	Code System
None			112000001910	ACC NCDR
1+ (mild)			112000000380	ACC NCDR
2+ (moderate)			112000000381	ACC NCDR
3+ (moderate to severe)			1000142345	ACC NCDR
4+ (severe)			112000000382	ACC NCDR

Element: 15223 Aortic Valvuloplasty Post-Intervention Aortic Valve Peak Systolic Gradient

Coding Instruction: Indicate the aortic valve peak systolic gradient in millimeters of mercury, after the balloon has been inflated during the aortic valvuloplasty procedure.

Target Value: The value on end of current procedure

Element: 15841 Post Dilation Aortic Valve Peak Systolic Gradient Not Documented

Coding Instruction: Indicate if the post dilation aortic valve peak systolic gradient is not documented.

Target Value: N/A

Element: 15213 Aortic Valvuloplasty Balloon Technique

Coding Instruction: Indicate the type of balloon technique used during the aortic valvuloplasty procedure.

Target Value: The value on current procedure

Balloon Technique - 1.3.6.1.4.1.19376.1.4.1.6.5.833

Selection	Definition	Source	Code	Code System
Single	A single balloon is inflated.		50607009	SNOMED CT
Double	Two balloons are simultaneously inflated.		1305003	SNOMED CT

Element: 15839 Balloon Diameter - Largest

Coding Instruction: Record the largest diameter of the balloon during inflation, in millimeters (mm).

Target Value: The value on current procedure

Element: 15219 Balloon Stabilization

Coding Instruction: Indicate if pharmacologic, mechanical or rapid pacing technique were used to stabilize the balloon during the procedure.

Target Value: The value on current procedure

Section: Patent Ductus Arteriosus (PDA) Closure

Parent: Procedure Information

Element: 16131 Respiratory Support

Coding Instruction: Indicate whether the patient is currently on respiratory support.

Target Value: The value on start of current procedure

Element: 15918 Respiratory Support Type

Coding Instruction: Indicate the respiratory support type required by the patient. This includes any form of continuous positive airway pressure therapy, conventional ventilation, high flow oxygen nasal cannula, high frequency oscillatory ventilation, jet ventilation, or other respiratory support.

Target Value: The value on start of current procedure

PDA Respiratory Support Type - 1.3.6.1.4.1.19376.1.4.1.6.5.995

Selection	Definition	Source	Code	Code System
Continuous positive airway pressure therapy	A non-invasive ventilation method that delivers continuous positive pressure to the airways to maintain airway patency and support breathing.		47545007	SNOMED CT
Conventional ventilation	Standard mechanical ventilation using a ventilator to deliver breaths to the patient at a set volume and rate via an endotracheal tube or tracheostomy.		706172005	SNOMED CT
High flow oxygen nasal cannula	Delivery of warmed oxygen at a high flow rate through nasal cannula to improve oxygenation and reduce work of breathing.		426854004	SNOMED CT
High frequency oscillatory ventilation	A type of mechanical ventilation that delivers very small tidal volumes at a very high frequency, typically used for severe respiratory failure.		243155002	SNOMED CT
Jet ventilation	A specialized ventilation technique that delivers short, rapid bursts of gas to maintain adequate oxygenation and ventilation, often used in airway surgeries.		4764004	SNOMED CT
Other	N/A		100000351	ACC NCDR

Element: 15928 Mean Airway Pressure

Coding Instruction: Indicate the mean airway pressure (MAP) assessed at the start of the patent ductus arteriosus procedure.

Target Value: The value on start of current procedure

Element: 15929 Mean Airway Pressure Not Assessed

Coding Instruction: Indicate whether the mean airway pressure (MAP) was not assessed at the start of the patent ductus arteriosus procedure.

Target Value: N/A

Element: 15926 Fraction of Inspired Oxygen

Coding Instruction: Record the fraction of inspired oxygen (FiO2) assessed at the start of the patent ductus arteriosus procedure. This value is a percentage.

Target Value: The value on start of current procedure

Element: 15927 Fraction of Inspired Oxygen Not Assessed

Coding Instruction: Indicate whether the fraction of inspired oxygen (FiO2) was not assessed at the start of the patent ductus arteriosus procedure.

Target Value: N/A

Element: 15921 Respiratory Severity Score

Coding Instruction: Indicate the respiratory severity score assessed at the start of the patent ductus arteriosus procedure. The respiratory severity score is calculated by multiplying mean airway pressure (MAP) by the fraction of inspired oxygen (FiO2). The score helps to assess the need for respiratory support in infants requiring assisted ventilation.
RSS=MAPxFiO2

Target Value: The value on start of current procedure

Element: 15922 Respiratory Severity Score Not Assessed

Coding Instruction: Indicate if the respiratory severity score was not assessed at the start of the patent ductus arteriosus procedure.

Target Value: N/A

Element: 15105 Inotrope Administered

Section: Patent Ductus Arteriosus (PDA) Closure**Parent: Procedure Information**

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

Note: Include positive inotropes only (e.g. dopamine, dobutamine, epinephrine, norepinephrine, vasopressin and milrinone).

Do not include isuprel when used as a diagnostic agent to induce arrhythmias during an EP procedure.

Target Value: The value on current procedure

Drug Administered - 1.3.6.1.4.1.19376.1.4.1.6.5.711

Selection	Definition	Source	Code	Code System
No			100014173	ACC NCDR
Yes			112000001851	ACC NCDR

Section: PDA Intra-Procedure

Parent: Patent Ductus Arteriosus (PDA) Closure

Element: 12871 Procedure Location

Coding Instruction: Indicate the location where the procedure was performed.

Target Value: The value on current procedure

PDA Procedure Location - 1.3.6.1.4.1.19376.1.4.1.6.5.1144

Selection	Definition	Source	Code	Code System
Cardiac Catheterization Laboratory			112000000616	ACC NCDR
Bedside/NICU			225739005	SNOMED CT
Other			100000351	ACC NCDR

Element: 15285 Patent Ductus Arteriosus Classification

Coding Instruction: Indicate the classification of the patent ductus arteriosus (PDA) defect.

Target Value: The value on start of current procedure

Patent Ductus Arteriosus Classifications - 1.3.6.1.4.1.19376.1.4.1.6.5.846

Selection	Definition	Source	Code	Code System
Type A (Conical)	The PDA has a conical shape, with a narrow distal opening and a wider proximal opening near the aorta. This is the most common PDA type.		112000002270	ACC NCDR
Type B (Window)	The PDA appears as a short, wide connection between the aorta and the pulmonary artery, resembling a window-like structure.		112000002271	ACC NCDR
Type C (Tubular)	The PDA is uniformly cylindrical, with little to no narrowing along its length.		112000002272	ACC NCDR
Type D (Complex)	The PDA has an irregular shape with multiple constrictions or branching, making it more anatomically complex.		112000002273	ACC NCDR
Type E (Elongated)	The PDA is significantly elongated, with a narrow, stretched structure		112000002274	ACC NCDR
Type F	A ductus that has tortuous morphology that does not fit in any of the above classifications. Sometimes called fetal type.		112000003764	ACC NCDR

Element: 15282 Patent Ductus Arteriosus Aortic Side Aortic Ampulla Dimension

Coding Instruction: Indicate the aortic ampulla dimension of the patent ductus arteriosus diameter on the aortic side in millimeters.

Note(s): The aortic ampulla refers to the funnel-shaped widening at the aortic side of the ductus arteriosus. This dimension may be obtained through angiography or echocardiography.

Target Value: The value on start of current procedure

Element: 15283 Patent Ductus Arteriosus Luminal Diameter

Coding Instruction: Indicate the patent ductus arteriosus (PDA) minimal luminal diameter in millimeters.

Target Value: The value on start of current procedure

Element: 15284 Patent Ductus Arteriosus Length

Coding Instruction: Indicate the length of the patent ductus arteriosus (PDA) in millimeters.

Target Value: The value on start of current procedure

Element: 15930 PDA Measurement Technique

Coding Instruction: Indicate the measurement technique used during the patent ductus arteriosus defect closure procedure. Indicate how the measurements about PDA length, luminal diameter, etc. were obtained.

Target Value: The value on current procedure

PDA Measurement Technique - 1.3.6.1.4.1.19376.1.4.1.6.5.997

Selection	Definition	Source	Code	Code System
Angiography			77343006	SNOMED CT
Echocardiography			40701008	SNOMED CT

Element: 15924 Pre PDA Closure Tricuspid Valve Regurgitation

Coding Instruction: Indicate the degree of tricuspid regurgitation prior to closure of the patent ductus arteriosus.

Section: PDA Intra-Procedure

Parent: Patent Ductus Arteriosus (PDA) Closure

Note(s): Code the highest value or most severe regurgitation when a range is reported. If 'physiologic' is documented, select 'Trace/Trivial'.

Target Value: The value on start of current procedure

Valve Regurgitation Severity - 1.3.6.1.4.1.19376.1.4.1.6.5.767

Selection	Definition	Source	Code	Code System
None			112000001910	ACC NCDR
Trace/Trivial			112000001911	ACC NCDR
Mild (1+)			112000000380	ACC NCDR
Moderate (2+)			112000000381	ACC NCDR
Moderate to severe (3+)			1000142345	ACC NCDR
Severe (4+)			112000000382	ACC NCDR

Element: 15931

PDA Ductal Angiography

Coding Instruction: Indicate whether ductal angiography was used during the patent ductus arteriosus closure procedure. Ductal angiography refers to the imaging technique used to visualize the patent ductus arteriosus and assess its anatomy and hemodynamics during the PDA closure procedure. This technique typically involves the injection of contrast dye into the PDA to provide clear imaging of the ductus and its relation to nearby structures.

Target Value: The value on current procedure

Section: PDA Closure Device

Parent: Patent Ductus Arteriosus (PDA) Closure

Element: 15965

Patent Ductus Arteriosus (PDA) Closure Device Counter

Coding Instruction: Patent Ductus Arteriosus (PDA) Closure device counter distinguishes individual devices when multiple are used during the procedure. At least one device must be specified for each procedure.

Note(s): If more than one device is used, enter only the initial device in counter one and the final device in counter two.

Target Value: N/A

Element: 15932

Catheter Technique

Coding Instruction: Indicate the catheter technique used during the patent ductus arteriosus procedure.

Target Value: The value on current procedure

PDA Catheter Technique - 1.3.6.1.4.1.19376.1.4.1.6.5.998

Selection	Definition	Source	Code	Code System
Balloon endhole	Select if a balloon-tipped catheter with an endhole was used to cross the PDA. This technique involves using the balloon to aid in crossing the ductus and positioning the catheter.		112000003765	ACC NCDR
Directional endhole with 0.014 wire	Select if a catheter with a directional endhole was used together with a microcatheter and a 0.014-inch guidewire to cross the PDA.		112000003766	ACC NCDR
Directional endhole with 0.035 wire	Select if a catheter with a directional endhole was used in conjunction with a 0.035-inch guidewire to cross the PDA.		112000003767	ACC NCDR
Other			100000351	ACC NCDR

Element: 15290

Patent Ductus Arteriosus Closure Device ID

Coding Instruction: Indicate the device utilized during the patent ductus arteriosus (PDA) closure procedure.

Note: If a device was utilized on multiple defects, specify it only once.

The device that should be collected in your application are controlled by a Master File. This file is maintained by the NCDR and will be made available on the internet for downloading and importing/updating into your application.

Target Value: The value on current procedure

Vendor Instruction: Patent Ductus Arteriosus Closure Device ID (15290) cannot be Null when Patent Ductus Arteriosus (PDA) Closure Device Counter (15965) has a value

Element: 15923

Unique Device Identifier - PDA Device

Coding Instruction: Indicate the unique device identifier (UDI) of the device. Enter all characters including the parenthesis. Leave blank if the UDI is unknown or unable to be collected due to state/local privacy laws.

Target Value: The value on current procedure

Supporting Definition: General Definition

The UDI identifies the specific individual device; no two devices have the same UDI. Refer to the FDA website for detailed explanation of UDIs.

The UDI is made up of five different identifiers and each identifier is preceded by a number in parentheses.

Example UDI below: Device Identifier (01), Expiration Date (17), Manufacturing date (11), Lot Number (10), and Serial Number (21)

Source:

Element: 15934

Waist Diameter PDA Closure Device

Coding Instruction: Record the waist diameter of the closure device used. This is the narrowest part of the device that sits within the ductus. Record the units in millimeters (mm).

Target Value: The value on current procedure

Element: 15935

Disc Diameter PDA Closure Device

Coding Instruction: Record the diameter of the disc(s) of the closure device used. Record the units in millimeters (mm). If the device has more than one disc and diameters differ, record the larger diameter unless otherwise specified.

Target Value: The value on current procedure

Section: PDA Closure Device

Parent: Patent Ductus Arteriosus (PDA) Closure

Element: 15936 Length PDA Closure Device

Coding Instruction: Record the length of the closure device used. Record the units in millimeters.

Target Value: The value on current procedure

Element: 15920 PDA Implant Technique

Coding Instruction: Indicate the technique used to implant the patent ductus arteriosus device.

Target Value: The value on current procedure

PDA Implant Technique - 1.3.6.1.4.1.19376.1.4.1.6.5.996

Selection	Definition	Source	Code	Code System
Antegrade (venous access)	Procedure performed using a venous access route		827097006	SNOMED CT
Retrograde (arterial access)	Procedure performed using an arterial access route.		260526008	SNOMED CT

Element: 15291 Outcome of Device

Coding Instruction: Indicate the outcome of the patent ductus arteriosus (PDA) closure device.

Target Value: The value on end of current procedure

Intervention Device Outcomes - Defect Closure - 1.3.6.1.4.1.19376.1.4.1.6.5.856

Selection	Definition	Source	Code	Code System
Device in place	The device was successfully implanted and remains in position within the PDA at the conclusion of the procedure.		260388006	SNOMED CT
Device removed by catheter	The device was implanted but subsequently retrieved and removed using a catheter-based approach during the procedure.		276272002	SNOMED CT
Intra-operative removal	The device was implanted but removed surgically during the same procedure.		387713003	SNOMED CT
Unknown	The outcome of the device could not be determined or is not documented in the medical records.		261665006	SNOMED CT

Section: PDA Outcome

Parent: Patent Ductus Arteriosus (PDA) Closure

Element: 15933 PDA Post Procedure Obstruction

Coding Instruction: Indicate whether any obstruction was observed at the end of the patent ductus arteriosus (PDA) closure procedure. Post-procedure obstruction refers to any blockage or restriction in the PDA or adjacent structures, such as the aorta or pulmonary artery, that occurs after the closure has been completed.

Target Value: The value on end of current procedure

Vendor Instruction: When PDA Post Procedure Obstruction (15933) is [No obstruction present], no other selections can be selected

PDA Post Procedure Obstruction - 1.3.6.1.4.1.19376.1.4.1.6.5.999

Selection	Definition	Source	Code	Code System
Aorta	Obstruction affecting the aorta defined as a continuous wave (CW) spectral Doppler velocity greater than 2.5 m/s.		15825003	SNOMED CT
Pulmonary artery	Obstruction affecting the pulmonary artery defined as a continuous wave (CW) spectral Doppler velocity greater than 2.5 m/s.		81040000	SNOMED CT
No obstruction present	Absence of obstruction affecting the PDA site.		100001231	ACC NCDR

Element: 16242 Post Procedure Obstruction Not Assessed

Coding Instruction: Indicate if post procedure obstruction was not assessed or not documented.

Target Value: N/A

Element: 15919 Post PDA Closure Tricuspid Valve Regurgitation

Coding Instruction: Indicate whether there is evidence of tricuspid valve regurgitation. Enter level of valve function associated with highest risk (i.e., worst performance).

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

If 'physiologic' is documented, select 'Trace/Trivial'.

Target Value: The highest value at end of current procedure

Valve Regurgitation Severity - 1.3.6.1.4.1.19376.1.4.1.6.5.767

Selection	Definition	Source	Code	Code System
None			112000001910	ACC NCDR
Trace/Trivial			112000001911	ACC NCDR
Mild (1+)			112000000380	ACC NCDR
Moderate (2+)			112000000381	ACC NCDR
Moderate to severe (3+)			1000142345	ACC NCDR
Severe (4+)			112000000382	ACC NCDR

Element: 15288 Patent Ductus Arteriosus Residual Shunt

Coding Instruction: Indicate the residual shunt of the patent ductus arteriosus (PDA) after device placement.

Target Value: The value on end of current procedure

Residual Shunt Types - 1.3.6.1.4.1.19376.1.4.1.6.5.848

Selection	Definition	Source	Code	Code System
None	No residual shunt is detected.		260413007	SNOMED CT
Trace/Trivial	A trace/trivial residual shunt is detected, as defined by the clinician.		100001111	ACC NCDR
Mild	A mild residual shunt is detected, as defined by the clinician.		255604002	SNOMED CT
Moderate	A moderate residual shunt is detected, as defined by the clinician.		6736007	SNOMED CT
Severe	A severe residual shunt is detected, as defined by the clinician.		24484000	SNOMED CT

Section: Transcatheter Pulmonary Valve Replacement

Parent: Procedure Information

Element: 15293 Transcatheter Pulmonary Valve Replacement Clinical Indication

Coding Instruction: Indicate the reason(s) for the procedure.

Target Value: The value on start of current procedure

Pulmonary Valve Replacement Clinical Indications - 1.3.6.1.4.1.19376.1.4.1.6.5.858

Selection	Definition	Source	Code	Code System
Arrhythmia	The presence of arrhythmias, such as right ventricular outflow tract arrhythmias, which may be associated with valvular issues or the need for symptomatic relief through valve replacement.		698247007	SNOMED CT
Symptomatic	Presence of symptoms such as fatigue, exercise intolerance, palpitations, or dyspnea, which may be attributed to valve-related issues or ventricular dysfunction.		418799008	SNOMED CT
Ventricular function decline	A decline in ventricular function as evidenced by reduced ejection fraction, which may be related to valve dysfunction or the need for ventricular stabilization.		250938005	SNOMED CT
Right ventricle dilation	Enlargement or dilation of the right ventricle due to increased pressure or volume load.		25322007	SNOMED CT

Element: 15294 Transcatheter Pulmonary Valve Replacement Hemodynamic Indication

Coding Instruction: Indicate the primary hemodynamic reason for the procedure.

Target Value: The value on start of current procedure

Pulmonary Valve Replacement Hemodynamic Indications - 1.3.6.1.4.1.19376.1.4.1.6.5.859

Selection	Definition	Source	Code	Code System
Predominant valve/conduit obstruction	Significant narrowing or blockage through the valve or conduit, restricting blood flow from the right ventricle to the pulmonary artery.		68646005	SNOMED CT
Predominant valve/conduit regurgitation	Significant backward flow (regurgitation) through the valve or conduit, indicating valve incompetence or failure to adequately close.		91434003	SNOMED CT
Mixed obstruction and regurgitation	A combination of both obstruction and regurgitation through the valve or conduit.		112000003532	ACC NCDR

Element: 16154 TPVR Prior Right Ventricular Outflow Tract Treatment

Coding Instruction: Select the prior treatment received to the right ventricular outflow tract.

Target Value: Any occurrence between birth and current procedure

TPVR Prior Right Ventricular Outflow Tract Treatment - 1.3.6.1.4.1.19376.1.4.1.6.5.1111

Selection	Definition	Source	Code	Code System
Prior balloon angioplasty	A procedure to widen a narrowed valve or blood vessel using a balloon catheter, specifically targeting the right ventricular outflow tract.		112000004098	ACC NCDR
Prior right ventricular outflow tract stent	The placement of a stent within the right ventricular outflow tract to maintain patency and prevent obstruction.		112000004099	ACC NCDR
Prior transannular patch	A patch used during surgery to relieve stenosis (narrowing) by extending the right ventricular outflow tract.		112000004100	ACC NCDR
Prior surgical valvotomy	A surgical procedure to widen a stenotic valve opening, specifically in the right ventricular outflow tract.		112000004101	ACC NCDR
Prior right ventricular-pulmonary artery conduit	Placement of a prosthetic conduit between the right ventricle and the pulmonary artery to bypass stenosis or defects.		112000004102	ACC NCDR
Prior surgical bioprosthesis	Implantation of a biologic valve prosthesis in the right ventricular outflow tract, often as a replacement or repair for congenital heart defects.		112000004103	ACC NCDR
Prior transcatheter pulmonary valve replacement	A procedure to replace a malfunctioning or inadequate valve within the right ventricular outflow tract, typically using a catheter-based technique.		112000004104	ACC NCDR
None			260413007	SNOMED CT

Element: 16158 Bioprosthesis Type

Coding Instruction: Select the type(s) of surgical prosthesis previously implanted.

Section: Transcatheter Pulmonary Valve Replacement

Parent: Procedure Information

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

TPVR Bioprosthesis Type - 1.3.6.1.4.1.19376.1.4.1.6.5.1113

Selection	Definition	Source	Code	Code System
Pulmonary homograft			174944001	SNOMED CT
Aortic homograft			174927000	SNOMED CT
Porcine			112000004107	ACC NCDR
Bovine			112000004108	ACC NCDR
Synthetic			112000004109	ACC NCDR
Other			100000351	ACC NCDR

Element: 15311 Transcatheter Pulmonary Valve Replacement Surgically Implanted Valve or Conduit Size

Coding Instruction: Record the size of the previously implanted surgical prosthesis (in mm).

Note: If there is a history of multiple previously implanted surgical prosthesis, enter the size of the most recent.

Target Value: The value on start of current procedure

Element: 15296 Transcatheter Pulmonary Valve Replacement Echocardiogram

Coding Instruction: Indicate if an echocardiogram was performed prior to the procedure.

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

Element: 15301 Transcatheter Pulmonary Valve Replacement Echocardiogram Left Ventricular Ejection Fraction

Coding Instruction: Indicate the LVEF obtained by echocardiogram prior to the procedure.

Note: If a percentage range is reported, report the center of the range (e.g., 50–55% is 52.5 reported to the next whole number is 53%. For EF measurements reported as "less than" or "greater than" code to the nearest whole number (e.g., <40% is coded as 39%, and >40% is coded as 41%).

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 last value between 6 months prior to procedure and the start of the current procedure

Element: 16157 Left Ventricular Ejection Fraction Not Assessed

Coding Instruction: Indicate if the left ventricular ejection fraction was not assessed.

Target Value: N/A

Element: 15297 Transcatheter Pulmonary Valve Replacement Echocardiogram Mean Gradient Across Valve/Conduit

Coding Instruction: Indicate the mean gradient (in mm Hg) across the valve/conduit prior to the TPVR procedure by echocardiogram.

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

Element: 16168 TPVR Mean Gradient Across Valve/Conduit Not Assessed

Coding Instruction: Indicate if the mean gradient (in mm Hg) across the valve/conduit prior to the TPVR procedure was not assessed.

Target Value: N/A

Element: 15298 Transcatheter Pulmonary Valve Replacement Echocardiogram Maximum Gradient Across Valve/Conduit

Coding Instruction: Indicate the maximum gradient (in mm Hg) across the valve/conduit prior to the TPVR procedure by echocardiogram.

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

Section: Transcatheter Pulmonary Valve Replacement

Parent: Procedure Information

Element: 16145 Maximum Gradient Across Valve/Conduit Not Assessed

Coding Instruction: Indicate if the maximum gradient (in mm Hg) across the valve/conduit prior to the TPVR procedure was not assessed.

Target Value: N/A

Element: 15299 Transcatheter Pulmonary Valve Replacement Echocardiogram Pulmonary Valve Regurgitation

Coding Instruction: Indicate the severity of pulmonary regurgitation observed by echocardiogram prior to the TPVR procedure.

Note(s): Code the highest value or most severe regurgitation when a range is reported.
If 'trivial, trace, or physiologic' is documented, select 'none'.

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

Pulmonary Valve Regurgitation Severity - 1.3.6.1.4.1.19376.1.4.1.6.5.860

Selection	Definition	Source	Code	Code System
None			112000001910	ACC NCDR
Mild			112000000380	ACC NCDR
Moderate			112000000381	ACC NCDR
Moderate to severe			1000142345	ACC NCDR
Severe			112000000382	ACC NCDR

Element: 15300 Transcatheter Pulmonary Valve Replacement Echocardiogram Tricuspid Valve Regurgitation Severity

Coding Instruction: Indicate the severity of tricuspid regurgitation observed by echocardiogram prior to the TPVR procedure. Code the highest value or most severe regurgitation when a range is reported.

Note(s): If 'trivial, trace, or physiologic' is documented, select 'none'.

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

Tricuspid Valve Regurgitation Severity - 1.3.6.1.4.1.19376.1.4.1.6.5.861

Selection	Definition	Source	Code	Code System
None			112000001910	ACC NCDR
Mild			112000000380	ACC NCDR
Moderate			112000000381	ACC NCDR
Moderate to severe			1000142345	ACC NCDR
Severe			112000000382	ACC NCDR

Element: 15302 Transcatheter Pulmonary Valve Replacement Magnetic Resonance Imaging

Coding Instruction: Indicate if an MRI was performed prior to the procedure.

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

Element: 15303 Transcatheter Pulmonary Valve Replacement Magnetic Resonance Imaging Right Ventricular Ejection Fraction

Coding Instruction: Indicate the right ventricular ejection fraction (RVEF) obtained by MRI.

Note: If a percentage range is reported, report the center of the range (e.g., 50–55% is 52.5 reported to the next whole number is 53%). For EF measurements reported as "less than" or "greater than" code to the nearest whole number (e.g., <40% is coded as 39%, and >40% is coded as 41%). 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 last value between 6 months prior to procedure and the start of the current procedure

Element: 16147 Right Ventricular Ejection Fraction Not Assessed with MRI

Coding Instruction: Indicate if the right ventricular ejection fraction was not assessed with MRI.

Target Value: N/A

Section: Transcatheter Pulmonary Valve Replacement

Parent: Procedure Information

Element: 15305	Transcatheter Pulmonary Valve Replacement Magnetic Resonance Imaging Pulmonary Regurgitant Fraction
Coding Instruction:	Indicate the pulmonary regurgitant fraction obtained by MRI prior to the procedure. Note: If a percentage range is reported, report the center of the range (e.g., 50–55% is 52.5 reported to the next whole number is 53%. For EF measurements reported as "less than" or "greater than" code to the nearest whole number (e.g., <40% is coded as 39%, and >40% is coded as 41%). 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 last value between 6 months prior to procedure and the start of the current procedure
Element: 16146	Pulmonary Regurgitant Fraction Not Assessed with MRI
Coding Instruction:	Indicate if the pulmonary regurgitant fraction was not assessed with MRI.
Target Value:	N/A
Element: 15306	Transcatheter Pulmonary Valve Replacement Magnetic Resonance Imaging Right Ventricular End-Diastolic Volume Index
Coding Instruction:	Indicate the right ventricular end diastolic volume (RVEDV) index obtained by MRI in milliliters per meters squared
Target Value:	The last value between 6 months prior to procedure and the start of the current procedure
Element: 16151	MRI Right Ventricular End-Diastolic Volume Index Not Assessed
Coding Instruction:	Indicate if the right ventricular end diastolic volume (RVEDV) index was not assessed by MRI.
Target Value:	N/A
Element: 15314	Transcatheter Pulmonary Valve Replacement Peak Gradient Across Valve or Conduit
Coding Instruction:	Indicate the peak gradient across the valve or conduit obtained using hemodynamic measurements during the procedure.
Target Value:	The value between start of procedure and prior to the intervention
Element: 16163	Pre-procedure Peak Gradient Across Valve or Conduit Not Assessed
Coding Instruction:	Indicate if the peak gradient across the valve or conduit obtained using hemodynamic measurements during the procedure was not assessed.
Target Value:	N/A
Element: 15315	Transcatheter Pulmonary Valve Replacement Narrowest Angiographic Valve or Conduit Diameter
Coding Instruction:	Indicate the narrowest angiographic conduit or valve diameter in millimeters.
Target Value:	The value between start of procedure and prior to the intervention
Element: 16164	Narrowest Valve or Conduit Diameter Not Assessed
Coding Instruction:	Indicate if the narrowest angiographic conduit or valve diameter during the procedure was not assessed.
Target Value:	N/A
Element: 16144	Pulmonary Valve Type
Coding Instruction:	Select the type of bioprosthetic pulmonary valve implanted.

Section: Transcatheter Pulmonary Valve Replacement

Parent: Procedure Information

Target Value: The value on end of current procedure

TPVR Pulmonary Valve Type - 1.3.6.1.4.1.19376.1.4.1.6.5.1110

Selection	Definition	Source	Code	Code System
Balloon expandable valve	The valve was expanded and deployed using a balloon catheter.		112000004095	ACC NCDR
Self expanding valve	The valve was deployed using a self-expanding stent that gradually opens to its intended size without balloon assistance.		112000004096	ACC NCDR

Element: 15318 Transcatheter Pulmonary Valve Replacement Coronary Artery Compression Testing

Coding Instruction: Indicate if coronary compression testing was performed.

Target Value: The value on current procedure

Element: 15320 Transcatheter Pulmonary Valve Replacement Coronary Artery Compression Present

Coding Instruction: Indicate if there is evidence of coronary artery compression present, as a result of coronary artery compression testing, prior to valve insertion.

Target Value: The value on current procedure

Supporting Definition: Coronary Artery Compression

Angiographic or echocardiographic evidence of a new, partial or complete obstruction of a coronary ostium, either by the valve prosthesis itself, the native leaflets, calcifications, or dissection, occurring during or after the procedure.

Source:

Present - 1.3.6.1.4.1.19376.1.4.1.6.5.852

Selection	Definition	Source	Code	Code System
No			100013073	ACC NCDR
Yes			100013072	ACC NCDR
Uncertain			100012985	ACC NCDR

Element: 16160 Coronary Compression Findings Impact On Case

Coding Instruction: Select the outcome of the coronary artery compression testing and its impact on the procedure. This refers to whether the results of the testing influenced the decision to proceed with valve implantation or required modifications during the procedure.

Target Value: The value on current procedure

TPVR Coronary Compression Findings Impact On Case - 1.3.6.1.4.1.19376.1.4.1.6.5.1115

Selection	Definition	Source	Code	Code System
Valve not implanted	Coronary artery compression testing identified a risk that prevented valve implantation during the procedure.		112000004112	ACC NCDR
Implanted with technical modifications	Valve implantation proceeded, but technical modifications (e.g., repositioning the valve, altering stent deployment technique) were made based on coronary artery compression testing findings.		112000004113	ACC NCDR

Element: 15292 Transcatheter Pulmonary Valve Replacement Conduit Pre-Dilation Performed

Coding Instruction: Indicate if pre-dilation of the conduit by angioplasty was performed.

Target Value: The value on current procedure

Element: 15321 Transcatheter Pulmonary Valve Replacement Conduit Pre-Dilation First Balloon Size

Coding Instruction: Indicate the manufacturer size of the first balloon used for the pre-dilation of the conduit.

Target Value: The value on current procedure

Element: 15322 Transcatheter Pulmonary Valve Replacement Conduit Pre-Dilation Maximum Balloon Size

Coding Instruction: Indicate the maximum dilation balloon inflation size used for conduit preparation.

Target Value: The value on current procedure

Section: TPVR Device

Parent: Transcatheter Pulmonary Valve Replacement

Element: 15339 Transcatheter Pulmonary Valve Replacement Device Counter

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

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

Target Value: N/A

Element: 15340 Transcatheter Pulmonary Valve Replacement Device ID

Coding Instruction: Indicate all devices utilized during the current pulmonary valve replacement procedure.

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

Target Value: The value on current procedure

Vendor Instruction: Transcatheter Pulmonary Valve Replacement Device ID (15340) cannot be Null when Transcatheter Pulmonary Valve Replacement Device Counter (15339) has a value

Element: 16161 TPVR Device Diameter

Coding Instruction: Record the diameter of the valve implanted during the procedure.

Target Value: The value on current procedure

Element: 16162 Valve Stability

Coding Instruction: Indicate the stability of the valve frame. This refers to whether the valve's frame remained secure and properly positioned within the intended site.

Target Value: The value on current procedure

TPVR Valve Stability - 1.3.6.1.4.1.19376.1.4.1.6.5.1116

Selection	Definition	Source	Code	Code System
Stable frame	The valve's frame was stable and securely positioned post-deployment, without evidence of migration, tilt, or other instability.		112000004114	ACC NCDR
Unstable frame	The valve's frame exhibited instability, such as movement, displacement, or failure to anchor securely within the intended site		112000004115	ACC NCDR

Element: 16156 Transcatheter Pulmonary Valve Implanted in Intended Location

Coding Instruction: Indicate whether the transcatheter pulmonary valve was implanted in the intended location.

Target Value: The value on current procedure

TPVR Self Expanding Implanted in Intended Location - 1.3.6.1.4.1.19376.1.4.1.6.5.1112

Selection	Definition	Source	Code	Code System
No			100013073	ACC NCDR
Yes - Supra-annular implant	The valve was implanted above the native or previous valve annulus (supra-annular position).		112000004105	ACC NCDR
Yes - Annular implant	The valve was implanted within the native or previous valve annulus.		112000004106	ACC NCDR

Element: 16150 Unique Device Identifier - IMPACT TPVR

Coding Instruction: Indicate the unique device identifier (UDI) of the device. Enter all characters including the parenthesis. Leave blank if the UDI is unknown or unable to be collected due to state/local privacy laws.

Target Value: The value on current procedure

Supporting Definition: General Definition

The UDI identifies the specific individual device; no two devices have the same UDI. Refer to the FDA website for detailed explanation of UDIs.

The UDI is made up of five different identifiers and each identifier is preceded by a number in parentheses.

Example UDI below: Device Identifier (01), Expiration Date (17), Manufacturing date (11), Lot Number (10), and Serial Number (21)

Source:

Section: TPVR Valve Deployed

Parent: Transcatheter Pulmonary Valve Replacement

Element: 15331 Transcatheter Pulmonary Valve Replacement Transcatheter Pulmonary Valve Deployed

Coding Instruction: Indicate if a pulmonary valve was deployed.

Target Value: The value on current procedure

Element: 15335 Transcatheter Pulmonary Valve Replacement Post-implant Right Ventricular Outflow Tract Peak Gradient

Coding Instruction: Indicate the post-implant right ventricular outflow tract (RVOT) peak gradient.

Target Value: The value on end of current procedure

Element: 16152 Right Post-Implant Right Ventricular Outflow Tract Peak Gradient Not Assessed

Coding Instruction: Indicate the post-implant right ventricular outflow tract peak gradient was not assessed.

Target Value: N/A

Element: 15336 Post-Implant Pulmonary Valve Central Regurgitation

Coding Instruction: Indicate the degree of post-implant pulmonary valve regurgitation.

Note(s): Code the highest value or most severe regurgitation when a range is reported. If 'trivial, trace, or physiologic' is documented, select 'none'

Target Value: The value on end of current procedure

Pulmonary Valve Regurgitation Severity - 1.3.6.1.4.1.19376.1.4.1.6.5.860

Selection	Definition	Source	Code	Code System
None			112000001910	ACC NCDR
Mild			112000000380	ACC NCDR
Moderate			112000000381	ACC NCDR
Moderate to severe			1000142345	ACC NCDR
Severe			112000000382	ACC NCDR

Element: 16159 Post-Implant Pulmonary Valve Perivalvular Regurgitation

Coding Instruction: Indicate the severity of post-implant pulmonary valve perivalvular regurgitation.

Note(s): Code the highest value or most severe regurgitation when a range is reported. If 'trivial, trace, or physiologic' is documented, select 'none'.

Target Value: The last value between the implant and the end of current procedure

Supporting Definition: TPVR Perivalvular Pulmonary Regurgitation

A leak that occurs between a prosthetic heart valve and the surrounding tissue.

Source:

TPVR Perivalvular Pulmonary Regurgitation - 1.3.6.1.4.1.19376.1.4.1.6.5.1114

Selection	Definition	Source	Code	Code System
None			260413007	SNOMED CT
Mild			255604002	SNOMED CT
Moderate			6736007	SNOMED CT
Moderate to severe			100001045	ACC NCDR
Severe			24484000	SNOMED CT

Element: 15338 Transcatheter Pulmonary Valve Replacement Reason Valve Not Deployed

Coding Instruction: Indicate the reason the pulmonary valve was not implanted.

Note: When multiple reasons are documented for why the valve was not deployed, code based off of priority.

Coronary artery compression risk
 Complication before deployment
 Device/Delivery system dysfunction/complication
 Valve could not be advanced to implant location
 No treatable landing zone
 Pre-stent implanted, electively staged
 Other

Target Value: The value on current procedure

Reason for Valve not Deployed - 1.3.6.1.4.1.19376.1.4.1.6.5.853

Selection	Definition	Source	Code	Code System
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Section: TPVR Valve Deployed		Parent: Transcatheter Pulmonary Valve Replacement	
Coronary artery compression risk	Valve deployment was not performed due to the risk of compressing the coronary arteries as identified during the procedure.	112000001837	ACC NCDR
Valve could not be advanced to implant location	The valve delivery system was unable to navigate to the intended implant site.	112000002302	ACC NCDR
Complication before deployment	The procedure was halted due to an intra-procedural complication that occurred before the valve could be deployed.	112000002303	ACC NCDR
Pre-stent implanted, electively staged TPVR at later date	A pre-stent was implanted during the procedure, with the plan to perform the valve replacement at a subsequent procedure.	112000002304	ACC NCDR
No treatable landing zone	Valve implantation was not possible because an adequate anatomical landing zone was not available.	112000002305	ACC NCDR
Other		100000351	ACC NCDR
Device/delivery system dysfunction/complication	Deployment was not possible due to a malfunction or complication with the valve or its delivery system.	112000004094	ACC NCDR

Element: 15330 Transcatheter Pulmonary Valve Replacement Delivery Balloon Size

Coding Instruction: Indicate the size of the balloon used to deliver the pulmonary valve.

Code based on the manufacturer size. If more than one valve is deployed, code the size that delivered the final valve.

Target Value: The value on current procedure

Section: TPVR Imaging

Parent: Transcatheter Pulmonary Valve Replacement

Element: 15342	Transcatheter Pulmonary Valve Replacement Post-Procedure Echocardiogram
Coding Instruction:	Indicate if an echocardiogram was performed post pulmonary valve placement.
Target Value:	The highest value between end of current procedure and discharge
Element: 15344	Transcatheter Pulmonary Valve Replacement Post-Procedure Echocardiogram Maximum Gradient Across Valve/Conduit
Coding Instruction:	Indicate the maximum gradient across the valve or conduit.
Target Value:	The highest value between end of current procedure and discharge
Element: 16149	Post-Procedure Echocardiogram Maximum Gradient Across Valve/Conduit Not Assessed
Coding Instruction:	Indicate if the maximum gradient across the valve or conduit was not assessed.
Target Value:	N/A
Element: 15343	Transcatheter Pulmonary Valve Replacement Post-Procedure Echocardiogram Mean Gradient Across Valve/Conduit
Coding Instruction:	Indicate the mean gradient across the pulmonary valve or conduit.
Target Value:	The highest value between end of current procedure and discharge
Element: 16148	Post-Procedure Echocardiogram Mean Gradient Across Valve/Conduit Not Assessed
Coding Instruction:	Indicate if the mean gradient across the pulmonary valve or conduit was not assessed.
Target Value:	N/A
Element: 15345	Post-Procedure Echocardiogram Pulmonary Valve Central Regurgitation
Coding Instruction:	Indicate the severity of post-procedure pulmonary valve central regurgitation.
	Note(s): Code the highest value or most severe regurgitation when a range is reported. If 'trivial, trace, or physiologic' is documented, select 'none'.
Target Value:	The highest value between end of current procedure and discharge

Pulmonary Valve Regurgitation Severity - 1.3.6.1.4.1.19376.1.4.1.6.5.860

Selection	Definition	Source	Code	Code System
None			112000001910	ACC NCDR
Mild			112000000380	ACC NCDR
Moderate			112000000381	ACC NCDR
Moderate to severe			1000142345	ACC NCDR
Severe			112000000382	ACC NCDR

Element: 16153	Post-Procedure Echocardiogram Pulmonary Valve Regurgitation Not Assessed
Coding Instruction:	Indicate if the degree of post-implant pulmonary valve regurgitation was not assessed.
Target Value:	N/A
Element: 16219	Perivalvular Regurgitation
Coding Instruction:	Indicate the severity of perivalvular regurgitation and whether it was present after the valve deployed.
	Note(s): Code the highest value or most severe regurgitation when a range is reported. If 'trivial, trace, or physiologic' is documented, select 'none'.
Target Value:	The highest value between end of current procedure and discharge

TPVR Perivalvular Pulmonary Regurgitation - 1.3.6.1.4.1.19376.1.4.1.6.5.1114

Selection	Definition	Source	Code	Code System
None			260413007	SNOMED CT
Mild			255604002	SNOMED CT
Moderate			6736007	SNOMED CT
Moderate to severe			100001045	ACC NCDR
Severe			24484000	SNOMED CT

Section: Non-module Intervention

Parent: Procedure Information

Element: 16216 Non-Module Intervention Counter

Coding Instruction: Non-module intervention counter distinguishes individual procedures when multiple are entered.

Target Value: N/A

Element: 15067 Specific Procedure ID

Coding Instruction: Indicate all applicable procedures which were performed in addition to the IMPACT primary procedures (data element 15081) during the cath lab visit.

Note(s):

The additional procedures that should be collected in your application are controlled by a Master File. This file is maintained by the NCDR and will be made available on the internet for downloading and importing/updating into your application.

Target Value: The value on current procedure

Procedure Master - 1.3.6.1.4.1.19376.1.4.1.6.5.892

Selection	Definition	Source	Code	Code System
Balloon dilation - Conduit - Sano modification - RV to PA valveless conduit			112000002462	ACC NCDR
Balloon dilation - Conduit - Sano modification-with valve - RV to PA valved conduit			112000002463	ACC NCDR
Balloon dilation - Conduit - LV to aorta			112000002465	ACC NCDR
Balloon dilation - Conduit - LV to PA			112000002466	ACC NCDR
Balloon dilation - Conduit - Other			112000002467	ACC NCDR
Balloon dilation - Conduit - RV to PA			112000002472	ACC NCDR
Balloon dilation - Conduit - Shunt - systemic-to-pulmonary			112000002473	ACC NCDR
Balloon dilation - Intracardiac-septum - Atrial baffle S-P atrial switch			112000002474	ACC NCDR
Balloon dilation - Intracardiac-septum - Atrial septum - Static balloon dilation without pullback			112000002475	ACC NCDR
Balloon dilation - Intracardiac-septum - Fontan baffle or extracardiac conduit			112000002476	ACC NCDR
Balloon dilation - Intracardiac-septum - Fontan fenestration			112000002477	ACC NCDR
Balloon dilation - Intracardiac-septum - Ventricular septum			112000002478	ACC NCDR
Balloon dilation - Pulmonary artery - Central - Proximal left and-or proximal right pulmonary artery including the pulmonary artery bifurcation			112000002479	ACC NCDR
Balloon dilation - Pulmonary artery - Main - Trunk			112000002480	ACC NCDR
Balloon dilation - Pulmonary artery - Peripheral			112000002481	ACC NCDR
Balloon dilation - Pulmonary vein - Left - Left pulmonary vein			112000002483	ACC NCDR
Balloon dilation - Pulmonary vein - Left lower - Left lower pulmonary vein			112000002484	ACC NCDR
Balloon dilation - Pulmonary vein - Left upper - Left upper pulmonary vein			112000002485	ACC NCDR
Balloon dilation - Pulmonary vein - Lingula - Lingular pulmonary vein			112000002486	ACC NCDR
Balloon dilation - Pulmonary vein - Pulmonary venous			112000002487	ACC NCDR

Section: Non-module Intervention		Parent: Procedure Information	
confluence			
Balloon dilation - Pulmonary vein - Pulmonary venous confluence with left atrium	112000002488	ACC	NCDR
Balloon dilation - Pulmonary vein - Right - Right pulmonary vein	112000002489	ACC	NCDR
Balloon dilation - Pulmonary vein - Right lower - Right lower pulmonary vein	112000002490	ACC	NCDR
Balloon dilation - Pulmonary vein - Right middle - Right middle pulmonary vein	112000002491	ACC	NCDR
Balloon dilation - Systemic artery - Aorta	112000002493	ACC	NCDR
Balloon dilation - Systemic artery - Systemic artery other than aorta	112000002494	ACC	NCDR
Balloon dilation - Systemic vein - Caval vein	112000002495	ACC	NCDR
Balloon dilation - Systemic vein - Non-Caval vein	112000002496	ACC	NCDR
Balloon dilation - Systemic vein	112000002497	ACC	NCDR
Balloon dilation - Systemic vein - Caval vein - Superior vena cava	112000002498	ACC	NCDR
Balloon dilation - Pulmonary artery - Proximal - Left	112000002509	ACC	NCDR
Balloon dilation - Pulmonary artery - Proximal - Right	112000002510	ACC	NCDR
Balloon dilation - Systemic artery - Aorta - Abdominal aorta - Coarctation	112000002511	ACC	NCDR
Balloon dilation - Systemic artery - Aorta - Abdominal aorta - Native - Primary coarctation	112000002512	ACC	NCDR
Balloon dilation - Systemic artery - Aorta - Abdominal aorta - Recurrent coarctation	112000002513	ACC	NCDR
Balloon dilation - Systemic artery - Systemic artery other than aorta - Coronary artery	112000002519	ACC	NCDR
Balloon dilation - Systemic artery - Systemic artery other than aorta - Femoral artery	112000002520	ACC	NCDR
Balloon dilation - Systemic artery - Systemic artery other than aorta - Iliac artery	112000002521	ACC	NCDR
Balloon dilation - Systemic artery - Systemic artery other than aorta - Innominate artery	112000002522	ACC	NCDR
Balloon dilation - Systemic artery - Systemic artery other than aorta - Renal artery	112000002523	ACC	NCDR
Balloon dilation - Systemic artery - Systemic artery other than aorta - Subclavian artery	112000002524	ACC	NCDR
Balloon dilation - Systemic vein - Non-Caval vein - Femoral vein	112000002525	ACC	NCDR
Balloon dilation - Systemic vein - Non-Caval vein - Iliac vein	112000002526	ACC	NCDR
Balloon dilation - Systemic vein - Non-Caval vein - Innominate - Brachiocephalic	112000002527	ACC	NCDR
Balloon valvotomy - Aortic valve	112000002529	ACC	NCDR
Balloon valvotomy - Mitral valve	112000002530	ACC	NCDR
Balloon valvotomy - Pulmonic valve	112000002531	ACC	NCDR

Section: Non-module Intervention		Parent: Procedure Information	
Balloon valvotomy - Tricuspid valve	112000002532	ACC NCDR	
Biopsy - RV not S-P heart transplant	112000002533	ACC NCDR	
Biopsy - RV post heart transplant	112000002534	ACC NCDR	
Coil implantation - Conduit - Sano modification - RV to PA valveless conduit	112000002538	ACC NCDR	
Coil implantation - Conduit - Sano modification-with valve - RV to PA valved conduit	112000002539	ACC NCDR	
Coil implantation - Conduit - LA to LV	112000002540	ACC NCDR	
Coil implantation - Conduit - LV to aorta	112000002541	ACC NCDR	
Coil implantation - Conduit - LV to PA	112000002542	ACC NCDR	
Coil implantation - Conduit - RA to PA	112000002544	ACC NCDR	
Coil implantation - Conduit - RA to RV	112000002546	ACC NCDR	
Coil implantation - Coronary artery fistula	112000002550	ACC NCDR	
Coil implantation - Intracardiac baffle leak	112000002552	ACC NCDR	
Coil implantation - Patent ductus arteriosus - PDA	112000002553	ACC NCDR	
Coil implantation - Perivalvar leak	112000002554	ACC NCDR	
Coil implantation - Pulmonary arteriovenous malformation	112000002555	ACC NCDR	
Coil implantation - Systemic arteriovenous malformation	112000002556	ACC NCDR	
Coil implantation - Systemic artery to pulmonary artery collateral	112000002557	ACC NCDR	
Coil implantation - Systemic vein to pulmonary vein collateral	112000002560	ACC NCDR	
Device implantation - Aortopulmonary window - AP window	112000002568	ACC NCDR	
Device implantation - Atrial septal defect - ASD	112000002569	ACC NCDR	
Device implantation - Conduit - Sano modification-with valve - RV to PA valved conduit	112000002571	ACC NCDR	
Device implantation - Conduit - LA to LV	112000002572	ACC NCDR	
Device implantation - Conduit - Shunt - systemic-to-pulmonary	112000002581	ACC NCDR	
Device implantation - Coronary artery fistula	112000002582	ACC NCDR	
Device implantation - Fontan fenestration	112000002583	ACC NCDR	
Device implantation - Intracardiac baffle leak	112000002584	ACC NCDR	
Device implantation - Patent ductus arteriosus - PDA	112000002585	ACC NCDR	
Device implantation - Patent Foramen Ovale - PFO	112000002586	ACC NCDR	
Device implantation - Perivalvar leak	112000002587	ACC NCDR	
Device implantation - Pulmonary arteriovenous malformation	112000002588	ACC NCDR	
Device implantation - Pulmonary artery	112000002589	ACC NCDR	
Device implantation - Systemic artery to pulmonary artery collateral	112000002591	ACC NCDR	

Section: Non-module Intervention		Parent: Procedure Information	
Device implantation - Systemic vein to pulmonary vein collateral	112000002594	ACC	NCDR
Device implantation - Ventricular septal defect - VSD	112000002598	ACC	NCDR
Device implantation - Conduit	112000002599	ACC	NCDR
Hemodynamic alteration - Oxygen-nitric test	112000002607	ACC	NCDR
Hemodynamic alteration - Inotropy test	112000002608	ACC	NCDR
Hemodynamic alteration - Fluid bolus challenge	112000002609	ACC	NCDR
Hybrid Approach - Transcardiac balloon dilation	112000002610	ACC	NCDR
Hybrid Approach - Transcardiac transcatheter device placement	112000002611	ACC	NCDR
Hybrid Approach Stage 1 - Application of RPA and LPA bands	112000002612	ACC	NCDR
Hybrid Approach Stage 1 - Stent placement in arterial duct - PDA	112000002613	ACC	NCDR
Hybrid Approach Stage 1 - Stent placement in arterial duct - PDA plus application of RPA and LPA bands	112000002614	ACC	NCDR
Hybrid approach Stage 2 - Aortopulmonary amalgamation plus Superior Cavopulmonary anastomosis- es plus PA Debanding plus Aortic arch repair - Norwood Stage 1 plus Superior Cavopulmonary anastomosis- es plus PA Debanding	112000002615	ACC	NCDR
Hybrid approach Stage 2 - Aortopulmonary amalgamation plus Superior Cavopulmonary anastomosis- es plus PA Debanding + Without aortic arch repair	112000002616	ACC	NCDR
Intravascular foreign body removal - Intravascular foreign body removal	112000002617	ACC	NCDR
Other invasive procedures- interventional techniques - Pericardiocentesis - elective	112000002618	ACC	NCDR
Other invasive procedures- interventional techniques - Pleuracentesis - elective	112000002620	ACC	NCDR
Other invasive procedures- interventional techniques - Snare foreign body	112000002622	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Atrietic aortic valve	112000002623	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Atrietic pulmonary valve	112000002624	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Atrial septum	112000002625	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Conduit - Sano modification - RV to PA valveless conduit	112000002626	ACC	NCDR
Perforation - establishing interchamber and-or	112000002627	ACC	NCDR

Section: Non-module Intervention		Parent: Procedure Information	
intervessel communication - Conduit - Sano modification- with valve - RV to PA valved conduit			
Perforation - establishing interchamber and-or intervessel communication - Conduit - LA to LV	112000002628	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Conduit - LV to PA	112000002630	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Conduit - Other	112000002631	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Conduit - RA to PA-pulmonary trunk	112000002633	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Conduit - RA to RV	112000002634	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Conduit - RV to aorta	112000002635	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Fontan Baffle	112000002638	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Systemic artery - Systemic artery other than aorta	112000002640	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Ventricular septum	112000002643	ACC	NCDR
Perforation - establishing interchamber and-or intervessel communication - Systemic artery	112000002645	ACC	NCDR
Septostomy - Septostomy by pullback - Rashkind - BAS	112000002652	ACC	NCDR
Septostomy - Blade atrial septostomy	112000002653	ACC	NCDR
Septostomy - Septostomy	112000002654	ACC	NCDR
Stent insertion - Conduit - Sano modification - RV to PA valveless conduit	112000002655	ACC	NCDR
Stent insertion - Conduit - LA to LV	112000002657	ACC	NCDR
Stent insertion - Conduit - LV to PA	112000002659	ACC	NCDR
Stent insertion - Conduit - Other	112000002660	ACC	NCDR
Stent insertion - Conduit - RV to PA	112000002665	ACC	NCDR
Stent insertion - Conduit - Shunt - systemic-to-pulmonary	112000002666	ACC	NCDR
Stent insertion - Intracardiac- septum - Atrial baffle S-P atrial switch	112000002667	ACC	NCDR
Stent insertion - Intracardiac- septum - Atrial septum	112000002668	ACC	NCDR
Stent insertion - Intracardiac- septum - Fontan Baffle	112000002669	ACC	NCDR
Stent insertion - Intracardiac- septum - Fontan fenestration	112000002670	ACC	NCDR

Section: Non-module Intervention		Parent: Procedure Information	
Stent insertion - Intracardiac-septum - Ventricular septum	112000002671	ACC	NCDR
Stent insertion - PDA	112000002672	ACC	NCDR
Stent insertion - Pulmonary artery - Central - Proximal left and-or proximal right pulmonary artery including the pulmonary artery bifurcation	112000002673	ACC	NCDR
Stent insertion - Pulmonary artery - Main - Trunk	112000002674	ACC	NCDR
Stent insertion - Pulmonary artery - Peripheral	112000002675	ACC	NCDR
Stent insertion - Pulmonary vein - Left - Left pulmonary vein	112000002677	ACC	NCDR
Stent insertion - Pulmonary vein - Left lower - Left lower pulmonary vein	112000002678	ACC	NCDR
Stent insertion - Pulmonary vein - Left upper - Left upper pulmonary vein	112000002679	ACC	NCDR
Stent insertion - Pulmonary vein - Lingula - Lingular pulmonary vein	112000002680	ACC	NCDR
Stent insertion - Pulmonary vein - Pulmonary venous confluence	112000002681	ACC	NCDR
Stent insertion - Pulmonary vein - Right - Right pulmonary vein	112000002683	ACC	NCDR
Stent insertion - Pulmonary vein - Right lower - Right lower pulmonary vein	112000002684	ACC	NCDR
Stent insertion - Pulmonary vein - Right middle - Right middle pulmonary vein	112000002685	ACC	NCDR
Stent insertion - Systemic artery - Aorta	112000002687	ACC	NCDR
Stent insertion - Systemic vein - Caval vein	112000002689	ACC	NCDR
Stent insertion - Systemic vein - Non-Caval vein	112000002690	ACC	NCDR
Stent insertion - Pulmonary artery - Peripheral - Lobar	112000002691	ACC	NCDR
Stent insertion - Pulmonary artery - Peripheral - Lobar - Left	112000002692	ACC	NCDR
Stent insertion - Systemic vein - Caval vein - Superior vena cava	112000002699	ACC	NCDR
Stent insertion - Systemic artery - Aorta - Abdominal aorta	112000002700	ACC	NCDR
Stent insertion - Systemic artery - Aorta - Thoracic aorta - Coarctation - Native - Primary coarctation	112000002706	ACC	NCDR
Stent insertion - Systemic artery - Aorta - Thoracic aorta - Transverse arch	112000002709	ACC	NCDR
Stent insertion - Systemic artery - Aorta - Thoracoabdominal aorta	112000002710	ACC	NCDR
Stent insertion - Systemic artery - Systemic artery other than aorta - Coronary artery	112000002711	ACC	NCDR
Stent insertion - Systemic artery - Systemic artery other than aorta - Femoral artery	112000002712	ACC	NCDR
Stent insertion - Systemic artery - Systemic artery other than aorta - Iliac artery	112000002713	ACC	NCDR
Stent insertion - Systemic	112000002714	ACC	NCDR

Section: Non-module Intervention		Parent: Procedure Information	
artery - Systemic artery other than aorta - Renal artery			
Stent insertion - Systemic artery - Systemic artery other than aorta - Subclavian artery	112000002715	ACC	NCDR
Stent insertion - Systemic artery - Systemic artery other than aorta - Systemic pulmonary vessel connection	112000002716	ACC	NCDR
Stent re-dilation - Conduit - Sano modification - RV to PA valveless conduit	112000002718	ACC	NCDR
Stent re-dilation - Conduit - LV to aorta	112000002721	ACC	NCDR
Stent re-dilation - Conduit - LV to PA	112000002722	ACC	NCDR
Stent re-dilation - Conduit - RV to PA	112000002728	ACC	NCDR
Stent re-dilation - Conduit - Shunt - systemic-to-pulmonary	112000002729	ACC	NCDR
Stent re-dilation - Intracardiaseptum - Atrial baffle S-P atrial switch	112000002730	ACC	NCDR
Stent re-dilation - Intracardiaseptum - Atrial septum	112000002731	ACC	NCDR
Stent re-dilation - Intracardiaseptum - Fontan Baffle	112000002732	ACC	NCDR
Stent re-dilation - Intracardiaseptum - Fontan fenestration	112000002733	ACC	NCDR
Stent re-dilation - PDA	112000002735	ACC	NCDR
Stent re-dilation - Pulmonary artery - Central - Proximal left and-or proximal right pulmonary artery including the pulmonary artery bifurcation	112000002736	ACC	NCDR
Stent re-dilation - Pulmonary artery - Main - Trunk	112000002737	ACC	NCDR
Stent re-dilation - Pulmonary artery - Peripheral	112000002738	ACC	NCDR
Stent re-dilation - Pulmonary vein - Left - Left pulmonary vein	112000002740	ACC	NCDR
Stent re-dilation - Pulmonary vein - Left lower - Left lower pulmonary vein	112000002741	ACC	NCDR
Stent re-dilation - Pulmonary vein - Left upper - Left upper pulmonary vein	112000002742	ACC	NCDR
Stent re-dilation - Pulmonary vein - Lingula - Lingular pulmonary vein	112000002743	ACC	NCDR
Stent re-dilation - Pulmonary vein - Right - Right pulmonary vein	112000002746	ACC	NCDR
Stent re-dilation - Pulmonary vein - Right lower - Right lower pulmonary vein	112000002747	ACC	NCDR
Stent re-dilation - Pulmonary vein - Right middle - Right middle pulmonary vein	112000002748	ACC	NCDR
Stent re-dilation - Pulmonary vein - Right upper - Right upper pulmonary vein	112000002749	ACC	NCDR
Stent re-dilation - Systemic artery - Aorta	112000002750	ACC	NCDR
Stent re-dilation - Systemic vein - Caval vein	112000002752	ACC	NCDR
Stent re-dilation - Systemic vein - Non-Caval vein	112000002753	ACC	NCDR
Transcatheter Fontan completion - Completion of total cavopulmonary connection - TCPC using transcatheter	112000002754	ACC	NCDR

Section: Non-module Intervention		Parent: Procedure Information	
covered stent			
Transcatheter implantation of valve - Pulmonary outflow position	112000002756		ACC NCDR
Transcatheter implantation of valve - Systemic outflow position	112000002757		ACC NCDR
Transcatheter implantation of valve - pulmonary ventricular inflow position	112000002758		ACC NCDR
Transcatheter implantation of valve - Systemic ventricular inflow position	112000002759		ACC NCDR
Transluminal test occlusion - Conduit - Sano modification - RV to PA valveless conduit	112000002760		ACC NCDR
Transluminal test occlusion - Conduit - Sano modification - with valve - RV to PA valved conduit	112000002761		ACC NCDR
Balloon dilation - Drug coated balloon	112000004439		ACC NCDR
Balloon dilation - Cutting balloon	112000004440		ACC NCDR
Device implantation - Systemic vein - Caval vein - Superior vena cava - Left	112000004441		ACC NCDR
Device insertion - Insertion of pulmonary artery flow restrictors	112000004442		ACC NCDR
Device insertion - Mitral Transcatheter Edge-Edge Repair - TEER	112000004443		ACC NCDR
Hybrid placement of transcatheter valve	112000004445		ACC NCDR
Hybrid placement of cardiac device or stent	112000004446		ACC NCDR
Hybrid Stage 1 - Stent placement in arterial duct - PDA application of RPA and LPA bands plus septal stent placement	112000004447		ACC NCDR
Hybrid stent dilation or stent placement in pulmonary artery	112000004448		ACC NCDR
Intracardiac echocardiography	112000003746		ACC NCDR
Lymphatic catheterization - Diagnostic	112000004449		ACC NCDR
Lymphatic catheterization - Interventional	112000004450		ACC NCDR
Mechanical thrombolysis or thrombus aspiration	112000004451		ACC NCDR
Perforation - Fontan baffle or extra cardiac conduit	112000004452		ACC NCDR
Pericardiocentesis - With drain placement	112000004453		ACC NCDR
Pleuracentesis - Without drain placement	112000004456		ACC NCDR
Pericardiocentesis - Without drain placement	112000004454		ACC NCDR
Pleuracentesis - With drain placement	112000004455		ACC NCDR
Pressure-volume loops acquisition using intracardiac conductance catheter	112000004457		ACC NCDR
Septostomy - Septostomy static balloon septoplasty	112000004458		ACC NCDR
Stent insertion - Atrial septum	112000004459		ACC NCDR
Stent insertion - Central/proximal branch pulmonary artery- Bilateral	112000004460		ACC NCDR
Stent insertion - Central/proximal branch	112000004461		ACC NCDR

Section: Non-module Intervention		Parent: Procedure Information	
pulmonary artery- Unilateral			
Stent insertion - Fontan fenestration	112000004463	ACC	NCDR
Stent insertion - Inferior vena cava	112000004464	ACC	NCDR
Stent insertion - Mid-distal descending thoracic aorta	112000004465	ACC	NCDR
Stent insertion - Peripheral/lobar pulmonary artery	112000004466	ACC	NCDR
Stent insertion - Proximal descending thoracic aorta	112000004467	ACC	NCDR
Stent insertion - RV outflow tract - Native RVOT	112000004468	ACC	NCDR
Stent insertion - Superior vena cava	112000004469	ACC	NCDR
Stent insertion - SVC - Sinus venosus ASD closure	112000004470	ACC	NCDR
Stent insertion - Systemic artery - Other	112000004471	ACC	NCDR
Stent insertion - Systemic vein - Other	112000004472	ACC	NCDR
Stent insertion - Systemic venous baffle S-P atrial switch	112000004473	ACC	NCDR
Stent insertion - Systemic-to-pulmonary artery shunt	112000004474	ACC	NCDR
Stent insertion - Innominate vein	112000004475	ACC	NCDR
Stent insertion - Covered stent from innominate vein to atrium for thoracic duct decompression	112000004476	ACC	NCDR
Stent re-dilation - Systemic venous baffle S-P atrial switch	112000004477	ACC	NCDR
Stent re-dilation - Abdominal aorta	112000004478	ACC	NCDR
Stent re-dilation - Atrial septum	112000004479	ACC	NCDR
Stent re-dilation - Central/proximal branch pulmonary artery- Bilateral	112000004480	ACC	NCDR
Stent re-dilation - Central/proximal branch pulmonary artery- Unilateral	112000004481	ACC	NCDR
Stent re-dilation - Coronary artery	112000004482	ACC	NCDR
Stent re-dilation - Fontan baffle or extra cardiac conduit	112000004483	ACC	NCDR
Stent re-dilation - Femoral artery	112000004484	ACC	NCDR
Stent re-dilation - Fontan fenestration	112000004485	ACC	NCDR
Stent re-dilation - Iliac artery	112000004486	ACC	NCDR
Stent re-dilation - Inferior vena cava	112000004487	ACC	NCDR
Stent re-dilation - Peripheral/lobar pulmonary artery	112000004488	ACC	NCDR
Stent re-dilation - Proximal descending thoracic aorta	112000004489	ACC	NCDR
Stent re-dilation - Renal artery	112000004490	ACC	NCDR
Stent re-dilation - RV outflow tract	112000004491	ACC	NCDR
Stent re-dilation - Superior vena cava	112000004492	ACC	NCDR
Stent re-dilation - SVC - Sinus venosus ASD closure	112000004493	ACC	NCDR
Stent re-dilation - Systemic artery - Other	112000004494	ACC	NCDR
Stent re-dilation - Systemic vein - Other	112000004495	ACC	NCDR
Stent re-dilation - Systemic-to-	112000004496	ACC	NCDR

Section: Non-module Intervention		Parent: Procedure Information	
pulmonary shunt			
Stent re-dilation - Transverse aortic arch	112000004497	ACC	NCDR
Stent re-dilation - Fontan baffle S-P lateral tunnel fontan	112000004498	ACC	NCDR
Stent re-dilation - Mid-distal descending thoracic aorta	112000004499	ACC	NCDR
Use of IVUS/OCT/FFR during vascular interventions	112000004500	ACC	NCDR
Device occlusion - Transhepatic access tract	112000004501	ACC	NCDR
Device insertion - Tricuspid Transcatheter Edge-Edge Repair - TEER	112000004444	ACC	NCDR
Endomyocardial biopsy - Not S/P heart transplant	112000004506	ACC	NCDR
Balloon dilation - Innominate vein	112000004504	ACC	NCDR
Balloon dilation - Transverse aortic arch	112000004505	ACC	NCDR
Transhepatic access for diagnostic or intervention	112000004507	ACC	NCDR

Section: Non-module Intervention Device
Parent: Non-module Intervention

Element: 16287 Non-Module Intervention Device Counter

Coding Instruction: The non-module intervention device counter distinguishes individual devices when multiple are used during one procedure.

Target Value: N/A

Element: 15937 Device Used Non-Module Intervention

Coding Instruction: Indicate the device(s) utilized during the current interventional catheterization procedure.

Note(s): Code all devices used during the procedure.

The devices that should be collected in your application are controlled by a Master File. This file is maintained by the NCDR and will be made available on the internet for downloading and importing/updating into your application.

Target Value: The value on current procedure

Vendor Instruction: Device Used Non-Module Intervention (15937) cannot be Null when Non-Module Intervention Device Counter (16287) has a value

Element: 15938 Unique Device Identifier - Non-Module

Coding Instruction: Indicate the unique device identifier (UDI) of the device. Enter all characters including the parenthesis. Leave blank if the UDI is unknown or unable to be collected due to state/local privacy laws.

Target Value: The value on current procedure

Supporting Definition: General Definition

The UDI identifies the specific individual device; no two devices have the same UDI. Refer to the FDA website for detailed explanation of UDIs.

The UDI is made up of five different identifiers and each identifier is preceded by a number in parentheses.

Example UDI below: Device Identifier (01), Expiration Date (17), Manufacturing date (11), Lot Number (10), and Serial Number (21)

Source:

Section: Wolff-Parkinson-White Syndrome

Parent: Procedure Information

Element: 15968

WPW Pre-Procedure Indication

Coding Instruction: Select the indication(s) for the procedure to treat WPW or another pre-excitation syndrome.

Target Value: The value on current procedure

WPW Pre-Procedure Indication - 1.3.6.1.4.1.19376.1.4.1.6.5.1012

Selection	Definition	Source	Code	Code System
Symptoms	The procedure was performed due to patient-reported symptoms		418799008	SNOMED CT
Risk assessment/treatment	The procedure was indicated based on the results of a risk assessment, such as identifying a high-risk accessory pathway or potential for life-threatening arrhythmias.		112000003811	ACC NCDR
Dyssynchrony cardiomyopathy	The procedure was performed to address cardiomyopathy caused by ventricular dyssynchrony.		458084001	SNOMED CT
Pre-operative	The ablation was performed as part of a preoperative strategy for another surgical or interventional procedure.		112000003812	ACC NCDR
Sudden cardiac arrest/Pre-excited AFib	The procedure was performed following a sudden cardiac arrest or documented pre-excited atrial fibrillation.		410429000	SNOMED CT
Drug refractory or side effects	The patient's condition was not adequately managed with antiarrhythmic medications or the patient experienced significant side effects from these medications.		62014003	SNOMED CT
Documented arrhythmia			112000004244	ACC NCDR
Other			100000351	ACC NCDR

Element: 15967

WPW Symptoms

Coding Instruction: Select the symptoms experienced by the patient prior to the procedure.

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

WPW Symptoms - 1.3.6.1.4.1.19376.1.4.1.6.5.1011

Selection	Definition	Source	Code	Code System
Palpitations	An unpleasant sensation of irregular and/or forceful beating of the heart		80313002	SNOMED CT
Arrhythmic syncope	The patient experienced syncope attributed to arrhythmia.		271594007	SNOMED CT
Other			100000351	ACC NCDR

Element: 15970

WPW Risk Assessment Performed

Coding Instruction: Indicate whether a risk assessment was conducted prior to the ablation procedure to evaluate the potential risks and benefits of treating the pre-excitation syndrome, such as WPW. This could include assessing the risk of sudden cardiac arrest, arrhythmia recurrence, or procedural complications.

Target Value: The value on current procedure

Element: 15971

WPW Assessments Used

Coding Instruction: Select the specific assessments used during the risk evaluation process for the ablation procedure in patients with pre-excitation syndrome.

Target Value: The value on current procedure

WPW Assessments Used - 1.3.6.1.4.1.19376.1.4.1.6.5.1014

Selection	Definition	Source	Code	Code System
Accessory pathway block cycle length (AP block CL)	Accessory Pathway Block Cycle Length was measured during the risk assessment. This measurement helps determine the shortest cycle length at which the accessory pathway can no longer conduct impulses, providing important information about the risk of rapid arrhythmias.		112000003814	ACC NCDR
Accessory pathway effective refractory period (APERP)	Accessory Pathway Effective Refractory Period (APERP) was evaluated. This refers to the minimum interval during which the accessory pathway cannot conduct impulses, used to assess the risk of rapid ventricular rates during atrial arrhythmias.		112000003815	ACC NCDR
Atrial fibrillation with shortest pre-excited R-R interval (AF/SPERRI)	Shortest Pre-Excited R-R Interval during Atrial Fibrillation (AF/SPERRI) was measured. This assessment evaluates the risk of extremely rapid ventricular responses in the event of atrial fibrillation,		112000003816	ACC NCDR

Section: Wolff-Parkinson-White Syndrome

Parent: Procedure Information

which can be dangerous in patients with WPW or other pre-excitation syndromes.

Section: WPW Procedure

Parent: Wolff-Parkinson-White Syndrome

Element: 16227 Wolff Parkinson White Syndrome Ablation Counter

Coding Instruction: The Wolff Parkinson White syndrome ablation counter is used to distinguish individual ablation targets or pathways when multiple targets or pathways are treated during one procedure.

Note: The software-assigned target counter should start at one and be incremented by one for each target or pathway. The target counter is reset back to one for each new lab visit.

Target Value: N/A

Element: 16225 WPW Targeted Substrate

Coding Instruction: Indicate the conduction pathway targeted during the ablation procedure for Wolff-Parkinson-White (WPW) syndrome.

Target Value: The value on current procedure

WPW targeted substrate - 1.3.6.1.4.1.19376.1.4.1.6.5.1146

Selection	Definition	Source	Code	Code System
Bidirectional Wolff Parkinson White	Ablation targeted a pathway conducting in both antegrade (atria to ventricles) and retrograde (ventricles to atria) directions.		112000004245	ACC NCDR
Antegrade Only Wolff Parkinson White	Ablation targeted a pathway conducting only in the antegrade direction (atria to ventricles).		112000004246	ACC NCDR
Unidirectional Antegrade Decremental - Mahaim	Ablation targeted an antegrade-only, decrementally conducting accessory pathway, typically associated with Mahaim fibers.		112000004247	ACC NCDR

Element: 15972 WPW Inducible Arrhythmia Pre-Excitation Syndromes

Coding Instruction: Indicate if an arrhythmia was induced during the electrophysiology study or ablation procedure for patients with a pre-excitation syndrome.

Target Value: The value on current procedure

Inducible arrhythmia - 1.3.6.1.4.1.19376.1.4.1.6.5.1007

Selection	Definition	Source	Code	Code System
Orthodromic reciprocating tachycardia (ORT)			233898003	SNOMED CT
Antidromic reciprocating tachycardia			233899006	SNOMED CT
Atrial Fibrillation			49436004	SNOMED CT
Sustained AFI/AF			5370000	SNOMED CT
None			260413007	SNOMED CT
Other			100000351	ACC NCDR

Element: 15973 WPW Isoproterenol Used

Coding Instruction: Indicate whether isoproterenol was used during the ablation procedure to provoke or enhance arrhythmias in patients with pre-excitation syndromes.

Target Value: The value on current procedure

Element: 16226 Indication for Isoproterenol

Coding Instruction: Indicate reason(s) for administering isoproterenol during the procedure.

Note: Capture the total related to the EP study (with or without ablation) and cardiovascular implantable electronic device procedure.

Target Value: The value on current procedure

Indication for isoproterenol - 1.3.6.1.4.1.19376.1.4.1.6.5.1147

Selection	Definition	Source	Code	Code System
Induction of arrhythmia	Isoproterenol was used to provoke or facilitate the identification of an arrhythmia.		112000004248	ACC NCDR
Risk assessment/treatment	Isoproterenol was used to evaluate the patient's susceptibility to arrhythmia or other hemodynamic responses.		112000003811	ACC NCDR
Other			100000351	ACC NCDR

Element: 15974 WPW Target Site Location

Coding Instruction: Select the target site location of the pre-excitation syndrome ablation.

Target Value: The value on current procedure

Section: WPW Procedure

Parent: Wolff-Parkinson-White Syndrome

Target Site Location - 1.3.6.1.4.1.19376.1.4.1.6.5.1009

Selection	Definition	Source	Code	Code System
Coronary sinus/middle cardiac vein			90219004	SNOMED CT
Coronary sinus - Distal			112000002373	ACC NCDR
Coronary sinus - Mid			112000002372	ACC NCDR
Coronary sinus - Proximal			112000002371	ACC NCDR
Left non-septal			112000003804	ACC NCDR
Mid-anterior septal			112000003806	ACC NCDR
Mitral annulus - Left anterolateral			112000002370	ACC NCDR
Mitral annulus - Left intermediate			112000002366	ACC NCDR
Mitral annulus - Left lateral			112000002369	ACC NCDR
Mitral annulus - Left posterior			112000002368	ACC NCDR
Mitral annulus - Left posterior/inferior septal			112000004502	ACC NCDR
Posterior septal			112000003805	ACC NCDR
Right non-septal			112000003803	ACC NCDR
Middle cardiac vein			73580002	SNOMED CT
Tricuspid annulus - Right anterior/superior septal (paraHisian)			112000002365	ACC NCDR
Tricuspid annulus - Right anterior			112000002360	ACC NCDR
Tricuspid annulus - Right intermediate septal			112000002364	ACC NCDR
Tricuspid annulus - Right lateral			112000002361	ACC NCDR
Tricuspid annulus - Right posterior			112000002362	ACC NCDR
Tricuspid annulus - Right posterior/inferior septal			112000004503	ACC NCDR

Element: 15975

WPW Outcome

Coding Instruction: Indicate the result of the procedure based on whether the pre-excitation syndrome was successfully treated. Code based on clinician interpretation of procedure success.

Target Value: The value on current procedure

Procedure Outcome - 1.3.6.1.4.1.19376.1.4.1.6.5.1010

Selection	Definition	Source	Code	Code System
Successful	Bidirectional WPW: Elimination of both antegrade and retrograde conduction for at least 30 min following successful ablation lesion for bidirectional WPW; documentation of appropriate response to adenosine is advised. Antegrade only WPW: Elimination of antegrade conduction for at least 30 min following successful ablation lesion for antegrade only WPW; documentation of appropriate response to adenosine is advised. Unidirectional antegrade decremental Mahaim: Elimination of antegrade conduction for at least 30 min following successful ablation lesion for unidirectional antegrade decremental Mahaim; documentation of appropriate response to adenosine is advised.		385669000	SNOMED CT
Unsuccessful	Persistence of either antegrade or retrograde conduction with or without echos/SVT		385671000	SNOMED CT
Indeterminant	Unknown, empiric, ambiguous, etc.		82334004	SNOMED CT

Section: Concealed Accessory Pathway and Permanent Junctional Reciprocating Tachycardia **Parent: Procedure Information**

Element: 15958 AP Pre-procedure Indication

Coding Instruction: Select the patient symptom(s) or condition(s) prompting the procedure.

Target Value: The value on current procedure

Pre-procedure Indications - 1.3.6.1.4.1.19376.1.4.1.6.5.1005

Selection	Definition	Source	Code	Code System
Symptoms	The procedure was indicated due to patient-reported symptoms.		418799008	SNOMED CT
Documented arrhythmia			112000004244	ACC NCDR
Heart failure/ventricular dysfunction	The patient presented with heart failure and/or ventricular dysfunction. Heart failure and ventricular dysfunction should be defined by the provider.		57809008	SNOMED CT
Other	N/A		100000351	ACC NCDR

Section: CAPPJRT Procedure

Parent: Concealed Accessory Pathway and Permanent Junctional Reciprocating Tachycardia

Element: 16228 Concealed Accessory Pathway and Permanent Junctional Reciprocating Tachycardia Ablation Target Counter

Coding Instruction: The concealed accessory pathway and permanent junctional reciprocating tachycardia ablation target counter is used to distinguish individual targets when multiple targets are treated during one procedure.

Note: 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.

Target Value: N/A

Element: 15960 AP Inducible Arrhythmia

Coding Instruction: If an arrhythmia was induced during the electrophysiology study or ablation procedure for the accessory pathway, select which was induced.

Target Value: The value on current procedure

Inducible arrhythmia - 1.3.6.1.4.1.19376.1.4.1.6.5.1007

Selection	Definition	Source	Code	Code System
Orthodromic reciprocating tachycardia (ORT)			233898003	SNOMED CT
Antidromic reciprocating tachycardia			233899006	SNOMED CT
Atrial Fibrillation			49436004	SNOMED CT
Sustained AFI/AF			5370000	SNOMED CT
None			260413007	SNOMED CT
Other			100000351	ACC NCDR

Element: 15961 AP Targeted Ablation Substrate

Coding Instruction: Select the type of accessory pathway (AP) or area targeted during the ablation procedure.

Target Value: The value on current procedure

AP Targeted Ablation Substrate - 1.3.6.1.4.1.19376.1.4.1.6.5.1008

Selection	Definition	Source	Code	Code System
Concealed Accessory Pathway			233922008	SNOMED CT
Permanent junctional reciprocating tachycardia (PJRT)			233904005	SNOMED CT

Element: 15962 AP Ablation Target Site Location

Coding Instruction: Indicate the anatomical location of the accessory pathway ablation target site.

Target Value: The value on current procedure

Target Site Location - 1.3.6.1.4.1.19376.1.4.1.6.5.1009

Selection	Definition	Source	Code	Code System
Coronary sinus/middle cardiac vein			90219004	SNOMED CT
Coronary sinus - Distal			112000002373	ACC NCDR
Coronary sinus - Mid			112000002372	ACC NCDR
Coronary sinus - Proximal			112000002371	ACC NCDR
Left non-septal			112000003804	ACC NCDR
Mid-anterior septal			112000003806	ACC NCDR
Mitral annulus - Left anterolateral			112000002370	ACC NCDR
Mitral annulus - Left intermediate			112000002366	ACC NCDR
Mitral annulus - Left lateral			112000002369	ACC NCDR
Mitral annulus - Left posterior			112000002368	ACC NCDR
Mitral annulus - Left posterior/inferior septal			112000004502	ACC NCDR
Posterior septal			112000003805	ACC NCDR
Right non-septal			112000003803	ACC NCDR
Middle cardiac vein			73580002	SNOMED CT
Tricuspid annulus - Right anterior/superior septal (paraHisian)			112000002365	ACC NCDR
Tricuspid annulus - Right			112000002360	ACC NCDR

Section: CAPPJRT Procedure	Parent: Concealed Accessory Pathway and Permanent Junctional Reciprocating Tachycardia
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anterior		
Tricuspid annulus - Right intermediate septal	112000002364	ACC NCDR
Tricuspid annulus - Right lateral	112000002361	ACC NCDR
Tricuspid annulus - Right posterior	112000002362	ACC NCDR
Tricuspid annulus - Right posterior/inferior septal	112000004503	ACC NCDR

Element: 15963 AP Procedure Outcome

Coding Instruction: Indicate the outcome of the ablation procedure for the accessory pathway as documented by the clinician.

Target Value: The value on current procedure

AP Procedure Outcome - 1.3.6.1.4.1.19376.1.4.1.6.5.1136

Selection	Definition	Source	Code	Code System
Successful	Elimination of retrograde AP conduction for at least 30 min following successful ablation lesion; documentation of appropriate response to adenosine is advised		385669000	SNOMED CT
Unsuccessful	Persistence or retrograde conduction with or without echos/SVT		385671000	SNOMED CT
Indeterminant	Unknown, empiric, ambiguous, etc.		82334004	SNOMED CT

Section: AV Nodal Reentrant Tachycardia
Parent: Procedure Information
Element: 15981

AVNRT Primary Indications

Coding Instruction: Select the primary indication(s) identified to perform the procedure.

Target Value: The value on current procedure

AVNRT Pre-Procedure Indications - 1.3.6.1.4.1.19376.1.4.1.6.5.1017

Selection	Definition	Source	Code	Code System
Symptoms	The procedure was indicated due to patient-reported symptoms.		418799008	SNOMED CT
Documented arrhythmia			112000004244	ACC NCDR
Other			100000351	ACC NCDR

Section: AVNRT Procedure

Parent: AV Nodal Reentrant Tachycardia

Element: 15406 AV Nodal Reentrant Tachycardia (AVNRT) Target Counter

Coding Instruction: The AV nodal reentrant tachycardia (AVNRT) target counter is used to distinguish individual targets when multiple targets are treated during one procedure.

Note: 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.

Target Value: N/A

Element: 15982 AVNRT Inducible Arrhythmia

Coding Instruction: Select the specific type(s) of atrioventricular nodal reentrant tachycardia (AVNRT) that was induced during the electrophysiology study or ablation procedure.

Target Value: The value on current procedure

AVNRT Inducible Arrhythmia - 1.3.6.1.4.1.19376.1.4.1.6.5.1018

Selection	Definition	Source	Code	Code System
Slow-fast AVNRT	Conduction proceeds down the slow pathway and returns via the fast pathway.		112000003820	ACC NCDR
Fast-slow AVNRT	Conduction proceeds down the fast pathway and returns via the slow pathway.		112000003821	ACC NCDR
Slow-slow AVNRT	Conduction involves two slow pathways within the AV node.		112000003822	ACC NCDR
Other AVNRT	The induced arrhythmia is a variant form of AVNRT not otherwise listed.		112000003823	ACC NCDR
Dual AV node physiology without AVNRT	Dual AV node physiology was observed, but AVNRT was not induced		112000003824	ACC NCDR

Element: 16258 No Inducible Arrhythmia

Coding Instruction: Select if no arrhythmia was induced.

Target Value: N/A

Element: 15983 AVNRT Isoproterenol Necessary For Induction

Coding Instruction: Indicate whether isoproterenol was used for the induction of atrioventricular nodal reentrant tachycardia during the ablation procedure.

Target Value: The value on current procedure

Element: 15984 AVNRT Targeted Ablation Substrate

Coding Instruction: Select the specific substrate targeted for ablation during the procedure for atrioventricular nodal reentrant tachycardia (AVNRT).

Target Value: The value on current procedure

AVNRT Targeted Ablation Substrate - 1.3.6.1.4.1.19376.1.4.1.6.5.1019

Selection	Definition	Source	Code	Code System
AVN fast pathway			112000003826	ACC NCDR
AVN Slow Pathway Right Inferior Extension			112000004240	ACC NCDR
AVN Slow Pathway Left Inferior Extension			112000004241	ACC NCDR
AVN other or unspecified			112000003827	ACC NCDR

Element: 15985 Procedure Anatomical Location

Coding Instruction: Select the specific anatomical location where the ablation was performed during the procedure.

Target Value: The value on current procedure

AVNRT Procedure Anatomical Location - 1.3.6.1.4.1.19376.1.4.1.6.5.1020

Selection	Definition	Source	Code	Code System
Right Inferior Extension in Triangle of Koch			112000004237	ACC NCDR
Left Inferior Extension Via Coronary Sinus			112000004238	ACC NCDR
Left Inferior Extension via Left Atrium			112000004239	ACC NCDR
Other			100000351	ACC NCDR

Section: AVNRT Procedure

Parent: AV Nodal Reentrant Tachycardia

Element: 15986

AVNRT Mapping

Coding Instruction: Select the specific mapping parameters used during the electrophysiology study for atrioventricular nodal reentrant tachycardia (AVNRT). These parameters help characterize the electrical activity and pathways in the heart, aiding in the identification of the target area for ablation.

Target Value: The value on current procedure

AVNRT Mapping - 1.3.6.1.4.1.19376.1.4.1.6.5.1021

Selection	Definition	Source	Code	Code System
Signal morphology	Signal morphology refers to the shape and characteristics of the electrical signals (electrograms) analyzed during the study. This can provide insights into the type and location of the arrhythmia.		112000002357	ACC NCDR
Anatomic	Anatomic mapping involves techniques that visualize the heart's structures and pathways, helping to guide catheter placement and ablation through imaging.		112000002355	ACC NCDR
Slow pathway potential	Slow pathway potential mapping focuses on identifying the electrical signals associated with the slow conduction pathway within the AV node, which is often targeted during AVNRT ablation.		112000003830	ACC NCDR
Voltage	Voltage mapping measures the electrical voltage in different areas of the heart. This helps to identify abnormal areas that may sustain arrhythmias based on the voltage readings.		112000002359	ACC NCDR
Activation	Activation mapping determines the sequence and timing of electrical activation across the heart, identifying critical areas involved in the arrhythmia circuit.		112000002354	ACC NCDR
Other			100000351	ACC NCDR

Element: 15987

Junctional Acceleration Observed During Any Ablation Energy Application

Coding Instruction: Indicate whether junctional acceleration was observed during the ablation procedure for atrioventricular nodal reentrant tachycardia. Junctional acceleration refers to an increase in heart rate originating from the junctional tissue, which may occur as a response to catheter manipulation or other factors during the procedure.

Target Value: The value on current procedure

Junctional Acceleration Observed During Ablation Energy Application - 1.3.6.1.4.1.19376.1.4.1.6.5.1148

Selection	Definition	Source	Code	Code System
No			100013073	ACC NCDR
Yes			100013072	ACC NCDR
Not applicable			NA	HL7NullFlavor

Element: 15988

AVNRT Outcome

Coding Instruction: Indicate the outcome of the ablation procedure for atrioventricular nodal reentrant tachycardia.

Slow pathway and dual AV node physiology should be defined by the presence of a critical AH jump and/or sustained PR > RR interval.

Target Value: The value on end of current procedure

AVNRT Outcome - 1.3.6.1.4.1.19376.1.4.1.6.5.1022

Selection	Definition	Source	Code	Code System
Successful - no slow pathway/dual AV node physiology present	No slow pathway/dual AV node physiology present for at least 30 min following successful ablation lesion		112000003831	ACC NCDR
Successful - no slow pathway/dual AV node physiology present but with single echos	No slow pathway/dual AV node physiology present but with single echos for at least 30 min following successful ablation lesion		112000003832	ACC NCDR
Successful - slow pathway/dual AV node physiology present without echos	Slow pathway/dual AVN physiology present without echos for at least 30 min following successful ablation lesion		112000003833	ACC NCDR
Successful - slow pathway/dual AV node physiology present with up to one echo	Slow pathway/dual AVN physiology present with up to one echo for at least 30 min following successful ablation lesion		112000003834	ACC NCDR
Unsuccessful	More than one AV nodal echo or AVNRT regardless of presence of slow pathway/dual AV node physiology		385671000	SNOMED CT
Indeterminant	Unknown, empiric, ambiguous		82334004	SNOMED CT

Element: 15989

AVNRT Isoproterenol Used for Post-Ablation Testing

Coding Instruction: Indicate whether isoproterenol was administered during post-ablation testing.

Section: AVNRT Procedure

Parent: AV Nodal Reentrant Tachycardia

Target Value: The value on current procedure

Section: Focal Atrial Tachycardia

Parent: Procedure Information

Element: 15976

Pre-Procedure Indication

Coding Instruction: Select the clinical reasons that prompted the decision to perform an ablation for ectopic atrial tachycardia.

Target Value: The value on current procedure

Pre-procedure Indications - 1.3.6.1.4.1.19376.1.4.1.6.5.1005

Selection	Definition	Source	Code	Code System
Symptoms	The procedure was indicated due to patient-reported symptoms.		418799008	SNOMED CT
Documented arrhythmia			112000004244	ACC NCDR
Heart failure/ventricular dysfunction	The patient presented with heart failure and/or ventricular dysfunction. Heart failure and ventricular dysfunction should be defined by the provider.		57809008	SNOMED CT
Other	N/A		100000351	ACC NCDR

Section: FAT Procedure

Parent: Focal Atrial Tachycardia

Element: 16229 Focal Atrial Tachycardia Ablation Target Counter

Coding Instruction: The focal atrial tachycardia ablation target counter is used to distinguish individual targets when multiple targets are treated during one procedure.

Note: 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.

Target Value: N/A

Element: 15977 Inducible Arrhythmia

Coding Instruction: Indicate whether ectopic atrial tachycardia was induced during the electrophysiological study or ablation procedure

Code 'No' if an ectopic atrial tachycardia was not induced, or if the arrhythmia induced was insufficient for mapping purposes.

Target Value: The value on current procedure

Element: 15978 Isoproterenol Necessary For Induction

Coding Instruction: Indicate whether isoproterenol was required to induce ectopic atrial tachycardia during the procedure

Target Value: The value on current procedure

Element: 15979 Procedure Anatomical Location

Coding Instruction: Select the anatomical location(s) of the ectopic atrial tachycardia focus that was targeted during the ablation procedure.

Target Value: The value on current procedure

EAT Procedure Anatomical Location - 1.3.6.1.4.1.19376.1.4.1.6.5.1016

Selection	Definition	Source	Code	Code System
Right atrium			73829009	SNOMED CT
Left atrium			82471001	SNOMED CT
Aortic coronary cusp			6530003	SNOMED CT
Coronary sinus/middle coronary vein			90219004	SNOMED CT
Other			100000351	ACC NCDR

Element: 15411 Methods to Localize Electrophysiology Ablation Target

Coding Instruction: Indicate the methods used to localize the target.

Target Value: The value on current procedure

Cardiac Mapping - 1.3.6.1.4.1.19376.1.4.1.6.5.883

Selection	Definition	Source	Code	Code System
Activation	Activation mapping determines the sequence and timing of electrical activation across the heart, identifying critical areas involved in the arrhythmia circuit.		112000002354	ACC NCDR
Anatomic	Anatomic mapping involves techniques that visualize the heart's structures and pathways, helping to guide catheter placement and ablation through imaging.		112000002355	ACC NCDR
High density mapping catheter			112000003908	ACC NCDR
Entrainment mapping	Entrainment mapping uses pacing from specific sites to assess the electrical circuit characteristics, such as in reentrant arrhythmias.		112000002356	ACC NCDR
Pace	Mapping involving pacing from different sites.		112000002358	ACC NCDR
Voltage mapping	Voltage mapping measures the electrical voltage in different areas of the heart. This helps to identify abnormal areas that may sustain arrhythmias based on the voltage readings.		112000002359	ACC NCDR
Insufficient for mapping			423437008	SNOMED CT
Other			100000351	ACC NCDR

Element: 16250 Method Used Localize Target Not Documented

Coding Instruction: Select if no method was used to localize the target or the method was not documented.

Target Value: N/A

Element: 15980 Outcome

Coding Instruction: Indicate the outcome of the ablation procedure for ectopic atrial tachycardia

Section: FAT Procedure
Parent: Focal Atrial Tachycardia

Target Value: The value on end of current procedure

EAT Procedure Outcome - 1.3.6.1.4.1.19376.1.4.1.6.5.1137

Selection	Definition	Source	Code	Code System
Successful	No spontaneous or inducible tachycardia > 1 beat of same morphology as the target arrhythmia for at least 30 min following successful ablation lesion		385669000	SNOMED CT
Unsuccessful	Spontaneous or inducible tachycardia > 1 beat of same morphology as the target arrhythmia		385671000	SNOMED CT
Indeterminant	Unknown, empiric, ambiguous		82334004	SNOMED CT

Section: Macroreentrant Atrial Tachycardia

Parent: Procedure Information

Element: 16069 Pre-procedure Indications

Coding Instruction: Identify the primary clinical reason(s) that led to the decision to perform an ablation for Atrial Flutter, Intra-Atrial Reentrant Tachycardia (IART), or Macro-entrant Atrial Tachycardia (MAT).

Target Value: The value on current procedure

AFIARTMRAT Pre-procedure Indications - 1.3.6.1.4.1.19376.1.4.1.6.5.1060

Selection	Definition	Source	Code	Code System
Symptoms	The procedure was performed due to patient-reported symptoms		418799008	SNOMED CT
Failure of medical therapy	The procedure was performed because prior medical therapy failed to control the arrhythmia effectively.		11200001944	ACC NCDR
Medication intolerance	The patient was unable to tolerate medical therapy due to side effects or adverse reactions.		59037007	SNOMED CT
Pre-operative	The ablation was performed as part of a preoperative strategy for another surgical or interventional procedure.		112000003812	ACC NCDR
Acute hemodynamic compromise/syncope	The procedure was performed due to acute hemodynamic instability (e.g., hypotension, shock) or syncope.		271594007	SNOMED CT
Medication declined	The patient chose ablation as an alternative to long-term medication use.		406149000	SNOMED CT
Documented Arrhythmia			112000004244	ACC NCDR
Heart Failure	Select if there is documentation of heart failure, a multi-dimensional clinical syndrome characterized by symptoms such as dyspnea, fatigue, exertional intolerance, or fluid retention. Heart failure results from structural or functional impairment in ventricular filling or blood ejection and may necessitate new or escalated pharmacologic therapy to manage symptoms.		84114007	SNOMED CT
Other			100000351	ACC NCDR

Element: 16129 Prior Cardioversion

Coding Instruction: Indicate whether the patient had a cardioversion prior to the procedure.

Target Value: Any occurrence between 6 months prior to procedure and the start of the current procedure

Element: 16070 Prior Cardioversion Method

Coding Instruction: Select the method(s) used to terminate the arrhythmia during a pre-procedure cardioversion. This refers to the specific approach or technique employed to achieve cardioversion and restore a normal heart rhythm.

Target Value: Any occurrence between 6 months prior to arrival at this facility and start of current procedure

AFIARTMRAT Cardioversion Method - 1.3.6.1.4.1.19376.1.4.1.6.5.1062

Selection	Definition	Source	Code	Code System
Pharmacologic	The arrhythmia was terminated using medications administered intravenously or orally.		440142000	SNOMED CT
Pace terminated via CIED	The arrhythmia was terminated using pacing from a cardiac implantable electronic device (CIED), such as a pacemaker or implantable cardioverter-defibrillator (ICD).		112000003942	ACC NCDR
Pace terminated via catheter	The arrhythmia was terminated using pacing via an intracardiac catheter.		19923001	SNOMED CT
Direct current (DC) cardioversion	Restores rhythm through the use of electrical shock(s).		180325003	SNOMED CT

Element: 16071 Pace Terminated Via Catheter Method

Coding Instruction: Select the method used for pace terminated cardioversion via catheter.

Target Value: Any occurrence between 6 months prior to procedure and the start of the current procedure

AFIARTMRAT Pace Terminated Via Catheter Method - 1.3.6.1.4.1.19376.1.4.1.6.5.1063

Selection	Definition	Source	Code	Code System
Intracardiac			264044002	SNOMED CT
Transesophageal			103383005	SNOMED CT

Element: 16072 Prior Surgical Ablation Type

Coding Instruction: Select the type(s) of surgical ablation performed.

Section: Macroreentrant Atrial Tachycardia

Parent: Procedure Information

Target Value: Any occurrence between birth and start of the current procedure

AFIARTMRAT Prior Surgical Ablation Type - 1.3.6.1.4.1.19376.1.4.1.6.5.1064

Selection	Definition	Source	Code	Code System
Localized or site specific	The prior surgical ablation was targeted to a specific site or region, rather than being part of a broader maze procedure.		255471002	SNOMED CT
Right maze	The prior surgical ablation was part of a maze procedure localized to the right atrium.		112000003944	ACC NCDR
Left maze	The prior surgical ablation was part of a maze procedure localized to the left atrium.		112000003945	ACC NCDR
Bilateral maze	The prior surgical ablation was part of a maze procedure that occurred in the right and left atriums.		112000003946	ACC NCDR

Element: 16074 Ejection Fraction Assessment

Coding Instruction: Indicate if the ejection fraction was assessed quantitatively (ejection fraction percentage), qualitatively (normal, mildly depressed, etc) or not assessed. If both an ejection fraction percentage and qualitative interpretation are available, then code only the ejection fraction percentage.

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

AFIARTMRATPre Ejection Fraction Assessment - 1.3.6.1.4.1.19376.1.4.1.6.5.1065

Selection	Definition	Source	Code	Code System
No			100013073	ACC NCDR
Yes - Ejection fraction documented	The EF was quantitatively measured and documented as a percentage.		30766002	SNOMED CT
Yes - Qualitative interpretation only	The EF was not measured as a percentage but was documented using qualitative terms such as "normal," or "mildly depressed," as an example.		26716007	SNOMED CT

Element: 16073 Ejection Fraction

Coding Instruction: Record the percentage of blood emptied from the left ventricle at the end of the contraction.

Notes:

Enter a percentage in the range of 01–99. If a percentage range is reported, report the center number in the range (e.g., 50–55% is 52.5 reported to the next whole number is 53%). For EF measurements reported as "less than" or "greater than," code to the nearest whole number (e.g., <40% is coded as 39%, and >40% is coded as 41%).

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

Element: 16075 Qualitative Interpretation

Coding Instruction: Select the qualitative interpretation recorded characterizing the ejection fraction.

Note: If two separate categories are documented (ex. mild-moderate) enter the selection associated with the more severe finding.

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

AFIARTMRATPre Qualitative Interpretation - 1.3.6.1.4.1.19376.1.4.1.6.5.1066

Selection	Definition	Source	Code	Code System
Normal			17621005	SNOMED CT
Mildly depressed			255604002	SNOMED CT
Moderately depressed			6736007	SNOMED CT
Severely depressed			24484000	SNOMED CT

Element: 16076 Number of Antiarrhythmics

Coding Instruction: Record the number of antiarrhythmics prescribed.

Target Value: Any occurrence between 6 months prior to the procedure and the procedure

Section: MRAT Procedure

Parent: Macroreentrant Atrial Tachycardia

Element: 16230 Macroreentrant Atrial Tachycardia Target Counter

Coding Instruction: The macroreentrant atrial tachycardia target counter is used to distinguish individual circuits or targets when multiple are treated during one procedure.

Note: 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.

Target Value: N/A

Element: 16007 Inducible Arrhythmia

Coding Instruction: Indicate whether atrial flutter, intra-atrial reentrant tachycardia (IART), or macro-entrant atrial tachycardia (MAT) was induced during the electrophysiological study or ablation procedure.

Target Value: The value on current procedure

Element: 16009 Isoproterenol Necessary for Induction

Coding Instruction: Indicate whether isoproterenol was used to induce the arrhythmia during the procedure

Target Value: The value on current procedure

Element: 16008 Method of Induction

Coding Instruction: Select the method used to induce the arrhythmia during the procedure.

Target Value: The value on current procedure

AFIARTMRAT Method of Induction - 1.3.6.1.4.1.19376.1.4.1.6.5.1031

Selection	Definition	Source	Code	Code System
Spontaneous	The arrhythmia occurred naturally without external provocation during the procedure.		5054005	SNOMED CT
Catheter manipulation	The arrhythmia was induced by mechanical stimulation or positioning of the catheter within the heart.		103712006	SNOMED CT
Pacing	Programmed electrical stimulation (pacing) was used to induce the arrhythmia.		18590009	SNOMED CT

Element: 16011 Mapping

Coding Instruction: Select the method(s) used for mapping the arrhythmia during the ablation procedure

Target Value: The value on current procedure

Cardiac Mapping - 1.3.6.1.4.1.19376.1.4.1.6.5.883

Selection	Definition	Source	Code	Code System
Activation	Activation mapping determines the sequence and timing of electrical activation across the heart, identifying critical areas involved in the arrhythmia circuit.		112000002354	ACC NCDR
Anatomic	Anatomic mapping involves techniques that visualize the heart's structures and pathways, helping to guide catheter placement and ablation through imaging.		112000002355	ACC NCDR
High density mapping catheter			112000003908	ACC NCDR
Entrainment mapping	Entrainment mapping uses pacing from specific sites to assess the electrical circuit characteristics, such as in reentrant arrhythmias.		112000002356	ACC NCDR
Pace	Mapping involving pacing from different sites.		112000002358	ACC NCDR
Voltage mapping	Voltage mapping measures the electrical voltage in different areas of the heart. This helps to identify abnormal areas that may sustain arrhythmias based on the voltage readings.		112000002359	ACC NCDR
Insufficient for mapping			423437008	SNOMED CT
Other			100000351	ACC NCDR

Element: 16252 No Mapping Used

Coding Instruction: Select if no arrhythmia mapping was done during the ablation procedure.

Target Value: N/A

Element: 15405 Electrophysiology Imaging System(s)

Coding Instruction: Indicate the imaging system(s) used during the electrophysiology study.

Section: MRAT Procedure

Parent: Macroreentrant Atrial Tachycardia

Target Value: The value on current procedure

Imaging System for Electrophysiology Procedure - 1.3.6.1.4.1.19376.1.4.1.6.5.879

Selection	Definition	Source	Code	Code System
CARTO 3 System			112000002340	ACC NCDR
CARTO XP System			112000002341	ACC NCDR
CARTO Sound			112000002342	ACC NCDR
EnSite NavX			112000002343	ACC NCDR
EnSite Balloon Array			112000002345	ACC NCDR
Fluoro Only			44491008	SNOMED CT
Other			100000351	ACC NCDR

Element: 16253 Electrophysiology Imaging System Not Used

Coding Instruction: Select if an electrophysiology imaging system was not used.

Target Value: N/A

Section: MRAT High Density Mapping Catheter

Parent: MRAT Procedure

Element: 16012

High Density Mapping Catheter

Coding Instruction: Select the high-density mapping catheter(s) that was used during the ablation procedure. High-density mapping catheters are specialized tools that provide detailed mapping of the heart's electrical activity by using multiple electrodes for high-resolution data.

Target Value: The value on current procedure

Section: MRAT

Parent: MRAT Procedure

Element: 16010 Circuit

Coding Instruction: Select the specific type(s) or location(s) of the reentrant circuit involved in the arrhythmia during the procedure.

Target Value: The value on current procedure

AFIARTMRAT Circuit - 1.3.6.1.4.1.19376.1.4.1.6.5.1032

Selection	Definition	Source	Code	Code System
Cavotricuspid isthmus (CTI)			112000003854	ACC NCDR
Cavomitral isthmus (CMI)			112000003855	ACC NCDR
Biatial			112000003856	ACC NCDR
Right atriotomy			44794004	SNOMED CT
Other incisional circuit (Right)			112000003857	ACC NCDR
Other incisional circuit (Left)			112000003858	ACC NCDR
Other post-ablation/scar circuitry (right, left, coronary sinus)			112000003859	ACC NCDR
Peri-mitral			112000003860	ACC NCDR
Upper loop/SVC			48345005	SNOMED CT
Lower loop/IVC			64131007	SNOMED CT
Septal			255584008	SNOMED CT
Roof (of left or right atrium)			112000003861	ACC NCDR
Fontan baffle			112000003862	ACC NCDR
Other			100000351	ACC NCDR

Element: 16015 Approach

Coding Instruction: Select the approach used during the ablation procedure. The approach refers to the method of catheter access to the heart and the specific anatomical route taken to perform the ablation. If more than one approach was used, select the successful approach.

Target Value: The value on current procedure

AFIARTMRAT Approach - 1.3.6.1.4.1.19376.1.4.1.6.5.1034

Selection	Definition	Source	Code	Code System
IVC			64131007	SNOMED CT
SVC			48345005	SNOMED CT
Transseptal			311996002	SNOMED CT
Transbaffle			112000002349	ACC NCDR
Retrograde aortic			260526008	SNOMED CT
Transhepatic			103381007	SNOMED CT

Element: 16017 Outcome

Coding Instruction: Select the outcome of the ablation procedure.

Target Value: The value on current procedure

AFIARTMRAT Procedure Outcome - 1.3.6.1.4.1.19376.1.4.1.6.5.1138

Selection	Definition	Source	Code	Code System
Successful	No spontaneous or inducible tachycardia > 1 beat and conduction block demonstrated across ablation line for at least 30 min following successful ablation lesion		385669000	SNOMED CT
Unsuccessful	Spontaneous or inducible tachycardia > 1 beat or persistent conduction demonstrated across ablation line		385671000	SNOMED CT
Indeterminant	Unknown, empiric, ambiguous		82334004	SNOMED CT

Element: 16018 Assessment of Result

Coding Instruction: Select how the outcome of the procedure was assessed.

Target Value: The value on current procedure

AFIARTMRAT Assessment of Result - 1.3.6.1.4.1.19376.1.4.1.6.5.1035

Selection	Definition	Source	Code	Code System
Termination during energy application	The arrhythmia terminated during the delivery of ablation energy.		112000003863	ACC NCDR
Conduction block demonstrated across ablation line	Testing confirmed a conduction block across the ablation line, indicating electrical isolation or disruption of the targeted pathway.		112000003864	ACC NCDR
Non-inducible	The arrhythmia could not be induced following ablation		112000003865	ACC NCDR

Section: MRAT
Parent: MRAT Procedure
Element: 16077 Procedural Imaging Used

Coding Instruction: Indicate the imaging modality(ies) used during the procedure.

Target Value: The value on current procedure

AFIARTMRATPre Prior Imaging - 1.3.6.1.4.1.19376.1.4.1.6.5.1067

Selection	Definition	Source	Code	Code System
CT/MRI merge	The process of integrating computed tomography (CT) or magnetic resonance imaging (MRI) scans into a real-time procedural imaging system. This technique enhances anatomical visualization by overlaying or fusing high-resolution 3D models of the patient's anatomy with live imaging.		112000003950	ACC NCDR
Transesophageal echocardiogram			105376000	SNOMED CT
Intracardiac echocardiogram			112000003746	ACC NCDR

Element: 16019 Isoproterenol Used for Post-Ablation Testing

Coding Instruction: Indicate whether isoproterenol was administered during post-ablation testing.

Target Value: The value on current procedure

Section: Ventricular Arrhythmias

Parent: Procedure Information

Element: 16053

Symptoms

Coding Instruction: Select the primary symptom(s) experienced by the patient that prompted the ablation for ventricular arrhythmias. This refers to clinical presentations directly related to the arrhythmia.

Target Value: Any occurrence between 6 months prior to procedure and the start of the current procedure

Vendor Instruction: When Symptoms (16053) is [Asymptomatic], no other selections can be selected

VA Symptoms - 1.3.6.1.4.1.19376.1.4.1.6.5.1051

Selection	Definition	Source	Code	Code System
Palpitations	An unpleasant sensation of irregular and/or forceful beating of the heart		80313002	SNOMED CT
Syncope	The patient has experienced syncope, a temporary loss of consciousness usually related to insufficient blood flow to the brain. It's also called fainting or "passing out".		271594007	SNOMED CT
Unstable ventricular tachycardia or sudden cardiac arrest	The patient experienced unstable or sustained ventricular tachycardia requiring urgent medical intervention or an episode of sudden cardiac arrest attributed to ventricular arrhythmias.		112000004034	ACC NCDR
Heart failure	The patient presented with heart failure. Heart failure should be defined by the provider.		84114007	SNOMED CT
Asymptomatic			84387000	SNOMED CT

Element: 16038

VA Ejection Fraction Assessed

Coding Instruction: Indicate whether ejection fraction was assessed during the procedure, either as an ejection fraction percentage or as a qualitative interpretation. If both are provided, select only ejection fraction percentage.

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

Ejection Fraction Assessed - 1.3.6.1.4.1.19376.1.4.1.6.5.1046

Selection	Definition	Source	Code	Code System
No	Ejection fraction was not assessed.		100013073	ACC NCDR
Yes - EF percent	The EF was quantitatively measured and documented as a percentage		112000003888	ACC NCDR
Yes - Qualitative interpretation only	The EF was not measured as a percentage but was documented using qualitative terms such as "normal," or "mildly reduced," as an example.		112000003889	ACC NCDR

Element: 16039

Left Ventricular Ejection Fraction

Coding Instruction: Record the left ventricular ejection fraction, in percent.

Notes:

Enter a percentage in the range of 01–99. If a percentage range is reported, report the center number in the range (e.g., 50–55% is 52.5 reported to the next whole number is 53%). For EF measurements reported as "less than" or "greater than," code to the nearest whole number (e.g., <40% is coded as 39%, and >40% is coded as 41%).

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

Element: 16041

Qualitative Interpretation

Coding Instruction: Select the qualitative assessment of ejection fraction.

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

Left Ventricular Ejection Fraction Qualitative Assessment - 1.3.6.1.4.1.19376.1.4.1.6.5.1047

Selection	Definition	Source	Code	Code System
Normal			17621005	SNOMED CT
Mildly depressed			255604002	SNOMED CT
Moderately depressed			6736007	SNOMED CT
Severely depressed			24484000	SNOMED CT

Element: 16067

Ventricular Arrhythmia in the Setting of an Inherited Arrhythmia Syndrome

Coding Instruction: Indicate whether the ventricular arrhythmia is associated with an inherited arrhythmia syndrome.

Target Value: The value on current procedure

Element: 16068

Inherited Arrhythmia Syndrome

Coding Instruction: Select the type of inherited arrhythmia syndrome associated with the ventricular arrhythmia.

Section: Ventricular Arrhythmias

Parent: Procedure Information

Target Value: The value on current procedure

Inherited Arrhythmia Syndrome - 1.3.6.1.4.1.19376.1.4.1.6.5.1059

Selection	Definition	Source	Code	Code System
Long QT syndrome	Disorder characterized by prolongation of the heart rate corrected QT interval that predisposes to ventricular arrhythmias and sudden death. As calculated by the Bazett formula.	Source: A Report of the ACC/AHA TF on CDS JACC Vol 70. No 8, August 22, 2017: 1029-95	9651007	SNOMED CT
Catecholaminergic polymorphic ventricular tachycardia	A rare genetic arrhythmia syndrome triggered by physical activity or emotional stress, characterized by polymorphic ventricular tachycardia.		419671004	SNOMED CT
Arrhythmogenic cardiomyopathy	A genetic disorder involving fibrofatty replacement of right ventricular myocardium, predisposing to arrhythmias and potential heart failure.		281170005	SNOMED CT
Brugada syndrome	Polymorphic ventricular tachycardia in the absence of structural heart disease, associated with a baseline ECG pattern during sinus rhythm showing right bundle branch block with ST segment elevation in leads V1 through V3. It can also be characterized by documentation of ECG patterns associated with Brugada Syndrome, some of which may be unmasked when provoked with drugs. The most common genetic mutations identified for Brugada syndrome are in a sodium channel gene (SCN5A). Sodium channel blocking drugs, therefore, may exacerbate the electrocardiographic features and clinical presentation. Brugada syndrome typically presents before the age of 50 years.		418818005	SNOMED CT
Other			100000351	ACC NCDR

Section: VA Procedure

Parent: Ventricular Arrhythmias

Element: 16231 Ventricular Arrhythmia Target Counter

Coding Instruction: The ventricular arrhythmia target counter is used to distinguish individual circuits or targets when multiple are treated during one procedure.

Note: 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.

Target Value: N/A

Element: 16057 VA Inducible Arrhythmia

Coding Instruction: Select the type(s) of ventricular arrhythmia induced during the procedure.

Target Value: The value on current procedure

Inducible Ventricular Arrhythmia - 1.3.6.1.4.1.19376.1.4.1.6.5.1052

Selection	Definition	Source	Code	Code System
Premature ventricular contractions	The arrhythmia consisted of isolated, early ventricular beats interrupting the normal heart rhythm.		427172004	SNOMED CT
Non-sustained monomorphic ventricular tachycardia	The arrhythmia was a short-lasting episode (less than 30 seconds) of regular, repetitive ventricular beats with a uniform QRS morphology.		1237128001	SNOMED CT
Non-sustained polymorphic ventricular tachycardia	The arrhythmia was a short-lasting episode (less than 30 seconds) of irregular ventricular beats with varying QRS morphologies.		112000003912	ACC NCDR
Sustained monomorphic ventricular tachycardia	The arrhythmia lasted 30 seconds or longer and consisted of regular, repetitive ventricular beats with a uniform QRS morphology.		1237127006	SNOMED CT
Sustained polymorphic ventricular tachycardia	The arrhythmia lasted 30 seconds or longer and consisted of regular, repetitive ventricular beats with a varying QRS morphology.		112000003911	ACC NCDR
Ventricular fibrillation	A life-threatening heart rhythm that results in a rapid, inadequate heartbeat.		71908006	SNOMED CT

Element: 16058 VA Mechanism

Coding Instruction: Indicate whether the ventricular arrhythmia was focal or reentrant. This refers to the underlying physiological process driving the arrhythmia. If it is not clearly documented, select 'unknown'.

Target Value: The value on current procedure

Ventricular Arrhythmia Mechanism - 1.3.6.1.4.1.19376.1.4.1.6.5.1053

Selection	Definition	Source	Code	Code System
Focal	The arrhythmia arises from abnormal impulse generation due to enhanced automaticity in ventricular cells.		87017008	SNOMED CT
Reentrant	The arrhythmia is caused by a reentrant circuit		112000003913	ACC NCDR
Unknown	The underlying mechanism of the ventricular arrhythmia could not be determined.		261665006	SNOMED CT

Element: 16059 Arrhythmia Mechanism Automatic Location

Coding Instruction: If the arrhythmia mechanism was identified as automatic, select the location(s) of the automatic ventricular arrhythmia.

Target Value: The value on current procedure

Automatic Ventricular Arrhythmia Location - 1.3.6.1.4.1.19376.1.4.1.6.5.1054

Selection	Definition	Source	Code	Code System
Outflow right	Ventricular arrhythmia is originating from the right ventricular outflow tract.		112000003914	ACC NCDR
Outflow left	Ventricular arrhythmia is originating from the left ventricular outflow tract.		112000003915	ACC NCDR
Aortic coronary cusp	Ventricular arrhythmia originates near the aortic coronary cusp.		112000003916	ACC NCDR
Left ventricular fascicular	Ventricular arrhythmia originates within the left ventricular fascicular system.		112000003917	ACC NCDR
Right ventricle - not outflow	Ventricular arrhythmia originates in the right ventricle, excluding the outflow tract.		112000003918	ACC NCDR
Left ventricular - not outflow or fascicular	Ventricular arrhythmia originates in the left ventricle, excluding the outflow tract and fascicular system.		112000003919	ACC NCDR
Single ventricle or other unknown ventricle morphology	Single Ventricle or Other Unknown Ventricle Morphology		112000003920	ACC NCDR

Section: VA Procedure

Parent: Ventricular Arrhythmias

Element: 16060 Arrhythmia Mechanism

Coding Instruction: Indicate the mechanism of ventricular arrhythmia in patients with single ventricle physiology or unknown ventricular morphology.

Target Value: The value on current procedure

Automatic Mechanism in Single Ventricle or Unknown Morphology - 1.3.6.1.4.1.19376.1.4.1.6.5.1055

Selection	Definition	Source	Code	Code System
Incisional	The arrhythmia mechanism is related to a surgical incision from a previous procedure.		112000003922	ACC NCDR
Scar based	The arrhythmia mechanism arises from scarring, not related to an incision.		112000003923	ACC NCDR
Other			100000351	ACC NCDR

Element: 16061 Ventricular Reentrant Mechanism Location

Coding Instruction: Select the location(s) of the reentrant arrhythmia mechanism. This refers to the anatomical site within the heart where the reentrant circuit is sustaining the arrhythmia.

Target Value: The value on current procedure

Ventricular Reentrant Mechanism Location - 1.3.6.1.4.1.19376.1.4.1.6.5.1056

Selection	Definition	Source	Code	Code System
Left ventricle	The reentrant arrhythmia is located in the left ventricle, including the free wall or other areas not specifically fascicular.		87878005	SNOMED CT
Fascicular of left ventricle	The reentrant arrhythmia is located in the left ventricular fascicular pathways, which may involve specialized conduction tissue, often seen in idiopathic VT.		112000003925	ACC NCDR
Right ventricle	The reentrant arrhythmia is located in the right ventricle, which may involve areas such as the right ventricular outflow tract or other regions involved in VT circuits.		53085002	SNOMED CT

Element: 16062 Tetralogy of Fallot or Tetralogy of Fallot Variant

Coding Instruction: Indicate, for a patient with reentrant ventricular arrhythmias, whether a Tetralogy of Fallot or Tetralogy of Fallot variant is present.

Target Value: The value on current procedure

Element: 16063 Tetralogy of Fallot or Tetralogy of Fallot Variant Reentrant Mechanism Locations

Coding Instruction: Select the location(s) of the reentrant arrhythmia mechanism if the patient has Tetralogy of Fallot (ToF) or a ToF variant.

Target Value: The value on current procedure

Tetralogy of Fallot or Tetralogy of Fallot Variant Reentrant Mechanism Locations - 1.3.6.1.4.1.19376.1.4.1.6.5.1057

Selection	Definition	Source	Code	Code System
Tricuspid annulus and scar or patch in the anterior right ventricular outflow isthmus	A reentrant mechanism involving the region between the tricuspid annulus and a scar or surgical patch located in the anterior right ventricular outflow tract.		112000003927	ACC NCDR
Pulmonary annulus and right ventricular free wall scar or patch isthmus	A reentrant mechanism involving the region between the pulmonary annulus and a scar or patch along the right ventricular free wall.		112000003928	ACC NCDR
Pulmonary annulus and septal scar or patch isthmus	A reentrant mechanism involving the region between the pulmonary annulus and a scar or patch on the interventricular septum.		112000003929	ACC NCDR
Septal scar or patch and tricuspid annulus isthmus	A reentrant mechanism involving the region between a septal scar or patch and the tricuspid annulus.		112000003930	ACC NCDR
Other			100000351	ACC NCDR

Element: 16064 Reentrant Ventricular Arrhythmia Origin

Coding Instruction: Select the origin of the reentrant ventricular arrhythmia.

Target Value: The value on current procedure

Reentrant Ventricular Arrhythmia Origin - 1.3.6.1.4.1.19376.1.4.1.6.5.1058

Selection	Definition	Source	Code	Code System
Right ventricle			53085002	SNOMED CT
Left ventricle			87878005	SNOMED CT
Single ventricle or unknown ventricular morphology			21814001	SNOMED CT

Section: VA Procedure

Parent: Ventricular Arrhythmias

Element: 16065 Reentrant Mechanism in Right Ventricle

Coding Instruction: Select the reentrant mechanism in the right ventricle.

Target Value: The value on current procedure

Automatic Mechanism in Single Ventricle or Unknown Morphology - 1.3.6.1.4.1.19376.1.4.1.6.5.1055

Selection	Definition	Source	Code	Code System
Incisional	The arrhythmia mechanism is related to a surgical incision from a previous procedure.		112000003922	ACC NCDR
Scar based	The arrhythmia mechanism arises from scarring, not related to an incision.		112000003923	ACC NCDR
Other			100000351	ACC NCDR

Element: 16066 Reentrant Mechanism in Left Ventricle

Coding Instruction: Select the reentrant mechanism in the left ventricle.

Target Value: The value on current procedure

Automatic Mechanism in Single Ventricle or Unknown Morphology - 1.3.6.1.4.1.19376.1.4.1.6.5.1055

Selection	Definition	Source	Code	Code System
Incisional	The arrhythmia mechanism is related to a surgical incision from a previous procedure.		112000003922	ACC NCDR
Scar based	The arrhythmia mechanism arises from scarring, not related to an incision.		112000003923	ACC NCDR
Other			100000351	ACC NCDR

Element: 16043 Procedure Imaging Used

Coding Instruction: Indicate the imaging modality(ies) used during the procedure.

Target Value: The value on current procedure

Procedure Imaging Used - 1.3.6.1.4.1.19376.1.4.1.6.5.1048

Selection	Definition	Source	Code	Code System
Computerized tomography magnetic resonance imaging merge	The process of integrating computed tomography (CT) or magnetic resonance imaging (MRI) scans into a real-time procedural imaging system. This technique enhances anatomical visualization by overlaying or fusing high-resolution 3D models of the patient's anatomy with live imaging.		113091000	SNOMED CT
Transesophageal echocardiogram			105376000	SNOMED CT
Intracardiac echocardiogram			40701008	SNOMED CT

Element: 16052 Isoproterenol Used For Induction

Coding Instruction: Indicate whether isoproterenol was necessary for induction.

Target Value: The value on current procedure

Element: 16044 Method of Induction

Coding Instruction: Select the method(s) of induction of the ventricular arrhythmia.

Target Value: The value on current procedure

Method of Induction - 1.3.6.1.4.1.19376.1.4.1.6.5.1049

Selection	Definition	Source	Code	Code System
Spontaneous	The arrhythmia occurred naturally without external provocation during the procedure.		5054005	SNOMED CT
Catheter manipulation or placement	The arrhythmia was induced by mechanical stimulation or positioning of the catheter within the heart.		103712006	SNOMED CT
Programmed stimulation	Programmed electrical stimulation (pacing) was used to induce the arrhythmia.		129272000	SNOMED CT
Ventricular fibrillation only	Ventricular fibrillation was the only arrhythmia induced.		71908006	SNOMED CT

Element: 16256 None or Insufficient PVC Burden or Tachycardia to Map

Coding Instruction: Select if the arrhythmia could not be adequately induced or sustained for mapping purposes.

Target Value: N/A

Element: 16045 Mapping

Section: VA Procedure

Parent: Ventricular Arrhythmias

Coding Instruction: Select the type(s) of mapping used during the ablation procedure.

Target Value: The value on current procedure

Cardiac Mapping - 1.3.6.1.4.1.19376.1.4.1.6.5.883

Selection	Definition	Source	Code	Code System
Activation	Activation mapping determines the sequence and timing of electrical activation across the heart, identifying critical areas involved in the arrhythmia circuit.		112000002354	ACC NCDR
Anatomic	Anatomic mapping involves techniques that visualize the heart's structures and pathways, helping to guide catheter placement and ablation through imaging.		112000002355	ACC NCDR
High density mapping catheter			112000003908	ACC NCDR
Entrainment mapping	Entrainment mapping uses pacing from specific sites to assess the electrical circuit characteristics, such as in reentrant arrhythmias.		112000002356	ACC NCDR
Pace	Mapping involving pacing from different sites.		112000002358	ACC NCDR
Voltage mapping	Voltage mapping measures the electrical voltage in different areas of the heart. This helps to identify abnormal areas that may sustain arrhythmias based on the voltage readings.		112000002359	ACC NCDR
Insufficient for mapping			423437008	SNOMED CT
Other			100000351	ACC NCDR

Element: 16251 No Mapping

Coding Instruction: Select if no mapping was used during the ablation procedure.

Target Value: N/A

Element: 16046 Mapping System

Coding Instruction: Select the mapping system used during the ablation procedure.

Target Value: The value on current procedure

Element: 16047 High Density Catheter Used

Coding Instruction: Select the high density catheter used during the procedure.

Target Value: The value on current procedure

Element: 16049 Outcome

Coding Instruction: Select the outcome of the ablation procedure.

Target Value: The value on current procedure

VT Procedure Outcome - 1.3.6.1.4.1.19376.1.4.1.6.5.1139

Selection	Definition	Source	Code	Code System
Successful	No spontaneous or inducible tachycardia > 1 beat and conduction block demonstrated across ablation line for reentrant circuits for at least 30 min following successful ablation lesion		385669000	SNOMED CT
Unsuccessful	Spontaneous or inducible tachycardia > 1 beat or persistent conduction demonstrated across ablation line for reentrant circuits		385671000	SNOMED CT
Indeterminant	Unknown, empiric, ambiguous		82334004	SNOMED CT

Element: 16050 Assessment of Result

Coding Instruction: Select the specific outcomes that were achieved during a successful ventricular ablation.

Target Value: The value on current procedure

Successful Ventricular Ablation Outcomes - 1.3.6.1.4.1.19376.1.4.1.6.5.1050

Selection	Definition	Source	Code	Code System
Termination during energy application	The arrhythmia terminated during the delivery of ablation energy.		112000003863	ACC NCDR
Conduction block demonstrated across ablation line	Testing confirmed a conduction block across the ablation line, indicating electrical isolation or disruption of the targeted pathway.		112000003864	ACC NCDR
Not Inducible	The arrhythmia could not be induced following ablation		112000003865	ACC NCDR

Element: 16051 Isoproterenol Used for Post-Ablation Testing

Section: VA Procedure

Parent: Ventricular Arrhythmias

Coding Instruction: Indicate whether isoproterenol was used to test inducibility of the ventricular arrhythmia.

Target Value: The value on current procedure

Section: Junctional Tachycardia

Parent: Procedure Information

Element: 15990 JT Pre-Procedure Indications

Coding Instruction: Select the clinical reasons that prompted the decision to perform a junctional tachycardia ablation.

Target Value: The value on current procedure

JT Pre-procedure Indications - 1.3.6.1.4.1.19376.1.4.1.6.5.1023

Selection	Definition	Source	Code	Code System
Symptoms	The procedure was performed due to patient-reported symptoms		418799008	SNOMED CT
Low cardiac output syndrome	The procedure was indicated due to low cardiac output syndrome. This is defined as inadequate cardiac output leading to hypoperfusion, tissue hypoxia.		44088000	SNOMED CT
Hemodynamic collapse/arrest	The procedure was performed in response to a hemodynamic emergency, such as cardiac arrest, profound hypotension, or shock		112000003839	ACC NCDR
Heart failure/ventricular dysfunction	The patient presented with heart failure and/or ventricular dysfunction. Heart failure and ventricular dysfunction should be defined by the provider.		84114007	SNOMED CT
Other			100000351	ACC NCDR

Element: 15991 Junctional Tachycardia Type

Coding Instruction: Select the type of junctional tachycardia that the patient has based on clinical presentation and diagnosis.

Target Value: The value on current procedure

Junctional Tachycardia Type - 1.3.6.1.4.1.19376.1.4.1.6.5.1024

Selection	Definition	Source	Code	Code System
Congenital	The patient's junctional tachycardia is determined to be congenital in origin. This refers to cases where the JT is present from birth, often due to inherent heart conduction system abnormalities.		255399007	SNOMED CT
Post-operative	The patient's junctional tachycardia occurred as a result of an interventional or surgical cardiac procedure.		262061000	SNOMED CT
Idiopathic (non-congenital)	The patient's junctional tachycardia cannot be attributed to congenital nor post-surgical causes.		54690008	SNOMED CT
Other			100000351	ACC NCDR

Element: 16035 Number of Post Operative Days

Coding Instruction: Record the number of days that have passed since the procedure or surgery that contributed to the junctional tachycardia.

Note: Date of Procedure is Day 0.

Target Value: The value on current procedure

Element: 15992 Pattern of Arrhythmia

Coding Instruction: Select the description of the junctional tachycardia based on frequency of the arrhythmia.

Target Value: The value on current procedure

JT Pattern of Arrhythmia - 1.3.6.1.4.1.19376.1.4.1.6.5.1025

Selection	Definition	Source	Code	Code System
Incessant junctional tachycardia	The junctional tachycardia is present continuously, without significant breaks or periods of normal sinus rhythm		112000003840	ACC NCDR
Persistent junctional tachycardia	The junctional tachycardia is ongoing, but there are occasional periods of another rhythm. The arrhythmia is not incessant but tends to recur frequently over time, lasting for minutes to hours.		112000003841	ACC NCDR
Paroxysmal junctional tachycardia	The junctional tachycardia occurs in sudden, brief episodes that start and stop spontaneously. The episodes are usually intermittent and may last for a few seconds to minutes, with longer periods of normal sinus rhythm between episodes.		112000003842	ACC NCDR
Not documented	Rhythm is not documented.		112000001830	ACC NCDR
Other			100000351	ACC NCDR

Element: 15997 Antiarrhythmic Class

Coding Instruction: Indicate the class(es) of antiarrhythmics prescribed.

Section: Junctional Tachycardia

Parent: Procedure Information

Target Value: Any occurrence between 2 weeks prior to current procedure and current procedure

Antiarrhythmic Class - 1.3.6.1.4.1.19376.1.4.1.6.5.1027

Selection	Definition	Source	Code	Code System
Class I antiarrhythmic agent	Sodium-channel blockers Examples include Proainamide, Quinidine, Mexiletine, Lidocaine, Felcainide, Propafenone.		373260001	SNOMED CT
Class II antiarrhythmic agent	Beta blockers Examples include Atenolol, Metoprolol, Propranolol.		373278006	SNOMED CT
Class III antiarrhythmic agent	Potassium blockers. Examples include Amiodarone, Sotalol.		372855004	SNOMED CT
Class IV antiarrhythmic agent	Calcium channel blockers or other agents Examples include Verapamil, Diltiazem.		372693007	SNOMED CT

Element: 16257 Antiarrhythmic Class Not Documented

Coding Instruction: Select if antiarrhythmic class is not documented.

Target Value: N/A

Element: 16036 Number of Antiarrhythmic Medications

Coding Instruction: Indicate the number of antiarrhythmic medications prescribed or administered to the patient.

Target Value: Any occurrence between 2 weeks prior to current procedure and current procedure

Element: 15993 Spontaneous Junctional Tachycardia Present

Coding Instruction: Indicate whether the junctional tachycardia (JT) was present spontaneously during the ablation procedure, without the need for external induction.

Target Value: The value on current procedure

Element: 15994 Inducible Junctional Tachycardia

Coding Instruction: Indicate whether the junctional tachycardia (JT) was inducible during the ablation procedure, meaning the arrhythmia could be initiated or provoked by external means.

Target Value: The value on current procedure

Element: 15995 Conditions That Induced Junctional Tachycardia

Coding Instruction: Indicate the conditions under which the junctional tachycardia was successfully induced during the ablation procedure.

Target Value: The value on current procedure

JT Conditions that induced arrhythmia - 1.3.6.1.4.1.19376.1.4.1.6.5.1026

Selection	Definition	Source	Code	Code System
Inducible at baseline	The arrhythmia was induced without pharmacological agents.		11200003843	ACC NCDR
Inducible with isoproterenol	The arrhythmia was induced after administering isoproterenol.		11200003844	ACC NCDR

Element: 15996 Ablation Outcome

Coding Instruction: Indicate the result of the ablation procedure for junctional tachycardia based on whether the arrhythmia was successfully treated.

Target Value: The value on current procedure

JT Procedure Outcome - 1.3.6.1.4.1.19376.1.4.1.6.5.1140

Selection	Definition	Source	Code	Code System
Successful	No spontaneous or inducible tachycardia > 1 beat of same morphology as the target arrhythmia for at least 30 min following successful ablation lesion		385669000	SNOMED CT
Unsuccessful	Spontaneous or inducible tachycardia > 1 beat of same morphology as the target arrhythmia		385671000	SNOMED CT
Indeterminant	Unknown, empiric, ambiguous		82334004	SNOMED CT

Element: 15998 Isoproterenol Used for Post-ablation Testing

Coding Instruction: Indicate whether isoproterenol was administered during post-ablation testing.

Target Value: The value on current procedure

Section: Device Information

Parent: Procedure Information

Element: 16214 Targeted Substrate Performed Device Counter

Coding Instruction: The targeted substrate counter distinguishes individual devices when multiple are used during one procedure.

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

Target Value: N/A

Element: 16003 Device Targeted Substrate

Coding Instruction: Select the substrate(s) that were targeted during the electrophysiology (EP) ablation.

Target Value: The value on current procedure

Ablation Information - 1.3.6.1.4.1.19376.1.4.1.6.5.1134

Selection	Definition	Source	Code	Code System
Wolff-Parkinson-White (WPW)			74390002	SNOMED CT
Concealed accessory pathway/permanent junctional reciprocating tachycardia			233922008	SNOMED CT
AV nodal reentrant tachycardia (AVNRT)			251166008	SNOMED CT
Focal atrial tachycardia			713424004	SNOMED CT
Macroreentrant atrial tachycardia			735682000	SNOMED CT
Ventricular arrhythmias (PVCs, VT, VF)			44103008	SNOMED CT
Junctional tachycardia			426648003	SNOMED CT
Other	Select only when the substrate is not represented by any existing options. Use this category exclusively when no other selection is appropriate.		100000351	ACC NCDR

Element: 15414 Electrophysiology Ablation Catheter Identification Number

Coding Instruction: Indicate all ablation catheters utilized during the current EP procedure.

Note: Code all devices used during the procedure.

Target Value: The value on current procedure

Vendor Instruction: Electrophysiology Ablation Catheter Identification Number (15414) cannot be Null when Targeted Substrate Performed Device Counter (16214) has a value

Element: 16037 Energy Source

Coding Instruction: Select the energy source used by the ablation catheter.

Target Value: The value on current procedure

Ablation Energy Source - 1.3.6.1.4.1.19376.1.4.1.6.5.947

Selection	Definition	Source	Code	Code System
Cryoablation			112000003639	ACC NCDR
Pulsed field ablation			112000003642	ACC NCDR
Non-irrigated radio frequency			112000003851	ACC NCDR
Irrigated radio frequency			112000003850	ACC NCDR

Element: 16004 Device Successful Catheter

Coding Instruction: Indicate whether the ablation catheter used was successful in achieving the intended outcome. This refers to selecting the specific catheter that created the lesion that was felt to be responsible for definitive change. Only one catheter should be marked as successful per substrate. Ensure that all catheters used in the procedure are documented, even if they were not successful.

Target Value: The value on current procedure

Element: 16005 Device Number of Lesions

Coding Instruction: Record the number of lesions created during the ablation procedure by a catheter.

Target Value: The value on current procedure

Element: 16236 Total Lesion Time

Coding Instruction: Indicate the total duration of energy application (lesion time) during the ablation procedure, measured in minutes. This represents the cumulative time across all lesions delivered by a catheter. It refers to the duration that an energy source was actively applied to tissue

Section: Device Information

Parent: Procedure Information

during the procedure.

Target Value: The value on current procedure

Element: 16006

Unique Device Identifier - IMPACT Ablation

Coding Instruction: Indicate the unique device identifier (UDI) of the device. Enter all characters including the parenthesis. Leave blank if the UDI is unknown or unable to be collected due to state/local privacy laws.

Target Value: The value on current procedure

Supporting Definition: General Definition

The UDI identifies the specific individual device; no two devices have the same UDI. Refer to the FDA website for detailed explanation of UDIs.

The UDI is made up of five different identifiers and each identifier is preceded by a number in parentheses.

Example UDI below: Device Identifier (01), Expiration Date (17), Manufacturing date (11), Lot Number (10), and Serial Number (21)

Source:

Section: New Cardiovascular Implantable Electronic Device

Parent: Procedure Information

Element: 15794

Final Device Type

Coding Instruction: Indicate the device type(s) that was implanted at the completion of the procedure.

Target Value: Any occurrence on current procedure

Implantation Device Type - Dynamic - 1.3.6.1.4.1.19376.1.4.1.6.5.982

Selection	Definition	Source	Code	Code System
Cardiac resynchronization therapy - Defibrillator	A cardiac resynchronization therapy device and a biventricular pacemaker that sends electrical signals to both ventricles that resynchronizes the heart chambers and helps it pump more effectively. It may or may not have an atrial pacing wire.		100001216	ACC NCDR
Extravascular ICD	The extravascular (EV) ICD system has a lead (thin wire) placed outside the heart and veins, under the sternum (breastbone).		112000003612	ACC NCDR
ICD dual chamber	A dual-chamber ICD defibrillates the ventricle and paces the atrium and ventricle.		100001215	ACC NCDR
ICD single chamber	A single-chamber ICD defibrillates the ventricle and paces the ventricle.		100001214	ACC NCDR
Subcutaneous ICD	The subcutaneous ICD consists of an ICD generator and a defibrillation lead however, the defibrillation lead remains completely outside the chest cavity. The SICD is implanted under the left breast, and the lead is placed under the skin along the left side of the breastbone.		100001217	ACC NCDR
Single chamber transvenous pacemaker	A type of pacemaker that uses one transvenous lead to stimulate either the right atrium or right ventricle of the heart.		112000003680	ACC NCDR
Dual chamber transvenous	A type of pacemaker that uses two transvenous leads to stimulate both the right atrium and right ventricle of the heart.		112000003679	ACC NCDR
Cardiac resynchronization therapy - Pacemaker	A cardiac resynchronization therapy device and a biventricular pacemaker that sends electrical signals to both ventricles that resynchronizes the heart chambers and helps it pump more effectively. It may or may not have an atrial pacing wire.		704708004	SNOMED CT
Leadless single chamber pacemaker	A self-contained transvenous pacemaker generator and electrode system implanted directly into the right ventricle. The device is implanted via a femoral vein transcatheter approach; it requires no chest incision or subcutaneous generator pocket.		112000002030	ACC NCDR
Leadless dual chamber pacemaker	A self-contained transvenous pacemaker generator and electrode system implanted directly into the right ventricle and right atrium. The device is implanted via a femoral vein transcatheter approach; it requires no chest incision or subcutaneous generator pocket.		112000003671	ACC NCDR
His bundle pacemaker	His-bundle pacing is a method for delivering permanent pacing. It produces physiological ventricular activation via the His-Purkinje system		112000003669	ACC NCDR
Left bundle pacemaker	Left bundle pacing is a method for delivering permanent pacing. It produces physiological ventricular activation via the Left bundle.		112000003670	ACC NCDR
Leadless left ventricle endocardial pacemaker	Left ventricular (LV) endocardial pacing is a treatment for patients with heart failure, severe LV dysfunction, and electrical dyssynchrony. It's an alternative therapy to cardiac resynchronization therapy (CRT) for patients who don't respond to conventional CRT or when it's not possible to place a lead through the coronary sinus.		112000003709	ACC NCDR

Element: 16203

Single Chamber Leadless Pacemaker Type

Coding Instruction: Select the type of single chamber leadless pacemaker used in the procedure.

Target Value: The value on current procedure

Pacemaker Type - 1.3.6.1.4.1.19376.1.4.1.6.5.1131

Selection	Definition	Source	Code	Code System
Atrial			33331003	SNOMED CT
Ventricular			54974006	SNOMED CT

Section: CIED Device**Parent: New Cardiovascular Implantable Electronic Device****Element: 7635** Implant Device ID**Coding Instruction:** Indicate the assigned identification number associated with the implanted device.**Note(s):**

The devices that should be collected in your application are controlled by a Defibrillator or Pacemaker Device Master file. This file is maintained by the NCDR and will be made available on the internet for downloading and importing/updating into your application.

Target Value: Any occurrence on current procedure**Element: 7640** Implant Device Serial Number**Coding Instruction:** Indicate the serial number of the device that was implanted.**Target Value:** Any occurrence on current procedure**Element: 7645** Implant Unique Device Identifier**Coding Instruction:** Indicate the direct identifier portion of the Unique Device Identifier (UDI) associated with the device used for implant. This ID is provided by the device manufacturer, and is either a GTIN or HIBC number.**Target Value:** Any occurrence on current procedure**Supporting Definition: Unique Device Identifier (UDI)**

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

Source: US FDA

Section: New Pacemaker Generator

Parent: New Cardiovascular Implantable Electronic Device

Element: 16117 Pacemaker Generator Indication

Coding Instruction: Select the indication(s) for pacemaker generator implantation.

Target Value: The value on current procedure

ICD Pacemaker Generator Indication - 1.3.6.1.4.1.19376.1.4.1.6.5.1089

Selection	Definition	Source	Code	Code System
Sinus node dysfunction	The pacemaker was implanted to treat conditions like sinus bradycardia, sinus arrest, or chronotropic incompetence.		60423000	SNOMED CT
AV junctional rhythm	The pacemaker was implanted to manage a junctional rhythm.		11849007	SNOMED CT
2nd degree or high grade block	The pacemaker was implanted to address any second-degree AV block or high-grade AV block.		195042002	SNOMED CT
Complete heart block	The pacemaker was implanted to treat complete (third-degree) AV block.		27885002	SNOMED CT
Ventricular dysfunction	The pacemaker was implanted to improve ventricular function.		112000004022	ACC NCDR
SVT treatment	The pacemaker was implanted to manage supraventricular tachycardias, such as through overdrive pacing.		6456007	SNOMED CT
Other			100000351	ACC NCDR

Element: 16118 Pacemaker Change

Coding Instruction: Indicate whether the pacemaker procedure is for a pacemaker change. This refers to the replacement or upgrade of an existing pacemaker device.

Target Value: The value on current procedure

Element: 7650 Reason(s) for Generator Replacement

Coding Instruction: Indicate the reason(s) for the replacement.

Target Value: Any occurrence on current procedure

Reimplant Reason - 1.3.6.1.4.1.19376.1.4.1.6.5.36

Selection	Definition	Source	Code	Code System
Device relocation	The device was replaced because it needed to be relocated.		100001087	ACC NCDR
End of expected battery life	The device was replaced due to its battery reaching the end of its expected lifespan.		100001088	ACC NCDR
Erosion	The device was replaced due to erosion of the device through the skin or surrounding tissue.		100014134	ACC NCDR
Faulty connector/header	A defect or malfunction in the connector block of a device, which is the part where the leads are attached to the device. This issue can compromise the electrical connection between the device and the leads, potentially leading to improper pacing or sensing functions.		100001089	ACC NCDR
Infection	The device was replaced due to infection.		100001091	ACC NCDR
Malfunction	The device was replaced due to a device malfunction or failure.		100001090	ACC NCDR
Replaced at time of lead revision	The device was replaced when the leads were being revised.		100001092	ACC NCDR
Replaced at time of upgrade	The device was replaced because an upgrade was being implanted.		100001094	ACC NCDR
Under manufacturer advisory/recalled	The device was replaced following a manufacturer-issued advisory or recall.		100001093	ACC NCDR
Other			112000003710	ACC NCDR

Element: 16119 Pacemaker Change Upgrade Type

Coding Instruction: Select the type of pacemaker change upgrade.

Target Value: The value on current procedure

Pacemaker Change Upgrade Type - 1.3.6.1.4.1.19376.1.4.1.6.5.1090

Selection	Definition	Source	Code	Code System
Single to dual chamber	The pacemaker was upgraded from a single-chamber system (either atrial or ventricular) to a dual-chamber system, providing pacing for both the atrium and ventricle.		112000003989	ACC NCDR

Section: New Pacemaker Generator

Parent: New Cardiovascular Implantable Electronic Device

Pacemaker to cardiac resynchronization therapy with pacemaker	The system was upgraded to include cardiac resynchronization therapy (CRT-P), adding or reconfiguring leads to synchronize ventricular contractions.	112000004024	ACC NCDR
Pacemaker to conduction system pacing	The pacemaker system was modified to pace the heart through the conduction system, such as His-bundle pacing or left bundle branch area pacing.	112000004025	ACC NCDR

Element: 16120 Pacemaker Implant Location

Coding Instruction: Select the pacemaker implant location.

Target Value: The value on current procedure

Pacemaker Implant Location - 1.3.6.1.4.1.19376.1.4.1.6.5.1091

Selection	Definition	Source	Code	Code System
Left axillary			112000004008	ACC NCDR
Left pre-pectoral			112000004006	ACC NCDR
Left sub-pectoral			112000004007	ACC NCDR
Right axillary			112000004013	ACC NCDR
Right pre-pectoral			112000004011	ACC NCDR
Right sub-pectoral			112000004012	ACC NCDR
Intrathoracic			112000004026	ACC NCDR
Subrectus			112000004009	ACC NCDR
Other			100000351	ACC NCDR

Section: ICD Generator

Parent: New Cardiovascular Implantable Electronic Device

Element: 7015 ICD Indication

Coding Instruction: Indicate the ICD procedure indication

Target Value: Any occurrence on current procedure

Procedure Indication - 1.3.6.1.4.1.19376.1.4.1.6.5.33

Selection	Definition	Source	Code	Code System
Primary prevention	An indication for an ICD to prevent sudden cardiac death. It refers to use of ICDs in individuals who are at risk for but have not yet had an episode of sustained ventricular tachycardia, ventricular fibrillation, or resuscitated cardiac arrest.		315233008	SNOMED CT
Secondary prevention	An indication for ICD exclusively for patients who have survived one or more cardiac arrests or sustained ventricular tachycardia. Patients with cardiac conditions associated with a high risk of sudden death who have unexplained syncope that is likely to be due to ventricular arrhythmias are considered to have a secondary indication.		315234002	SNOMED CT

Element: 16108 ICD Generator Change

Coding Instruction: Indicate whether the current procedure was done to change a prior pacemaker or ICD generator to an ICD generator.

Target Value: The value on current procedure

Element: 16109 ICD Generator Change Rationale

Coding Instruction: Indicate the reason(s) for the implantable cardioverter defibrillator procedure generator change.

Target Value: The value on current procedure

ICD Generator Change Reason - 1.3.6.1.4.1.19376.1.4.1.6.5.1082

Selection	Definition	Source	Code	Code System
Device relocation	The device was replaced because it needed to be relocated.		112000003953	ACC NCDR
End of expected battery life	The device was replaced due to its battery reaching the end of its expected lifespan.		112000003984	ACC NCDR
Erosion	The device was replaced due to erosion of the device through the skin or surrounding tissue.		100014134	ACC NCDR
Faulty connector or header	A defect or malfunction in the connector block of a device, which is the part where the leads are attached to the device. This issue can compromise the electrical connection between the device and the leads, potentially leading to improper pacing or sensing functions.		112000003988	ACC NCDR
Infection	The device was replaced due to infection.		40733004	SNOMED CT
Device malfunction	The device was replaced due to a device malfunction or failure.		112000001504	ACC NCDR
Replaced at time of lead revision	The device was replaced when the leads were being revised.		112000003985	ACC NCDR
Replaced at time of upgrade	The device was replaced because an upgrade was being implanted.		112000003986	ACC NCDR
Under manufacturer advisory/recalled	The device was replaced following a manufacturer-issued advisory or recall.		112000003987	ACC NCDR
Other			100000351	ACC NCDR

Element: 16110 ICD Change Type

Coding Instruction: Select the procedure type (upgrade or downgrade) being done for the implantable cardioverter defibrillator.

Target Value: The value on current procedure

ICD Upgrade Type - 1.3.6.1.4.1.19376.1.4.1.6.5.1083

Selection	Definition	Source	Code	Code System
Single chamber ICD to dual chamber ICD			112000003989	ACC NCDR
ICD to cardiac resynchronization therapy with defibrillator			112000003990	ACC NCDR
Pacemaker to ICD			112000003991	ACC NCDR
ICD or pacemaker to subcutaneous ICD			112000003992	ACC NCDR

Section: ICD Generator

Parent: New Cardiovascular Implantable Electronic Device

Subcutaneous ICD to transvenous ICD	112000003993	ACC NCDR
Transvenous pacemaker or ICD to EV-ICD	112000004201	ACC NCDR
Subcutaneous ICD to EV-ICD	112000004202	ACC NCDR

Element: 16111 Specify ICD Change

Coding Instruction: For additional detail, select the implantable cardioverter defibrillator procedure upgrade type from the list.

Target Value: The value on current procedure

ICD Upgrade Type Detail - 1.3.6.1.4.1.19376.1.4.1.6.5.1084

Selection	Definition	Source	Code	Code System
Ventricular pacemaker to single chamber ICD			112000003995	ACC NCDR
Ventricular pacemaker to dual chamber ICD			112000003996	ACC NCDR
Ventricular pacemaker to cardiac resynchronization therapy defibrillator			112000003997	ACC NCDR
Ventricular pacemaker to conduction system pacing defibrillator			112000003998	ACC NCDR
Atrial pacemaker to dual chamber ICD			112000003999	ACC NCDR
Atrial pacemaker to cardiac resynchronization therapy defibrillator			112000004000	ACC NCDR
Atrial pacemaker to conduction system pacing defibrillator			112000004001	ACC NCDR
Transvenous ICD to subcutaneous ICD			112000004002	ACC NCDR
Cardiac resynchronization therapy pacemaker to cardiac resynchronization therapy defibrillator			112000004003	ACC NCDR
Cardiac resynchronization therapy pacemaker to conduction system pacing defibrillator			112000004004	ACC NCDR
Subcutaneous ICD to transvenous ICD			112000004148	ACC NCDR
Single chamber ICD to single chamber PPM			112000004200	ACC NCDR
Transvenous to EV-ICD			112000004201	ACC NCDR
S-ICD to EV-ICD			112000004202	ACC NCDR
Single/dual chamber to CRT-P			112000004203	ACC NCDR
Dual chamber to conduction system pacing			112000004204	ACC NCDR
Single/dual chamber to leadless			112000004205	ACC NCDR
Dual chamber ICD to dual chamber PPM			112000004206	ACC NCDR
Single chamber to conduction system pacing			112000004207	ACC NCDR

Element: 16112 ICD Implant Location

Coding Instruction: Select the implantable cardioverter defibrillator implant location.

Target Value: The value on current procedure

Pacemaker Implant Location - 1.3.6.1.4.1.19376.1.4.1.6.5.1091

Selection	Definition	Source	Code	Code System
Left axillary			112000004008	ACC NCDR
Left pre-pectoral			112000004006	ACC NCDR
Left sub-pectoral			112000004007	ACC NCDR
Right axillary			112000004013	ACC NCDR
Right pre-pectoral			112000004011	ACC NCDR
Right sub-pectoral			112000004012	ACC NCDR
Intrathoracic			112000004026	ACC NCDR
Subrectus			112000004009	ACC NCDR

Section: ICD Generator

Parent: New Cardiovascular Implantable Electronic Device

Other 100000351 ACC NCDR

Element: 16113 ICD Defibrillation Threshold Testing Performed

Coding Instruction: Indicate whether defibrillation threshold testing was performed.

Target Value: The value on current procedure

ICD Defibrillation Threshold Testing Performed - 1.3.6.1.4.1.19376.1.4.1.6.5.1086

Selection	Definition	Source	Code	Code System
No			100013073	ACC NCDR
Yes - Successful			385669000	SNOMED CT
Yes - Unsuccessful			385671000	SNOMED CT

Element: 16114 ICD Defibrillation Threshold Testing Reason Unsuccessful

Coding Instruction: Select the reason the defibrillation threshold testing was not successful.

Target Value: The value on current procedure

ICD Defibrillation Threshold Testing Reason Unsuccessful - 1.3.6.1.4.1.19376.1.4.1.6.5.1087

Selection	Definition	Source	Code	Code System
Unable to induce ventricular tachycardia or ventricular fibrillation	DFT testing was unsuccessful because attempts to provoke ventricular arrhythmias for defibrillation assessment were unsuccessful.		112000004015	ACC NCDR
Could not defibrillate	DFT testing was unsuccessful due to failure of the device to successfully terminate ventricular tachycardia (VT) or ventricular fibrillation (VF).		112000004016	ACC NCDR
Ventricular tachycardia or Ventricular fibrillation not detected	DFT testing was unsuccessful because the induced VT or VF could not be sensed by the ICD.		112000004017	ACC NCDR
Other			100000351	ACC NCDR

Element: 16115 ICD Changes Made To Meet Defibrillation Threshold At End Of Procedure

Coding Instruction: If defibrillation threshold testing was unsuccessful, indicate whether adjustments were made to the settings of the ICD to meet the defibrillation thresholds at the end of the procedure. These adjustments may include modifications to shock waveforms, energy levels, or other relevant parameters to achieve a successful outcome.

Target Value: The value on end of current procedure

Element: 16116 ICD Interventions That Led to Meeting Defibrillation Threshold

Coding Instruction: Select the interventions that led to successful defibrillation threshold testing.

Target Value: The value on current procedure

ICD Interventions That Led to Meeting Defibrillation Threshold - 1.3.6.1.4.1.19376.1.4.1.6.5.1088

Selection	Definition	Source	Code	Code System
Programming change	Adjustments made to the device's settings or parameters, such as shock waveform, energy level, polarity, or shock sequence, to achieve successful defibrillation.		112000004020	ACC NCDR
Hardware change	Modifications involving physical components of the defibrillation system, such as repositioning leads, replacing a lead or generator, or adding an additional shocking coil to improve defibrillation success.		112000004021	ACC NCDR
Other	Any intervention not encompassed by the categories above that contributed to successful defibrillation		100000351	ACC NCDR

Section: New Implantable Loop Recorder (ILR)

Parent: New Cardiovascular Implantable Electronic Device

Element: 16078 Indication for New Implantable Loop Recorder

Coding Instruction: Select the reason(s) the loop recorder was implanted.

Target Value: The value on current procedure

ILRP Indications - 1.3.6.1.4.1.19376.1.4.1.6.5.1068

Selection	Definition	Source	Code	Code System
Abnormal ECG or Holter monitor results	The device was implanted due to abnormal findings on prior ECG or Holter monitor studies.		1000142474	ACC NCDR
Palpitations	The device was implanted due to palpitations.		80313002	SNOMED CT
Pre-syncope	The device was implanted to investigate episodes of near-fainting or lightheadedness.		427461000	SNOMED CT
Replacement	The device was implanted as a replacement for a previous device.		384728007	SNOMED CT
Risk of malignant arrhythmia	The device was implanted to monitor for potentially life-threatening arrhythmias.		698247007	SNOMED CT
Syncope	The device was implanted due to syncope.		271594007	SNOMED CT
At Risk Genotype	The device was implanted because of a genetic predisposition to arrhythmias or other cardiac conditions.		112000004230	ACC NCDR
Other			100000351	ACC NCDR

Element: 16079 Reimplantation of Implantable Loop Recorder

Coding Instruction: Indicate whether the procedure involved the reimplantation of an implantable loop recorder (ILR). This refers to the placement of a new ILR device after the removal or malfunction of a previous one.

Target Value: The value on current procedure

Element: 16080 Indication for Reimplantation of Implantable Loop Recorder

Coding Instruction: Select the indication(s) for loop recorder reimplantation.

Target Value: The value on current procedure

Indication For Reimplantation of Implantable Loop Recorder - 1.3.6.1.4.1.19376.1.4.1.6.5.1143

Selection	Definition	Source	Code	Code System
Reimplant reason - end of battery life	The device was replaced due to its battery reaching the end of its expected lifespan.		100001088	ACC NCDR
Replaced at time of other surgery	The device was replaced during a surgical procedure performed for an unrelated indication.		112000004229	ACC NCDR
Infection	The device was replaced due to infection.		112000002137	ACC NCDR
Device erosion	The device was replaced due to erosion of the device through the skin or surrounding tissue.		100014134	ACC NCDR
Under manufacturer advisory/recall	The device was replaced following a manufacturer-issued advisory or recall.		100001093	ACC NCDR
Device malfunction	The device was replaced due to a device malfunction or failure.		112000001504	ACC NCDR
Device relocation	The device was replaced because it needed to be relocated.		112000003953	ACC NCDR
Other			100000351	ACC NCDR

Element: 16081 Implantable Loop Recorder Device ID

Coding Instruction: Select the device used from the list of implantable loop recorders.

Note(s):

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

Target Value: The value on current procedure

Element: 16082 Implantable Loop Recorder Device Laterality

Coding Instruction: Select the laterality of the loop recorder after implantation.

Target Value: The value on current procedure

ILRP Device Laterality - 1.3.6.1.4.1.19376.1.4.1.6.5.1072

Selection	Definition	Source	Code	Code System
Right chest			112000003956	ACC NCDR

Section: New Implantable Loop Recorder (ILR)
Parent: New Cardiovascular Implantable Electronic Device

Left chest 112000003957 ACC NCDR

Element: 16083 Implantable Loop Recorder Location

Coding Instruction: Select the location where the loop recorder was implanted.

Target Value: The value on current procedure

ILRP Implantable Loop Recorder Location - 1.3.6.1.4.1.19376.1.4.1.6.5.1073

Selection	Definition	Source	Code	Code System
Parasternal			261149009	SNOMED CT
Intercostal			1197041002	SNOMED CT
Axillary			91470000	SNOMED CT
Other			100000351	ACC NCDR

Section: Leads

Parent: New Cardiovascular Implantable Electronic Device

Element: 7710 Lead Counter

Coding Instruction: The software-assigned lead counter should start at one and be incremented by one for each new or existing lead documented.

Target Value: N/A

Element: 7715 Lead Identification

Coding Instruction: Indicate if the lead is a new or existing lead. All new leads placed or existing leads extracted, abandoned, or reused should be identified in the leads section.

Note(s):

If a lead was attempted, but not actually implanted, do not include it. For example, if a lead turns out to be too short, or with inadequate coil spacing, or is too large/unstable for the coronary sinus branch vein, do not include it in the registry.

Target Value: The value on current procedure

New or Existing Lead - 1.3.6.1.4.1.19376.1.4.1.6.5.182

Selection	Definition	Source	Code	Code System
New			100001047	ACC NCDR
Existing			100001001	ACC NCDR

Element: 7720 Lead Identification Number

Coding Instruction: Indicate the assigned identification for new or existing leads placed, reused, extracted or abandoned during the procedure.

Note(s):

The lead devices that should be collected in your application are controlled by a Leads Device Master file. This file is maintained by the NCDR and will be made available on the internet for downloading and importing/updating into your application.

Target Value: The value on current procedure

Vendor Instruction: Lead Identification Number (7720) cannot be Null when Lead Counter (7710) has a value

Element: 7725 Lead Serial Number

Coding Instruction: Indicate the manufacturer's serial number of the lead.

Target Value: The value on current procedure

Element: 7730 Lead Unique Device Identifier

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

Target Value: The value on current procedure

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

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

Source: US FDA

Element: 16169 Lead Type

Coding Instruction: Select the cardiac implantable electronic device (CIED) lead type used in the procedure.

Target Value: The value on current procedure

CIED Lead Type - 1.3.6.1.4.1.19376.1.4.1.6.5.1119

Selection	Definition	Source	Code	Code System
Atrial pace or sense lead	A lead placed in the atrium to deliver pacing therapy or sense atrial activity.		112000004120	ACC NCDR
Ventricular pace or sense lead	A lead placed in the ventricle to deliver pacing therapy or sense ventricular activity.		112000004121	ACC NCDR
Coronary sinus pace or sense lead	A lead positioned in the coronary sinus, typically used for left ventricular pacing in cardiac resynchronization therapy.		112000004122	ACC NCDR
Implantable cardioverter defibrillator lead	A lead that delivers defibrillation and/or pacing therapy, placed in the right ventricle or another chamber as appropriate.		112000004123	ACC NCDR
Subcutaneous implantable cardioverter defibrillator lead	A lead used with a subcutaneous ICD system.		112000004124	ACC NCDR
Implantable cardioverter defibrillator coil only	A component of the ICD system that functions solely as a defibrillation coil without sensing or pacing capabilities.		112000004125	ACC NCDR

Section: Leads

Parent: New Cardiovascular Implantable Electronic Device

Implantable cardioverter defibrillator patch	A patch electrode used to deliver defibrillation therapy, commonly associated with epicardial or subcutaneous ICD systems.	112000004126	ACC NCDR
Other		100000351	ACC NCDR
Extravascular ICD (EV-ICD) lead	A lead used with the Extravascular ICD (EV-ICD) system.	112000003612	ACC NCDR

Element: 16170

Lead Location

Coding Instruction: Select the location for lead placement.

Target Value: The value on current procedure

Location of Lead Dislodgement - 1.3.6.1.4.1.19376.1.4.1.6.5.1098

Selection	Definition	Source	Code	Code System
Transvenous/endocardial - right atrium			112000004051	ACC NCDR
Transvenous/endocardial - right ventricle			112000004052	ACC NCDR
Transvenous/endocardial - left ventricle			112000004053	ACC NCDR
Transvenous/endocardial - Coronary sinus			112000004054	ACC NCDR
Transvenous/endocardial - baffle			112000004055	ACC NCDR
Transvenous/endocardial - SVC			112000004056	ACC NCDR
Transvenous/endocardial - other			112000004057	ACC NCDR
Epicardial - atrium			112000004058	ACC NCDR
Epicardial - right ventricle			112000004059	ACC NCDR
Epicardial - left ventricle			112000004060	ACC NCDR
Epicardial - single ventricle			112000004061	ACC NCDR
Epicardial - anterior pericardial space			112000004062	ACC NCDR
Epicardial - posterior pericardial space			112000004063	ACC NCDR
Epicardial - other			112000004064	ACC NCDR
Subcutaneous - right axillary			112000004065	ACC NCDR
Subcutaneous - left axillary			112000004066	ACC NCDR
Subcutaneous - right parasternal			112000004067	ACC NCDR
Subcutaneous - left parasternal			112000004068	ACC NCDR
Subcutaneous - other			112000004069	ACC NCDR
Extravascular			112000004199	ACC NCDR

Element: 16171

Ventricular Lead Location

Coding Instruction: Select the location of the ventricular lead.

Target Value: The value on current procedure

Ventricular Lead Dislodgement Location - 1.3.6.1.4.1.19376.1.4.1.6.5.1094

Selection	Definition	Source	Code	Code System
Septum			10746000	SNOMED CT
Free wall			112000004045	ACC NCDR

Element: 16172

Septum or Free Wall Lead Location

Coding Instruction: Select the location of the ventricular lead on the free wall or septum.

Target Value: The value on current procedure

Septum or free wall lead location - 1.3.6.1.4.1.19376.1.4.1.6.5.1095

Selection	Definition	Source	Code	Code System
Base			112000004046	ACC NCDR
Mid-ventricle			112000004047	ACC NCDR
Apex			112000003978	ACC NCDR
Parahisian			112000004048	ACC NCDR
Targeted left bundle pacing			74031005	SNOMED CT

Section: Leads
Parent: New Cardiovascular Implantable Electronic Device

Element: 16173 **Lead Status After Current CIED Procedure**

Coding Instruction: Select the lead status after the current cardiac implantable electronic device (CIED) procedure.

Target Value: The value on current procedure

CIED Lead Status After Procedure - 1.3.6.1.4.1.19376.1.4.1.6.5.1121

Selection	Definition	Source	Code	Code System
Active	The lead remains functional and is connected to the device for continued use.		55561003	SNOMED CT
Abandoned	The lead was left in place but is no longer functional or connected to an active device.		100000925	ACC NCDR
Explanted	The lead was physically removed during the procedure.		100001141	ACC NCDR

Section: IPP Events

Parent: Intra- and Post-Procedure Events

Element: 15153

Intra or Post Procedure Events

Coding Instruction: Indicate if there were any Intra or Post Procedure Events (up to 72 hours post procedure).

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Vendor Instruction: An Intra or Post Procedure Events (15153) should not be duplicated in a lab visit

Intra or Post Procedure Events - 1.3.6.1.4.1.19376.1.4.1.6.5.706

Selection	Definition	Source	Code	Code System
Arteriovenous (AV) fistula requiring treatment	Select if there is documentation of an arteriovenous fistula at the access site that requires medical or surgical intervention to address abnormal communication between an artery and vein. This condition may result from access site complications during catheterization procedures.		128617001	SNOMED CT
Closure device related injury (access site)	Select if there is documentation of an injury to any vascular access site used during the procedure caused by the use or malfunction of a vascular closure device. This includes complications such as vascular trauma or device-related malfunction requiring additional treatment or intervention. Routine or minor bleeding, such as oozing commonly associated with anticoagulant use, is excluded.		112000003782	ACC NCDR
Hematoma at access site	Select if there is documentation of hematoma at access site meeting any of the following criteria for adult patients (in patients 18 years or older on arrival): 1. A hemoglobin drop of ≥ 3 g/dL (in patients 18 years or older on arrival). 2. Transfusion of whole blood or packed red blood cells. 3. Procedural intervention or surgery to address bleeding, such as surgical closure, exploration of the arteriotomy site, balloon angioplasty, or similar interventions to stop or correct the bleeding. Or meeting any of the following criteria for pediatric patients (in patients less than 18 years on arrival): 1. Unplanned transfusion of whole blood or packed red blood cells. 2. Procedural intervention or surgery to address bleeding, such as surgical closure, exploration of the arteriotomy site, balloon angioplasty, or similar interventions to stop or correct the bleeding.		385494008	SNOMED CT
Pseudoaneurysm requiring treatment	Select if there is documentation of a pseudoaneurysm, an outpouching of a blood vessel at the access site that does not involve all layers of the vessel wall, requiring medical or surgical intervention.		443089001	SNOMED CT
Pulse loss requiring treatment	Select if there is documentation of the loss of distal pulse or markedly diminished pulses requiring medical or surgical intervention.		112000003790	ACC NCDR
Rebleed after bandaging	Select if there is documentation of bleeding at the access site that recurs after initial bandaging or compression, requiring an additional procedural or surgical intervention to control the bleeding.		112000003791	ACC NCDR
Sheath related intimal injury	Select if there is documentation of damage to the intimal layer of a blood vessel caused by the insertion, manipulation, or removal of a vascular sheath.		112000003792	ACC NCDR
Thrombosis (at access site)	Select if there is documentation of thrombus formation at the vascular access site, which may present as arterial and/or venous thrombosis.		439127006	SNOMED CT
Aspiration of gastric contents	Select if there is documentation of gastric contents entering the respiratory tract, occurring during sedation, intubation, extubation, or other instances related to airway management.		14766002	SNOMED CT

Section: IPP Events		Parent: Intra- and Post-Procedure Events	
Broncho/laryngospasm while intubated	Select if there is documentation of an uncontrolled or involuntary spasm of the bronchioles or vocal cords occurring during intubation, potentially causing airway obstruction or respiratory distress.	112000003781	ACC NCDR
Conscious sedation requiring rescue intubation	Select if there is documentation of the need for intubation during conscious sedation due to airway compromise, respiratory distress, or other complications requiring airway management.	112000003783	ACC NCDR
Corneal abrasion	Select if there is documentation of a corneal abrasion, defined as a scratch or injury to the cornea occurring during anesthetic management.	85848002	SNOMED CT
Delirium	Select if there is documentation of a dissociated state of consciousness following general anesthesia, characterized by confusion, disorientation, inconsolable crying, irritability, or uncooperative behavior.	2776000	SNOMED CT
Dental injury	Select if there is documentation of damage to the teeth, such as fracture, dislodgement, or avulsion, occurring during a procedure or anesthetic management.	284002000	SNOMED CT
Endotracheal tube malposition	Select if there is documentation of improper positioning of the endotracheal tube (ETT) after initial intubation and securing, requiring repositioning. This includes cases where the tube was placed too deep (e.g., mainstem intubation) or too high, identified during post-procedure assessment	112000003787	ACC NCDR
Lung collapse	Select if there is documentation of lung collapse, defined as the partial or complete collapse of the lung or a section of the lung (e.g., a lobe), confirmed by imaging or clinical diagnosis.	46621007	SNOMED CT
Malignant hyperthermia - hyperpyrexia	Select if there is documentation of malignant hyperthermia, a life-threatening hypermetabolic condition triggered by certain anesthetic agents (e.g., volatile anesthetics or succinylcholine), characterized by a rapid and extreme increase in body temperature (hyperpyrexia), muscle rigidity, tachycardia, hypercapnia, and metabolic acidosis.	405501007	SNOMED CT
Post extubation stridor	Select if there is documentation of post-extubation stridor, characterized as a high-pitched, wheezing sound during inhalation caused by partial airway obstruction or narrowing occurring immediately after the removal of an endotracheal tube.	112000003291	ACC NCDR
Oral/airway injury or bleeding	Select if there is documentation of injury to the oral cavity, airway structures, or associated bleeding.	262664007	SNOMED CT
Unanticipated difficult airway	Select if there is documentation of an unanticipated difficult intubation or re-intubation, defined as unforeseen challenges in securing the airway, requiring additional attempts or alternative techniques.	718448006	SNOMED CT
Unplanned extubation	Select if there is documentation of an unplanned extubation, defined as the unintended removal of an endotracheal tube in the operating room (OR), procedure location, or during patient transfer, outside of the intended anesthetic plan.	112000003266	ACC NCDR
Aneurysm	Select if there is documentation of an aneurysm, defined as a localized dilation or ballooning of a blood vessel wall, that developed as a complication of an angioplasty procedure.	432119003	SNOMED CT
Contained tear requiring treatment - Angioplasty	Select if there is documentation of a contained tear or dissection, defined as a partial disruption of the blood vessel wall without full rupture, that occurred as a complication of an angioplasty procedure and required treatment.	112000003784	ACC NCDR
Tear/Dissection - Angioplasty related	Select if there is documentation of a tear or dissection, defined as a disruption or splitting of the layers of a blood vessel wall, occurring as a complication of an angioplasty procedure.	112000001090	ACC NCDR
Thrombosis (at target site)	Select if there is documentation of thrombosis, defined as the formation of a blood clot at the site of angioplasty intervention.	112000003798	ACC NCDR
Angioplasty related vessel/conduit rupture	Select if there is documentation of vessel or conduit rupture, defined as a complete tear through the blood vessel or graft wall, occurring	112000003796	ACC NCDR

Section: IPP Events		Parent: Intra- and Post-Procedure Events	
Arrhythmia requiring treatment	as a complication of an angioplasty procedure. Select if there is documentation of an arrhythmia occurring during or after the procedure that required intervention, such as pharmacologic therapy, direct current cardioversion (DCCV), or the use of temporary or permanent pacing.	698247007	SNOMED CT
Cardiac arrest	Cardiac arrest is defined as acute cardiac event documented by one of the following: ventricular fibrillation, rapid ventricular tachycardia or bradycardia rhythms with hemodynamic compromise causing loss of consciousness, pulseless rhythms (PEA), or asystole requiring cardiopulmonary resuscitation (two or more chest compressions or open chest massage, emergency temporary pacing, pericardiocentesis, institution of ECMO, or defibrillation) and without these measures death would have almost certainly resulted. Note: If an event occurs that meets the above definition of cardiac arrest, code "yes" regardless of a resuscitation status of DNR/Hospice/Comfort care.	410429000	SNOMED CT
Cardiac perforation	Select if there is documentation of a tear or puncture in the cardiac wall resulting in potential or actual leakage of blood into the pericardial space or surrounding structures. This may be identified by imaging, clinical signs, or require intervention to address the condition.	36191001:123005000=302509004	SNOMED CT
Cardiac tamponade	Select if there is documentation of cardiac tamponade, defined as the presence of pericardial fluid in the pericardial space leading to hemodynamic instability and requiring unplanned or emergent intervention.	35304003	SNOMED CT
Coronary artery compression	Select if there is documentation of coronary compression, defined as external pressure on a coronary artery causing obstruction to blood flow, identified by imaging or clinical symptoms.	112000001837	ACC NCDR
Coronary vasospasm requiring treatment	Select if there is documentation of coronary artery vasospasm, defined as transient narrowing of the coronary artery causing myocardial ischemia. The condition must have required intervention, such as pharmacologic therapy (e.g., nitrates, calcium channel blockers) or other procedural measures, to alleviate symptoms or prevent progression to acute coronary syndrome, myocardial infarction, or other serious outcomes.	263924000	SNOMED CT
Event requiring ECMO	Select if there is documentation that the patient experienced an event requiring extracorporeal membrane oxygenation (ECMO) for cardiopulmonary support.	112000004039	ACC NCDR
Heart block	Select if there is an unintended high-grade block at the end of the procedure. There may be more than one successive nonconducted P wave, resulting in several P waves in a row without QRS complexes, termed "advanced" or "high grade AV block." The AV conduction ratio may or may not have a regular pattern (ie, 3:1, 4:1, etc). This is an advanced form of Mobitz type II second-degree AV block.	112000002919	ACC NCDR
Mechanical circulatory support required	Select if there is documentation of a mechanical device to provide temporary or long-term support for cardiac or respiratory function was required. This includes devices such as intra-aortic balloon pumps (IABP), extracorporeal membrane oxygenation (ECMO), ventricular assist devices (VADs), or other mechanical circulatory support systems required to stabilize hemodynamic status or address cardiac or respiratory failure.	232957001	SNOMED CT
Pacemaker or ICD implant due to cath complication	A pacemaker or implantable cardioverter defibrillator (ICD) implant was required as a direct result of a complication that occurred during a catheterization procedure.	112000004072	ACC NCDR
Pericardial effusion	Select if there is documentation of pericardial effusion, defined as the accumulation of excess fluid in the pericardial sac surrounding the heart.	373945007	SNOMED CT

Section: IPP Events		Parent: Intra- and Post-Procedure Events	
New aortic valve insufficiency	Select if there is documentation of new aortic valve insufficiency, defined as the retrograde flow of blood from the aorta into the left ventricle due to incomplete closure of the aortic valve.	60234000	SNOMED CT
New tricuspid valve insufficiency	Select if there is documentation of new tricuspid valve insufficiency, defined as the retrograde flow of blood from the right ventricle into the right atrium due to incomplete closure of the tricuspid valve.	111287006	SNOMED CT
New mitral valve insufficiency	Select if there is documentation of new mitral valve insufficiency, defined as the retrograde flow of blood from the left ventricle into the left atrium due to incomplete closure of the mitral valve.	48724000	SNOMED CT
New pulmonary valve insufficiency	Select if there is documentation of new pulmonary valve insufficiency, defined as the retrograde flow of blood from the pulmonary artery into the right ventricle due to incomplete closure of the pulmonary valve.	91434003	SNOMED CT
New or exacerbation of heart failure	Select if there is a new diagnosis of heart failure or worsening of a previously diagnosed heart failure during or following the procedure.	112000004339	ACC NCDR
Urgent cardiac surgery	Select if there is documentation that the patient required an unplanned or emergent cardiac surgery, defined as a non-elective procedure performed urgently to address an acute cardiac condition.	112000001892	ACC NCDR
Valve injury	Select if there is documentation of valve injury, defined as damage to a heart valve occurring during or as a result of a procedure. This includes, but is not limited to, perforation, rupture, tearing, or functional impairment of the valve, as determined by clinical evaluation, imaging findings, or the need for intervention	762610001	SNOMED CT
Valvular regurgitation	Select if there is documentation that the patient was diagnosed with valvular regurgitation, characterized by the backward flow of blood due to improper closure of one or more heart valves.	40445007	SNOMED CT
Coil embolization	Select if there is documentation of coil embolization, defined as the use of coils to intentionally occlude a blood vessel or vascular abnormality, such as an aneurysm or arteriovenous malformation, as part of a therapeutic intervention.	112000003498	ACC NCDR
Coil malposition	Select if there is documentation of coil malposition, defined as the unintended placement or migration of a coil to a location outside the target site.	112000003497	ACC NCDR
Device embolization	Select if there is documentation of device embolization, defined as the unintended movement or migration of a device from its intended position to another location within the vascular system or body.	112000001324	ACC NCDR
Device embolization for leadless pacemakers requiring retrieval	Select if there is documentation of device embolization associated with leadless pacemaker placement, where the device unintentionally migrates from its intended position to another location within the vascular system or body, necessitating retrieval.	112000004235	ACC NCDR
Device erosion	Select if there is documentation that the device was replaced due to erosion through the skin or surrounding tissue.	100014134	ACC NCDR
Device malposition	Select if there is documentation of device malposition, defined as the incorrect placement or displacement of a device from its intended position during or after a procedure.	112000003786	ACC NCDR
Lead dislodgement	Select if there is documentation that the patient experienced lead dislodgement, defined as the unintended movement of a cardiac device lead from its original implantation site within the heart or vascular system.	234233007	SNOMED CT
Set screw problem	Select if there is documentation that the patient experienced a pacing and/or sensing problem associated with high impedance due to a poor connection between a lead and an ICD caused by a loose set screw.	112000004042	ACC NCDR

Section: IPP Events		Parent: Intra- and Post-Procedure Events	
Contrast allergy	Select if there is documentation of an allergic reaction to contrast material, defined as an adverse immune-mediated response occurring after the administration of contrast agents.	293637006	SNOMED CT
Medication allergy	Select if there is documentation of an allergic reaction to a medication, defined as an adverse immune-mediated response occurring after the administration of a drug.	416098002	SNOMED CT
Air embolus in systemic circulation	Select if there is documentation of an air embolus in the systemic circulation, defined as the presence of air bubbles in the arterial system that may obstruct blood flow to organs or tissues.	112000003416	ACC NCDR
Air embolus in venous/pulmonary circulation	Select if there is documentation of an air embolus in the venous or pulmonary circulation, defined as the presence of air bubbles in the venous system or pulmonary arteries, potentially obstructing blood flow.	112000003417	ACC NCDR
Bleeding Event	Select if there is documentation of a bleeding event meeting any of the following criteria for adult patients (in patients 18 years or older on arrival): 1. A hemoglobin drop of ≥ 3 g/dL (in patients 18 years or older on arrival). 2. Transfusion of whole blood or packed red blood cells. 3. Procedural intervention or surgery to address bleeding, such as surgical closure, exploration of the arteriotomy site, balloon angioplasty, or similar interventions to stop or correct the bleeding. Or meeting any of the following criteria for pediatric patients (in patients less than 18 years on arrival): 1. Unplanned transfusion of whole blood or packed red blood cells. 2. Procedural intervention or surgery to address bleeding, such as surgical closure, exploration of the arteriotomy site, balloon angioplasty, or similar interventions to stop or correct the bleeding.	131148009	SNOMED CT
Bacteremia (post catheterization)	Select if there is documentation of bacteremia, defined as the presence of bacteria in the bloodstream occurring after a catheterization procedure.	5758002	SNOMED CT
Complication of bladder catheterization	Select if there is documentation of an issue or condition arising from bladder catheterization, defined as any unintended outcome directly related to the use, insertion, or maintenance of a bladder catheter.	410024004	SNOMED CT
Fall	Select if there is documentation of a fall, defined as an unintentional descent to the ground, floor, or lower level.	398117008	SNOMED CT
Gastrointestinal bleeding	Select if there is documentation of gastrointestinal bleeding meeting any of the following criteria for adult patients (in patients 18 years or older on arrival): 1. A hemoglobin drop of ≥ 3 g/dL (in patients 18 years or older on arrival). 2. Transfusion of whole blood or packed red blood cells. 3. Procedural intervention or surgery to address bleeding, such as surgical closure, exploration of the arteriotomy site, balloon angioplasty, or similar interventions to stop or correct the bleeding. Or meeting any of the following criteria for pediatric patients (in patients less than 18 years on arrival):	74474003	SNOMED CT

Section: IPP Events

Parent: Intra- and Post-Procedure Events

	1. Unplanned transfusion of whole blood or packed red blood cells.		
	2. Procedural intervention or surgery to address bleeding, such as surgical closure, exploration of the arteriotomy site, balloon angioplasty, or similar interventions to stop or correct the bleeding.		
Hypoglycemia	Select if there is documentation of hypoglycemia, defined as a blood glucose level below the lower normal threshold (<70 mg/dL or as specified in the medical record).	302866003	SNOMED CT
Hypothermia	Select if there is documentation of hypothermia, defined as a core body temperature below 35°C (95°F).	386689009	SNOMED CT
Infection requiring antibiotics	Select if there is documentation that the patient experienced an infection related to the current device or lead procedure requiring antibiotics.	112000004041	ACC NCDR
Medication error	Select if there is documentation of a medication error, defined as an unintended deviation from the prescribed or intended medication process.	398240004	SNOMED CT
Necrotizing enterocolitis	Select if there is documentation of necrotizing enterocolitis, defined as an acute reduction in the supply of oxygenated blood to the small or large intestine, typically resulting in acidosis, abdominal distention, pneumatosis intestinalis, and/or intestinal perforation.	2707005	SNOMED CT
New requirement for dialysis	Select if there is documentation of acute or worsening renal failure necessitating the initiation of renal dialysis, defined as hemodialysis or peritoneal dialysis. Include patients receiving continuous veno-venous hemofiltration (CVVH) specifically for renal failure and not for fluid removal in the context of heart failure.	100014076	ACC NCDR
Peripheral nerve injury	Select if there is documentation that the patient experienced a peripheral nerve injury, defined as damage to the nerves outside the brain and spinal cord, resulting in symptoms such as weakness, numbness, or pain.	73590005	SNOMED CT
Pressure injury	Select if there is documentation of a localized injury to the skin and/or underlying tissue, typically over a bony prominence, resulting from prolonged pressure or pressure in combination with shear.	1163215007	SNOMED CT
Post procedure fever greater than 38 degrees celcius	Select if there is documentation of a fever exceeding 38°C occurring after a procedure, which may indicate an inflammatory response, infection, or other postoperative complication.	112000003387	ACC NCDR
Radiation exposure injury	Select if there is documentation of tissue damage resulting from exposure to ionizing radiation during a procedure.	218190002	SNOMED CT
RBC transfusion	Select if there was a transfusion(s) of packed red blood cells.	116863004	SNOMED CT
Retained foreign body	Select if there is documentation of an object inadvertently left in the body following a procedure.	125670008	SNOMED CT
Retroperitoneal bleeding	Select if there is documentation of retroperitoneal bleeding meeting any of the following criteria for adult patients (in patients 18 years or older on arrival): 1. A hemoglobin drop of ≥3 g/dL (in patients 18 years or older on arrival). 2. Transfusion of whole blood or packed red blood cells. 3. Procedural intervention or surgery to address bleeding, such as surgical closure, exploration of the arteriotomy site, balloon angioplasty, or similar interventions to stop or correct the bleeding. Or meeting any of the following criteria for pediatric patients (in patients less than 18 years on arrival):	95549001	SNOMED CT

Section: IPP Events
Parent: Intra- and Post-Procedure Events

1. Unplanned transfusion of whole blood or packed red blood cells.
2. Procedural intervention or surgery to address bleeding, such as surgical closure, exploration of the arteriotomy site, balloon angioplasty, or similar interventions to stop or correct the bleeding.

Retroperitoneal hematoma	Select if there is documentation of retroperitoneal hematoma meeting any of the following criteria for adult patients (in patients 18 years or older on arrival): 1. A hemoglobin drop of ≥ 3 g/dL (in patients 18 years or older on arrival). 2. Transfusion of whole blood or packed red blood cells. 3. Procedural intervention or surgery to address bleeding, such as surgical closure, exploration of the arteriotomy site, balloon angioplasty, or similar interventions to stop or correct the bleeding. Or meeting any of the following criteria for pediatric patients (in patients less than 18 years on arrival): 1. Unplanned transfusion of whole blood or packed red blood cells. 2. Procedural intervention or surgery to address bleeding, such as surgical closure, exploration of the arteriotomy site, balloon angioplasty, or similar interventions to stop or correct the bleeding.	236002003	SNOMED CT
Skeletal trauma or injury	Select if there is documentation of damage to bones or the skeletal system occurring as a complication of a procedure or injury.	284003005	SNOMED CT
Transfusion reaction	Select if there is documentation of a transfusion reaction, defined as a response associated with the transfusion of whole blood or one of its components.	112000003344	ACC NCDR
Brachial plexus injury	Select if there is documentation of a brachial plexus injury, defined as damage to the brachial plexus nerves.	6836001	SNOMED CT
Phrenic nerve injury	Select if there is documentation of phrenic nerve injury, defined as a newly acquired or newly recognized deficit in unilateral or bilateral peripheral nerve function, as indicated by physical exam findings, imaging studies, or both.	100001076	ACC NCDR
Seizures (new onset)	Select if there is documentation of new-onset seizures, defined as unprovoked episodes of abnormal electrical activity in the brain.	112000000437	ACC NCDR
Spinal cord ischemia	Select if there is documentation of spinal cord ischemia, defined as reduced blood flow to the spinal cord.	371029002	SNOMED CT
Stroke	Select if there is documentation/diagnosis of any type of stroke. A stroke is defined as an acute episode of focal or global neurological dysfunction caused by presumed brain, spinal cord, or retinal vascular injury. It may be a hemorrhagic stroke, ischemic stroke or an undetermined type of stroke. Note: Subdural hematomas are intracranial hemorrhagic events and not strokes.	100000977	ACC NCDR
Transient ischemic attack	Select if there is documentation that the patient was diagnosed with a transient ischemic attack (TIA), characterized by a temporary episode of neurological dysfunction resulting from a brief interruption in blood supply to the brain.	266257000	SNOMED CT
Phrenic nerve paralysis	Select if there is documentation of a newly acquired or newly recognized deficit of unilateral or bilateral peripheral nerve function indicated by	277321001	SNOMED CT

Section: IPP Events		Parent: Intra- and Post-Procedure Events	
Airway event requiring escalation of care	physical exam findings, imaging studies, or both.		
	Select if there is documentation that the patient experienced apnea, hypoxia, or airway obstruction requiring unplanned escalation of airway management. Examples of Escalation: Laryngeal Mask Airway (LMA) Continuous Positive Airway Pressure (CPAP) Bilevel Positive Airway Pressure (BIPAP) Bag Mask Ventilation (BMV) Intubation Tracheostomy	112000002228	ACC NCDR
Hemothorax	Select if there is documentation that the patient experienced hemothorax, defined as any accumulation of blood in the thorax/pleural space.	31892009	SNOMED CT
Pneumonia	Select if there is documentation of pneumonia, defined as an infection of one or both lungs caused by bacteria, viruses, fungi, chemicals, or aspiration. Pneumonia is confirmed by clinical symptoms such as cough, chest pain, fever, and difficulty breathing, along with diagnostic imaging or sputum examination.	233604007	SNOMED CT
Pneumothorax	Select if there is documentation of pneumothorax, defined as the presence of air in the pleural cavity, occurring when air accumulates between the parietal and visceral pleura. This condition causes lung collapse and is typically identified by imaging or clinical symptoms.	36118008	SNOMED CT
Pulmonary embolism	Select if there is documentation of a pulmonary embolism, defined as the intravascular migration of a venous thrombus to the pulmonary arterial circulation, resulting in a blood clot in the pulmonary arteries.	59282003	SNOMED CT
Pulmonary hemorrhage	Select if there is documentation of pulmonary hemorrhage, defined as an acute event characterized by bleeding in the lungs, often presenting as bloody discharge from the upper respiratory tract or endotracheal tube.	78144005	SNOMED CT
Reperfusion injury	Select if there is documentation of reperfusion injury, defined as tissue damage resulting from the restoration of blood flow to previously ischemic tissue.	276232006	SNOMED CT
Bronchial compression	Select if there is documentation of bronchial compression, defined as external pressure on the bronchial airways, such as from a great vessel, causing obstruction and resulting in symptoms like inspiratory stridor or expiratory wheezing. This may include specific cases, such as compression of the left mainstem bronchus following aortic arch reconstruction.	3304005	SNOMED CT
Contained tear requiring treatment - Stent	Select if there is documentation of a contained tear or dissection, defined as a tear in a blood vessel or structure that does not result in rupture but requires treatment to prevent progression or complications.	112000003785	ACC NCDR
Coronary artery compression caused by stenting	Documentation of coronary compression, defined as external pressure on a coronary artery causing obstruction to blood flow, identified by imaging or clinical symptoms, specifically occurring in the context of stent deployment or positioning. This includes compression due to the stent itself or mechanical effects from adjacent structures altered by the stent placement.	112000004243	ACC NCDR
Jailing of side branch resulting in compromised flow	Select if there is documentation of jailing of a side branch, defined as obstruction or partial blockage of a side branch vessel during a procedure.	112000003788	ACC NCDR
Stent malposition	Select if there is documentation of stent malposition, defined as improper placement or displacement of a stent from its intended position within the vessel or conduit.	112000003759	ACC NCDR
Stent embolization	Select if there is documentation of stent embolization, defined as the migration of a stent from its intended position within the vascular system.	112000003758	ACC NCDR

Section: IPP Events		Parent: Intra- and Post-Procedure Events	
Stent thrombosis	Select if there is documentation of stent thrombosis, defined as the formation of a blood clot within or adjacent to a stent.	100013014	ACC NCDR
Stent related vessel/conduit rupture	Select if there is documentation of stent-related vessel or conduit rupture, defined as a tear in a vessel or conduit caused by a stent.	112000003797	ACC NCDR
Vascular compression - other adjacent vessel	Select if there is documentation of vascular compression, defined as external pressure on a vessel adjacent to the treatment site, causing compromised blood flow.	112000003793	ACC NCDR
Coronary artery dissection	Select if there is documentation of coronary artery dissection, defined as a tear in the inner layer of a coronary artery that results in separation of the vessel layers and potential disruption of blood flow. This may be identified by the presence of contrast material outside the expected luminal dimensions of the vessel, extending longitudinally beyond the lesion.	732230001	SNOMED CT
Coronary artery injury	Select if there is documentation of coronary artery injury, defined as damage to the coronary artery occurring during or as a result of a procedure. This includes, but is not limited to, coronary artery dissection, perforation, rupture, or thrombosis, leading to clinical symptoms or requiring medical intervention.	112000003852	ACC NCDR
Deep Vein Thrombosis	Select if there is documentation that the patient was diagnosed with a deep vein thrombosis (DVT), which refers to the formation of one or more blood clots (thrombus/thrombi) in one of the body's large veins, most commonly in the lower limbs, such as the lower leg or calf.	128053003	SNOMED CT
Pocket hematoma requiring intervention	Select if there is documentation that the patient developed a pocket hematoma as a result of the procedure, requiring reoperation, evacuation, or transfusion.	112000004040	ACC NCDR
Thrombus (at intervention site)	Select if there is documentation of a thrombus, defined as a blood clot forming at the site of intervention.	1776291018	SNOMED CT
Vascular dissection (vessel other than coronary artery)	Select if there is documentation of vascular dissection, defined as a tear in the inner lining of a vessel, resulting in separation of the vessel layers and potential flow disruption.	112000003794	ACC NCDR
Vascular perforation (vessel other than coronary artery)	Select if there is documentation of vascular perforation, defined as a puncture or tear through a vessel wall.	112000003795	ACC NCDR
Vascular injury requiring treatment	Select if there is documentation of vascular injury requiring treatment, defined as damage to a blood vessel during or as a result of a procedure, necessitating medical or surgical intervention. This includes, but is not limited to, dissection, perforation, rupture, thrombosis, or pseudoaneurysm requiring repair, stenting, thrombectomy, or other therapeutic measures.	30904006:363702006=57662003	SNOMED CT
Other vascular complication requiring treatment	Indicate if there is documentation that the patient experienced any other vascular complication attributable to the current procedure that required an 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.	213217008	SNOMED CT

Element: 15207 Intra and Post-Procedure Event(s) Occurred

Coding Instruction: Indicate if the intra or post-procedure event did or did not occur.

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Vendor Instruction: Intra and Post-Procedure Event(s) Occurred (15207) cannot be Null when an Intra or Post Procedure Event (15153) is selected

Section: IPP Event Details

Parent: Intra- and Post-Procedure Events

Element: 15951 Access Site Thrombosis Type

Coding Instruction: Indicate the access site thrombosis type.

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Supporting Definition: Thrombosis

The formation or presence of a blood clot within a blood vessel.

Source: NCDR

Thrombosis Type - 1.3.6.1.4.1.19376.1.4.1.6.5.1001

Selection	Definition	Source	Code	Code System
Venous			111293003	SNOMED CT
Arterial			65198009	SNOMED CT

Element: 15952 Tear/Dissection Resulting in Flow Obstruction - Angioplasty

Coding Instruction: Indicate if there was a tear or dissection that occurred during angioplasty that caused flow (of blood) to become obstructed.

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Element: 15949 Arrhythmia (Intra- and Post Procedure Event) Types

Coding Instruction: Record the type(s) of arrhythmia's that occurred that required treatment.

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Arrhythmia Type - 1.3.6.1.4.1.19376.1.4.1.6.5.809

Selection	Definition	Source	Code	Code System
Atrial fibrillation			49436004	SNOMED CT
Atrial flutter			5370000	SNOMED CT
1st degree AV block			270492004	SNOMED CT
2nd degree AV block			195042002	SNOMED CT
3rd degree AV block			27885002	SNOMED CT
Bradycardia requiring intervention			48867003	SNOMED CT
Bundle branch block (persistent)			6374002	SNOMED CT

Element: 15955 Cardiac Arrest Etiology

Coding Instruction: Indicate the cause of the cardiac arrest.

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Cardiac Arrest Etiology - 1.3.6.1.4.1.19376.1.4.1.6.5.1002

Selection	Definition	Source	Code	Code System
Supraventricular Tachycardia			6456007	SNOMED CT
Ventricular fibrillation			71908006	SNOMED CT
Ventricular Tachycardia			25569003	SNOMED CT
Complete heart block			27885002	SNOMED CT
Pulseless electrical activity			234172002	SNOMED CT
Acute hemorrhage			8573003	SNOMED CT
Coronary Ischemia			112000004226	ACC NCDR
Cardiac Tamponade			35304003	SNOMED CT
Progressive low cardiac output			112000003305	ACC NCDR
Pulmonary hypertensive crises			112000003312	ACC NCDR
Respiratory arrest			87317003	SNOMED CT

Element: 16248 Etiology Unknown

Coding Instruction: Select if the etiology of the cardiac arrest is unknown.

Target Value: N/A

Element: 15953 Biopsy Related Cardiac Perforation

Coding Instruction: Indicate whether cardiac perforation occurred as a result of an endomyocardial biopsy.

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Supporting Definition: Cardiac Perforation

Section: IPP Event Details

Parent: Intra- and Post-Procedure Events

A perforation of the myocardium, aortic annulus or aorta, with or without tamponade associated with the perforation. If tamponade occurs there would be fluid in the pericardial space compromising cardiac filling, and requiring intervention such as pericardiocentesis or returning to the operating room. This should be documented by either:

1. Echo showing pericardial fluid and signs of tamponade such as right heart compromise, or
2. Systemic hypotension due to pericardial fluid compromising cardiac function.

Source:

Element: 16125 Cardiac Perforation Requiring Treatment

Coding Instruction: Indicate whether the patient experienced a cardiac perforation that required treatment.

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Element: 16126 Cardiac Perforation Treatment

Coding Instruction: Select the treatment required for the cardiac perforation. Treatment can include a pericardial drain, implantation of a device to cover the perforation, surgery or extracorporeal membrane oxygenation (ECMO).

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Cardiac Perforation Treatment - 1.3.6.1.4.1.19376.1.4.1.6.5.1096

Selection	Definition	Source	Code	Code System
Pericardial or pleural drain	The treatment required the placement of a drain to remove fluid or blood from the pericardial or pleural space.		112000004049	ACC NCDR
Surgical procedure	Surgical intervention was required to repair the perforation		387713003	SNOMED CT
Mechanical ventricular support device			360064003	SNOMED CT
Catheter based device	A catheter-based intervention (e.g. placement of covered stent, coil embolization, etc.) was required to repair the perforation.		112000004050	ACC NCDR

Element: 15954 Biopsy Related Tricuspid Valve Injury

Coding Instruction: Indicate if a new tricuspid valve injury occurred as a result of an endomyocardial biopsy.

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Element: 15956 Embolized Coil Retrieved

Coding Instruction: If there was coil embolization, indicate whether the coil was retrieved (either through surgical extraction or endovascular retrieval).

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Element: 15945 Embolized Device Retrieved

Coding Instruction: If there was device embolization, indicate if the device was retrieved (either percutaneous or surgical retrieval).

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Element: 16127 Device Embolization Requiring Retrieval

Coding Instruction: Indicate how the device was retrieved.

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Device Embolization Requiring Retrieval - 1.3.6.1.4.1.19376.1.4.1.6.5.1097

Selection	Definition	Source	Code	Code System
Retrieved via catheterization	The implanted device was retrieved via catheterization.		276272002	SNOMED CT
Retrieved via surgery	The implanted device was retrieved via surgery.		387713003	SNOMED CT

Element: 15946 Device Malposition Blood Flow Obstruction

Coding Instruction: Indicate if device malposition caused significant obstruction of blood flow.

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Element: 15947 Stroke Type

Coding Instruction: Indicate the type of stroke that occurred.

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Section: IPP Event Details

Parent: Intra- and Post-Procedure Events

HAS-BLED Stroke Type - 1.3.6.1.4.1.19376.1.4.1.6.5.773

Selection	Definition	Source	Code	Code System
Hemorrhagic Stroke	Indicate whether the patient experienced a hemorrhagic stroke. Hemorrhagic stroke is identified as an acute episode of focal or global cerebral or spinal dysfunction caused by intraparenchymal, intraventricular, or subarachnoid hemorrhage. Hemorrhage may be a consequence of ischemic stroke. In this situation, the stroke is an ischemic stroke with hemorrhagic transformation and NOT a hemorrhagic stroke. Note: Subdural hematomas are intracranial hemorrhagic events and not strokes.		230706003	SNOMED CT
Ischemic Stroke	Indicate whether the patient experienced an ischemic stroke. An ischemic stroke is an acute episode of focal or global neurological dysfunction cause by brain, spinal cord, or retinal vascular injury as a result of infarction of central nervous system tissue.		422504002	SNOMED CT
Undetermined Stroke	Indicate whether the patient experienced a stroke of unknown origin. A stroke with insufficient information to allow categorization as either ischemic or hemorrhagic. A stroke is defined as an acute episode of focal or global neurological dysfunction caused by presumed brain, spinal cord, or retinal vascular injury.		230713003	SNOMED CT

Element: 15948

Intervention Site Thrombosis Type

Coding Instruction: Indicate the procedure site thrombus type.

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Supporting Definition: Thrombosis

The formation or presence of a blood clot within a blood vessel.

Source: NCDR

Thrombosis Type - 1.3.6.1.4.1.19376.1.4.1.6.5.1001

Selection	Definition	Source	Code	Code System
Venous			111293003	SNOMED CT
Arterial			65198009	SNOMED CT

Element: 16128

Location of Lead Dislodgement

Coding Instruction: Select the location of the lead that was dislodged.

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Location of Lead Dislodgement - 1.3.6.1.4.1.19376.1.4.1.6.5.1098

Selection	Definition	Source	Code	Code System
Transvenous/endocardial - right atrium			112000004051	ACC NCDR
Transvenous/endocardial - right ventricle			112000004052	ACC NCDR
Transvenous/endocardial - left ventricle			112000004053	ACC NCDR
Transvenous/endocardial - Coronary sinus			112000004054	ACC NCDR
Transvenous/endocardial - baffle			112000004055	ACC NCDR
Transvenous/endocardial - SVC			112000004056	ACC NCDR
Transvenous/endocardial - other			112000004057	ACC NCDR
Epicardial - atrium			112000004058	ACC NCDR
Epicardial - right ventricle			112000004059	ACC NCDR
Epicardial - left ventricle			112000004060	ACC NCDR
Epicardial - single ventricle			112000004061	ACC NCDR
Epicardial - anterior pericardial			112000004062	ACC NCDR

Section: IPP Event Details

Parent: Intra- and Post-Procedure Events

space		
Epicardial - posterior pericardial space	112000004063	ACC NCDR
Epicardial - other	112000004064	ACC NCDR
Subcutaneous - right axillary	112000004065	ACC NCDR
Subcutaneous - left axillary	112000004066	ACC NCDR
Subcutaneous - right parasternal	112000004067	ACC NCDR
Subcutaneous - left parasternal	112000004068	ACC NCDR
Subcutaneous - other	112000004069	ACC NCDR
Extravascular	112000004199	ACC NCDR

Element: 16123 Ventricular Lead Dislodgement Location

Coding Instruction: Indicate the location of the ventricular lead dislodgement.

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Ventricular Lead Dislodgement Location - 1.3.6.1.4.1.19376.1.4.1.6.5.1094

Selection	Definition	Source	Code	Code System
Septum			10746000	SNOMED CT
Free wall			112000004045	ACC NCDR

Element: 16124 Septum or Free Wall Lead Dislodgement Location

Coding Instruction: Indicate the location of the septum or free wall lead dislodgement.

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Septum or free wall lead location - 1.3.6.1.4.1.19376.1.4.1.6.5.1095

Selection	Definition	Source	Code	Code System
Base			112000004046	ACC NCDR
Mid-ventricle			112000004047	ACC NCDR
Apex			112000003978	ACC NCDR
Parahisian			112000004048	ACC NCDR
Targeted left bundle pacing			74031005	SNOMED CT

Section: Post-Procedure Treatments

Parent: Procedure Information

Element: 15171 Intra or Post Procedure Treatment

Coding Instruction: Indicate if there were any Intra or Post Procedure Treatment (up to 72 hours post procedure).

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Intra or Post Procedure Treatment - 1.3.6.1.4.1.19376.1.4.1.6.5.822

Selection	Definition	Source	Code	Code System
Cardiac surgery - planned	Any surgery involving the coronary arteries, valves, or a structural repair of the heart. Planned refers to a surgery that was scheduled prior to the procedure. This may include a surgery that is part of a staged treatment approach or to address known conditions requiring surgical intervention.		64915003	SNOMED CT
Cardiac surgery - unplanned due to cath complication	The patient subsequently underwent an unplanned cardiac surgery as a direct result of a catheterization-related complication. Examples may include, but are not limited to, sternotomy for cardiac tamponade, CABG, surgical removal of embolized device, establishing a pericardial window for drainage, surgical closure of a septal defect.		112000001892	ACC NCDR
Vascular surgery - unplanned due to cath complication	Any vascular surgery that was not planned and due to a complication from catheterization. Examples may include surgical repair of pseudoaneurysms or AV fistula.		30904006	SNOMED CT
Subsequent cardiac cath due to cath complication	The patient had a cardiac catheterization as a direct result of a complication arising from the initial catheterization procedure. This may include but is not limited to: a second catheterization for stenting or vascular repair; to assess or treat vessel occlusion or embolism caused during the initial procedure; to reposition or retrieve a dislodged device or address malfunctioning implants; to manage persistent bleeding or pressure abnormalities; to evaluate or treat residual shunts, stenosis, or valvular issues identified post-procedure.		41976001	SNOMED CT
Other surgery - unplanned	Any other surgery that occurred due to the primary procedure and is not represented in other selections.		112000000411	ACC NCDR

Element: 15208 Intra and Post-Procedure Treatment(s) Occurred

Coding Instruction: Indicate if the intra or post-procedure treatment did or did not occur.

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Vendor Instruction: Intra and Post-Procedure Treatment(s) Occurred (15208) cannot be Null when an Intra or Post Procedure Treatment (15171) is selected

Section: Post-Procedure Treatment Details

Parent: Procedure Information

Element: 15172 Other Unplanned Surgery Due to Cath Complication

Coding Instruction: Indicate if the other unplanned surgery was due to a catheterization complication.

Target Value: Any occurrence between start of procedure and 72 hours post procedure and prior to next procedure/surgery or discharge

Section: Discharge

Parent: Root

Element: 10101 Discharge Date and Time

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

Note(s):

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

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

0000 - 0559 (midnight to before 6AM) code 0300

0600 - 1159 (6AM - before noon) code 0900

1200 - 1759 (noon before 6PM) code 1500

1800 - 2359 (6PM to before midnight) code 2100

Target Value: The value on discharge

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

Discharge Date and Time (10101) must be >= 07/01/2026

Element: 10105 Discharge Status

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

Target Value: The value on discharge

Discharge Life Status - 1.3.6.1.4.1.19376.1.4.1.6.5.42

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

Element: 10120 Death During the Procedure

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

Target Value: Any occurrence on discharge

Element: 10125 Cause of Death

Coding Instruction: Indicate the primary cause of death, i.e. the first significant abnormal event which ultimately led to death.

Target Value: The value on time of death

Cause of Death Clinical Finding - 1.3.6.1.4.1.19376.1.4.1.6.5.88

Selection	Definition	Source	Code	Code System
Cardiac			100014107	ACC NCDR
Non-Cardiac			112000000343	ACC NCDR
Undetermined			112000000342	ACC NCDR

Section: Administration

Parent: Root

Element: 1000	Participant ID
Coding Instruction:	Indicate the participant ID of the submitting facility.
Target Value:	N/A
Element: 1010	Participant Name
Coding Instruction:	Indicate the full name of the facility where the procedure was performed.
Note(s):	Values should be full, official hospital names with no abbreviations or variations in spelling.
Target Value:	N/A
Element: 1020	Time Frame of Data Submission
Coding Instruction:	Indicate the time frame of data included in the data submission. Format: YYYYQQ. e.g.,2016Q1
Target Value:	N/A
Element: 1040	Transmission Number
Coding Instruction:	This is a unique number created, and automatically inserted by the software into export file. It identifies the number of times the software has created a data submission file. The transmission number should be incremented by one every time the data submission files are exported. The transmission number should never be repeated.
Target Value:	N/A
Element: 1050	Vendor Identifier
Coding Instruction:	Vendor identification (agreed upon by mutual selection between the vendor and the NCDR) to identify software vendor. This is entered into the schema automatically by vendor software. Vendors must use consistent name identification across sites. Changes to vendor name identification must be approved by the NCDR.
Target Value:	N/A
Element: 1060	Vendor Software Version
Coding Instruction:	Vendor's software product name and version number identifying the software which created this record (assigned by vendor). Vendor controls the value in this field. This is entered into the schema automatically by vendor software.
Target Value:	N/A
Element: 1070	Registry Identifier
Coding Instruction:	The NCDR registry identifier describes the data registry to which these records apply. It is implemented in the software at the time the data is collected and records are created. This is entered into the schema automatically by software.
Target Value:	N/A
Element: 1071	Registry Schema Version
Coding Instruction:	Schema version describes the version number of the Registry Transmission Document (RTD) schema to which each record conforms. It is an attribute that includes a constant value indicating the version of schema file. This is entered into the schema automatically by software.
Target Value:	N/A
Element: 1085	Submission Type
Coding Instruction:	Indicate if the data contained in the harvest/data file contains either standard patient episode of care records (arrival date to discharge only) or if it contains patient follow-up records.
	A transmission file with all episode of care records (from Arrival to Discharge only) is considered a 'Base Registry Record'.
	A file with patient follow-up records (any follow-up assessments performed during the quarter selected) is considered a 'Follow-Up Record'.
Note(s):	Selecting 'Follow-Up Records Only' will transmit all patient records with Follow-up Assessment Dates (Element Ref# 11000) contained in the selected timeframe, regardless of the procedure or discharge date. For example, if a patient has a procedure on 3/30/2017, is discharged on 3/31/2017, and has a follow-up assessment on 5/6/2017, the patient's episode of care data will be transmitted in the 2017Q1 Base Registry Record file, but the Follow-up data will be transmitted in the 2017Q2 Follow-Up File.

Section: Administration

Parent: Root

Target Value: N/A

Submission Type

Selection	Definition	Source	Code	Code System
Episode of Care Records Only			1000142424	ACC NCDR