



Section: Demog	raphics	Parent: Root
Element: 2000		Last Name
	Coding Instruction:	Indicate the patient's last name. Hyphenated names should be recorded with a hyphen.
	-	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.
	Ū	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
	-	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
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	<b>.</b>	Sex
	-	Indicate the patient's sex at birth.
	-	The value on arrival at this facility
	4.1.19376.1.4.1.6.5.19 Definition	Source Code Code Syste
		M HL7 Administrative Gend
Selection Male Female	Definition	





Section: Demographics	Parent: Root
Element: 2065	Patient Zip Code
	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
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):
Towned Males	If the patient has multiple race origins, specify them using the other race selections in addition to this one.
Supporting Definition:	The value on arrival at this facility White
Supporting Demittion.	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
	Indicate if the patient is Black or African American as determined by the patient/family.
	Note(s):
Torget Value	If the patient has multiple race origins, specify them using the other race selections in addition to this one.
-	The value on arrival at this facility Black or African American
Supporting Deminion.	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.
-	The value on arrival at this facility American Indian or Alaska Native
Supporting Definition.	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
	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:	
	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: 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
Element: 14780	Original Patient ID
Coding Instruction:	This is the ID generated when the patient was first submitted to the Registry. This field will be provided to vendors as part of the participant vendor migration process for all patients currently in the Registry. For patients submitted to the Registry the first time by a vendor, it should be populated with the NCDR Patient ID assigned by the vendor.
Target Value:	N/A
Element: 14781	Original NCDR Vendor
	This is the vendor identifier of the vendor who first submitted the patient to the Registry. This field will be provided to vendors as part of
Coding Instruction:	the vendor indextension of all patients currently in the registry. For patients submitted to the Registry for the first time by a vendo it should be populated with the Vendor Identifier of the submitting vendor.





Section: Episode I	monnation	Parent: Episode of Care		
Element: 2999		Episode Unique Key		
c	oding Instruction:	Indicate the unique key associated with each patient episode record as assigned by	the EMR/EHR or your software a	application.
	Target Value:	N/A		
Element: 3000		Arrival Date		
c	oding Instruction:	Indicate the date the patient arrived at your facility.		
	Target Value:	N/A		
V	endor Instruction:	Patient must be at least 18 years old at the time of Arrival Date (3000)		
		Arrival Date (3000) must be Less than or Equal to Discharge Date (10100)		
Element: 3005		Health Insurance		
с	oding Instruction:	Indicate if the patient has health insurance.		
	Target Value:	The value on arrival at this facility		
Element: 3010		Health Insurance Payment Source		
c	oding Instruction:	Indicate the patient's health insurance payment type.		
		Note(s): If the patient has multiple insurance payors, select all payors.		
		If there is uncertainty regarding how to identify a specific health insurance plan, plea understand how it should be identified in the registry.	se discuss with your billing depa	artment to
	Target Value:	The value on arrival at this facility		
Payor Category - 1.3.6.1				
Selection	Definition	Source	Code	Code System
Private Health Insurance	provided throug by an individua company. A hea	nsurance is coverage by a health plan gh an employer or union or purchased I from a private health insurance alth maintenance organization (HMO) is rate health insurance.	5	PHDSC
Medicare	Medicare is the health care cos	Federal program which helps pay sts for people 65 and older and for under 65 with long-term disabilities.	1	PHDSC
Medicare Advantage	among health p	gram that gives you more choices https://www.cms.gov/apps/glossary/ lans. Everyone who has Medicare Parts ble, except those who have End-Stage	112000002025	ACC NCDF

Renal Disease (unless certain exceptions apply). Medicare Advantage Plans used to be called Medicare

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. 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

State Specific Plans - Some states have their own

individuals. These health plans may be known by

health insurance programs for low-income uninsured

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

Non-US insurance refers to individuals with a payor

that does not originate in the United States.

Department of Veterans Affairs (VA).

different names in different states.

provided at non-HIS facilities.

+ Choice Plans.

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Medicaid

Medicaid)

Military Health Care

State-Specific Plan (non-

Indian Health Service

Non-US Insurance

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31

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PHDSC

PHDSC

PHDSC

PHDSC

ACC NCDR





Section: Episode Information		Parent: Episode of Care	
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. Intended for future use.	
	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. Intended for future use.
	Target Value:	N/A
	Vendor Instruction:	Research Study Name (3025) must be a valid study name for LAAO.
		A Research Study Name (3025) may only be entered/selected once
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: LAAO Intervention

Parent: Episode of Care

Element: 14791

Admission for Left Atrial Appendage Occlusion Intervention

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

Target Value: The value on arrival at this facility





Section: CHA2	IA2DS2-VASc Risk Scores Parent: History and Risk Factors			
Element: 4005		CHA2DS2-VASc Congestive Heart Failure		
	Coding Instruction:	Indicate if the patient has been diagnosed with heart failure according to	o the CHA2DS2-VASc definition.	
		Note(s): A diagnosis of heart failure must be specifically documented in patient symptoms.	the medical record and not coded by the abstractor ba	ased upor
	Target Value:	Any occurrence between 30 days prior to the procedure and the proc	edure	
	Supporting Definition:	CHA2DS2-VASc Congestive Heart Failure		
		The presence of signs and symptoms of either right (elevated central venous pressure, hepatomegaly, dependent edema) or left ventricular failure (exertionaldyspnea, cough, fatigue, orthopnea, paroxysmal nocturnal dyspnea, cardiac enlargement, rales, gallop rhythm, pulmonary venous congestion) or both, confirmed by non-invasive or invasive measurements demonstrating objective evidence of cardiac dysfunction.		
		<b>Source:</b> Refining clinical risk stratification for predicting stroke and th approach: the euro heart survey on atrial fibrillation Lip GH, Nieuwlaat F		
Element: 4010		NYHA Functional Classification		
	Coding Instruction:	Indicate the patient's New York Heart Association (NYHA) Functional C at the time of the current procedure.	lassification based upon the physician documented cla	assification
		Note(s): The NYHA Functional Classification must be specifically documented in patient symptoms.	the medical record and not coded by the abstractor ba	ased upon
	Target Value:	The highest value on the first procedure in this admission		
	Supporting Definition:	NYHA		
		The NYHA classes focus on exercise capacity and the symptomatic status of the disease.		
		Source: 2013 ACCF/AHA Guideline for the Management of Heart Fai doi:10.1016/j.jacc.2013.05.019	ure; J Am Coll Cardiol. 2013;62(16):e147-e239.	
NYHA Functional (	Classification - 1.3.6.1.4.1	19376.1.4.1.6.5.8		
Selection	Definition	Source		ode Syste
Class I	limitations of pl	rdiac disease but without resulting ysical activity. Ordinary physical activity Association. Nomenclature and undue fatigue, palpitation, or dyspnea. Diseases of the Heart and Gre Boston, Mass: Little, Brown & C	Criteria for Diagnosis of at Vessels. 9th ed.	SNOMED

	does not cause	e undue fatigue, palpitation, or dyspnea.	Diseases of the Heart and Great Vessels. 9th ed. Boston, Mass: Little, Brown & Co; 1994:253-256.		
Class II	of ordinary phy rest. Ordinary p than two blocks than one flight o	diac disease resulting in slight limitation sical activity. Patient is comfortable at physical activity such as walking more s or climbing more of stairs results in limiting symptoms alpitation, dyspnea, or anginal pain).	The Criteria Committee of the New York Heart Association. Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Great Vessels. 9th ed. Boston, Mass: Little, Brown & Co; 1994:253-256.	421704003	SNOMED CT
Class III	limitation of phy rest. Less than one to two leve	diac disease resulting in marked ysical activity. Patient is comfortable at ordinary physical activity (e.g., walking el blocks or climbing one causes fatigue, palpitation, dyspnea, or	The Criteria Committee of the New York Heart Association. Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Great Vessels. 9th ed. Boston, Mass: Little, Brown & Co; 1994:253-256.	420913000	SNOMED CT
Class IV	carry on any pl Symptoms are	ardiac disease resulting in inability to hysical activity without discomfort. present even at rest or minimal exertion. activity is undertaken, discomfort is		422293003	SNOMED CT
Element: 4015		CHA2DS2-VASc LV Dysfunction	ı		
	Coding Instruction:	Indicate if the patient has been diagno	sed with Left Ventricular (LV) Dysfunction according to the	e CHA2DS2-VASc de	finition.
	Target Value:	Any occurrence between 30 days price	or to the procedure and the procedure		
	Supporting Definition:	CHA2DS2 -VASc LV Dysfunction			
		Left Ventricular Ejection Fraction < 409	%.		
			ation for predicting stroke and thromboembolism in atrial fi ial fibrillation Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crij		
Element: 4020		CHA2DS2-VASc Hypertension			
	Coding Instruction:	Indicate if the patient has been diagno	sed with hypertension according to the CHA2DS2-VASc d	efinition.	
	Target Value:	Any occurrence between 30 days pric	or to the procedure and the procedure		
	Supporting Definition:	CHA2DS2-VASc Hypertension			





Section: CHA2DS2-VASc Risk Score	Parent: History and Risk Factors
	A resting blood pressure >140mmHg systolic and/or >90mmHg diastolic on at least 2 occasions or current antihypertensive pharmacologic treatment.
	<b>Source:</b> Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest.2010;137(2):263-272.
Element: 4025	CHA2DS2-VASc Diabetes Mellitus
Coding Instruction:	Indicate if the patient has been diagnosed with diabetes mellitus according to the CHA2DS2-VASc definition.
Target Value:	Any occurrence between 30 days prior to the procedure and the procedure
Supporting Definition:	CHA2DS2-VASc Diabetes Mellitus
	Fasting plasma glucose level ≥7.0 mmol/L (126 mg/dL) or treatment with oral hypoglycemic agent and/or insulin.
	<b>Source:</b> Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest.2010;137(2):263-272.
Element: 4030	CHA2DS2-VASc Stroke
Coding Instruction:	Indicate if the patient has been diagnosed with an ischemic stroke according to the CHA2DS2-VASc definition.
	Note(s): Patients with a history of stroke documented as undetermined in origin may be coded, but patients with a history of stroke documented as hemorrhagic in origin should not be coded.
-	Any occurrence between birth and the procedure
Supporting Definition:	CHA2DS2-VASc Stroke
	Ischemic stroke is defined as a focal neurologic deficit of sudden onset as diagnosed by a neurologist, lasting > 24 h and caused by ischemia.
	<b>Source:</b> Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest.2010;137(2):263-272.
Element: 4035	CHA2DS2-VASc TIA
Coding Instruction:	Indicate if the patient has been diagnosed with a transient ischemic attack (TIA) according to the CHA2DS2-VASc definition.
_	Any occurrence between birth and the procedure
Supporting Definition:	
	Transient ischemic attack (TIA) is defined as a focal neurologic deficit of sudden onset as diagnosed by a neurologist, lasting < 24 hr.
	<b>Source:</b> Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation. Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest. 2010;137(2):263-272.
Element: 4040	CHA2DS2-VASc Thromboembolic Event
Coding Instruction:	Indicate if the patient has been diagnosed with a thromboembolic event (TE) according to the CHA2DS2-VASc definition.
	Note(s): A thromboembolic event is defined as a thrombus formed in a blood vessel that breaks loose and travels to occlude another vessel.
Target Value:	Any occurrence between birth and the procedure
Supporting Definition:	Thromboembolic Events (peripheral)
	Peripheral embolism is defined as a thromboembolic event (TE) outside the brain, heart, eyes, and lungs. Pulmonary embolism is defined by the responsible physician.
	TE is defined as either an ischemic stroke, peripheral embolism, or pulmonary embolism.
	<b>Source:</b> Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation. Lip GH, Nieuwlaat R, Pisters R, Lane DA, Crijns HM. Chest. 2010;137(2):263-272.
Element: 4045	CHA2DS2-VASc Vascular Disease
Coding Instruction:	Indicate if the patient has been diagnosed with vascular disease according to the CHA2DS2-VASc definition.
	Note(s): CHA2DS2-VASc Score Vascular disease (defined as prior MI, PAD, or aortic plaque) if Yes = + 1; If the clinician has utilized the presence of CAD, PCI, CABG, or carotid disease in the patient's history as determining factors for selecting the CHA2DS2-VASc Vascular Disease element when considering the patient's risk score, please note CAD, PCI, CABG, and carotid disease were not part of the original validated vascular disease criterion for the CHA2DS2-VASc score.
Target Value:	Any occurrence between birth and the procedure
Element: 4050	Vascular Disease Type





## Section: CHA2DS2-VASc Risk Scores

Parent: History and Risk Factors

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

Note(s):

The following conditions are not part of the original definition of CHA2DS2-VASc Vascular Disease type: CAD, PCI, CABG, Carotid Disease, Carotid Stent, or Carotid Endarterectomy. Any finding of these conditions in the patient's medical history does not automatically allow coding of yes. Please code only if the physician utilized any of these conditions as part of the assessment when documenting or determining the patient's CHA2DS2-VASc risk score.

Target Value: Any occurrence between birth and the procedure

#### Vascular Disease Type - 1.3.6.1.4.1.19376.1.4.1.6.5.221

Selection	Definition	Source	Code	Code System
Prior Myocardial Infarction (MI)			399211009	SNOMED CT
Peripheral Arterial Occlusive Disease (PAD)	Current or previous history of peripheral arterial disease (includes subclavian, iliac, femoral, and upper - and lower-extremity vessels; excludes renal, coronary, cerebral, and mesenteric vessels and aneurysms). This can include: * Claudication on exertion * Amputation for arterial vascular insufficiency * Vascular reconstruction, bypass surgery, or percutaneous revascularization in the arteries of the extremities * Positive noninvasive test (e.g., ankle brachial index <= 0.9, ultrasound, MR or CT imaging of >50% diameter stenosis in any peripheral artery (i.e., subclavian, femoral, iliac) or angiographic imaging)	ACCF/AHA 2011 Key Data Elements and Definitions of r a Base Cardiovascular Vocabulary for Electronic Health Records (JACC 2011;58;202-222)	399957001	SNOMED CT
Known Aortic Plaque	Discovery of a complex aortic plaque (> 4 mm thick, or mobile, ulcerated, or pedunculated) may occur when TEE is performed as part of the evaluation for an acute stroke or peripheral embolism. Imaging techniques used for detection of aortic plaques have included transesophageal echocardiogram (TEE), computed tomography (CT), magnetic resonance imaging (MRI), and transthoracic echocardiogram (TTE).	r Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the Euro Heart Survey on atrial fibrillation. Lip GY, Nieuwlaat R, Pisters R, et al. Chest. 2010;137:263-72.	1522000 15825003	SNOMED CT
Coronary Artery Disease (CAD)*	Current or previous history of any of the following: * Coronary artery stenosis >=50% (by cardiac catheterization or other modality or of direct imaging of the coronary arteries) * Previous CABG surgery * Previous PCI * Previous MI	ACCF/AHA 2011 Key Data Elements and Definitions of a Base Cardiovascular Vocabulary for Electronic Health Records (JACC 2011;58;202-222)	53741008	SNOMED CT
Percutaneous Coronary Intervention (PCI)*	Current or previous history of percutaneous coronary artery, coronary valvular or coronary structural intervention.	,	415070008	SNOMED CT
Coronary Artery Bypass Graft (CABG)*	Current or previous history of coronary artery bypass graft.	3	232717009	SNOMED CT
Carotid Artery Disease*	Current or previous history of carotid disease.		371160000	SNOMED CT





	BLED Risk Scores	Parent: History and Risk Facto			
Element: 4055		HAS-BLED Hypertension (Uncontrolled)			
	Coding Instruction:	Indicate if the patient has been diagnosed with uncontrolled hypertension as defined H	HAS- BLED Risk Model.		
	Target Value:	Any occurrence between 30 days prior to the procedure and the procedure			
	Supporting Definition:	HAS-BLED Hypertension (Uncontrolled)			
		Uncontrolled Hypertension is defined as a systolic blood pressure >160 mmHg despit pressure. This may also be documented as Hypertension resistant to medical therapy		ent's blood	
		<b>Source:</b> A novel user-friendly score (HAS-BLED) to assess 1-year risk of major ble Heart Survey. Pisters R, Lane DA, Nieuwlaat R, et al. Chest. 2010;138(5):1093-1100	eeding in patients with atrial fibrillat	ion: the Euro	
lement: 4060		HAS-BLED Abnormal Renal Function			
	Coding Instruction:	Indicate if the patient has been diagnosed with abnormal renal function as defined by	the HAS-BLED Risk Model.		
	Target Value:	Any occurrence between 30 days prior to the procedure and the procedure			
	Supporting Definition:	HAS-BLED Abnormal Renal Function			
		Abnormal Renal Function is defined by the HAS-BLED Risk Model by any one of the lat least one kidney transplant or chronic dialysis in the past or a dialysis treatment in 200 micromole/L (≥2.6 mg/dL). Chronic is defined as three months or greater.			
		Dialysis treatment includes hemodialysis and peritoneal dialysis.			
		Source: A novel user-friendly score (HAS-BLED) to assess 1-year risk of major ble Heart Survey. Pisters R, Lane DA, Nieuwlaat R, et al. Chest. 2010;138(5):1093-1100	eeding in patients with atrial fibrillat	ion: the Euro	
Element: 4065		HAS-BLED Abnormal Liver Function			
	Coding Instruction:	Indicate if the patient has been diagnosed with abnormal liver function as defined by the HAS-BLED Risk Model.			
	Target Value:	Any occurrence between 30 days prior to the procedure and the procedure			
Supporting Definition:		HAS-BLED Abnormal Liver Function			
		Abnormal liver function is defined by the HAS-BLED Risk Model as chronic hepatic di significant hepatic derangement (eg, bilirubin more than two times the upper limit of ne transaminase/alanine transaminase/alkaline phosphatase more than three times the up	ormal, in association with aspartate		
		Chronic is defined as three months or greater. <b>Source:</b> A novel user-friendly score (HAS-BLED) to assess 1-year risk of major ble Heart Survey. Pisters R, Lane DA, Nieuwlaat R, et al. Chest. 2010;138(5):1093-1100	eeding in patients with atrial fibrillat	ion: the Euro	
lement: 4070		HAS-BLED Stroke			
	Coding Instruction:	Indicate if the patient has experienced a stroke in the past as defined by the HAS-BLE	D Risk Model.		
	Target Value:	Any occurrence between birth and the procedure			
	Supporting Definition:	HAS-BLED Stroke			
		A stroke is defined by the HASBLED Risk Model as an acute episode of focal or globa cord, or retinal vascular injury as a result of hemorrhage or infarction.	al neurological dysfunction caused	by brain, spinal	
		<b>Source:</b> A novel user-friendly score (HAS-BLED) to assess 1-year risk of major ble Heart Survey. Pisters R, Lane DA, Nieuwlaat R, et al. Chest. 2010;138(5):1093-1100 HAS-BLED Scores for thromboprophylaxis in atrial fibrillation. Am J Med. 2011 Feb;12	Lip GY. Implications of the CHA(2)		
Element: 14792		HAS-BLED Stroke Type			
	Coding Instruction:	Indicate what type of stroke the patient has experienced in the past as defined by the	HAS-BLED Risk Model.		
	Target Value:	Any occurrence between birth and the procedure			
	Supporting Definition:	HAS-BLED Stroke			
		A stroke is defined by the HASBLED Risk Model as an acute episode of focal or globa cord, or retinal vascular injury as a result of hemorrhage or infarction.	al neurological dysfunction caused	by brain, spina	
		<b>Source:</b> A novel user-friendly score (HAS-BLED) to assess 1-year risk of major ble Heart Survey. Pisters R, Lane DA, Nieuwlaat R, et al. Chest. 2010;138(5):1093-1100 HAS-BLED Scores for thromboprophylaxis in atrial fibrillation. Am J Med. 2011 Feb;12	Lip GY. Implications of the CHA(2)		
AS-BLED Stroke 1	Гуре - 1.3.6.1.4.1.19376.1	4.1.6.5.773			
election	Definition	Source	Code	Code Syst	
lemorrhagic Stroke		ay be a consequence of ischemic ituation, the stroke is an ischemic stroke	230706003	SNOMED	

stroke. In this situation, the stroke is an ischemic stroke with hemorrhagic transformation and not a hemorrhagic





Section: HAS-E	BLED Risk Scores	Parent: History and Ris	C Factors
	stroke.		
	Hemorrhagic st	oke is defined as an acute episode of	
	•	erebral or spinal dysfunction caused mal, intraventricular, or subarachnoid	
	hemorrhage.		
	Note: Subdural	ematomas are intracranial hemorrhagic	
	events and not	-	
schemic Stroke		ke is an acute episode of focal or cal dysfunction caused by brain, spinal	422504002 SNOM
	cord, or retinal	ascular injury as a result of infarction	
Indetermined Stroke		us system tissue. termined origin is defined as an acute	230713003 SNOM
	episode of foca	or global neurological dysfunction	
		med brain, spinal cord, or retinal s a result of hemorrhage or infarction	
	but with insuffic	ent information to allow categorization	
	as ischemic or l	emorrnagic.	
Element: 4095		HAS-BLED Bleeding	
	Coding Instruction:	Indicate if the patient has a history of a major bleeding event or predispositio the HAS-BLED Risk Model.	n to bleeding (eg, bleeding diathesis, anemia) as defined
		Note(s): Major bleeding defined as any bleeding requiring hospitalization, and requiring blood transfusion that was not hemorrhagic stroke.	l/or causing a decrease in hemoglobin level > 2 g/dL, and
	Target Value:	Any occurrence between birth and the procedure	
	Supporting Definition:	HAS-BLED Bleeding	
		Bleeding is defined by the HAS-BLED Risk Model as a history of a major blee	ding event or predisposition to bleeding (eg, bleeding
		diathesis, anemia). Source: A novel user-friendly score (HAS-BLED) to assess 1-year risk of	major bleeding in patients with atrial fibrillation: the Euro
		Heart Survey. Pisters R, Lane DA, Nieuwlaat R, et al. Chest. 2010;138(5):10	, , , , , , , , , , , , , , , , , , , ,
Element: 4100		HAS-BLED Labile INR	
	Coding Instruction:	Indicate if the patient has experienced a labile international normalized ratios BLED Risk Model.	(INR) while on Warfarin therapy as defined by the HAS-
	Target Value:	Any occurrence between 30 days prior to the procedure and the procedure	
	Supporting Definition:	HAS-BLED Labile INR	
		Labile INR is defined by the HAS-BLED Risk Model as unstable/high internati	onal normalized ratios (INR) or <60 percent of INR values
		therapeutic range. Therapeutic range is defined as 2 - 3 inclusive.	
		Source: A novel user-friendly score (HAS-BLED) to assess 1-year risk of Heart Survey. Pisters R, Lane DA, Nieuwlaat R, et al. Chest. 2010;138(5):10	
Element: 4105		HAS-BLED Alcohol	
	-	Indicate if the patient uses alcohol in excess as defined by the HAS-BLED R	sk Score.
	Target Value:	Any occurrence between 30 days prior to the procedure and the procedure	
	Supporting Definition:		
		Alcohol excess is defined by the HAS-BLED Risk Model as consuming >=8 u	
		Source: A novel user-friendly score (HAS-BLED) to assess 1-year risk of Heart Survey. Pisters R, Lane DA, Nieuwlaat R, et al. Chest. 2010;138(5):10	, , , , , , , , , , , , , , , , , , , ,
Element: 4110		HAS-BLED Drugs - Antiplatelet	
	Coding Instruction:	Indicate if the patient is taking antiplatelet medications.	
		Note(s): If the patient is taking any dosage of aspirin code as "Yes".	
	Target Value:	Any occurrence between 30 days prior to the procedure and the procedure	
		HAS-BLED Drugs - Antiplatelets	
		Concomitant use of ASA/NSAIDS or antiplatelet medication with alcohol may	predisposed the patient to bleeding per the HAS-BLED R
		Model.	
		Source: A novel user-friendly score (HAS-BLED) to assess 1-year risk of Heart Survey. Pisters R, Lane DA, Nieuwlaat R, et al. Chest. 2010;138(5):10	
Element: 4115		HAS-BLED Drugs - NSAIDS	





## Section: HAS-BLED Risk Scores

## Parent: History and Risk Factors

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

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

Supporting Definition: HAS-BLED Drugs - NSAIDS

Concomitant use of ASA/NSAIDS or antiplatelet medication with alcohol may predisposed the patient to bleeding per the HAS-BLED Risk Model.

Source: A novel user-friendly score (HAS-BLED) to assess 1-year risk of major bleeding in patients with atrial fibrillation: the Euro Heart Survey. Pisters R, Lane DA, Nieuwlaat R, et al. Chest. 2010;138(5):1093-1100



Section: Additional Stroke and Bleeding Pick Factor

Parent: History and Pisk Factor



Element: 14793	Increased Fall Risk		
Coding Instruction	<ul> <li>Indicate if the patient has an increased susceptibility to falling that may cause physical harm as def Society.</li> </ul>	ined by the Americ	can Geriatrics
Target Value	e: Any occurrence between 12 months prior to the procedure and start of the procedure		
Supporting Definition	n: Increased Fall Risk		
	A patient is at increased risk for falls if they have experienced any of the following: two or more fa with an acute fall for this episode of care; or experiences difficultly walking or balancing.	Ils in the prior 12 n	nonths; presents
	<b>Source:</b> American Geriatrics Society/British Geriatrics Society Clinical Practice Guideline for Prev Geriatr Soc. 2010.	ention of Falls in C	Dider Persons. J Am
Element: 14794	Clinically Relevant Bleeding Event		
Coding Instruction	n: Indicate if the patient had any of the following associated with a Clinically Relevant Bleeding Event.		
Target Value	e: Any occurrence between birth and the procedure		
Supporting Definition	n: Clinically Relevant Bleeding Event		
	<ul> <li>A clinically relevant bleeding event is defined as any one of the following:</li> <li>Hemoglobin drop of &gt;=3 g/dL;</li> <li>Transfusion of packed red blood cells;</li> <li>Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding</li> <li>Hospital admission with primary discharge diagnosis related to a bleeding event.</li> </ul>		
	Source: NCDR		
Element: 14796	Bleeding Event Type		
Coding Instruction	n:		
Target Value	e: Any occurrence between birth and the procedure		
Supporting Definition	n: Bleeding Event		
	A bleeding event observed and documented in the medical record that was associated with a hem hemoglobin drop of ≥3 g/dL or that required transfusion or surgical intervention.	atocrit drop of ≥10	% and/or a
	Source: Cannon CP, Brindis RG, Chaitman BR, et al. 2013 ACCF>AHA Key Date Elements and D Management and Outcomes of Patients with Acute Coronary Syndromes and Coronary Artery Dise		
Bleeding Event Type - 1.3.6.1.4.1.19376.1.			
Selection Definition	Source	Code	Code System
ntracranial Bleed		1386000 249366005	SNOMED C SNOMED C
Enjetavje		74474003	SNOMED C SNOMED C
Epistaxis Gastrointestinal Bleed			ON OWLD U
Epistaxis Gastrointestinal Bleed Other		1000142371	ACC NCD
Gastrointestinal Bleed	Genetic Coagulopathy		ACC NCD
Gastrointestinal Bleed Dther Element: 14797			ACC NCD

Element: 14798

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

Target Value: Any occurrence between birth and the procedure

Concurrent Anticoagulant Therapy





Section: Rhythm History	Parent: History and Risk Factors
Element: 13709	Atrial Fibrillation
Coding Instruction:	Indicate if the patient has a history of atrial fibrillation.
Target Value:	Any occurrence between birth and current procedure
Element: 4400	Atrial Fibrillation Classification
Coding Instruction:	Indicate the type of atrial fibrillation experienced by the patient.
Target Value:	Any occurrence between birth and the first procedure in this admission
Supporting Definition:	Atrial Fibrillation Classification
	Atrial Fibrillation is a supraventricular tachyarrhythmia with uncoordinated atrial activation and consequently ineffective atrial contraction.
	Electrocardiogram (ECG) characteristics include: 1) irregular R-R intervals (when atrioventricular [AV] conduction is present), 2) absence of distinct repeating P waves, and 3) irregular atrial activity.
	Atrial Fibrillation can be further characterized as:
	<ul> <li>Paroxysmal AF is defined as AF that terminates spontaneously or with intervention within seven days of onset. Episodes may recur with variable frequency.</li> <li>Persistent AF is defined as AF that fails to self-terminate within seven days. Episodes often require pharmacologic or electrical cardioversion to restore sinus rhythm.</li> <li>Long-standing persistent AF is defined as AF that has lasted for more than 12 month</li> <li>Permanent AF is defined as when the patient and clinician make a joint decision to stop further attempts to restore and/or maintain sinus rhythm. Acceptance of AF represents a therapeutic attitude on the part of the patient and clinician rather than an inherent pathophysiological attribute of AF. Acceptance of AF may change as symptoms, efficacy of therapeutic interventions, and patient and clinician preferences evolve.</li> <li>Source: January CT, Wann LS, Alpert JS, et al. 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol 2014. DOI: 10.1016/j.jacc.2014.03.022</li> </ul>

#### Atrial Fibrillation Classification - 1.3.6.1.4.1.19376.1.4.1.6.5.17

Selection	Definition	Source	Code	Code System
Paroxysmal (terminating spontaneously within 7 days	) within 7 days o	AF that terminates spontaneously or with intervention within 7 days of onset. Episodes may recur with variable frequency.		SNOMED CT
Persistent (greater than 7 days)		that is sustained >7 days or with rmacological termination.	62459000	SNOMED CT
Long-standing persistent (greater than 1 year)	Continuous AF	Continuous AF of >12 months duration. The term "permanent AF" is used when the patient and		ACC NCDR
Permanent	clinician make a	anent AF" is used when the patient and joint decision to stop further attempts to aintain sinus rhythm.	6934004	SNOMED CT
	on the part of th	AF represents a therapeutic attitude e patient and clinician rather than an hysiological attribute of the AF.		
		AF may change as symptoms, the peutic interventions, and patient and nces evolve.		
Element: 4380		Valvular Atrial Fibrillation		
Cod	ling Instruction:	Indicate if the patient has atrial fibrillation occurring in the setting of valvular hear attributable to valvular heart disease (especially mitral valvular disease).	t disease and believed to be, at least	in part, directly
	Target Value:	Any occurrence between birth and the procedure		
Element: 14799		History of Rheumatic Valve Disease		
Cod	ling Instruction:	Indicate if the patient has a history of rheumatic valve disease.		
	Target Value:	Any occurrence between birth and the procedure		
Element: 4385		History of Mitral Valve Replacement		
Cod	ling Instruction:	Indicate if the patient has a history of mitral valve replacement either via open su	urgical or a percutaneous transcathete	er intervention.
	Target Value:	Any occurrence between birth and the procedure		



Coder's Data Dictionary v1.4



Section: Rhyth	nm History	Parent: History and Risk Factors
Element: 4390		Mechanical Valve in Mitral Position
	-	Indicate if the patient has a mechanical valve placed in the mitral position.
	Target Value:	Any occurrence between birth and the procedure
Element: 4395		History of Mitral Valve Repair
	Coding Instruction:	Indicate if the patient has a history of mitral valve repair, specifically via the surgical route. Either a surgical repair of a mitral valve leaflet or mitral annuloplasty qualifies as repair.
	Target Value:	Any occurrence between birth and the procedure
Element: 4410		Attempt at Atrial Fibrillation Termination
	Coding Instruction:	Indicate if the patient has had previous attempts to terminate the atrial fibrillation.
	Target Value:	Any occurrence between birth and the procedure
	Supporting Definition:	Previous Attempt at Atrial Fibrillation Termination
		Therapeutic options for conversion of AF to sinus rhythm includes: antiarrhythmic drugs, direct current cardioversion, catheter ablation and surgical ablation.
		<b>Source:</b> McNamara RL, Brass LM, Drozda JP, Jr, et al. ACC/AHA key data elements and definitions for measuring the clinical management and outcomes of patients with atrial fibrillation: A report of the American College of Cardiology/American Heart Association Task Force on clinical data standards (writing committee to develop data standards on atrial fibrillation). J Am Coll Cardiol. 2004;44(2):475-495
Element: 4415		Atrial Fibrillation Termination - Pharmacologic Cardioversion
	Coding Instruction:	Indicate if the patient has a history of pharmacological cardioversion.
	Target Value:	Any occurrence between birth and the procedure
	Supporting Definition:	Pharmacologic Cardioversion
		Antiarrhythmic drugs can be administered for attempted conversion of AF to sinus rhythm or to facilitate electrical cardioversion.
		Source: January CT, Wann LS, Alpert JS, et al. 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol 2014. DOI: 10.1016/j.jacc.2014.03.022
Element: 4420		Atrial Fibrillation Termination - DC Cardioversion
	Coding Instruction:	Indicate if the patient has a history of direct current (DC) cardioversion.
	Target Value:	Any occurrence between birth and the procedure
	Supporting Definition:	DC Cardioversion
		Direct-current cardioversion involves the delivery of an electrical shock synchronized with the QRS complex to avoid inducing ventricular fibrillation as can occur by a shock applied during ventricular repolarization on the T wave.
		<b>Source:</b> January CT, Wann LS, Alpert JS, et al. 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol 2014. DOI: 10.1016/j.jacc.2014.03.022
Element: 4425		Atrial Fibrillation Termination - Catheter Ablation
	Coding Instruction:	Indicate if the patient has a history of catheter ablation for termination of atrial fibrillation.
	Target Value:	Any occurrence between birth and the procedure
	Supporting Definition:	Catheter Ablation
		Various methods of catheter ablation are used. Currently most techniques focus on isolating the triggers in the pulmonary veins (PVs) from the vulnerable substrate in the left atrium. The majority of ablations performed use radiofrequency energy or cryothermy (cryoballoon ablation).
		<b>Source:</b> January CT, Wann L, Alpert JS, et al. 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol. 2014;64(21):e1-e76.
Element: 4430		Atrial Fibrillation Most Recent Catheter Ablation Date
	Coding Instruction:	Indicate the date of the most recent attempt to terminate the atrial fibrillation via catheter ablation.
		Note(s): If the month or day is unknown, please code 01/01/YYYY. If the specific year is unknown in the current record, the year may be estimated based on timeframes found in prior medical record documentation (Example: If the patient had "most recent ablation"
		Effective for Patients Discharged on/after October





### Section: Rhythm History

#### Parent: History and Risk Factors

documented in a record from 2011, then the year 2011 can be utilized and coded as 01/01/2011).

Target Value: Any occurrence between birth and the procedure

Vendor Instruction: Atrial Fibrillation Most Recent Catheter Ablation Date

Element: 4435

Prior Catheter Ablation Strategy

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

Note(s):

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

Target Value: Any occurrence between birth and the procedure

#### Ablation Strategy - 1.3.6.1.4.1.19376.1.4.1.6.5.211

Selection	Definition	Source	Code	Code System
Complex Fractionated Atrial Electrogram		tegy targeting areas of continuous high nplex fractionated) atrial electrograms.	100000910	ACC NCDR
Convergent Procedure	followed by enablation in patie	t procedure consists of epicardial (Epi) locardial (Endo) radio-frequency ents (pts) with atrial fibrillation (AF), risk of recurrence with endo ablation	100000911	ACC NCDR
Cryoablation		r freezing technology, involves a coolant into the catheter's balloon to freeze and e.	233161001	SNOMED CT
Empiric LA Linear Lesions	lesions (such a may accompar	ttegy that can include adjunctive linear s a roof line or mitral annular line) that y WACA, PVI, or other approaches, reventing development of subsequent	100000912	ACC NCDR
Focal Ablation	putative trigger a trigger of AF accompanies A	ategy targeting one or more foci of s of atrial fibrillation. Ablation may be of or just of a focal atrial tachycardia that F or emerges following previous AF s a stand-alone rhythm).	100000913	ACC NCDR
Ganglion Plexus Ablation	An ablation stra	tegy targeting one or more regions of e lexit around the left atrium.	100000914	ACC NCDR
Pulmonary Vein Isolation	of atrial myoca	tegy defined as electrical disconnection dium extending into the pulmonary veins of the left atrium.	100000915	ACC NCDR
of pulmonary venou the body of the left a		ategy with the goal of electrical isolation enous atrial tachycardia triggers from left atrium by ablating segmentally rentially within a vein or near the	100000916	ACC NCDR
Rotor Based Mapping		ategy guided by mapping software loyed to identify specific atrial fibrillation	100000917	ACC NCDR
Wide Area Circumferential Ablation	An ablation stra circumferential and left venous modification, is This approach	tegy that includes placement of large ablation lesion sets encircling the right antra with the goal of either substrate plation of the pulmonary veins, or both. generally implies that formal testing for and/or exit block is NOT performed.	100000918	ACC NCDR
Element: 4440		Atrial Fibrillation Termination - Surgical Ablation		
Cod	ing Instruction:	Indicate if the patient has a history of surgical ablation.		
	-	Any occurrence between birth and the procedure		
Suppo	rting Definition:	Surgical Ablation         The Maze operation is one surgical ablation option treat patients with both paroxysmal a therapy.         Source:       The surgical treatment of atrial fibrillation. IV. Surgical technique. Cox JL . J T		
Element: 4445		Atrial Fibrillation, Most Recent Surgical Ablation Date		
Cod	ing Instruction:	Indicate the date of the most recent attempt to terminate the atrial fibrillation via surgical a	ablation.	
		Note(s): If the month or day is unknown, please code 01/01/YYYY. If the specific year is unknow	vn in the current record, the	year may be

estimated based on timeframes found in prior medical record documentation (Example: If the patient had "most recent surgical ablation"





Section: Rhythm History	Parent: History and Risl	k Factors
	documented in a record from 2011, then the year 2011 can be utilized and co	oded as 01/01/2011).
Target	/alue: Any occurrence between birth and the procedure	
Supporting Defi	nition: Surgical Ablation	
	The Maze operation is one surgical ablation option treat patients with both pa	aroxysmal and chronic AF refractory to antiarrhythmic
	therapy.	Que II - LTheres Que lines Que 1004 404(4) 504
	<b>Source:</b> The surgical treatment of atrial fibrillation. IV. Surgical technique.	
Vendor Instru	ction: Atrial Fibrillation Most Recent Surgical Ablation Date (4445) must be Less that	in or Equal to the Procedure Start Date and Time (7000)
Element: 4450	Atrial Flutter	
Coding Instru	ction: Indicate if the patient has a history of atrial flutter.	
Target	/alue: Any occurrence between birth and the procedure	
Supporting Defi	nition: Atrial Flutter	
	Atrial flutter is defined as a cardiac arrhythmia arising in the atrium which ha length 240-170 ms) in the absence of antiarrhythmic drugs.	as a regular rate typically between 250 and 350 bpm (cycle
	<b>Source:</b> January CT, Wann LS, Alpert JS, Calkins H, Cleveland Jr JC, Cigari KT, Sacco RL, Stevenson WG, Tchou PJ, Tracy CM, Yancy CW, 2014 AHA/A Atrial Fibrillation, Journal of the American College of Cardiology (2014), doi: 1	ACC/HRS Guideline for the Management of Patients With
Element: 4455	Atrial Flutter Classification	
Coding Instru	ction: Indicate the predominate type of atrial flutter experienced by the patient.	
Target	/alue: Any occurrence between birth and the procedure	
Supporting Defi	nition: Atrial Flutter Type	
	Atrial flutter is further classified into typical or atypical dependent on whether cavotricuspid isthmus.	er or not re-entry is dependent upon conduction through the
	Source: January CT, Wann LS, Alpert JS, Calkins H, Cleveland Jr JC, Cigari KT, Sacco RL, Stevenson WG, Tchou PJ, Tracy CM, Yancy CW, 2014 AHA/A Atrial Fibrillation, Journal of the American College of Cardiology (2014), doi: 1	ACC/HRS Guideline for the Management of Patients With
Atrial Flutter Classification - 1.3.6.1.	.1.19376.1.4.1.6.5.191	
Selection Definit	on Source	Code Code System
(CTI) Dependent tachyca down th cavotric tricuspi	atrial flutter is a macro-re-entrant atrial dia that usually proceeds up the atrial septum, e lateral atrial wall, and through the uspid (subeustachian) isthmus between the I valve annulus and inferior vena cava, where monly targeted for ablation.	100000982 ACC NCDF
Atypical Atypica	flutter, or "noncavotricuspid isthmus- nt macro-re-entrant atrial tachycardia".	112231000 SNOMED C
•	es macro-re-entrant atrial tachycardias that are	
	of the typical forms of atrial flutter that use the uspid isthmus.	
Element: 4460		
	Attempt at Atrial Flutter Termination	
-	ction: Indicate if the patient has had previous attempts to terminate the atrial flutter.	
-	/alue: Any occurrence between birth and the procedure	
Supporting Defi	hition: Previous Attempt at Atrial Flutter Termination Therapeutic options for conversion of atrial flutter to sinus rhythm includes: a catheter ablation.	antiarrhythmic drugs, direct current cardioversion, and
	Source: McNamara RL, Brass LM, Drozda JP, Jr, et al. ACC/AHA key data	a elements and definitions for measuring the clinical
	management and outcomes of patients with atrial fibrillation: A report of the A Task Force on clinical data standards (writing committee to develop data star -495.	American College of Cardiology/American Heart Association
Element: 4465	Atrial Flutter Termination - Pharmacologic Cardioversion	
Coding Instru		ate the atrial flutter.
	ction: Indicate if the patient has a history of pharmacologic cardioversion to termina	
Target	<ul><li>ction: Indicate if the patient has a history of pharmacologic cardioversion to termina</li><li>/alue: Any occurrence between birth and the procedure</li></ul>	
-		
-	/alue: Any occurrence between birth and the procedure	o sinus rhythm or to facilitate electrical cardioversion.
-	Value:         Any occurrence between birth and the procedure           nition:         Pharmacologic Cardioversion           Antiarrhythmic drugs can be administered for attempted conversion of AF to	o sinus rhythm or to facilitate electrical cardioversion. eline for the Management of Patients With Atrial Fibrillation: A





# Section: Rhythm History

# Parent: History and Risk Factors

Element: 4470		Atrial Flutter Termination - DC Cardioversion
	Coding Instruction:	Indicate if the patient has a history of DC cardioversion to terminate the atrial flutter.
	Target Value:	Any occurrence between birth and the procedure
	Supporting Definition:	DC Cardioversion
		Direct-current cardioversion involves the delivery of an electrical shock synchronized with the QRS complex to avoid inducing ventricular fibrillation as can occur by a shock applied during ventricular repolarization on the T wave.
		Source: January CT, Wann LS, Alpert JS, et al. 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol 2014. DOI: 10.1016/j.jacc.2014.03.022
Element: 4475		Atrial Flutter Termination - Catheter Ablation
	Coding Instruction:	Indicate if the patient has a history of catheter ablation to terminate the atrial flutter.
	Target Value:	Any occurrence between birth and the procedure
Element: 4480		Atrial Flutter Most Recent Catheter Ablation Date
	Coding Instruction:	Indicate the date of the most recent catheter ablation.
		Note(s): If the month or day is unknown, please code 01/01/YYYY. If the specific year is unknown in the current record, the year may be estimated based on timeframes found in prior medical record documentation (Example: If the patient had "most recent ablation" documented in a record from 2011, then the year 2011 can be utilized and coded as 01/01/2011).
	Target Value:	Any occurrence between birth and the procedure
	Man dan biatun di se	Article Fully a Mart Devent Orthogon Altarian Data (4400) and the Level theory Foundation the Deventory Orthogon (7000)

Vendor Instruction: Atrial Flutter Most Recent Catheter Ablation Date (4480) must be Less than or Equal to the Procedure Start Date and Time (7000)



and Diak Ea



Section: Interventions	Parent: History and Risk Factors
Element: 14802	Cardiac Structural Intervention
5	Indicate if the patient has a history of cardiac structural interventions (percutaneously or surgically). Any occurrence between birth and the procedure
Element: 14803	Cardiac Structural Intervention Type
Coding Instruction:	Indicate the type of prior cardiac structural intervention.
Target Value:	Any occurrence between birth and the procedure
Cardiac Structural Intervention Type - 1.3.6.	1.4.1.19376.1.4.1.6.5.775

Selection	Definition	Source	Code	Code System
Aortic Balloon Valvulo	plasty		77166000	SNOMED CT
Transcatheter Aortic N Replacement (TAVR)	/alve		41873006	SNOMED CT
AV Replacement - Sur	rgical		725351001	SNOMED CT
AV Repair - Surgical			112816004	SNOMED CT
Mitral Balloon Valvulop	blasty		112000001951	ACC NCDR
Transcatheter Mitral V Repair (TMVR)	alve		112000001801	ACC NCDR
MV Replacement - Sur	rgical		53059001	SNOMED CT
MV Repair - Surgical			384641003	SNOMED CT
Mitral Annuloplasty Rir Surgical	ng -		232744004	SNOMED CT
Mitral Transcatheter - valve	Valve-in-		112000002069	ACC NCDR
ASD Closure			112811009	SNOMED CT
PFO Closure			41817002	SNOMED CT
Pulmonic Replacement	t		88045004	SNOMED CT
Pulmonic Repair			386749005	SNOMED CT
Tricuspid Replacement	t		25236004	SNOMED CT
Tricuspid Repair			384643000	SNOMED CT

Element: 14804

Left Atrial Appendage Occlusion Intervention

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

Note(s): Previously "Aborted" LAA interventions should be captured in this element.

Target Value: Any occurrence between birth and the procedure

Element: 14806

Left Atrial Appendage Intervention Type

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

Target Value: Any occurrence between birth and the procedure

#### Left Atrial Appendage Intervention Type - 1.3.6.1.4.1.19376.1.4.1.6.5.776

Selection	Definition	Source	Code	Code System
Epicardial Ligation	Ligation via an epicardial approach, isolating the left atrial appendage (LAA) from circulation via inside the pericardial space.		11200002072	ACC NCDR
Surgical Amputation	Amputation and complete excision of the left atrial appendage (LAA) until no trabeculated portion remains and the neck of the LAA is sewn closed. Another term for this technique is left atrial appendectomy.		112000002073	ACC NCDR
Surgical Ligation	Ligation via surgical approach where the left atrial appendage (LAA) is permanently sealed off from the rest of the heart preventing blood from circulating and pooling in the appendage.		11200002074	ACC NCDR
Percutaneous Occlusion	Occlusion of the left atrial appendage (LAA) using solely a percutaneous, catheter-based method.		11200002076	ACC NCDR
Surgical Closure Device	Left atrial appendage (LAA) surgical closure device was used.		112000002077	ACC NCDR
Surgical Stapling	Excision or exclusion technique of the left atrial appendage (LAA) via surgical approach using pericardial buttressing of the LAA staple line.		11200002075	ACC NCDR





Target Element: 4570 Coding Instru Target <sup>1</sup>	Cardiomyopathy (CM)         tion:       Indicate if the patient has a history of cardiomyopathy.         alue:       Any occurrence between birth and the procedure         Cardiomyopathy Type       Cardiomyopathy type         tion:       Indicate the type of cardiomyopathy experienced by the patient.		
Element: 4570 Coding Instru Target 1 Supporting Defin	alue: Any occurrence between birth and the procedure Cardiomyopathy Type		
Element: 4570 Coding Instru Target 1 Supporting Defin	Cardiomyopathy Type		
Coding Instru Target 1 Supporting Defin			
Target Supporting Defin	tion: Indicate the type of cardiomyopathy experienced by the patient.		
Supporting Defin			
Supporting Defin	Note(s): If the patient has had multiple cardiomyopathies, select all applicable types.		
	alue: Any occurrence between birth and the procedure		
ardiomyonathy Type - 1 3 6 1 4 1 10	tion: Cardiomyopathy Type		
Cardiomyonathy Type - 1 3 6 1 4 1 10	Hypertrophic: Characterized morphologically and defined by a hypertrophied, nondilated LV is capable of producing the magnitude of wall thickening evident (eg, systemic customarily made with 2-dimensional echocardiography (or alternatively with o otherwise unexplained LV wall thickening, usually in the presence of a small I as part of family screening. [1]	c hypertension, aortic valve stenosis). Clin cardiac magnetic resonance imaging) by c	iical diagnosis is detection of
Cardiomyonathy Type - 1 3 6 1 4 1 10	Restrictive: Non Hypertrophied, Non Dilated: A rare form of heart muscle disease and a ca decreased volume of both ventricles associated with biatrial enlargement, nor filling with restrictive physiology, and normal (or near normal) systolic function	rmal LV wall thickness and AV valves, imp	
Cardiomyonathy Type - 1 3 6 1 4 1 10	Non ischemic: Includes cardiomyopathies resulting from volume or pressure overload, such a	as hypertension or valvular heart disease	. [2]
Cardiomyonathy Type - 1 3 6 1 4 1 10	Ischemic: Considered to be present in patients with HF who have had a myocardial infar myocardium or, on angiography, severe coronary disease. The term ischemic impaired left ventricular function (left ventricular ejection fraction ≤35 to 40 pe the common clinical use of the term ischemic cardiomyopathy, ventricular dys cardiomyopathy as defined by the 2006 American Heart Association and 2008	c cardiomyopathy has been used to descri ercent) that results from coronary artery di sfunction caused by coronary disease is n	be significantly sease. Despite ot a
Cardiomyonathy Type - 1 3 6 1 4 1 10	The term ischemic cardiomyopathy has been used to describe significantly im fraction ≤35 to 40 percent) that results from coronary artery disease. Despite t cardiomyopathy, ventricular dysfunction caused by coronary disease is not a Association and 2008 European Society of Cardiology statements. [2]	the common clinical use of the term ische	mic
cardiomyonathy Type - 1 3 6 1 4 1 10	Other cardiomyopathy type: The term "unclassified cardiomyopathy" was included in the 2008 ESC classi into any of the above phenotypic categories [3]. Examples cited include LV no cardiomyopathy. [3]		
Cardiomyonathy Type - 1 3 6 1 4 1 19	Source: [1] Barry J. Maron, MD, Chair; Jeffrey A. Towbin, MD, FAHA; Gaetano Thiene, MD; Charles Antzelevitch, PhD, FAHA; Domenico Corrado, MD, PhD; Donna Arnett, PhD, FAHA; Arthur J. Moss, MD, FAHA; Christine E. Seidman, MD, FAHA;		
Cardiomyonathy Type - 1 3 6 1 4 1 19	James B. Young, MD, FAHA. Contemporary definitions and classification of th Scientific Statement from the Council on Clinical Cardiology, Heart Failure and T Research and Functional Genomics and Translational Biology Interdisciplinary Prevention. Circulation. 2006;113(14):1807.	Transplantation Committee; Quality of Care	e and Outcomes
Cardiomyonathy Type - 1 3 6 1 4 1 10	[2] Yancy CW, Jessup M, Bozkurt B, et al. 2013 ACCF/AHA Guideline for the N College of Cardiology Foundation/American Heart Association Task Force on P e239. doi:10.1016/j.jacc.2013.05.019.		
Cardiomyonathy Type - 1 3 6 1 4 1 19	[3] Richardson P, McKenna W, Bristow M, Maisch B, Mautner B, O'Connell J, O Report of the 1995 World Health Organization/International Society and Federa Classification of cardiomyopathies. Circulation. 1996;93(5):841		
	cardiomyopathies resulting from volume or	Code 111000119104	Code System SNOMED
schemic cardiomyopathy Conside	overload, such as hypertension or valvular	426856002	SNOMED

had a myocardial infarction (MI) or have evidence of viable hibernating myocardium or, on angiography,





Section: Additional His	story and Ris	k Factors Parent: History	and Risk Factors	
	severe coronar	y disease.		
	describe signifi (left ventricular results from co common clinica cardiomyopath coronary disea by the 2006 Am	nic cardiomyopathy has been used to cantly impaired left ventricular function ejection fraction =35 to 40 percent) that onary artery disease. Despite the I use of the term ischemic , ventricular dysfunction caused by se is not a cardiomyopathy as defined erican Heart Association and 2008 ety of Cardiology statements. [2]		
Restrictive cardiomyopathy	muscle disease characterized b ventricles asso LV wall thickne	ied, Non Dilated: A rare form of heart and a cause of heart failure that is y normal or decreased volume of both ciated with biatrial enlargement, normal ss and AV valves, impaired ventricular ctive physiology, and normal (or near function.	415295002	SNOMED CT
Hypertrophic cardiomyopathy	hypertrophied, systemic or car producing the n systemic hyper diagnosis is cus echocardiograp magnetic reson otherwise unex the presence o	norphologically and defined by a nondilated LV in the absence of another diac disease that is capable of nagnitude of wall thickening evident (eg, ension, aortic valve stenosis). Clinical tomarily made with 2-dimensional why (or alternatively with cardiac ance imaging) by detection of plained LV wall thickening, usually in a small LV cavity, after suspicion is inical profile or as part of family	233873004	SNOMED CT
Other cardiomyopathy type	The term "uncla in the 2008 ESC disorders that of phenotypic cate	assified cardiomyopathy" was included C classification system to describe o not readily fit into any of the above gories [3]. Examples cited include LV and stress-induced (takotsubo)	100001065	ACC NCDR
Element: 4575		Chronic Lung Disease		
Codir	ng Instruction:	Indicate if the patient has a history of chronic lung disease.		
		Note(s): A history of chronic inhalation reactive disease (asbestosis, meso chronic lung disease. Radiation induced pneumonitis or radiation a transient condition and does not qualify.		
	Target Value:	Any occurrence between birth and the procedure		
Support	ting Definition:	Chronic Lung Disease		
		Chronic lung disease can include patients with chronic obstructive include a patient who is currently being chronically treated with in anti-inflammatory agent, leukotriene receptor antagonist, or steroi have chronic lung disease. <b>Source:</b> ACC/AHA Key Data Elements and Definitions for Meas	haled or oral pharmacological therapy (e.g., beta-adre id). Patients with asthma or seasonal allergies are not o	nergic agonist, considered to
Element: 4285		Heart Failure Circulation. 2005;112:1888-1916 Coronary Artery Disease		
	ng Instruction:	Indicate if the patient has a history of coronary artery disease (C.	AD).	
Cour	-	Any occurrence between birth and the procedure	,	
Support	-	Coronary Artery Disease		
		A history of any of the following: - Coronary artery stenosis >=50% (by cardiac catheterization or of - Previous CABG surgery - Previous PCI - Previous MI <b>Source:</b> ACCF/AHA 2011 Key Data Elements and Definitions of (JACC 2011;58;202-222).		
Element: 4580		Sleep Apnea		
Codir	ng Instruction:	Indicate if the patient has a history of sleep apnea that has been Note(s):	diagnosed by a sleep study.	
		· · · · · · · · ·		





Section: Additional History and Risk Factors

Parent: History and Risk Factors

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

CPAP or BiPAP therapy is not a requirement to code "Yes" for sleep apnea.

Both Obstructive Sleep Apnea (recurrent collapse of the pharynx during sleep) and Central Sleep apnea: (transient cessation of neural drive to respiratory muscles) should be considered. Capture patients with prescribed home therapy despite frequency of use. Do not capture suspected sleep apnea or that reported by family members as sleep apnea. Sleep apnea must be diagnosed by a physician.

Target Value: Any occurrence between birth and the procedure

Element: 4585

Sleep Apnea Recommended Treatment Followed

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

Note(s):

CPAP or BiPAP therapy is not a requirement to code 'Yes' for sleep apnea.

Both Obstructive Sleep Apnea (recurrent collapse of the pharynx during sleep) and Central Sleep Apnea (transient cessation of neural drive to respiratory muscles) should be considered.

Capture patients with prescribed home therapy despite frequency of use. Code 'No' if sleep apnea has been surgically corrected.

Target Value: Any occurrence between birth and the procedure





Section: Epicardia	I Access Assess	nent	Parent: History and Risk Factors		
Element: 14824		Epicardial Approach Considered			
	Coding Instruction:	Indicate if an epicardial approach to th	e left atrial appendage intervention was considered for	or this episode of care.	
	Target Value:	Any occurrence between birth and the	e procedure		
Element: 14823		Medical Conditions			
	Coding Instruction:	Indicate if any of the following medical	conditions were present.		
	Target Value:	Any occurrence between birth and the	eprocedure		
	-	·			
Medical Conditions - 1. Selection	3.6.1.4.1.19376.1.4.1 Definition	.6.5.781	Source	Code	Code System
Cardiac Surgery		volving the coronary arteries, valves, or		64915003	SNOMED CT
		pair of the heart.			
Pericarditis	characterized b changes and o	by chest pain, electrocardiographic ften pericardial effusion. It is often the ectious or a noninfectious process but	Chiabrando JG, Bonaventure A, Vecchie A, et al. Management of acute and recurrent pericarditis. J An Coll Cardiol 2020;75:76-92.	3238004 m	SNOMED CT
Epicardial Access				11200002078	ACC NCDR
Thoracic Radiation Thera	ру			11200002090	ACC NCDR
Pectus Excavatum				391987005	SNOMED CT
Epigastric Surgery	0 1	dure in the epigastric region of the en, including epigastric hernia repair.		112000002091	ACC NCDR
Autoimmune Disease				85828009	SNOMED CT
Hepatomegaly				80515008	SNOMED CT
Hiatal Hernia		hiatus hernia is an abnormal bulging of stomach through the diaphragm	https://www.merckmanuals.com/home/digestive- disorders/esophageal-and-swallowing- disorders/hiatus-hernia	84089009	SNOMED CT
Element: 14825		Lupus Erythematosus			
	Coding Instruction:	Indicate if an Lupus Erythematosus was considered for this episode of care.	as the condition for which an epicardial approach to the	ne left atrial appendage i	ntervention was

Target Value: Any occurrence between birth and the procedure



Section: Diagnostic Studies

Parent: Root



Atrial Rhythm - 1.3.6.1 Selection Sinus node rhythm Atrial fibrillation Atrial tachycardia Atrial flutter Sinus arrest	Target Value:	Indicate the patient's atrial rhythm at the start of the procedure. The last value within 30 days prior to the first procedure in this admission		
Selection Sinus node rhythm Atrial fibrillation Atrial tachycardia Atrial flutter	.4.1.19376.1.4.1.6.5.18			
Selection Sinus node rhythm Atrial fibrillation Atrial tachycardia Atrial flutter		7		
Sinus node rhythm Atrial fibrillation Atrial tachycardia Atrial flutter	Definition			
Atrial fibrillation Atrial tachycardia Atrial flutter		Source	Code	Code System
Atrial tachycardia Atrial flutter			106067008 49436004	SNOMED C
Atrial flutter			276796006	SNOMED C
			5370000	SNOMED C
Sinus anesi			5609005	SNOMED C
Atrial paced			251268003	SNOMED C
Not Documented			100001116	ACC NCD
Element: 5110		LVEF Assessed		
	Coding Instruction:	Indicate if a left ejection fraction percentage has been assessed.		
	Target Value:	The last value between 90 days prior to the start of the current procedure and the start of	procedure	
Element: 5115		Most Recent LVEF %		
	Coding Instruction:	Indicate the most recent left ventricular ejection fraction.		
	Target Value:	The last value between 90 days prior to the start of the current procedure and the start of	procedure	
Si	upporting Definition:	Most Recent LVEF %		
		The left ventricular ejection fraction is the percentage of blood emptied from the left ventric	le at the end of contraction.	
		Source: ACC Clinical Data Standards, Society for Thoracic Surgeons Adult Cardiac Surg		
Element: 5120		Transthoracic Echo (TTE) Performed		
	Coding Instruction:	Indicate if a transthoracic echocardiogram (TTE) was performed prior to the procedure.		
	Target Value:	The last value between 90 days prior to the start of the current procedure and the start of	procedure	
Element: 5125		Most Recent TTE Date		
	Coding Instruction:	Indicate the date of the most recent transthoracic echocardiogram (TTE) performed and us	ed to evaluate the patient fo	r this intervention.
	Target Value:	The last value between 90 days prior to the start of the current procedure and the start of	procedure	
	Vendor Instruction:	Most Recent TTE Date (5125) must be Less than or Equal to the Procedure Start Date and T	ïme (7000)	
Element: 5170		Baseline Imaging Performed		
	Coding Instruction:	Indicate if pre-procedure imaging was performed.		
	-	The last value between 90 days prior to the start of the current procedure and the start of	procedure	
Element: 5175		Baseline CT Performed		
	Coding Instruction:	Indicate if pre-procedure imaging was performed via CT.		
	Target Value:	The last value between 90 days prior to the start of the current procedure and the start of	procedure	
Element: 5180		Most Recent CT Date		
	Coding Instruction:	Indicate the date of the most recent CT imaging.		
	Target Value:	The last value between 90 days prior to the start of the current procedure and the start of	procedure	
	Vendor Instruction:	Most Recent CT Date (5180) must be Less than or Equal to the Procedure Start Date and Ti	me (7000)	
Element: 5185		Baseline MRI Performed		
	Coding Instruction:	Indicate if pre-procedure imaging was performed via MRI.		
	Target Value:	The last value between 90 days prior to the start of the current procedure and the start of	procedure	





Section: Diagnostic Studies	Parent: Root
Coding Instruction:	Indicate the date of the most recent MRI imaging.
Target Value:	The last value between 90 days prior to the start of the current procedure and the start of procedure
Vendor Instruction:	Most Recent MRI Date (5190) must be Less than or Equal to the Procedure Start Date and Time (7000)
Element: 14826	Intracardiac Echo Performed
Coding Instruction:	Indicate if pre-procedure imaging was performed via intracardiac echo (ICE).
Target Value:	The last value between 90 days prior to the start of the current procedure and the start of procedure
Supporting Definition:	Intracardiac three dimensional echocardiography
	Intracardiac echocardiography (ICE) is an imaging technique that is increasingly available as an alternative to transoesophageal echocardiography to guide percutaneous interventional procedures.
	<b>Source:</b> Mitchell ARJ, Puwanarajah P, Timperley J, Becher H, Wilson N, Ormero OJ. The Emerging Role of Intracardiac Echocardiography Into the ICE Age. Br J Cardiol. 2007;14(1):31-36.
Element: 14827	Date of Intracardiac Echo
Coding Instruction:	Indicate the date of the most recent intracardiac echo (ICE).
Target Value:	The last value between 90 days prior to the start of the current procedure and the start of procedure
Supporting Definition:	Intracardiac three dimensional echocardiography
	Intracardiac echocardiography (ICE) is an imaging technique that is increasingly available as an alternative to transoesophageal echocardiography to guide percutaneous interventional procedures.
	<b>Source:</b> Mitchell ARJ, Puwanarajah P, Timperley J, Becher H, Wilson N, Ormero OJ. The Emerging Role of Intracardiac Echocardiography Into the ICE Age. Br J Cardiol. 2007;14(1):31-36.





Section: Physic	cal Exam and Labs	Parent: Root
Element: 6000		Height
	Coding Instruction:	Indicate the patient's height in centimeters.
	-	The last value prior to the start of the first procedure
	-	
Element: 6005		Weight
	Coding Instruction:	Indicate the patient's weight in kilograms.
	Target Value:	The last value prior to the start of the first procedure
Element: 6010		Dular
	Coding Instruction	Pulse
	-	Indicate the patient's heart rate (beats per minute). The last value prior to the start of the first procedure
	Target value.	
Element: 6015		Systolic BP
	Coding Instruction:	Indicate the patient's systolic blood pressure in mmHg.
	Target Value:	The last value prior to the start of the first procedure
Element: 6020		Diastolic BP
	Coding Instruction:	Indicate the patient's diastolic blood pressure in mmHg.
	Target Value:	The last value prior to the start of the first procedure
Element: 6030		Hemoglobin
	Coding Instruction:	Indicate the hemoglobin (Hgb) value in g/dL.
	county instruction.	
		Note(s): This may include POC (Point of Care) testing results or results obtained prior to arrival at this facility.
	Target Value:	The last value within 30 days prior to the first procedure in this admission
	Supporting Definition:	Hemoglobin
		Hemoglobin (Hb or Hgb) is the iron-containing oxygen-transport metalloprotein in the red blood cells. It carries oxygen from the lungs to the rest of the body (i.e. the tissues) where it releases the oxygen to burn nutrients and provide energy. Hemoglobin concentration measurement is among the most commonly performed blood tests, usually as part of a complete blood count. If the concentration is below normal, this is called anemia. Anemias are classified by the size of red blood cells: "microcytic" if red cells are small, "macrocytic" if they are large, and "normocytic" if otherwise. Dehydration or hyperhydration can greatly influence measured hemoglobin levels. <b>Source:</b> http://s.details.loinc.org/LOINC/718-7.html?sections=Simple
Element: 6031		Hemoglobin Not Drawn
	Coding Instruction:	Indicate if the hemoglobin was not drawn.
	Target Value:	The last value within 30 days prior to the first procedure in this admission
	Supporting Definition:	Hemoglobin
		Hemoglobin (Hb or Hgb) is the iron-containing oxygen-transport metalloprotein in the red blood cells. It carries oxygen from the lungs to the rest of the body (i.e. the tissues) where it releases the oxygen to burn nutrients and provide energy. Hemoglobin concentration measurement is among the most commonly performed blood tests, usually as part of a complete blood count. If the concentration is below normal, this is called anemia. Anemias are classified by the size of red blood cells: "microcytic" if red cells are small, "macrocytic" if they are large, and "normocytic" if otherwise. Dehydration or hyperhydration can greatly influence measured hemoglobin levels. <b>Source:</b> http://s.details.loinc.org/LOINC/718-7.html?sections=Simple
Element: 6040		Prothrombin Time (PT)
	Coding Instruction:	Indicate the last prothrombin time (PT) in seconds.
		Note(s): This may include POC (Point of Care) testing results.
		Most recent values prior to the start of the procedure.
	Target Value:	The last value between 1 day prior to the procedure and the current procedure
	Supporting Definition:	Prothrombin Time (PT)
		The prothrombin time (PT) and its derived measures of prothrombin ratio (PR) and international normalized ratio (INR) are measures of the extrinsic pathway of coagulation. They are used to determine the clotting tendency of blood, in the measure of warfarin dosage, liver Effective for Patients Discharged on/after October (
American College of C	ardiology Foundation	4/4/2025 1:41:46 PM Page 2





Section: Phys	ical Exam and Labs	Parent: Root
		damage and vitamin K status. The reference range for prothrombin time is usually around 12-15 seconds; the normal range for the INR is 0.8-1.2. It is used in conjunction with the activated partial thromboplastin time (aPTT) which measures the intrinsic pathway. PT is sometimes used as the third screening test in the lupus anticoagulant testing algorithm and is included in the LOINC LA aPTT & dRVVT & PT panel. <b>Source:</b> http://s.details.loinc.org/LOINC/5902-2.html?sections=Simple
Element: 6041		Prothrombin Not Drawn
	0	Indicate if prothrombin (PT) was not drawn.
	Target Value:	
	Supporting Definition:	Prothrombin Time (PT) The prothrombin time (PT) and its derived measures of prothrombin ratio (PR) and international normalized ratio (INR) are measures of the extrinsic pathway of coagulation. They are used to determine the clotting tendency of blood, in the measure of warfarin dosage, liver damage and vitamin K status. The reference range for prothrombin time is usually around 12-15 seconds; the normal range for the INR is 0.8-1.2. It is used in conjunction with the activated partial thromboplastin time (aPTT) which measures the intrinsic pathway. PT is sometimes used as the third screening test in the lupus anticoagulant testing algorithm and is included in the LOINC LA aPTT & dRVVT & PT panel. Source: http://s.details.loinc.org/LOINC/5902-2.html?sections=Simple
Element: 6045		International Normalized Ratio (INR)
	Coding Instruction:	Indicate the international normalized ratio (INR) if the patient was on routine Warfarin/Coumadin therapy.
		Note(s): This may include POC (Point of Care) testing results.
	Target Value:	Most recent values prior to the start of the procedure. The last value between 1 day prior to the procedure and the current procedure
	_	International Normalized Ratio (INR)
		The INR is specifically intented for evaluating protime results on patients stabilized on long term oral anticoagulant therapy. The INR is not appropriate to evaluate hemostatic function in patients with liver disease, for screening for hereditary factor deficiencies or acquired vitamin K deficiencies, or for routine preoperative screening; this should be evaluated on the normal range in seconds. INR is calculated by the equation, INR = (PTR) raised to the power of ISI, where ISI = International Sensitivity Index (assigned to each reagent thromboplastin). PTR = prothrombin time ratio (pat PT/pop mean PT). Computation of the INR of specific thromboplastin reagent should allow for uniformity in prothrombin time testing regardless of the reagent system or instrumentation used. <b>Source:</b> http://s.details.loinc.org/LOINC/6301-6.html?sections=Simple
Element: 6046		International Normalized Ratio Not Drawn
	Coding Instruction:	Indicate if INR was not drawn.
	Target Value:	N/A
	Supporting Definition:	International Normalized Ratio (INR)
		The INR is specifically intented for evaluating protime results on patients stabilized on long term oral anticoagulant therapy. The INR is not appropriate to evaluate hemostatic function in patients with liver disease, for screening for hereditary factor deficiencies or acquired vitamin K deficiencies, or for routine preoperative screening; this should be evaluated on the normal range in seconds. INR is calculated by the equation, INR = (PTR) raised to the power of ISI, where ISI = International Sensitivity Index (assigned to each reagent thromboplastin). PTR = prothrombin time ratio (pat PT/pop mean PT). Computation of the INR of specific thromboplastin reagent should allow for uniformity in prothrombin time testing regardless of the reagent system or instrumentation used. <b>Source:</b> http://s.details.loinc.org/LOINC/6301-6.html?sections=Simple
Element: 6050		Creatinine
	Coding Instruction:	Indicate the creatinine (Cr) level mg/dL.
		Note(s): This may include POC (Point of Care) testing results or results obtained prior to arrival at this facility.
	-	The last value between 30 days prior to the procedure and the current procedure
	Supporting Definition:	Creatinine Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine results in the formation of creatinine. It is transferred to the kidneys by blood plasma, whereupon it is eliminated by glomerular filtration and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A rise in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver and pancreas. <b>Source:</b> http://s.details.loinc.org/LOINC/2160-0.html?sections=Simple
Element: 6051		Creatinine Not Drawn
		Effective for Patients Discharged on/after October 0





Section: Physical Exa	n and Labs	Parent: Root		
Codin	g Instruction:	Indicate if a creatinine level was not drawn.		
	Target Value:	N/A		
Support	ing Definition:			
		Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. results in the formation of creatinine. It is transferred to the kidneys by blood plasma, where and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and me in blood creatinine levels is observed only with marked damage to functioning nephrons; the early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver <b>Source:</b> http://s.details.loinc.org/LOINC/2160-0.html?sections=Simple	eupon it is eliminated by gla easuring its serum level is a nerefore this test is not suit	omerular filtration a simple test. A rise
Element: 14210		Albumin		
Codin	g Instruction:	Indicate the total albumin (in g/dL).		
	Target Value:	The last value between 30 days prior to the procedure and the current procedure		
Element: 14211		Albumin Not Drawn		
Codin	g Instruction:	Indicate true if the total albumin was not drawn		
	Target Value:	N/A		
Element: 13213		Platelet Count		
Codin	g Instruction:	Indicate the pre-procedure platelet count in platelets per microliter.		
	-	The last value between 30 days prior to the procedure and the current procedure		
Element: 13214		Platelet Count Not Drawn		
Codin	a Instruction:	Indicate if a platelet count was not drawn prior to the procedure.		
	Target Value:			
Element: 14805		Modified Rankin Scale		
Codin	g Instruction:	Indicate the patient's functional ability according to the modified Rankin Scale (mRS) admin	istered pre-procedure.	
	Target Value:	The last value between 30 days prior to the procedure and the current procedure		
Support	ing Definition:	Modified Rankin Scale		
	-	The Modified Rankin Scale is a standardized neurological examination of patients with disa	bility that provides a scale	of global disability.
		Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med	J. 1957; 2:200-15.	
		Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stro	oke. Stroke. 1988;19(12):14	197-1500.
Rankin Scale Assessment F	-			
Selection	Definition	Source	Code LA6111-4	Code Syster
0: No symptoms at all 1: No significant disability despite symptoms	Able to carry or	ut all usual duties and activities.	LA6111-4 LA6112-2	LOIN
2: Slight disability		out all previous activities, but able to affairs without assistance.	LA6113-0	LOIN
3: Moderate disability	Requiring some assistance.	help, but able to walk without	LA6114-8	LOIN
4: Moderately severe disability		without assistance and unable to attend eeds without assistance.	LA6115-5	LOIN
5: Severe disability	Bedridden, inco care and attent	ontinent and requiring constant nursing ion.	LA10137-0	LOIN
6: Death			419620001	SNOMED C
Element: 9130		Modified Rankin Scale Not Administered		
Codin	-	Indicate if the Modified Rankin Scale was not administered after the current procedure.		
_	Target Value:			
Support	ing Definition:	Modified Rankin Scale	hility that provides a sector	of global disability
		The Modified Rankin Scale is a standardized neurological examination of patients with disa <b>Source:</b> Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med		or giodal disadility.
			J. 1997, Z.200-13.	

Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.





# Section: Pre-Procedure Medications

Parent: Root

Element: 6985

Coding Instruction: Indicate the NCDR-assigned IDs for the medications prescribed within 24 hours prior the procedure.

Target Value: Any occurrence within 24 hours prior to start of current procedure

Pre-procedure Medication Code

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

#### Pre-Procedure Medication - 1.3.6.1.4.1.19376.1.4.1.6.5.216

Selection	Definition	Source	Code	Code System
Fondaparinux			321208	RxNorm
Heparin Derivative			100000921	ACC NCDR
Low Molecular Weigh	nt Heparin		373294004	SNOMED CT
Unfractionated Hepar	rin		96382006	SNOMED CT
Warfarin			11289	RxNorm
Aspirin 81 to 100 mg			11200002080	ACC NCDR
Aspirin 101 to 324 mg	g		11200002081	ACC NCDR
Aspirin 325 mg			317300	RxNorm
Aspirin/Dipyridamole			226716	RxNorm
Vorapaxar			1537034	RxNorm
Apixaban			1364430	RxNorm
Dabigatran			1546356	RxNorm
Edoxaban			1599538	RxNorm
Rivaroxaban			1114195	RxNorm
Cangrelor			1656052	RxNorm
Clopidogrel			32968	RxNorm
Other P2Y12			112000001003	ACC NCDR
Prasugrel			613391	RxNorm
Ticagrelor			1116632	RxNorm
Ticlopidine			10594	RxNorm

Element: 14883

Medication Administered

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

Target Value: Any occurrence within 24 hours prior to start of current procedure

Vendor Instruction: When a Pre-procedure Medication Code (6985) is selected, Medication Administered (14883) cannot be Null

#### Pre-procedure Medication Administration - 1.3.6.1.4.1.19376.1.4.1.6.5.44

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





Section: Pre-Procedure Diagnostic	S Parent: Procedure Information
Element: 14828	Transesophageal Echocardiogram (TEE) Performed
Coding Instruction:	Indicate if transesophageal echocardiogram (TEE) was performed prior to the device insertion or attempted device insertion during the current procedure.
	Note: Prior to current procedure refers to prior to start of current procedure.
Target Value:	The last value between 1 week prior to current procedure and current procedure
Element: 14829	Most Recent TEE Date
Coding Instruction:	Indicate the date of the most recent transesophageal echocardiogram (TEE) performed prior to the device insertion or attempted device insertion during the current procedure.
Target Value:	The last value between 1 week prior to current procedure and current procedure
Vendor Instruction:	Most Recent TEE Date (14829) must be Less than or Equal to the Procedure Start Date and Time (7000)
Element: 14838	Atrial Thrombus Detected
Coding Instruction:	Indicate if an atrial thrombus was detected or suspected.
Target Value:	The last value between 1 week prior to current procedure and current procedure
Supporting Definition:	Atrial Thrombus Detected
	Presence of thrombus is considered to be definite if 3 of the following 5 criteria are present: Clear borders, echogenicity from the surrounding structures, independent mobility, longest diameter > 15mm, seen in more than one echocardiographic plane.
	<b>Source:</b> Buxton AE, Calkins H, Callans DJ, et al. ACC/AHA/HRS 2006 Key Data Elements and Definitions for Electrophysiological Studies and Procedures: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Data Standards (ACC/AHA/HRS Writing Committee to Develop Data Standards on Electrophysiology). J Am Coll Cardiol. 2006;48(11):2360-2396.
Element: 14830	Left Atrial Appendage Occlusion Orifice width
Coding Instruction:	Indicate the maximal orifice width of the left atrial appendage (LAA) in mm.

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





	lure	Parent: Procedure Information		
Element: 7000		Procedure Start Date and Time		
	Coding Instruction:	Indicate the procedure start time as the time that the patient entered the location in which the proced	dure is intended to	be performed.
	Target Value:	Any occurrence on current procedure		
	Vendor Instruction:	Procedure Start Date and Time (7000) must be Greater than or Equal to Arrival Date (3000)		
		Procedure Start Date and Time (7000) must be Less than or Equal to Procedure End Date and Time (	(7005)	
		Procedure Start Date and Time (7000) must be Less than or Equal to Discharge Date (10100)		
Element: 7005		Procedure End Date and Time		
	Coding Instruction:	Indicate the ending date and time at which the operator completes the procedure and breaks scrub	at the end of the p	rocedure.
		Note(s):		
		If more than one operator is involved in the case then use the date and time the last operator breaks	s scrub for the last	time.
	Target Value:	The value on current procedure		
	Vendor Instruction:	Procedure End Date and Time (7005) must be Less than or Equal to Discharge Date (10100)		
		Procedure End Date and Time (7005) and Procedure Start Date and Time (7000) must not overlap or	n multiple procedur	es
Element: 14732		Shared Decision Making		
	Coding Instruction:	Indicate if shared decision making was performed for the procedure.		
	Target Value:	The value on current procedure		
Element: 14733		Shared Decision Making Tool Used		
	Coding Instruction:	Indicate if a shared decision making tool was used.		
	Target Value:	The value on current procedure		
Element: 14734		Shared Decision Making Tool Name		
	Coding Instruction:	Indicate what tool was used. If the tool used is not in the drop-down list, please contact NCDR@acc.org to have a selection adde	d.	
	Target Value:	The value on current procedure		
hared Decision Mal	king Tools - 1.3.6.1.4.1.	.19376.1.4.1.6.5.765		
election	Definition	Source	Code	Code Syste
			100000351	
	Making		100000001	ACC NC
ool	iviaking	Procedure Location	100000001	ACC NC
ool		Procedure Location Indicate the location where the procedure was performed.		ACC NC
ool	Coding Instruction:			ACC NC
cool Element: 12871 Procedure Location	Coding Instruction: Target Value: - 1.3.6.1.4.1.19376.1.4.1	Indicate the location where the procedure was performed. The value on current procedure 1.6.5.327		
ool Element: 12871 Procedure Location	Coding Instruction: Target Value:	Indicate the location where the procedure was performed. The value on current procedure I.6.5.327 Source	Code 225738002	Code Syste
Cool Element: 12871 Procedure Location Selection Operating Room	Coding Instruction: Target Value: - 1.3.6.1.4.1.19376.1.4.1 Definition	Indicate the location where the procedure was performed. The value on current procedure I.6.5.327 Source	Code	Code Syst
Tool Element: 12871 Procedure Location Selection Deperating Room Hybrid Operating Room Cardiac Catheterization	Coding Instruction: Target Value: - 1.3.6.1.4.1.19376.1.4.1 Definition	Indicate the location where the procedure was performed. The value on current procedure I.6.5.327 Source 1120	<b>Code</b> 225738002	Code Syst SNOMED ACC NC
Cool Element: 12871 Procedure Location Selection Deperating Room Hybrid Operating Room Cardiac Catheterization aboratory Hybrid Catheterization	Coding Instruction: Target Value: - 1.3.6.1.4.1.19376.1.4.1 Definition	Indicate the location where the procedure was performed. The value on current procedure I.6.5.327 Source 1120 1120 1120	<b>Code</b> 225738002 000001265	Code Syst SNOMED ACC NC ACC NC
Cool Element: 12871 Procedure Location Election Operating Room Sybrid Operating Room Cardiac Catheterization aboratory Hybrid Catheterization aboratory Suite	Coding Instruction: Target Value: - 1.3.6.1.4.1.19376.1.4.1 Definition	Indicate the location where the procedure was performed. The value on current procedure I.6.5.327 Source 1124 1124 1124 1124	<b>Code</b> 225738002 000001265 000000616	Code Syst SNOMED ACC NC ACC NC ACC NC
Cool Element: 12871 Procedure Location Selection Deprating Room Hybrid Operating Roorr Ladoratory Hybrid Catheterization Laboratory Hybrid Catheterization Laboratory Suite EP Lab	Coding Instruction: Target Value: - 1.3.6.1.4.1.19376.1.4.1 Definition	Indicate the location where the procedure was performed. The value on current procedure I.6.5.327 Source 1124 1124 1124 1124	Code 225738002 000001265 000000616 000001266	Code Syst SNOMED ACC NC ACC NC ACC NC
Fool Element: 12871 Procedure Location - Selection Operating Room Hybrid Operating Room Cardiac Catheterization Laboratory Hybrid Catheterization Laboratory Suite EP Lab	Coding Instruction: Target Value: - 1.3.6.1.4.1.19376.1.4.1 Definition	Indicate the location where the procedure was performed. The value on current procedure I.6.5.327 Source 1120 1120 1120 1120 1120 1120 1120 112	Code 225738002 000001265 000000616 000001266	Code Syst SNOMED ACC NC ACC NC ACC NC
Cool Element: 12871 Procedure Location Selection Deprating Room Hybrid Operating Roorr Ladoratory Hybrid Catheterization Laboratory Hybrid Catheterization Laboratory Suite EP Lab	Coding Instruction: Target Value: - 1.3.6.1.4.1.19376.1.4.1 Definition	Indicate the location where the procedure was performed. The value on current procedure  I.6.5.327  Source  1120 1120 1120 1120 Sedation	Code 225738002 000001265 000000616 000001266	Code Syste SNOMED ACC NC ACC NC ACC NC
Fool Element: 12871 Procedure Location Selection Operating Room Hybrid Operating Room Hybrid Operating Room Cardiac Catheterization Laboratory Hybrid Catheterization Laboratory Suite EP Lab Element: 7130 Sedation Method - 1.	Coding Instruction: Target Value: -1.3.6.1.4.1.19376.1.4.1 Definition	Indicate the location where the procedure was performed. The value on current procedure  I.6.5.327  Source  1121 1121 1122 1122 1122 Sedation Indicate the type of sedation used for the intervention. The value on current procedure 5.199	Code 225738002 000001265 000000616 000001266 000002109	Code Syste SNOMED ACC NCI ACC NCI ACC NCI
Selection Derating Room Hybrid Operating Room Cardiac Catheterization Laboratory Hybrid Catheterization Laboratory Suite EP Lab Element: 7130	Coding Instruction: Target Value: -1.3.6.1.4.1.19376.1.4.1 Definition	Indicate the location where the procedure was performed. The value on current procedure  I.6.5.327  Source  I120 I120 I120 I120 I120 I120 I120 I12	Code 225738002 000001265 000000616 000001266	Code Syste



# Coder's Data Dictionary v1.4



## Section: Procedure

Deep sedation/Analgesia		426155000	SNOMED CT
General Anesthesia		420653000	SNOMED CT
Element: 14837	LAA Occlusion Indication		

Parent: Procedure Information

\_ \_ \_ \_

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

Target Value: The value on current procedure

Supporting Definition: Procedure Indication

The primary reason the procedure is being performed

Source:

#### LAAO Indications - 1.3.6.1.4.1.19376.1.4.1.6.5.784

Selection	Definition	Source	Code	Code System
High fall risk			11200000398	ACC NCDR
History of major bleed			112000002105	ACC NCDR
Clinically significant bleeding risk (Other than those listed here)			711536002	SNOMED CT
Increased thromboembolic stroke risk			112000002106	ACC NCDR
Labile INR			100001024	ACC NCDR
Non-compliance with anticoagulation therapy			112000002108	ACC NCDR
Patient preference			11200002107	ACC NCDR

#### Element: 14834

Procedure Canceled

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

Target Value: The value on current procedure

Element: 14833

Procedure Canceled Reason

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

Target Value: The value on current procedure

#### Procedure Canceled Reasons - 1.3.6.1.4.1.19376.1.4.1.6.5.783

Selection	Definition	Source	Code	Code System
Anatomy not conducive for implant	r		112000002093	ACC NCDR
Appendage too large (for device implant)			112000002096	ACC NCDR
Appendage too small (for device implant)			112000002097	ACC NCDR
Catherization challenge			11200002094	ACC NCDR
Decompensation in patient condition			112000002098	ACC NCDR
Epicardial access issue			112000002100	ACC NCDR
Thrombus detected			11200002095	ACC NCDR
Unanticipated patient condi	tion		11200002099	ACC NCDR
Patient/Family choice			112000002101	ACC NCDR

#### Element: 14831

Procedure Aborted

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

#### Target Value: The value on current procedure

Vendor Instruction: If Device Successfully Deployed (14968) is 'Yes' for at least one device under the procedure, then Procedure Aborted (14831) must be 'No'.

If Device Successfully Deployed (14968) is 'No' for all the devices under the procedure, then Procedure Aborted (14831) must be 'Yes'.

If Procedure Aborted (14831) is 'No', at least one device within the procedure must have Device Successfully Deployed (14968) equal to 'Yes'

Element: 14832





#### Section: Procedure

#### **Parent: Procedure Information**

 $\label{eq:coding_loss} \textbf{Coding Instruction:} \quad \text{Indicate the reason(s) why the procedure was aborted.}$ 

Target Value: The value on current procedure

#### Procedure Aborted Reasons - 1.3.6.1.4.1.19376.1.4.1.6.5.782

Selection	Definition	Source	Code	Code System
Anatomy not conducive timplant	for		112000002093	ACC NCDR
Appendage too large (for device implant)	r		112000002096	ACC NCDR
Appendage too small (fo device implant)	r		112000002097	ACC NCDR
Catherization challenge			11200002094	ACC NCDR
Decompensation in patier condition	nt		112000002098	ACC NCDR
Device related			112000001828	ACC NCDR
Transcatheter device ret	rieval		112000002124	ACC NCDR
Device release criteria no	ot met		11200002104	ACC NCDR
Epicardial access issue			11200002100	ACC NCDR
Surgical device retrieval			112000001838	ACC NCDR
Device associated throm developed during proced			112000002103	ACC NCDR
Unanticipated patient con	ndition		11200002099	ACC NCDR
Patient/Family choice			112000002101	ACC NCDR

Element: 14848

# Device Margin Residual Leak

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

Target Value: The value on current procedure

#### Element: 14849 De

Device Margin Residual Leak Not Assessed

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

Target Value: The value on current procedure

Element: 7200

Guidance Method

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

Note(s):

The method(s) that should be collected in your application are controlled by a Guidance Method 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

Selection	Definition	Source	Code	Code System	
Intracardiac three dimension echocardiography	nal		448761005	SNOMED CT	
Electro Anatomic Mapping			100000908	ACC NCDR	
Fluoroscopy			44491008	SNOMED CT	
Transesophageal Echocardiogram (TEE)		105376000 SNO			
Element: 14846		Conversion to Open Heart Surgery			
Co	ding Instruction:	Indicate if this procedure converted to open heart surgery.			
	Target Value:	The value on current procedure			
Element: 14847		Conversion to Open Heart Surgery Reason			
Co	ding Instruction:	Indicate the reason why the procedure converted to open heart surgical access.			
	Target Value:	The value on current procedure			
Conversion to Open Hea	rt Surgery Reaso	ns - 1.3.6.1.4.1.19376.1.4.1.6.5.787			

Selection	Definition	Source	Code	Code System
Complication			88797001	SNOMED CT
Device Retrieval			112000001838	ACC NCDR
Unfavorable Anatomy			112000002114	ACC NCDR





Section: Procedure			
Medical decision for ope ligation of appendage	n	11200002115	ACC NCD
Element: 14855		Concomitant Procedures Performed	
	Coding Instruction:	Indicate if other procedures (Afib Ablation, ICD, PCI, TAVR or TMVR) were performed during the same lab visit as this	procedure.
	Target Value:	The value on current procedure	
Element: 14857		Concomitant Procedures	
	Coding Instruction:	Indicate which specific other procedures were performed during the same lab visit.	
	Target Value:	The value on ourrest procedure	
	ranget value.	The value on current procedure	
Concomitant Procedu	-		
Concomitant Procedu Selection	-		Code Systen
Selection	res Type - 2.16.840.1.	.113883.3.3478.6.4.10	
Selection AFib Ablation - Cryo	res Type - 2.16.840.1.	113883.3.3478.6.4.10 Source Code	ACC NCD
Selection AFib Ablation - Cryo AFib Ablation - PFA AFib Ablation -	res Type - 2.16.840.1.	113883.3.3478.6.4.10 Source Code 11200004250	ACC NCD ACC NCD
Selection AFib Ablation - Cryo AFib Ablation - PFA AFib Ablation - Radiofrequency	res Type - 2.16.840.1.	113883.3.3478.6.4.10  Source Code 11200004250 11200004251	ACC NCD ACC NCD ACC NCD
Selection AFib Ablation - Cryo AFib Ablation - PFA AFib Ablation - Radiofrequency AFib Ablation - Other	res Type - 2.16.840.1.	Source         Code           112000004250         112000004250           112000004251         112000004252	ACC NCD ACC NCD ACC NCD ACC NCD
Selection AFib Ablation - Cryo AFib Ablation - PFA AFib Ablation - Radiofrequency AFib Ablation - Other AFib Ablation	res Type - 2.16.840.1.	Source         Code           112000004250         112000004250           112000004251         112000004252           112000004252         112000004252	ACC NCD ACC NCD ACC NCD ACC NCD ACC NCD SNOMED C
Selection AFib Ablation - Cryo AFib Ablation - PFA AFib Ablation - Radiofrequency AFib Ablation - Other AFib Ablation CD	res Type - 2.16.840.1.	Source         Code           11200004250         11200004250           11200004251         11200004251           11200004252         11200004253           11200004253         11200004253           11200004253         11200004253	ACC NCD ACC NCD ACC NCD ACC NCD SNOMED C ACC NCD
Selection AFib Ablation - Cryo AFib Ablation - PFA AFib Ablation - Radiofrequency AFib Ablation - Other AFib Ablation CD	res Type - 2.16.840.1.	Source         Code           11200004250         11200004250           11200004251         11200004251           11200004252         11200004253           11200004253         11200004253           11200004253         11200004253           ACC-NCDR-ICD         ACC-NCDR-ICD	ACC NCD ACC NCD ACC NCD ACC NCD SNOMED C ACC NCD SNOMED C
Selection AFib Ablation - Cryo AFib Ablation - PFA AFib Ablation - Radiofrequency AFib Ablation - Other AFib Ablation ICD PCI TAVR	res Type - 2.16.840.1.	Source         Code           11200004250         11200004250           11200004251         11200004252           11200004253         11200004253           11200004253         1120	ACC NCD ACC NCD ACC NCD ACC NCD SNOMED C ACC NCD SNOMED C SNOMED C
Selection AFib Ablation - Cryo AFib Ablation - PFA AFib Ablation - Radiofrequency AFib Ablation - Other AFib Ablation ICD PCI TAVR TMVR	res Type - 2.16.840.1.	Source         Code           112883.3.3478.6.4.10         112000004250           112000004250         112000004251           112000004252         112000004252           112000004253         112000004253 </td <td>ACC NCD ACC NCD ACC NCD ACC NCD SNOMED C ACC NCD SNOMED C SNOMED C ACC NCD</td>	ACC NCD ACC NCD ACC NCD ACC NCD SNOMED C ACC NCD SNOMED C SNOMED C ACC NCD
	res Type - 2.16.840.1.	Source         Code           11200004250         11200004250           11200004251         11200004252           11200004253         11200004253           11200004253         11200004253           11200004253         11200004253           11200004253         11200004253           11200004253         11200004253           112000004253         112000004253           112000004253         112000004253           112000004253         112000004253           112000004253         112000004253           11200001801         112000001801	Code System ACC NCDI ACC NCDI ACC NCDI ACC NCDI SNOMED C SNOMED C SNOMED C ACC NCDI SNOMED C ACC NCDI





Section: Operator Information	Parent: Procedure
Element: 14861	Operator Last Name
	Indicate the last name of operator.
	Note(s):
	If the name exceeds 50 characters, enter the first 50 characters only.
Target Value:	The value on current procedure
Vendor Instruction:	Operator Last Name (14861) cannot be Null
Element: 14860	Operator First Name
Coding Instruction:	Indicate the first name of operator.
	Note(s):
	If the name exceeds 50 characters, enter the first 50 characters only.
Target Value:	The value on current procedure
Vendor Instruction:	Operator First Name (14860) cannot be Null
Element: 14862	Operator Middle Name
Coding Instruction:	Indicate the middle name of operator.
	Note(s):
	If the name exceeds 50 characters, enter the first 50 characters only.
Target Value:	The value on current procedure
Element: 14863	LAAO 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:	LAAO Operator NPI (14863) cannot be Null
	LAAO Operator NPI (14863) may only be entered/selected once.





Section: Fellow Information	Parent: Procedure
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:	Fellow NPI (15436) may only be entered/selected once.
	The LAAO Operator NPI (14863) cannot be equal to the Fellow NPI (15436) within the same procedure, i.e., an individual cannot be the Operator and Fellow for the same 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.
	<b>Source:</b> A list of programs by specialty can be found here: ACGME - Accreditation Data System (ADS): https://apps.acgme.org/ads/Public/Reports/Report/1.





Section: Access S	systems	Parent: Procedure Information
Element: 14840		Access System Counter
	Coding Instruction:	The access system counter distinguishes an individual access system when multiple are used during one procedure.
	Target Value:	The value on current procedure
Element: 14839		Access System ID
	Coding Instruction:	Indicate the access system(s) utilized during the current procedure.
	Target Value:	The value on current procedure
,	Vendor Instruction:	Access System ID (14839) cannot be Null when Procedure Canceled (14834) is No





Section: Device	es	Parent: Access Systems		
Element: 14842		Device Counter		
	Coding Instruction:	The device counter distinguishes individual devices when multiple are used during one procedure.		
	-	The value on current procedure		
Element: 14841		Device ID		
	Coding Instruction:	Indicate the device(s) utilized during the current procedure.		
	Target Value:	The value on current procedure		
Element: 14843		Device UDI Direct Identifier		
	Coding Instruction:	[Reserved for Future Use] Indicate the direct identifier portion of the Unique Device Identifier (UDI) asso ID is provided by the device manufacturer, and is either a GTIN or HIBBC number.	ociated with the	device used. This
	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 through its distribution and use. This value is supplied to the FDA by the manufacturer.	to uniquely iden	tify a device
		Source: US FDA		
Element: 14844		LAA Isolation Approach		
	Coding Instruction:	Indicate which approach was used to deliver the closure device.		
	Target Value:	The value on current procedure		
	es - 1.3.6.1.4.1.19376.1.4			
Selection	Definition	Source	Code	Code Syste
Epicardial Percutaneous			0002078 3388001	ACC NCE SNOMED (
Element: 14968		Device Successfully Deployed		
	Coding Instruction:	Indicate whether the device was successfully deployed.		
	Target Value:	The value on current procedure		
	Vendor Instruction:	When Device ID (14841) is provided then Device Successfully Deployed (14968) cannot be Null.		
		If more than one Device Counter (14842) within the Procedure/Lab Visit have identical LAA Isolation A	pproach (14844)	) values, then only
		one Device Counter (14842) can have a Device Successfully Deployed (14968) = 'Yes'.		
Element: 14845		one Device Counter (14842) can have a Device Successfully Deployed (14968) = 'Yes'. Reason Device Not Deployed Successfully		
Element: 14845	Coding Instruction:			
Element: 14845	-	Reason Device Not Deployed Successfully		
Element: 14845	Target Value:	Reason Device Not Deployed Successfully Indicate the outcome listed for the device unsuccessfully deployed.	(14845) cannot	be Null
	Target Value:	Reason Device Not Deployed Successfully Indicate the outcome listed for the device unsuccessfully deployed. The value on current procedure When Device Successfully Deployed (14968) is No then Outcome of Device Unsuccessfully Deployed	(14845) cannot	be Null
	Target Value: Vendor Instruction: Outcomes - 1.3.6.1.4.1. Definition	Reason Device Not Deployed Successfully Indicate the outcome listed for the device unsuccessfully deployed. The value on current procedure When Device Successfully Deployed (14968) is No then Outcome of Device Unsuccessfully Deployed .19376.1.4.1.6.5.786 Source	(14845) cannot   Code )002112	be Null Code Syste ACC NCI

Not Deployed

Device retrieved

ACC NCDR

ACC NCDR

112000002113

112000001838





Section: Radiation Exposure	Parent: Procedure Information
Element: 7210	Cumulative Air Kerma
Coding Instruction:	Indicate the total radiation dose (Cumulative Air Kerma, or Reference Air Kerma) recorded to the nearest milligray (mGy) or gray (Gy). The value recorded should include the total dose for the lab visit. Cumulative air kerma is the total air kerma accrued from the beginning of an examination or procedure and includes all contributions from fluoroscopic and radiographic irradiation.
Target Value:	The total between start of current procedure and end of current procedure
Supporting Definition:	Cumulative (Reference) Air kerma
	Cumulative air kerma (also known as reference, reference dose, cumulative dose, or cumulative dose at a reference point) is the air kerma accumulated at a specific point in space (the patient entrance reference point) relative to the gantry of the fluoroscopy system.
	The quantity, kerma, originated from the acronym, KERMA, for Kinetic Energy Released per unit Mass (of air).
	Source: Miller DL, et al. Radiation doses in interventional radiology procedures. (J Vasc Interv Radiol 2003;14:711-727.)
Element: 7215	Contrast Volume
Coding Instruction:	Indicate the volume of contrast (ionic and non-ionic) used in milliliters (ml). The volume recorded should be the total volume for the lab visit.
Target Value:	The total between start of current procedure and end of current procedure
Element: 14278	Dose Area Product
Coding Instruction:	Indicate the total fluoroscopy dose to the nearest integer. The value recorded should include the total dose for the lab visit.
Target Value:	The total between start of current procedure and end of current procedure
Supporting Definition:	Dose Area Product
	Dose Area Product is the integral of air kerma (the energy extracted from an x-ray beam per unit mass of air in a small irradiated air volume; for diagnostic x-rays, the dose delivered to that volume of air) across the entire x-ray beam emitted from the x-ray tube. It is a surrogate measure of the amount of energy delivered to the patient.
	Also known as KAP (Kerma Area Product).

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



# Coder's Data Dictionary v1.4



Section: Intrapr	ocedure Anticoagu	lation Strategy Parent: Procedure Information	
Element: 7225		Intraprocedure Anticoagulation	
	Coding Instruction:	Indicate if intraprocedure anticoagulation therapy was provided.	
	-	The value on current procedure	
	Taiget value.	The value on current procedure	
Element: 7230		Uninterrupted Warfarin Therapy	
	Coding Instruction:	Indicate if the patient continued on warfarin therapy and it was not held for the procedure.	
	Target Value:	The value on current procedure	
Element: 15139		Heparin Administered During Procedure	
	Coding Instruction:	Indicate if heparin was administered during the procedure.	
	Target Value:	The value on current procedure	
	-		
Inticoagulation Admiselection	ninistration - 1.3.6.1.4.1 Definition	.19376.1.4.1.6.5.819 Source Code	Codo Svetor
lo - Not Prescribed	Definition	11200000168	Code Syster ACC NCD
es - Prescribed		100001247	ACC NCD
Element: 14852		Heparin Initial Administration Timing	
		Indicate the timing of initial administration of heparin.	
	Coding Instruction:		
	-	Any occurrence on current procedure	
Andioation Adminic	Target Value:	Any occurrence on current procedure	
	Target Value: tration Timing - 1.3.6.1.	Any occurrence on current procedure 4.1.19376.1.4.1.6.5.169	Code System
Selection	Target Value: tration Timing - 1.3.6.1. Definition	Any occurrence on current procedure 4.1.19376.1.4.1.6.5.169 Source Code	
Selection Pre-transseptal Punct	Target Value: tration Timing - 1.3.6.1. Definition ure	Any occurrence on current procedure 4.1.19376.1.4.1.6.5.169	ACC NCD
election Pre-transseptal Puncto Post-transseptal Punc	Target Value: tration Timing - 1.3.6.1. Definition ure	Source         Code           100001082         100001081	ACC NCD
Selection Pre-transseptal Puncto Post-transseptal Punc	Target Value: tration Timing - 1.3.6.1. Definition ure ture	Source         Code           100001082         100001082           100001081         Bivalirudin	ACC NCD
Selection Pre-transseptal Puncto Post-transseptal Punc	Target Value: tration Timing - 1.3.6.1. Definition ure ture	Source         Code           100001082         100001081	ACC NCD
Selection Pre-transseptal Puncto Post-transseptal Punc	Target Value: tration Timing - 1.3.6.1. Definition ure ture Coding Instruction:	Source         Code           100001082         100001082           100001081         Bivalirudin	ACC NCD
election Pre-transseptal Punct Post-transseptal Punc Element: 15140	Target Value: tration Timing - 1.3.6.1. Definition ure ture Coding Instruction:	Any occurrence on current procedure 4.1.19376.1.4.1.6.5.169   Source Code 100001082 100001082 100001081  Bivalirudin  Indicate if bivalirudin was administered during the procedure. The value on current procedure	ACC NCD
Selection Pre-transseptal Punct Post-transseptal Punct Element: 15140 Anticoagulation Adr	Target Value: tration Timing - 1.3.6.1. Definition ure ture Coding Instruction: Target Value:	Any occurrence on current procedure 4.1.19376.1.4.1.6.5.169   Source Code 100001082 100001082 100001081  Bivalirudin  Indicate if bivalirudin was administered during the procedure. The value on current procedure	ACC NCD
Selection Pre-transseptal Punct Post-transseptal Punct Element: 15140 Element: Administration Adm Selection	Target Value: tration Timing - 1.3.6.1. Definition Jure ture Coding Instruction: Target Value: ninistration - 1.3.6.1.4.1	Any occurrence on current procedure 4.1.19376.1.4.1.6.5.169    Source Code 100001082 100001082 100001081  Bivalirudin  Indicate if bivalirudin was administered during the procedure. The value on current procedure .19376.1.4.1.6.5.819	ACC NCD ACC NCD ACC NCD
Selection Pre-transseptal Punct Post-transseptal Punct Element: 15140 Selection Selection Io - Not Prescribed	Target Value: tration Timing - 1.3.6.1. Definition Jure ture Coding Instruction: Target Value: ninistration - 1.3.6.1.4.1	Any occurrence on current procedure 4.1.19376.1.4.1.6.5.169  Source Code 100001082 100001082 100001081 Bivalirudin Bivalirudin Indicate if bivalirudin was administered during the procedure. The value on current procedure .19376.1.4.1.6.5.819  Code	ACC NCD ACC NCD Code System ACC NCD
Selection Pre-transseptal Punct Post-transseptal Punct Element: 15140 Election No - Not Prescribed Yes - Prescribed	Target Value: tration Timing - 1.3.6.1. Definition Jure ture Coding Instruction: Target Value: ninistration - 1.3.6.1.4.1	Any occurrence on current procedure 4.1.19376.1.4.1.6.5.169  Source Code 100001082 100001082 100001081 Bivalirudin Bivalirudin Indicate if bivalirudin was administered during the procedure. The value on current procedure .19376.1.4.1.6.5.819  Code 11200000168	ACC NCD ACC NCD Code System ACC NCD
Selection Pre-transseptal Punct Post-transseptal Punct Element: 15140 Election No - Not Prescribed Yes - Prescribed	Target Value: tration Timing - 1.3.6.1. Definition ure ture Coding Instruction: Target Value: ninistration - 1.3.6.1.4.1 Definition	Any occurrence on current procedure 4.1.19376.1.4.1.6.5.169    Source Code 100001082 100001081  Bivalirudin Indicate if bivalirudin was administered during the procedure. The value on current procedure .19376.1.4.1.6.5.819   Source Code 11200000168 100001247	ACC NCD ACC NCD Code System ACC NCD
Selection Pre-transseptal Punct Post-transseptal Punct Element: 15140 Election No - Not Prescribed Yes - Prescribed	Target Value: tration Timing - 1.3.6.1. Definition ure ture Coding Instruction: Target Value: ninistration - 1.3.6.1.4.1 Definition Coding Instruction:	Any occurrence on current procedure 4.1.19376.1.4.1.6.5.169   Source Code 100001082 100001081 Bivalirudin Indicate if bivalirudin was administered during the procedure. The value on current procedure .19376.1.4.1.6.5.819  Source Code 11200000168 100001247 Other Anticoagulant	ACC NCD ACC NCD Code System ACC NCD
Selection Pre-transseptal Punct Post-transseptal Punc Element: 15140 Anticoagulation Adr Selection No - Not Prescribed (es - Prescribed Element: 15138	Target Value: tration Timing - 1.3.6.1. Definition ure ture Coding Instruction: Target Value: ninistration - 1.3.6.1.4.1 Definition Coding Instruction:	Any occurrence on current procedure  4.1.19376.1.4.1.6.5.169	ACC NCDI ACC NCDI Code System ACC NCDI
Selection Pre-transseptal Punct Post-transseptal Punc Element: 15140 Anticoagulation Adr Selection No - Not Prescribed Yes - Prescribed Element: 15138	Target Value: tration Timing - 1.3.6.1. Definition ure ture Coding Instruction: Target Value: ninistration - 1.3.6.1.4.1 Definition Coding Instruction: Target Value:	Any occurrence on current procedure  4.1.19376.1.4.1.6.5.169    Code  100001082  100001081   Bivalirudin  Indicate if bivalirudin was administered during the procedure. The value on current procedure  .19376.1.4.1.6.5.819   Code  11200000168  100001247  Other Anticoagulant  Indicate if any other anticoagulation medical therapy, not listed above, was used during the procedure. The value on current procedure .19376.1.4.1.6.5.819   Other Anticoagulant Indicate if any other anticoagulation medical therapy, not listed above, was used during the procedure. The value on current procedure .19376.1.4.1.6.5.819	Code System ACC NCDF ACC NCDF ACC NCDF Code System ACC NCDF ACC NCDF
Selection Pre-transseptal Punct Post-transseptal Punc Element: 15140 Anticoagulation Adr Selection No - Not Prescribed Yes - Prescribed Element: 15138	Target Value: tration Timing - 1.3.6.1. Definition ure ture Coding Instruction: Target Value: ninistration - 1.3.6.1.4.1 Definition Coding Instruction: Target Value: ninistration - 1.3.6.1.4.1	Any occurrence on current procedure  4.1.19376.1.4.1.6.5.169	ACC NCDF ACC NCDF Code System ACC NCDF ACC NCDF

#### Element: 14853

Anticoagulation Reversal

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

Target Value: Any occurrence on current procedure





## Section: Intra or Post-Procedure Events

Element: 12153

Intra or Post Procedure Events

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

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

Vendor Instruction: An Intra or Post Procedure - combination of Events (12153), Occurred (9002) and Event Date (14275) - may only be entered/selected once

Parent: Procedure Information

#### Intra or Post Procedure Events - 1.3.6.1.4.1.19376.1.4.1.6.5.706

Selection Definition Source	Code	Code System
Air Embolism	271376002	SNOMED CT
Cardiac Arrest	410429000	SNOMED CT
Heart Failure	84114007	SNOMED CT
Heart Valve Damage	368009	SNOMED CT
Left Atrial Thrombus	473360003	SNOMED CT
Myocardial Infarction	22298006	SNOMED CT
Pericardial Effusion (no intervention required)	112000002125	ACC NCDR
Pericarditis	3238004	SNOMED CT
Anaphylaxis	39579001	SNOMED CT
Arterial Thrombosis	65198009	SNOMED CT
Deep Vein Thrombosis	128053003	SNOMED CT
Systemic Thromboembolism (other than stroke) (Complete Adjudication)	112000002126	ACC NCDR
Esophageal Injury (resulting from TEE probe)	112000002127	ACC NCDR
Hepatic Injury	112000002128	ACC NCDR
New Requirement for Dialysis	100014076	ACC NCDR
Device Explant	100001141	ACC NCDR
Device Infection	112000002137	ACC NCDR
Device Migration	370512004	SNOMED CT
Device Thrombus	112000001839	ACC NCDR
Device Systemic Embolization (catheter retrieval)	112000002138	ACC NCDR
Device Systemic Embolization (surgical retrieval)	112000002139	ACC NCDR
AV Fistula (no intervention required)	112000002140	ACC NCDR
AV Fistula (requiring surgical repair) (Complete Adjudication)	11200002141	ACC NCDR
Pseudoaneurysm (no intervention required)	112000002143	ACC NCDR
Pseudoaneurysm (requiring endovascular repair) (Complete Adjudication)	112000002144	ACC NCDR
Pseudoaneurysm (requiring surgical repair) (Complete Adjudication)	112000002145	ACC NCDR
Pseudoaneurysm (requiring thrombin injection only) (Complete Adjudication)	112000002146	ACC NCDR
Hemorrhagic Stroke (Complete Adjudication)	230706003	SNOMED CT
Intracranial Hemorrhage (other than hemorrhagic stroke) (Complete Adjudication)	1386000	SNOMED CT
Ischemic Stroke (Complete Adjudication)	422504002	SNOMED CT
TIA (Complete Adjudication)	266257000	SNOMED CT
Undetermined Stroke (Complete Adjudication)	230713003	SNOMED CT
Access Site Bleeding (Complete Adjudication)	1000142440	ACC NCDR
GI Bleeding (Complete Adjudication)	74474003	SNOMED CT
Hematoma (Complete Adjudication)	385494008	SNOMED CT
Hemothorax (not requiring	112000002147	ACC NCDR





Section: Intra or Post-Procedure E	vents Parent: Procedure Information	
drainage) (Complete Adjudication)		
Hemothorax (requiring drainage) (Complete Adjudication)	100001011	ACC NCDF
Other Hemorrhage (non- intracranial) (Complete Adjudication)	50960005	SNOMED C
Pericardial Effusion (requiring open heart surgery) (Complete Adjudication)	11200002148	ACC NCDF
Pericardial Effusion with tamponade (requiring percutaneous drainage) (Complete Adjudication)	11200002149	ACC NCDF
Pericardial Effusion without tamponade (requiring percutaneous drainage) (Complete Adjudication)	11200002150	ACC NCDF
Retroperitoneal Bleeding (Complete Adjudication)	95549001	SNOMED C
Vascular Complications (Complete Adjudication)	213217008	SNOMED C
Pleural Effusion	60046008	SNOMED C
Pneumonia	233604007	SNOMED C
Pneumothorax (no intervention required)	112000002153	ACC NCDF
Pneumothorax (requiring intervention)	11200002152	ACC NCDF
Pulmonary Embolism	59282003	SNOMED C
Respiratory Failure	409622000	SNOMED CT
Element: 9002	Intra/Post-Procedure Events Occurred	
Coding Instruction:	Indicate if the specific intra or post procedure event(s) occurred.	
Target Value:	Any occurrence between start of procedure and until next procedure or discharge	
Vendor Instruction:	When an Intra or Post-Procedure Event (12153) selection/code is provided more than once in a single Lab Visit, the Procedure Events Occurred (9002) value cannot have conflicting responses or be duplicate negatives.	nen its Intra/Post-
	When an Intra or Post Procedure Events (12153) is selected then Intra/Post-Procedure Events Occurred (9002) m	nust not be Null

 Element: 14275
 Intra and Post Procedure Event Date

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

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

 Vendor Instruction
 Intra and Post Procedure Event Date (14275) must be Greater than or Equal to Procedure Start Date and Time (7000)

Intra and Post Procedure Event Date (14275) must be Less than or Equal to Discharge Date (10100)





## Section: In-Hospital Adjudication

#### Parent: Procedure Information

#### Element: 14312 Adjudication Event

Coding Instruction: Indicate the event being adjudicated.

Target Value: N/A

Vendor Instruction: An Adjudication - combination of Event (14312) and Date (14313) - may only be entered/selected once

Adjudication Event (14312) cannot be Null if Intra or Post Procedure Events (12153) is Equal to (Hemorrhagic Stroke, Intracranial Hemorrhage (other than hemorrhagic stroke), Ischemic Stroke, TIA, Undetermined Stroke, Access Site Bleeding, GI Bleeding, Hematoma, Hemothorax (not requiring drainage), Hemothorax (requiring drainage), Other Hemorrhage (non-intracranial), Pericardial Effusion (requiring open heart surgery), Pericardial Effusion with tamponade (requiring percutaneous drainage), Pericardial Effusion without tamponade (requiring percutaneous drainage), Retroperitoneal Bleeding, Vascular Complications, Systemic Thromboembolism (other than stroke), AV Fistula (requiring surgical repair), Pseudoaneurysm (requiring endovascular repair), Pseudoaneurysm (requiring surgical repair), Pseudoaneurysm (requiring events Occurred (9002) is Yes. Every Intra or Post Procedure Event (combination of Event (12153), Occurred (9002) and Event Date (14275)) that requires adjudication must have a corresponding adjudication record (combination of Event (14312) and Event Date (14213).

#### Intra or Post Procedure Events - 1.3.6.1.4.1.19376.1.4.1.6.5.706

Selection	Definition	Source	Code	Code System
Air Embolism			271376002	SNOMED CT
Cardiac Arrest			410429000	SNOMED CT
Heart Failure			84114007	SNOMED CT
Heart Valve Damage			368009	SNOMED CT
Left Atrial Thrombus			473360003	SNOMED CT
Myocardial Infarction			22298006	SNOMED CT
Pericardial Effusion (no intervention required)			112000002125	ACC NCDR
Pericarditis			3238004	SNOMED CT
Anaphylaxis			39579001	SNOMED CT
Arterial Thrombosis			65198009	SNOMED CT
Deep Vein Thrombosis			128053003	SNOMED CT
Systemic Thromboembolis (other than stroke) (Comp Adjudication)			112000002126	ACC NCDR
Esophageal Injury (resultir from TEE probe)	ng		112000002127	ACC NCDR
Hepatic Injury			112000002128	ACC NCDR
New Requirement for Dial	lysis		100014076	ACC NCDR
Device Explant			100001141	ACC NCDR
Device Infection			112000002137	ACC NCDR
Device Migration			370512004	SNOMED CT
Device Thrombus			112000001839	ACC NCDR
Device Systemic Emboliza (catheter retrieval)	ation		112000002138	ACC NCDR
Device Systemic Emboliza (surgical retrieval)	ation		112000002139	ACC NCDR
AV Fistula (no intervention required)	n		112000002140	ACC NCDR
AV Fistula (requiring surg repair) (Complete Adjudica			112000002141	ACC NCDR
Pseudoaneurysm (no intervention required)			112000002143	ACC NCDR
Pseudoaneurysm (requirir endovascular repair) (Complete Adjudication)	ng		112000002144	ACC NCDR
Pseudoaneurysm (requirir surgical repair) (Complete Adjudication)			112000002145	ACC NCDR
Pseudoaneurysm (requirir thrombin injection only) (Complete Adjudication)	ng		112000002146	ACC NCDR
Hemorrhagic Stroke (Com Adjudication)	plete		230706003	SNOMED CT
Intracranial Hemorrhage ( than hemorrhagic stroke) (Complete Adjudication)			1386000	SNOMED CT
Ischemic Stroke (Complete Adjudication)	e		422504002	SNOMED CT
				SNOMED CT





Section: In-Hospital Adjudication	Parent: Procedure Information	
Undetermined Stroke (Complete Adjudication)	230713003	SNOMED CT
Access Site Bleeding (Complete Adjudication)	1000142440	ACC NCDR
GI Bleeding (Complete Adjudication)	74474003	SNOMED CT
Hematoma (Complete Adjudication)	385494008	SNOMED CT
Hemothorax (not requiring drainage) (Complete Adjudication)	11200002147	ACC NCDR
Hemothorax (requiring drainage) (Complete Adjudication)	100001011	ACC NCDR
Other Hemorrhage (non- intracranial) (Complete Adjudication)	50960005	SNOMED CT
Pericardial Effusion (requiring open heart surgery) (Complete Adjudication)	11200002148	ACC NCDR
Pericardial Effusion with tamponade (requiring percutaneous drainage) (Complete Adjudication)	112000002149	ACC NCDR
Pericardial Effusion without tamponade (requiring percutaneous drainage) (Complete Adjudication)	112000002150	ACC NCDR
Retroperitoneal Bleeding (Complete Adjudication)	95549001	SNOMED CT
Vascular Complications (Complete Adjudication)	213217008	SNOMED CT
Pleural Effusion	60046008	SNOMED CT
Pneumonia	233604007	SNOMED CT
Pneumothorax (no intervention required)	11200002153	ACC NCDR
Pneumothorax (requiring intervention)	11200002152	ACC NCDR
Pulmonary Embolism	59282003	SNOMED CT
Respiratory Failure	409622000	SNOMED CT

Element: 14313

Adjudication Event Date

Coding Instruction: Indicate the date the clinical event being adjudicated occurred.

Target Value: N/A

Vendor Instruction: When Adjudication Event (14312) is selected, Adjudication Event Date (14313) cannot be Null

The Adjudication Event Date (14313) / Adjudication Event Code (14312) must match with Intra or Post-Procedure Event Date (14275) / Intra or Post Procedure Event Code (12153)

Adjudication Event Date (14313) must be Less than or Equal to Discharge Date (10100)





	ogic	Parent: In-Hospital Adjudication	
Element: 14902		Adjudication Status	
	Coding Instruction:	Indicate whether the patient was alive or deceased on the date the adjudication was performed.	
	Target Value:	Any value between start of current procedure and discharge	
	Vendor Instruction:	Adjudication Status (14902) cannot be Null if Adjudication Event (14312) is Equal to (Hemorrhagic Stroke, Intracranial Hen	norrhage,
		Ischemic Stroke, TIA, Undetermined Stroke)	
-	atus - 1.3.6.1.4.1.19376.		
Selection Alive	Definition	Source         Code           438949009         438949009	Code Syste
Deceased			charge dispositi
Element: 14903		Adjudication Date of Death	
Liement. 14903	Coding Instruction:		
	-	Indicate the date the patient was declared deceased.	
	-	Any value between start of current procedure and discharge	
	vendor instruction:	Adjudication Date of Death (14903) must be Greater than or Equal to Procedure Start Date and Time (7000)	
		Adjudication Date of Death (14903) must be Greater than or Equal to Adjudication Event Date (14313)	
		Adjudication Date of Death (14903) must be Greater than or Equal to Symptom Onset Date (14904)	
		Adjudication Date of Death (14903) must be Less than or Equal to Discharge Date (10100)	
Element: 14904		Symptom Onset Date	
	Coding Instruction:	Indicate the date of symptom onset associated with this event.	
	Target Value:	Any value between start of current procedure and discharge	
	Vendor Instruction:	Symptom Onset Date (14904) must be Greater than or Equal to Procedure Start Date and Time (7000)	
		Symptom Onset Date (14904) must be Less than or Equal to Discharge Date (10100)	
Element: 14905		Neurologic Deficit with Rapid Onset	
	Coding Instruction:	Indicate if the patient had a sudden onset of a focal or global neurologic deficit regardless of the duration of symptoms.	
		Rapid onset means sudden or maximal within minutes.	
	Target Value:	Any value between start of current procedure and discharge	
-			
Element: 14906		Neurologic Deficit Clinical Presentation	
		Indicate the clinical presentation of the neurologic deficit.	
	Target Value:	Any value between start of current procedure and discharge	
		.3.6.1.4.1.19376.1.4.1.6.5.716	
Selection	Definition	Source         Code           100014109         100014109	Code Syste ACC NCI
Stroke-related		11200001860	ACC NCI
		11200001000	
Non-Stroke-related			
Stroke-related Non-Stroke-related Element: 14907	Coding Instruction	Diagnosis Confirmation by Neurology	
Non-Stroke-related	-	Diagnosis Confirmation by Neurology Indicate if the diagnosis was confirmed by a neurologist or a neurosurgeon.	
Non-Stroke-related	-	Diagnosis Confirmation by Neurology	
Non-Stroke-related	-	Diagnosis Confirmation by Neurology Indicate if the diagnosis was confirmed by a neurologist or a neurosurgeon. Any value between start of current procedure and discharge	
Non-Stroke-related Element: 14907	Target Value:	Diagnosis Confirmation by Neurology Indicate if the diagnosis was confirmed by a neurologist or a neurosurgeon. Any value between start of current procedure and discharge Brain Imaging Performed	
Non-Stroke-related	Target Value:	Diagnosis Confirmation by Neurology         Indicate if the diagnosis was confirmed by a neurologist or a neurosurgeon.         Any value between start of current procedure and discharge         Brain Imaging Performed         Indicate if neuro imaging (such as CT, MRI, cerebral angiography) was performed in an attempt to confirm the diagnosis.	
Non-Stroke-related Element: 14907	Target Value:	Diagnosis Confirmation by Neurology Indicate if the diagnosis was confirmed by a neurologist or a neurosurgeon. Any value between start of current procedure and discharge Brain Imaging Performed	
Non-Stroke-related Element: 14907 Element: 14908	Target Value:	Diagnosis Confirmation by Neurology         Indicate if the diagnosis was confirmed by a neurologist or a neurosurgeon.         Any value between start of current procedure and discharge         Brain Imaging Performed         Indicate if neuro imaging (such as CT, MRI, cerebral angiography) was performed in an attempt to confirm the diagnosis.	
Non-Stroke-related Element: 14907	Target Value: Coding Instruction: Target Value:	Diagnosis Confirmation by Neurology         Indicate if the diagnosis was confirmed by a neurologist or a neurosurgeon.         Any value between start of current procedure and discharge         Brain Imaging Performed         Indicate if neuro imaging (such as CT, MRI, cerebral angiography) was performed in an attempt to confirm the diagnosis.         All values between start of current procedure and discharge         Brain Imaging Type	
Non-Stroke-related Element: 14907 Element: 14908	Coding Instruction: Target Value: Target Value: Coding Instruction:	Diagnosis Confirmation by Neurology         Indicate if the diagnosis was confirmed by a neurologist or a neurosurgeon.         Any value between start of current procedure and discharge         Brain Imaging Performed         Indicate if neuro imaging (such as CT, MRI, cerebral angiography) was performed in an attempt to confirm the diagnosis.         All values between start of current procedure and discharge	



# Coder's Data Dictionary v1.4



Section: Neurol	ogic	Parent: In-Hospital Adjudication	
Selection	Definition	Source Code	Code Syster
Cerebral Angiography		3258003	SNOMED C
Computed Tomography	/	77477000	SNOMED C
Magnetic Resonance Ir	naging	113091000	SNOMED C
Other		112000001862	ACC NCD
Element: 14910		Deficit Type	
	Coding Instruction:	Indicate the type of deficit identified by the neuroimaging study.	
	Target Value:	All values between start of procedure and end of procedure	
Brain Imaging Findin	g - 1.3.6.1.4.1.19376.1.4	.1.6.5.717	
Selection	Definition	Source Code	Code Syste
No deficit		100001231	ACC NCD
Infarction		55641003	SNOMED C
Hemorrhage		50960005	SNOMED C
Both		11200002004	ACC NCD
Element: 14911		Hemorrhagic Stroke Type	
	Coding Instruction:	For patients presenting with an intracranial hemorrhage, indicate the hemorrhage location.	
	Target Value:	All values between start of current procedure and discharge	
Hemorrhagic Stroke	Type - 1.3.6.1.4.1.1937	6.1.4.1.6.5.794	
Selection	Definition	Source Code	Code Syster
Intracerebral		274100004	SNOMED C
Subarachnoid		21454007	SNOMED C
Subdural		35486000	SNOMED C
Element: 14912		Subsequent Intravenous Recombinant Tissue Plasminogen Activator Administered	
	Coding Instruction:	Indicate if intravascular (IV) recombinant tissue plasminogen activator (rtPA) was used as a treatment option re	lated to this event.
	-	Any value between start of current procedure and discharge	
Element: 14913		Subsequent Endovascular Therapeutic Intervention	
	Coding Instruction:	Indicate if an endovascular interventional therapy was performed as a treatment option related to this event.	
	Target Value:	Any value between start of current procedure and discharge	
Element: 14914		Neurologic Symptoms Duration	
	Coding Instruction:	Indicate the duration (in hours) of the neurologic symptoms.	
	Target Value:	All values between start of procedure and end of procedure	
Duration - 1.3.6.1.4.1.			
Selection	Definition	Source Code	Code Syster
Less than 1 Hour		11200002130	ACC NCD
1 - 24 Hours Greater than 24 Hours		11200002132 11200002131	ACC NCD ACC NCD
Element: 14915		Trauma	
	Coding Instruction:	Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event.	
	Target Value:	Any value between start of current procedure and discharge	
Element: 14916		Madified Bankin Scolo	
Liement. 14916	Codina Instantions	Modified Rankin Scale	
	-	Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the a	event.
-	-	Any value between start of current procedure and discharge	
5	Supporting Definition:	Modified Rankin Scale	
		The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a <b>Source:</b> Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.	scale of global disability.
		Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(	12):1497-1500.
Pankin Socia Access	mont Finding 1201		
nalikili Scale Assess	sment ringing - 1.3.6.1	.4.1.19376.1.4.1.6.5.139	





Section: Neurologic				
Selection	Definition	Source	Code	Code Syster
0: No symptoms at all			LA6111-4	LOIN
1: No significant disability despite symptoms	Able to carry ou	It all usual duties and activities.	LA6112-2	LOIN
2: Slight disability		out all previous activities, but able to affairs without assistance.	LA6113-0	LOIN
3: Moderate disability	Requiring some assistance.	help, but able to walk without	LA6114-8	LOIN
4: Moderately severe disability		without assistance and unable to attend eeds without assistance.	LA6115-5	LOIN
5: Severe disability	Bedridden, inco care and attenti	ntinent and requiring constant nursing on.	LA10137-0	LOIN
6: Death			419620001	SNOMED C
Element: 14917		Adjudication Modified Rankin Scale Not Administered		
Codir	ng Instruction:	Indicate if the modified Rankin Scale (mRS) was not administered following the event.		
	Target Value:	Any value between start of current procedure and discharge		
Support	ing Definition:	Modified Rankin Scale		
	-	The Modified Rankin Scale is a standardized neurological examination of patients with	h disability that provides a scale	of global disability
		Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott		or global alcability.
		Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after	er stroke. Stroke. 1988;19(12):14	97-1500.
Flement: 14918			er stroke. Stroke. 1988;19(12):14	97-1500.
Element: 14918 Codir	ng Instruction:	Procedure Related Neurologic Event Indicate using the following selections the likelihood in which this event is related to the		
	-	Procedure Related Neurologic Event Indicate using the following selections the likelihood in which this event is related to the clinical judgement.		
Codir	Target Value:	Procedure Related Neurologic Event Indicate using the following selections the likelihood in which this event is related to the clinical judgement. Any value between start of current procedure and discharge		
Codir Qualifier Value - 1.3.6.1.4.1.1	Target Value: 9376.1.4.1.6.5.7	Procedure Related Neurologic Event Indicate using the following selections the likelihood in which this event is related to the clinical judgement. Any value between start of current procedure and discharge 96	he LAAO procedure based upon	the clinician's best
Codir Qualifier Value - 1.3.6.1.4.1.1 Selection	Target Value: 9376.1.4.1.6.5.7 Definition	Procedure Related Neurologic Event Indicate using the following selections the likelihood in which this event is related to the clinical judgement. Any value between start of current procedure and discharge 96 Source	he LAAO procedure based upon	the clinician's best Code Systen
Codir Qualifier Value - 1.3.6.1.4.1.1 Selection	Target Value: 9376.1.4.1.6.5.7 Definition The clinical adv relationship to ti	Procedure Related Neurologic Event Indicate using the following selections the likelihood in which this event is related to the clinical judgement. Any value between start of current procedure and discharge 96	he LAAO procedure based upon	the clinician's best Code Systen
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Codir Qualifier Value - 1.3.6.1.4.1.1 Selection Certain	Target Value: 9376.1.4.1.6.5.7 Definition The clinical adv relationship to ti by concurrent of The clinical adv time sequence	Procedure Related Neurologic Event Indicate using the following selections the likelihood in which this event is related to the clinical judgement. Any value between start of current procedure and discharge 96 Source erse event occurs in a plausible time he procedure and cannot be explained disease or other drugs or devices. rerse event occurs within a reasonable to the procedure and it is unlikely to be	he LAAO procedure based upon <u>Code</u> 17162000	the clinician's best Code System SNOMED C
Codir Qualifier Value - 1.3.6.1.4.1.1 Selection Certain	Target Value: 9376.1.4.1.6.5.7 Definition The clinical adv relationship to ti by concurrent of The clinical adv time sequence	Procedure Related Neurologic Event Indicate using the following selections the likelihood in which this event is related to the clinical judgement. Any value between start of current procedure and discharge 96 Source erse event occurs in a plausible time he procedure and cannot be explained disease or other drugs or devices. verse event occurs within a reasonable	he LAAO procedure based upon <u>Code</u> 17162000	the clinician's best Code System SNOMED C
Codir Qualifier Value - 1.3.6.1.4.1.1 Selection Certain Probable	Target Value: 9376.1.4.1.6.5.7 Definition The clinical adv relationship to ti by concurrent of The clinical adv time sequence attributed to con devices.	Procedure Related Neurologic Event Indicate using the following selections the likelihood in which this event is related to the clinical judgement. Any value between start of current procedure and discharge 96 Source rerse event occurs in a plausible time he procedure and cannot be explained disease or other drugs or devices. rerese event occurs within a reasonable to the procedure and it is unlikely to be necurrent disease or other drugs or rerese event occurs within a reasonable	he LAAO procedure based upon <u>Code</u> 17162000	the clinician's best Code System SNOMED C ACC NCD
Codir Qualifier Value - 1.3.6.1.4.1.1 Selection Certain Probable	Target Value: 9376.1.4.1.6.5.7 Definition The clinical adv relationship to ti by concurrent of The clinical adv time sequence attributed to con devices. The clinical adv time sequence	Procedure Related Neurologic Event Indicate using the following selections the likelihood in which this event is related to the clinical judgement. Any value between start of current procedure and discharge 96 Source rerse event occurs in a plausible time he procedure and cannot be explained disease or other drugs or devices. rerse event occurs within a reasonable to the procedure and it is unlikely to be neurrent disease or other drugs or rerse event occurs within a reasonable to the procedure, but the event could	he LAAO procedure based upon Code 17162000 112000002134	the clinician's best Code System SNOMED C ACC NCD
Codir Qualifier Value - 1.3.6.1.4.1.1 Selection Certain Probable	Target Value: 9376.1.4.1.6.5.7 Definition The clinical adv relationship to ti by concurrent of The clinical adv time sequence attributed to con devices. The clinical adv time sequence	Procedure Related Neurologic Event Indicate using the following selections the likelihood in which this event is related to the clinical judgement. Any value between start of current procedure and discharge 96 Source erse event occurs in a plausible time he procedure and cannot be explained disease or other drugs or devices. rerse event occurs within a reasonable to the procedure and it is unlikely to be necurrent disease or other drugs or rerse event occurs within a reasonable to the procedure, but the event could ed by concurrent disease or other	he LAAO procedure based upon Code 17162000 112000002134	the clinician's best Code System SNOMED C ACC NCD
Codir Qualifier Value - 1.3.6.1.4.1.1 Selection Certain Probable Possible	Target Value: 9376.1.4.1.6.5.7 Definition The clinical adv relationship to ti by concurrent of The clinical adv time sequence is attributed to coo devices. The clinical adv time sequence also be explain drugs or device The clinical adv	Procedure Related Neurologic Event Indicate using the following selections the likelihood in which this event is related to the clinical judgement. Any value between start of current procedure and discharge 96 Source erse event occurs in a plausible time he procedure and cannot be explained disease or other drugs or devices. rerse event occurs within a reasonable to the procedure and it is unlikely to be ncurrent disease or other drugs or rerese event occurs within a reasonable to the procedure, but the event could ed by concurrent disease or other s. erse event, based upon its temporal	he LAAO procedure based upon Code 17162000 112000002134	Code System SNOMED C ACC NCD SNOMED C
Codir Qualifier Value - 1.3.6.1.4.1.1 Selection Certain Probable Possible	Target Value: 9376.1.4.1.6.5.7 Definition The clinical adv relationship to ti by concurrent of The clinical adv time sequence a attributed to con devices. The clinical adv time sequence also be explain drugs or device The clinical adv relationship to ti	Procedure Related Neurologic Event Indicate using the following selections the likelihood in which this event is related to the clinical judgement. Any value between start of current procedure and discharge 96 Source rerse event occurs in a plausible time he procedure and cannot be explained disease or other drugs or devices. rerse event occurs within a reasonable to the procedure and it is unlikely to be neurrent disease or other drugs or rerse event occurs within a reasonable to the procedure, but the event could ed by concurrent disease or other ss. erse event, based upon its temporal he procedure, makes a causal	he LAAO procedure based upon Code 17162000 112000002134 371930009	the clinician's best Code System SNOMED C ACC NCD SNOMED C
Codir Qualifier Value - 1.3.6.1.4.1.1 Selection Certain Probable Possible	Target Value: 9376.1.4.1.6.5.7 Definition The clinical adv relationship to ti by concurrent of The clinical adv time sequence attributed to con devices. The clinical adv time sequence also be explain drugs or devices The clinical adv relationship to ti relationship imp	Procedure Related Neurologic Event Indicate using the following selections the likelihood in which this event is related to the clinical judgement. Any value between start of current procedure and discharge 96 Source erse event occurs in a plausible time he procedure and cannot be explained disease or other drugs or devices. rerse event occurs within a reasonable to the procedure and it is unlikely to be ncurrent disease or other drugs or rerese event occurs within a reasonable to the procedure, but the event could ed by concurrent disease or other s. erse event, based upon its temporal	he LAAO procedure based upon Code 17162000 112000002134 371930009	Code System SNOMED C ACC NCD SNOMED C
Codir Qualifier Value - 1.3.6.1.4.1.1 Selection Certain Probable Possible Unlikely	Target Value: 9376.1.4.1.6.5.7 Definition The clinical adv relationship to ti by concurrent of The clinical adv time sequence attributed to con devices. The clinical adv time sequence also be explain drugs or devices The clinical adv relationship to ti relationship imp	Procedure Related Neurologic Event Indicate using the following selections the likelihood in which this event is related to the clinical judgement. Any value between start of current procedure and discharge 96 Source erse event occurs in a plausible time he procedure and cannot be explained disease or other drugs or devices. rerse event occurs within a reasonable to the procedure and it is unlikely to be nourrent disease or other drugs or rerse event occurs within a reasonable to the procedure, but the event could ed by concurrent disease or other is. erse event, based upon its temporal he procedure, makes a causal probable. Additionally, other drugs,	he LAAO procedure based upon Code 17162000 112000002134 371930009	Code System SNOMED C ACC NCDI SNOMED C
Codir Qualifier Value - 1.3.6.1.4.1.1 Selection Certain Probable Possible Unlikely	Target Value: 9376.1.4.1.6.5.7 Definition The clinical adv relationship to ti by concurrent of The clinical adv time sequence attributed to con devices. The clinical adv time sequence also be explain drugs or device The clinical adv relationship to ti relationship inp devices or unde explanations. The clinical adv	Procedure Related Neurologic Event Indicate using the following selections the likelihood in which this event is related to the clinical judgement. Any value between start of current procedure and discharge 96 Source Prese event occurs in a plausible time the procedure and cannot be explained disease or other drugs or devices. Prese event occurs within a reasonable to the procedure and it is unlikely to be to the procedure and it is unlikely to be to the procedure, but the event could ed by concurrent disease or other ss. Prese event, based upon its temporal the procedure, makes a causal probable. Additionally, other drugs, errying disease provide plausible Prese event is reported yet more data is Prese event is prese event is reported yet more data is Prese event is reported yet more data is Prese event is prese event is reported yet more data is Prese event is prese event is reported yet more data is Prese event is prese event is reported yet more data is Prese event is preserved event	he LAAO procedure based upon Code 17162000 112000002134 371930009	Code System SNOMED C ACC NCDI SNOMED C
Codir Qualifier Value - 1.3.6.1.4.1.1 Selection Certain Probable Possible Unlikely	Target Value: 9376.1.4.1.6.5.7 Definition The clinical adv relationship to ti by concurrent of The clinical adv time sequence to attributed to co devices. The clinical adv time sequence also be explain drugs or devices The clinical adv relationship to ti relationship to ti relat	Procedure Related Neurologic Event Indicate using the following selections the likelihood in which this event is related to the clinical judgement. Any value between start of current procedure and discharge 96 Source erse event occurs in a plausible time he procedure and cannot be explained disease or other drugs or devices. erse event occurs within a reasonable to the procedure and it is unlikely to be neurrent disease or other drugs or erse event occurs within a reasonable to the procedure, but the event could ed by concurrent disease or other ss. erse event, based upon its temporal he procedure, makes a causal robable. Additionally, other drugs, ertying disease provide plausible erse event is reported yet more data is proper assessment OR the clinical	he LAAO procedure based upon Code 17162000 112000002134 371930009 112000002135	the clinician's best
Codir Qualifier Value - 1.3.6.1.4.1.1	Target Value: 9376.1.4.1.6.5.7 Definition The clinical adv relationship to ti by concurrent of The clinical adv time sequence attributed to con- devices. The clinical adv time sequence also be explain- drugs or devices The clinical adv relationship to ti relationship to ti relationship to to relationship to relationship to to relationship to rela	Procedure Related Neurologic Event Indicate using the following selections the likelihood in which this event is related to the clinical judgement. Any value between start of current procedure and discharge 96 Source Prese event occurs in a plausible time the procedure and cannot be explained disease or other drugs or devices. Prese event occurs within a reasonable to the procedure and it is unlikely to be to the procedure and it is unlikely to be to the procedure, but the event could ed by concurrent disease or other ss. Prese event, based upon its temporal the procedure, makes a causal probable. Additionally, other drugs, errying disease provide plausible Prese event is reported yet more data is Prese event is prese event is reported yet more data is Prese event is reported yet more data is Prese event is prese event is reported yet more data is Prese event is prese event is reported yet more data is Prese event is prese event is reported yet more data is Prese event is preserved event	he LAAO procedure based upon Code 17162000 112000002134 371930009 112000002135	Code System SNOMED C ACC NCDF SNOMED C





# Section: Neurologic

Parent: Neurologic

Element: 14931

Device Related Neurologic Event

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

Target Value: Any value between start of current procedure and discharge

Selection	Definition	Source Code	Code System
Certain	The clinical adverse event occurs in a plausible time relationship to the procedure and cannot be explaine by concurrent disease or other drugs or devices.	17162000	SNOMED CT
Probable	The clinical adverse event occurs within a reasonabl time sequence to the procedure and it is unlikely to be attributed to concurrent disease or other drugs or devices.		ACC NCDR
Possible	The clinical adverse event occurs within a reasonabl time sequence to the procedure, but the event could also be explained by concurrent disease or other drugs or devices.	e 371930009	SNOMED CT
Unlikely	The clinical adverse event, based upon its temporal relationship to the procedure, makes a causal relationship improbable. Additionally, other drugs, devices or underlying disease provide plausible explanations.	11200002135	ACC NCDR
Unclassifiable	The clinical adverse event is reported yet more data essential for a proper assessment OR the clinical adverse event is reported yet the causality cannot be judged because information is insufficient or contradictory, and cannot be supplemented or verifie	3	ACC NCDR





Section: Bleeding		Parent: In-Hospital Adjudication		
Element: 14924		Adjudication Status		
	-	Indicate whether the patient was alive or deceased on the date the adjudication was performed.		
	Target Value:	Any value between start of current procedure and discharge		
Adjudication Life Sta	Vendor Instruction: 11.1.19376.	Adjudication Status (14924) cannot be Null if Adjudication Event (14312) is Equal to (Access Site Bleeding, GI Hemothorax (not requiring drainage), Hemothorax (requiring drainage), Other Hemorrhage, Pericardial Effusio surgery), Pericardial Effusion with tamponade (requiring percutaneous drainage), Pericardial Effusion without percutaneous drainage), Retroperitoneal Bleeding, Vascular Complications, AV Fistula (requiring surgical repa (requiring endovascular repair), Pseudoaneurysm (requiring surgical repair), Pseudoaneurysm (requiring through 14165726	n (requiring open cardiac tamponade (requiring air), Pseudoaneurysm	
Selection	Definition	Source Cod	e Code Syste	
Alive		43894900		
Deceased		2	0 HL7 Discharge disposition	
Element: 14930		Adjudication Date of Death		
	Coding Instruction:	Indicate the date the patient was declared deceased.		
	Target Value:	Any value between start of current procedure and discharge		
	Vendor Instruction:	Adjudication Date of Death (14930) must be Greater than or Equal to Procedure Start Date and Time (7000)		
		Adjudication Date of Death (14930) must be Greater than or Equal to Adjudication Event Date (14313)		
Element: 14929		Invasive Intervention Required		
	Coding Instruction:	Indicate if there was a surgical or percutaneous intervention required to treat the patient for this bleeding eve	nt.	
	-	Any value between start of current procedure and discharge		
Element: 14919	Cadina Instantions	RBC Transfusion		
	-	Indicate if there was at least one transfusion of PRBCs given to treat the patient for this bleeding event. All values between start of current procedure and discharge		
	Target Value.			
Element: 14920		Number of RBC Units Transfused		
	Coding Instruction:	Indicate the number of PRBC units transfused for treatment of this bleeding event.		
	Target Value:	All values between start of current procedure and discharge		
Element: 14921		Hemoglobin Pre-Transfusion		
	Coding Instruction:	Indicate the lowest hemoglobin (Hgb) value (g/dL), obtained via lab assay or point of care assay, between the	e intra or post procedure	
		bleeding event and prior to the transfusion.		
	Target Value:	All values between start of current procedure and discharge		
Element: 14922		Diagnostic Imaging Performed		
	Coding Instruction:	Indicate if imaging (such as CT, MRI) was performed in an attempt to confirm the diagnosis.		
	Target Value:	All values between start of current procedure and discharge		
=				
Element: 14923		End Organ Damage		
	-	Indicate if the patient was diagnosed with end organ damage after this bleeding event.		
	Target Value:	All values between start of procedure and end of procedure		
Element: 14927		Major Surgery		
	Coding Instruction:	Indicate if the patient underwent surgery within 30 days prior to this bleeding event.		
	Target Value:	Any value between start of current procedure and discharge		
Elemente 14000				
Element: 14928	Cadina Instructi	Percutaneous Coronary Intervention	a antas da data foto a dia a	
		Indicate if the patient had a percutaneous coronary artery or percutaneous valvular intervention within 30 day event.	s prior to mis bleeding	





#### Section: Bleeding

### Parent: In-Hospital Adjudication

#### Target Value: Any value between start of current procedure and discharge

# Element: 14925 Procedure Related Bleeding Event Coding Instruction: Indicate using the following selections the likelihood in which this event is related to the LAAO procedure based upon the clinician's best clinical judgement. Target Value: Any value between start of current procedure and discharge Supporting Definition: Bleeding Event A bleeding event observed and documented in the medical record that was associated with a hematocrit drop of ≥10% and/or a hemoglobin drop of ≥3 g/dL or that required transfusion or surgical intervention.

Source: Cannon CP, Brindis RG, Chaitman BR, et al. 2013 ACCF>AHA Key Date Elements and Definitions for Measuring the Clinical Management and Outcomes of Patients with Acute Coronary Syndromes and Coronary Artery Disease. Circulation. 2013;127;1052-1089.

#### Qualifier Value - 1.3.6.1.4.1.19376.1.4.1.6.5.796

Selection	Definition	Source	Code	Code System
Certain	The clinical adverse event occurs in a plausible relationship to the procedure and cannot be exp by concurrent disease or other drugs or device	plained	17162000	SNOMED CT
Probable	The clinical adverse event occurs within a reas time sequence to the procedure and it is unlikely attributed to concurrent disease or other drugs devices.	y to be	112000002134	ACC NCDR
Possible	The clinical adverse event occurs within a reas time sequence to the procedure, but the event or also be explained by concurrent disease or oth drugs or devices.	could	371930009	SNOMED CT
Unlikely	The clinical adverse event, based upon its temp relationship to the procedure, makes a causal relationship improbable. Additionally, other drug devices or underlying disease provide plausible explanations.	S,	112000002135	ACC NCDR
Unclassifiable	The clinical adverse event is reported yet more essential for a proper assessment OR the clini adverse event is reported yet the causality can judged because information is insufficient or contradictory, and cannot be supplemented or	cal not be	112000002136	ACC NCDR





Section: Bleeding	Parent: Bleeding
Element: 14926	Device Related Bleeding Event
Coding Instruction	: Indicate using the following selections the likelihood in which this event is related to the LAAO device based upon the clinician's best clinical judgement.

Target Value: Any value between start of current procedure and discharge

Supporting Definition: Bleeding Event

A bleeding event observed and documented in the medical record that was associated with a hematocrit drop of  $\geq$ 10% and/or a hemoglobin drop of  $\geq$ 3 g/dL or that required transfusion or surgical intervention.

Source: Cannon CP, Brindis RG, Chaitman BR, et al. 2013 ACCF>AHA Key Date Elements and Definitions for Measuring the Clinical Management and Outcomes of Patients with Acute Coronary Syndromes and Coronary Artery Disease. Circulation. 2013;127;1052-1089.

#### Qualifier Value - 1.3.6.1.4.1.19376.1.4.1.6.5.796

Selection	Definition	Source	Code	Code System
Certain	The clinical adverse event occurs in a plausible time relationship to the procedure and cannot be explained by concurrent disease or other drugs or devices.		17162000	SNOMED CT
Probable	The clinical adverse event occurs within a reasonable time sequence to the procedure and it is unlikely to be attributed to concurrent disease or other drugs or devices.		112000002134	ACC NCDR
Possible	The clinical adverse event occurs within a reasonable time sequence to the procedure, but the event could also be explained by concurrent disease or other drugs or devices.	3	371930009	SNOMED CT
Unlikely	The clinical adverse event, based upon its temporal relationship to the procedure, makes a causal relationship improbable. Additionally, other drugs, devices or underlying disease provide plausible explanations.		112000002135	ACC NCDR
Unclassifiable	The clinical adverse event is reported yet more data i essential for a proper assessment OR the clinical adverse event is reported yet the causality cannot be judged because information is insufficient or contradictory, and cannot be supplemented or verifier		112000002136	ACC NCDR





Section. System	nic Thromboemboli	sm Parent: In-Hospital Adjudication	
Element: 14932		Adjudication Status	
	Coding Instruction:	Indicate whether the patient was alive or deceased on the date the adjudication was performed.	
	-	Any value between start of current procedure and discharge	
	-	Adjudication Status (14932) cannot be Null if Adjudication Event (14312) is Equal to (Systemic Thromboembolis	m (other than stroke))
Adjudication Life Sta	atus - 1.3.6.1.4.1.19376. Definition	1.4.1.6.5.726 Source Code	Code Syste
live		438949009	SNOMED
eceased		20	HL7 Discharge disposit
Element: 14933		Adjudication Date of Death	
	Coding Instruction:	Indicate the date the patient was declared deceased.	
	Target Value:	Any value between start of current procedure and discharge	
	Vendor Instruction:	Adjudication Date of Death (14933) must be Greater than or Equal to Procedure Start Date and Time (7000)	
		Adjudication Date of Death (14933) must be Greater than or Equal to Adjudication Event Date (14313)	
Element: 14934		Cause of Death	
	Coding Instruction:	If deceased, indicate if the patient's death cause was due to systemic thromboembolization, or focal end-organ from systemic thromboembolism, or therapeutic intervention to treat systemic thromboembolism.	hypoperfusion resulting
	Target Value:	Any value between start of current procedure and discharge	
Element: 14935		Focal End-Organ Hypoperfusion Present	
	Coding Instruction:	Indicate if focal end-organ hypoperfusion resulted from the systemic thromboembolism event.	
	Target Value:	Any value between start of current procedure and discharge	
Element: 14939		Systemic Thromboembolization Imaging Evidence	
	Coding Instruction:	Indicate if imaging evidence indicated systemic thromboembolism.	
	Target Value:	All values between start of procedure and end of procedure	
Element: 14936		Imaging Method	
	Coding Instruction:	Indicate the imaging method to identify systemic thromboembolism.	
	Target Value:	All values between start of current procedure and discharge	
	.1.4.1.19376.1.4.1.6.5.41		Cada Sust
election	Definition	Source         Code           77343006         77343006	Code Syst SNOMED
Computed Tomography	У	77477000	
lagnetic Resonance Ir	maging	113091000	SNOMED
Iltrasound		11200001042	ACC NC
Other Imaging		11200001862	ACC NC
Element: 14937		Therapeutic Intervention Performed	
	Coding Instruction:	Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was performed to treat the thromboembolism.	systemic
	Target Value:	All values between start of procedure and end of procedure	
Element: 14938		Intervention Type	
	Coding Instruction:	Indicate the intervention type.	
	Target Value:	All values between start of procedure and end of procedure	
	.3.6.1.4.1.19376.1.4.1.6		
Selection	Definition	Source Code	Code Syste
Catheter		276272002	
Pharmacological		182832007	SNOMED
Surgical		387713003	
Other		11200000172	ACC NC





Section: Systemic Thromboembolism

Parent: In-Hospital Adjudication





# Section: In-Hospital Adjudication Medications

Parent: In-Hospital Adjudication

Element: 14940

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

Target Value: All values between start of current procedure and discharge

Adjudication Medication Code

Vendor Instruction: Adjudication Medication Code (14940) should not be duplicated within an adjudication event

#### Pre-Procedure Medication - 1.3.6.1.4.1.19376.1.4.1.6.5.216

Selection	Definition	Source	Code	Code System
Fondaparinux			321208	RxNorm
Heparin Derivative			100000921	ACC NCDR
Low Molecular Weigh	t Heparin		373294004	SNOMED CT
Unfractionated Hepar	in		96382006	SNOMED CT
Warfarin			11289	RxNorm
Aspirin 81 to 100 mg			11200002080	ACC NCDR
Aspirin 101 to 324 mg	]		11200002081	ACC NCDR
Aspirin 325 mg			317300	RxNorm
Aspirin/Dipyridamole			226716	RxNorm
Vorapaxar			1537034	RxNorm
Apixaban			1364430	RxNorm
Dabigatran			1546356	RxNorm
Edoxaban			1599538	RxNorm
Rivaroxaban			1114195	RxNorm
Cangrelor			1656052	RxNorm
Clopidogrel			32968	RxNorm
Other P2Y12			112000001003	ACC NCDR
Prasugrel			613391	RxNorm
Ticagrelor			1116632	RxNorm
Ticlopidine			10594	RxNorm

Element: 14941

Medication Administered

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

Target Value: All values between start of procedure and end of procedure

Vendor Instruction: When an Adjudication Medication Code (14940) is selected, Medication Administered (14941) cannot be Null

Drug Administered - 1.3.6.1.4.1.19376.1.4.1.6.5.711

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





Section: Post Procedure Labs	Parent: Procedure Information
Element: 14868	Post Procedure Peak Creatinine
Coding Instruction:	Indicate the post-procedure peak creatinine (Cr) level (mg/dL).
Target Value:	The highest value between end of current procedure and discharge
Supporting Definition:	Creatinine
	Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine results in the formation of creatinine. It is transferred to the kidneys by blood plasma, whereupon it is eliminated by glomerular filtration and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A rise in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver and pancreas.
	Source: http://s.details.loinc.org/LOINC/2160-0.html?sections=Simple
Element: 14870	Post Procedure Peak Creatinine Not Drawn
Coding Instruction:	Indicate if post-procedure peak creatinine level could not be assessed as either only one level or no creatinine labs were drawn.
Target Value:	N/A
Supporting Definition:	
	Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine results in the formation of creatinine. It is transferred to the kidneys by blood plasma, whereupon it is eliminated by glomerular filtration and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A rise in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver and pancreas.
	Source: http://s.details.loinc.org/LOINC/2160-0.html?sections=Simple
Element: 14871	Post Procedure Hemoglobin
Coding Instruction:	Indicate the lowest hemoglobin (Hgb) value (g/dL), obtained via lab assay or point of care assay, between the end of the procedure and the time of discharge.
Target Value:	The lowest value between end of current procedure and discharge
Supporting Definition:	Hemoglobin
	Hemoglobin (Hb or Hgb) is the iron-containing oxygen-transport metalloprotein in the red blood cells. It carries oxygen from the lungs to the rest of the body (i.e. the tissues) where it releases the oxygen to burn nutrients and provide energy. Hemoglobin concentration measurement is among the most commonly performed blood tests, usually as part of a complete blood count. If the concentration is below normal, this is called anemia. Anemias are classified by the size of red blood cells: "nicrocytic" if red cells are small, "macrocytic" if they are large, and "normocytic" if otherwise. Dehydration or hyperhydration can greatly influence measured hemoglobin levels. <b>Source:</b> http://s.details.loinc.org/LOINC/718-7.html?sections=Simple
Element: 14872	Post Procedure Hemoglobin Not Drawn
Coding Instruction:	Indicate if the post-procedure hemoglobin was not drawn.
Target Value:	N/A
	Hemoglobin
Supporting Definition:	
Supporting Definition:	Hemoglobin (Hb or Hgb) is the iron-containing oxygen-transport metalloprotein in the red blood cells. It carries oxygen from the lungs to the rest of the body (i.e. the tissues) where it releases the oxygen to burn nutrients and provide energy. Hemoglobin concentration measurement is among the most commonly performed blood tests, usually as part of a complete blood count. If the concentration is below normal, this is called anemia. Anemias are classified by the size of red blood cells: "microcytic" if red cells are small, "macrocytic" if they are large, and "normocytic" if otherwise. Dehydration or hyperhydration can greatly influence measured hemoglobin levels. <b>Source:</b> http://s.details.loinc.org/LOINC/718-7.html?sections=Simple





Section: Post Procedure Creatining	e Parent: Post Procedure Labs
Element: 14869	Post Procedure Creatinine
Coding Instruction:	Indicate the post-procedure creatinine (Cr) level (mg/dL).
Target Value:	The last value between end of last procedure and discharge
Supporting Definition:	Creatinine
	Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine results in the formation of creatinine. It is transferred to the kidneys by blood plasma, whereupon it is eliminated by glomerular filtration and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A rise in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver and pancreas. Source: http://s.details.loinc.org/LOINC/2160-0.html?sections=Simple
Element: 14867	Post Procedure Creatinine Not Drawn
Coding Instruction:	Indicate if the post-procedure creatinine level was not drawn.
Target Value:	N/A
Supporting Definition:	Creatinine
	Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine results in the formation of creatinine. It is transferred to the kidneys by blood plasma, whereupon it is eliminated by glomerular filtration and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A rise in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver and pancreas.

Source: http://s.details.loinc.org/LOINC/2160-0.html?sections=Simple





Section: Discha	rge	Parent: Root	
Element: 14835		Surgery	
	<b>.</b>		
	-	Indicate if the patient had an inpatient operation during this episode of care.	
	Target Value:	The value on discharge	
Element: 14836		Percutaneous Coronary Intervention	
	Coding Instruction:	Indicate if the patient had any other percutaneous coronary artery, coronary valvular or coronary structural interpisode of care.	erventions during this
	Target Value:	The value on discharge	
s	Supporting Definition:	Percutaneous Coronary Intervention	
		A percutaneous coronary intervention (PCI) is the placement of an angioplasty guide wire, balloon, or other dev atherectomy, brachytherapy, or thrombectomy catheter) into a native coronary artery or coronary artery bypas mechanical coronary revascularization. <b>Source:</b> Medline Plus, 2017 by Merriam-Webster, Incorporated	
Element: 10100		Discharge Date	
	Coding Instruction:	Indicate the date on which the patient was discharged from your facility.	
	-	The value on discharge	
	-	-	
	Vendor Instruction:	Discharge Date (10100) and Arrival Date (3000) must not overlap on multiple episodes	
		Discharge Date (10100) must be Greater than or Equal to 10/01/2022	
Element: 10105		Discharge Status	
	Coding Instruction:	Indicate whether the patient was alive or deceased at discharge.	
	-	The value on discharge	
Discharge Life Status Selection	s - 1.3.6.1.4.1.19376.1.4 Definition	.1.6.5.42 Source Code	Codo Svoto
Alive	Demition	438949009	Code Syste SNOMED
Deceased			HL7 Discharge dispositi
Element: 10110		Discharge Location	
	Coding Instruction:	Indicate the location to which the patient was discharged.	
	-	The value on discharge	
Discharge Location -	1.3.6.1.4.1.19376.1.4.1.	·	
Selection	Definition	Source Code	Code Syste
Home			HL7 Discharge disposit
Extended Care/TCU/Re	hab		HL7 Discharge dispositi
Other acute care hospi	ital	02	HL7 Discharge disposit
Skilled Nursing facility		64	HL7 Discharge disposit
Other		100001249	ACC NC
Left against medical ac AMA)	lvice	07	HL7 Discharge disposit
Element: 10115		Hospice Care	
	Coding Instruction:	Indicate if the patient was discharged to hospice care.	
	Target Value:	The value on discharge	
Element: 10120		Death During the Procedure	
	Coding Instruction:	Indicate if the patient expired during the procedure.	
		Note(s): Make sure to only capture 'death during the procedure' in the procedure appropriate registry.	
		For example, if the patient had a CathPCI procedure and a TVT procedure in the same episode of care (hospita	lization) but different cath
		lab visits and the death occurred during the TVT procedure, code 'Yes' only in the TVT Registry and not the Cat CathPCI procedure and TVT procedure occurred during the same cath lab visit then code 'Yes' in both registries	

Target Value: Any occurrence on discharge





Section: Discharge		Parent: Root
Element: 10125		Cause of Death
	Coding Instruction:	Indicate the primary cause of death, i.e. the first significant abnormal event which ultimately led to death.
	Target Value:	The value on time of death
	Vendor Instruction:	When Cause of Death (10125) is Equal to Stroke, at least one of the following Adjudication Events (14312) must be selected: Hemorrhagic Stroke, Intracranial Hemorrhage, Ischemic Stroke, TIA, Undetermined Stroke
		When Cause of Death (10125) is Equal to (Cardiovascular hemorrhage, Hemorrhage), at least one of the following Adjudication Events (14312) must be selected: Access Site Bleeding, GI Bleeding, Hematoma, Hemothorax (not requiring drainage), Hemothorax (requiring drainage), Other Hemorrhage, Pericardial Effusion (requiring open cardiac surgery), Pericardial Effusion with tamponade (requiring percutaneous drainage), Pericardial Effusion without tamponade (requiring percutaneous drainage), Retroperitoneal Bleeding, Vascular Complications, AV Fistula (requiring surgical repair), Pseudoaneurysm

## Cause of Death Clinical Finding - 1.3.6.1.4.1.19376.1.4.1.6.5.88

Selection	Definition	Source	Code	Code System
Acute myocardial infa	Acute myocardial infarction		100000960	ACC NCDR
Sudden cardiac death	l		100000978	ACC NCDR
Heart failure			100000964	ACC NCDR
Stroke			100000977	ACC NCDR
Cardiovascular proce	dure		100000962	ACC NCDR
Cardiovascular hemo	rrhage		100000961	ACC NCDR
Other cardiovascular	reason		100000972	ACC NCDR
Pulmonary			100000975	ACC NCDR
Renal			100000976	ACC NCDR
Gastrointestinal			100000963	ACC NCDR
Hepatobiliary			10000966	ACC NCDR
Pancreatic			100000974	ACC NCDR
Infection			100000967	ACC NCDR
Inflammatory/Immunol	ogic		100000968	ACC NCDR
Hemorrhage			100000965	ACC NCDR
Non-cardiovascular p	rocedure		100000971	ACC NCDR
or surgery				
Trauma			100000980	ACC NCDR
Suicide			100000979	ACC NCDR
Neurological			100000970	ACC NCDR
Malignancy			100000969	ACC NCDR
Other non-cardiovasc	cular		100000973	ACC NCDR
reason				





Section: Discharge Medications		Parent: Discharge
	Element: 10200	Discharge Medication Code
	Coding Instruction	: Indicate the assigned identification number associated with the medications the patient was prescribed upon discharge.

Note(s): Discharge medications not required for patients who expired, discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care.

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

Target Value: N/A

Vendor Instruction: Discharge Medication Code (10200) should not be duplicated in an episode

#### Discharge Medication - 1.3.6.1.4.1.19376.1.4.1.6.5.165

Code System	Code	Source	Definition	Selection
RxNorm	321208			Fondaparinux
ACC NCDF	100000921		tive	Heparin Derivative
SNOMED CT	373294004		Low Molecular Weight Heparin	
SNOMED CT	96382006		Heparin	Unfractionated Heparin
RxNorm	11289			Warfarin
RxNorm	1191			Aspirin
RxNorm	226716		amole	Aspirin/Dipyridamole
RxNorm	1537034			Vorapaxar
RxNorm	1364430			Apixaban
RxNorm	1546356			Dabigatran
RxNorm	1599538			Edoxaban
RxNorm	1114195			Rivaroxaban
RxNorm	1656052			Cangrelor
RxNorm	32968			Clopidogrel
ACC NCDF	112000001003			Other P2Y12
RxNorm	613391			Prasugrel
RxNorm	1116632			Ticagrelor
RxNorm	10594			Ticlopidine

Element: 10205

**Discharge Medication Prescribed** 

Coding Instruction: Indicate if the medication was prescribed, not prescribed, or was not prescribed for either a medical or patient reason.

Target Value: The value on discharge

#### Discharge Medication Administration - 1.3.6.1.4.1.19376.1.4.1.6.5.86

Selection	Definition	Source	Code	Code System
Yes			100001247	ACC NCDR
No - No Reason			100001048	ACC NCDR
No - Medical Reason			100001034	ACC NCDR
No - Patient Reason			100001071	ACC NCDR

Element: 10207

Discharge Medication Dose

Coding Instruction: Indicate the category of the medication dose prescribed.

Target Value: The value on discharge

#### Medication Dose - 1.3.6.1.4.1.19376.1.4.1.6.5.321

Selection	Definition	Source	Code	Code System
Aspirin 81 to 100 mg			11200002080	ACC NCDR
Aspirin 101 to 324 mg			11200002081	ACC NCDR
Aspirin 325 mg			317300	RxNorm





	-Up	Parent: Root	
Element: 10999		Follow-Up Unique Key	
	Coding Instruction:	Indicate the unique key associated with each patient follow-up record as assigned by the EMR/EHR or your	software application
	Target Value:		software application.
	Target Value.		
Element: 11000		Follow-Up Assessment Date	
	Coding Instruction:	Indicate the date of the follow-up assessment was performed.	
	Target Value:	The value on Follow-up	
	Vendor Instruction:	Follow-Up Assessment Date (11000) must be Greater than the Follow-Up Reference Procedure Start Date a	nd Time (11001)
		Follow-Up Assessment Date (11000) must be Greater than or Equal to 10/01/2022	
Element: 14851		Follow Up Interval	
	Coding Instruction:	Indicate the interval of follow-up: 45 days, 6 months, 1 year or 2 years.	
	-	The value on Follow-up	
	-		In Reference Broodure St
	vendor instruction:	A Follow Up - combination of Follow Up Interval (14851), Follow-Up Assessment Date (11000) and Follow-U Date and Time (11001) - may only be entered/selected once	p Reference Procedure Sta
		The date difference between Follow-up Assessment Date (11000) and Follow-up Reference Procedure Star must fall within the valid range for the Follow Up Interval (14851). The valid ranges for the Follow Up Interval follows:	( )
		45 day: 1-91 days 6 month: 92-256 days 1 year: 257-548 days 2 year: 549-913 days	
Follow Up Interval - 1 Selection	1.3.6.1.4.1.19376.1.4.1.6 Definition	5.5.806 Source Co	de Code Syste
45 day	Dominion	112000021	
6 month		3000420	01 SNOMED
1 year		1836270	
2 year		112000021	18 ACC NC
Element: 14946		Reference Episode Arrival Date	
	Coding Instruction:	Indicate the date and time of arrival for the episode of care that included the reference procedure.	
	Target Value:	The value on Follow-up	
Element: 14338		Follow-Up Reference Discharge Date	
Element: 14338	Coding Instruction:		
Element: 14338	-	Follow-Up Reference Discharge Date	
Element: 14338	Target Value:	Follow-Up Reference Discharge Date Indicate the date of discharge for the episode of care that included the reference procedure.	
	Target Value:	Follow-Up Reference Discharge Date Indicate the date of discharge for the episode of care that included the reference procedure. The value on Follow-up	
	Target Value: Vendor Instruction:	Follow-Up Reference Discharge Date Indicate the date of discharge for the episode of care that included the reference procedure. The value on Follow-up Follow-up Reference Discharge Date (14338) must not be Null Follow-Up Reference Procedure Start Date and Time	
	Target Value: Vendor Instruction: Coding Instruction:	Follow-Up Reference Discharge Date Indicate the date of discharge for the episode of care that included the reference procedure. The value on Follow-up Follow-up Reference Discharge Date (14338) must not be Null	
Element: 11001	Target Value: Vendor Instruction: Coding Instruction:	Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-up Reference Discharge Date (14338) must not be Null         Follow-Up Reference Procedure Start Date and Time         Indicate the reference procedure start date and time on the follow-up assessment date.         The value on Follow-up	
Element: 11001	Target Value: Vendor Instruction: Coding Instruction: Target Value:	Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-up Reference Discharge Date (14338) must not be Null         Follow-Up Reference Procedure Start Date and Time         Indicate the reference procedure start date and time on the follow-up assessment date.         The value on Follow-up         Method to Determine Follow-Up Status	
Element: 14338 Element: 11001 Element: 11003	Target Value: Vendor Instruction: Coding Instruction: Target Value: Coding Instruction:	Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-up Reference Discharge Date (14338) must not be Null         Follow-Up Reference Procedure Start Date and Time         Indicate the reference procedure start date and time on the follow-up assessment date.         The value on Follow-up         Method to Determine Follow-Up Status         Indicate the method(s) used to determine the patient's vital status for follow up.	
Element: 11001 Element: 11003	Target Value: Vendor Instruction: Coding Instruction: Target Value: Coding Instruction: Target Value:	Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-up Reference Discharge Date (14338) must not be Null         Follow-Up Reference Procedure Start Date and Time         Indicate the reference procedure start date and time on the follow-up assessment date.         The value on Follow-up         Method to Determine Follow-Up Status         Indicate the method(s) used to determine the patient's vital status for follow up.         The value on Follow-up	
Element: 11001 Element: 11003 Method to Determine	Target Value: Vendor Instruction: Coding Instruction: Target Value: Coding Instruction: Target Value: e Follow-up status - 1.3	Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-up Reference Discharge Date (14338) must not be Null         Follow-Up Reference Procedure Start Date and Time         Indicate the reference procedure start date and time on the follow-up assessment date.         The value on Follow-up         Method to Determine Follow-Up Status         Indicate the method(s) used to determine the patient's vital status for follow up.         The value on Follow-up         3.6.1.4.1.19376.1.4.1.6.5.370	de Code Svsta
Element: 11001 Element: 11003 Method to Determine Selection	Target Value: Vendor Instruction: Coding Instruction: Target Value: Coding Instruction: Target Value:	Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-up Reference Discharge Date (14338) must not be Null         Follow-Up Reference Procedure Start Date and Time         Indicate the reference procedure start date and time on the follow-up assessment date.         The value on Follow-up         Method to Determine Follow-Up Status         Indicate the method(s) used to determine the patient's vital status for follow up.         The value on Follow-up	,
Element: 11001 Element: 11003	Target Value: Vendor Instruction: Coding Instruction: Target Value: Coding Instruction: Target Value: e Follow-up status - 1.3	Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-up Reference Discharge Date (14338) must not be Null         Follow-Up Reference Procedure Start Date and Time         Indicate the reference procedure start date and time on the follow-up assessment date.         The value on Follow-up         Method to Determine Follow-Up Status         Indicate the method(s) used to determine the patient's vital status for follow up.         The value on Follow-up         3.6.1.4.1.19376.1.4.1.6.5.370	01 SNOMED
Element: 11001 Element: 11003 Method to Determine Selection Office visit	Target Value: Vendor Instruction: Coding Instruction: Target Value: Coding Instruction: Target Value: e Follow-up status - 1.3 Definition	Follow-Up Reference Discharge Date         Indicate the date of discharge for the episode of care that included the reference procedure.         The value on Follow-up         Follow-up Reference Discharge Date (14338) must not be Null         Follow-Up Reference Procedure Start Date and Time         Indicate the reference procedure Start Date and Time         Indicate the reference procedure start date and time on the follow-up assessment date.         The value on Follow-up         Method to Determine Follow-Up Status         Indicate the method(s) used to determine the patient's vital status for follow up.         The value on Follow-up         3.6.1.4.1.19376.1.4.1.6.5.370	01         SNOMED           60         ACC NC           61         ACC NC

Social Security Death Master

File

ACC NCDR

1000142362



# Coder's Data Dictionary v1.4



Section: Follow-U	Jp	Parent: Root	
Hospitalization		1000142363	ACC NCDF
Other		100000351	ACC NCDF
Element: 11004		Follow-Up Status	
	Coding Instruction:	Indicate whether the patient is alive or deceased.	
	Target Value:	The value on Follow-up	
Follow-Up Status - 1.3.			
Selection	Definition	Source Code	Code System
Alive		438949009	SNOMED C
Deceased		20	0 1
ost to follow-up		399307001	SNOMED C
Element: 11006		Follow-Up Date of Death	
	Coding Instruction:	Indicate the date of death.	
	Target Value:	The value on Follow-up	
	Vendor Instruction:	Follow-Up Date of Death (11006) must be Greater than the Follow-Up Reference Procedure Start Date and Time	e (11001)
		Follow-Up Date of Death (11006) must be Greater than or Equal to the Follow-Up Event Date (14277)	
Element: 11007		Cause of Death	
	Coding Instruction:	Indicate the primary cause of death, i.e. the first significant abnormal event which ultimately led to death.	
	Target Value:	The value on Follow-up	
	Vendor Instruction:	When Cause of Death (11007) is Equal to Stroke, at least one of the following Adjudication Events (14967) must Hemorrhagic Stroke, Intracranial Hemorrhage, Ischemic Stroke, TIA, Undetermined Stroke	t be selected:
		When Cause of Death (11007) is Equal to (Cardiovascular hemorrhage, Hemorrhage), at least one of the follow (14967) must be selected: Access Site Bleeding, GI Bleeding, Hematoma, Hemothorax (not requiring drainage), drainage), Other Hemorrhage, Pericardial Effusion (requiring open cardiac surgery), Pericardial Effusion without tamponade (requiring percutaneous drainage), Retroperito Complications, AV Fistula (requiring surgical repair), Pseudoaneurysm (requiring endovascular repair), Pseudoaneurysm (requiring thrombin injection only)	Hemothorax (requiring mponade (requiring meal Bleeding, Vascular

Selection	Definition	Source	Code	Code System
Acute myocardial infarction			100000960	ACC NCDR
Sudden cardiac death	ı		100000978	ACC NCDR
Heart failure			100000964	ACC NCDR
Stroke			100000977	ACC NCDR
Cardiovascular proce	dure		100000962	ACC NCDR
Cardiovascular hemo	rrhage		100000961	ACC NCDR
Other cardiovascular	reason		100000972	ACC NCDR
Pulmonary			100000975	ACC NCDR
Renal			100000976	ACC NCDR
Gastrointestinal			100000963	ACC NCDR
Hepatobiliary			100000966	ACC NCDR
Pancreatic			100000974	ACC NCDR
Infection			100000967	ACC NCDR
Inflammatory/Immunol	ogic		100000968	ACC NCDR
Hemorrhage		100000965	ACC NCDR	
Non-cardiovascular p	rocedure		100000971	ACC NCDR
or surgery				
Trauma			100000980	ACC NCDR
Suicide			100000979	ACC NCDR
Neurological			100000970	ACC NCDR
Malignancy			100000969	ACC NCDR
Other non-cardiovaso reason	cular		100000973	ACC NCDR

Element: 14858

Left Ventricular Ejection Fraction Assessed

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

Target Value: The value on Follow-up





Section: Follow	v-0p	Parent: Root
Element: 13690		Left Ventricular Ejection Fraction
	Coding Instruction:	Indicate the left ventricular ejection fraction.
	Target Value:	The value on Follow-up
	Supporting Definition:	Most Recent LVEF %
		The left ventricular ejection fraction is the percentage of blood emptied from the left ventricle at the end of contraction.
		Source: ACC Clinical Data Standards, Society for Thoracic Surgeons Adult Cardiac Surgery Database (STS)
Element: 14859		Transthoracic Echo Performed
Liement. 14039	Coding Instruction	
	-	Indicate if a transthoracic echocardiogram (TTE) was performed.
	Target value:	The value on Follow-up
Element: 14873		TTE Date
	Coding Instruction:	Indicate the date of the most recent transthoracic echo study performed.
	-	The value on Follow-up
	-	TTE Date (14873) must be Greater than the Follow-Up Reference Procedure Start Date and Time (11001)
Element: 14874		Transesophageal Echocardiogram (TEE) Performed
	Coding Instruction:	Indicate if transesophageal echocardiogram (TEE) was performed.
	Target Value:	The value on Follow-up
Element: 14875		TEE Date
	Coding Instruction:	Indicate the date of the most recent transesophageal echocardiogram (TEE).
	Target Value:	The value on Follow-up
	Vendor Instruction:	TEE Date (14875) must be Greater than the Follow-Up Reference Procedure Start Date and Time (11001)
Element: 14876		Cardiac CT Performed
	Coding Instruction:	Indicate if cardiac computed tomography (CT) was performed.
	Target Value:	The value on Follow-up
Element: 14877		Cardiac CT Date
	Coding Instruction:	
	-	Indicate the date of the most recent cardiac computed tomography (CT). The value on Follow-up
	-	Cardiac CT Date (14877) must be Greater than the Follow-Up Reference Procedure Start Date and Time (11001)
	venuor matruction.	
Element: 14878		Cardiac MRI Performed
	Coding Instruction:	Indicate if cardiac magnetic resonance imaging (MRI) was performed.
	-	The value on Follow-up
Element: 14879		Cardiac MRI Date
	Coding Instruction:	Indicate the date of the most recent cardiac magnetic resonance imaging (MRI).
	Target Value:	The value on Follow-up
	Vendor Instruction:	Cardiac MRI Date (14879) must be Greater than the Follow-Up Reference Procedure Start Date and Time (11001)
Element: 14880		Intracardiac Echo Performed
	Coding Instruction:	Indicate if intracardiac echo (ICE) was performed.
	Target Value:	The value on Follow-up
	Supporting Definition:	Intracardiac three dimensional echocardiography
		Intracardiac echocardiography (ICE) is an imaging technique that is increasingly available as an alternative to transoesophageal echocardiography to guide percutaneous interventional procedures.
		Source: Mitchell ARJ, Puwanarajah P, Timperley J, Becher H, Wilson N, Ormero OJ. The Emerging Role of Intracardiac





Section: Follow-Up	Parent: Root
	Echocardiography Into the ICE Age. Br J Cardiol. 2007;14(1):31-36.
Element: 14881	Date of Intracardiac Echo
Coding Instruction:	Indicate the date of the most recent intracardiac echo (ICE).
-	The value on Follow-up
-	Intracardiac three dimensional echocardiography
	Intracardiac echocardiography (ICE) is an imaging technique that is increasingly available as an alternative to transoesophageal echocardiography to guide percutaneous interventional procedures.
	Source: Mitchell ARJ, Puwanarajah P, Timperley J, Becher H, Wilson N, Ormero OJ. The Emerging Role of Intracardiac Echocardiography Into the ICE Age. Br J Cardiol. 2007;14(1):31-36.
Element: 14882	Atrial Thrombus Detected
Coding Instruction:	Indicate if a left atrial thrombus was detected.
Target Value:	The value on Follow-up
Supporting Definition:	Atrial Thrombus Detected
	Presence of thrombus is considered to be definite if 3 of the following 5 criteria are present: Clear borders, echogenicity from the surrounding structures, independent mobility, longest diameter > 15mm, seen in more than one echocardiographic plane.
	<b>Source:</b> Buxton AE, Calkins H, Callans DJ, et al. ACC/AHA/HRS 2006 Key Data Elements and Definitions for Electrophysiological Studies and Procedures: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Data Standards (ACC/AHA/HRS Writing Committee to Develop Data Standards on Electrophysiology). J Am Coll Cardiol. 2006;48(11):2360-2396.
Element: 14884	Device Margin Residual Leak
Coding Instruction:	Indicate the residual leak at the device margin in millimeters (mm).
Target Value:	The value on Follow-up
Element: 14885	Device Margin Residual Leak Not Assessed
Coding Instruction:	Indicate if the residual leak at the device margin was not assessed.
Target Value:	The value on Follow-up
Element: 14886	Creatinine
Coding Instruction:	Indicate the most recent creatinine (Cr) level (mg/dL).
Target Value:	The value on Follow-up
Supporting Definition:	Creatinine
	Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine results in the formation of creatinine. It is transferred to the kidneys by blood plasma, whereupon it is eliminated by glomerular filtration and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A ris in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting early kidney disease. Creatinine and creatinine are metabolized in the kidneys, muscle, liver and pancreas.
	Source: http://s.details.loinc.org/LOINC/2160-0.html?sections=Simple
Element: 14887	Creatinine Not Drawn
Coding Instruction:	Indicate if the creatinine level was not drawn.
Target Value:	The value on Follow-up
Supporting Definition:	
	Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine results in the formation of creatinine. It is transferred to the kidneys by blood plasma, whereupon it is eliminated by glomerular filtration and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A ris in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver and pancreas. <b>Source:</b> http://s.details.loinc.org/LOINC/2160-0.html?sections=Simple
Element: 14888	Lowest Hemoglobin Value
	Indicate the lowest hemoglobin (Hgb) value (g/dL), obtained via lab assay or point of care assay, after discharge if 45 day follow up; or
Toward Molecon	the lowest value between the prior follow up visit and current follow up visit for any follow up after the 45 day follow up.
Target Value:	The value on Follow-up





Section: Follow-Up	Parent: Root
Supporting Definition:	Hemoglobin
	Hemoglobin (Hb or Hgb) is the iron-containing oxygen-transport metalloprotein in the red blood cells. It carries oxygen from the lungs to the rest of the body (i.e. the tissues) where it releases the oxygen to burn nutrients and provide energy. Hemoglobin concentration measurement is among the most commonly performed blood tests, usually as part of a complete blood count. If the concentration is below normal, this is called anemia. Anemias are classified by the size of red blood cells: "microcytic" if red cells are small, "macrocytic" if they are large, and "normocytic" if otherwise. Dehydration or hyperhydration can greatly influence measured hemoglobin levels.
	Source: http://s.details.loinc.org/LOINC/718-7.html?sections=Simple
Element: 14889	Hemoglobin Not Drawn
Coding Instruction:	Indicate if the hemoglobin was not drawn.
Target Value:	The value on Follow-up
Supporting Definition:	Hemoglobin
	Hemoglobin (Hb or Hgb) is the iron-containing oxygen-transport metalloprotein in the red blood cells. It carries oxygen from the lungs to the rest of the body (i.e. the tissues) where it releases the oxygen to burn nutrients and provide energy. Hemoglobin concentration measurement is among the most commonly performed blood tests, usually as part of a complete blood count. If the concentration is below normal, this is called anemia. Anemias are classified by the size of red blood cells: "microcytic" if red cells are small, "macrocytic" if they are large, and "normocytic" if otherwise. Dehydration or hyperhydration can greatly influence measured hemoglobin levels.
	Source: http://s.details.loinc.org/LOINC/718-7.html?sections=Simple
Element: 13148	Modified Rankin Scale Score
Coding Instruction:	Indicate the Modified Rankin Scale score.
Target Value:	The value on Follow-up
Supporting Definition:	Modified Rankin Scale
	The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.
	Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.
	Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.

#### Rankin Scale Assessment Finding - 1.3.6.1.4.1.19376.1.4.1.6.5.139

Selection	Definition	Source Code	Code System
0: No symptoms at all		LA6111-4	LOING
1: No significant disability despite symptoms	Able to carry ou	t all usual duties and activities. LA6112-2	LOING
2: Slight disability	,	out all previous activities, but able to LA6113-0	LOIN
	look after own	affairs without assistance.	
3: Moderate disability	Requiring some assistance.	help, but able to walk without LA6114-8	LOINC
4: Moderately severe disability		without assistance and unable to attend LA6115-5 eeds without assistance.	LOINC
5: Severe disability	Bedridden, inco care and attenti	ntinent and requiring constant nursing LA10137-0 on.	LOINC
6: Death		419620001	SNOMED CT
Element: 14890		Modified Rankin Scale Not Administered	
Codir	ng Instruction:	Indicate if the Modified Rankin Scale was not administered at follow-up.	
	Target Value:	The value on Follow-up	
Support	-	The value on Follow-up Modified Rankin Scale	
Support	-		le of global disability.
Support	-	Modified Rankin Scale	le of global disability.
Support	-	Modified Rankin Scale The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sca	0 ,
Support Element: 14891	-	Modified Rankin Scale The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sca Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.	0 ,
<b>Element:</b> 14891	ting Definition:	Modified Rankin Scale The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sca Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15. Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12)	1497-1500.
<b>Element:</b> 14891	ng Instruction:	Modified Rankin Scale The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sca Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15. Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12) Barthel Index Evaluation Performed Indicate if the Barthel Index Evaluation was performed. The Barthel Index (BI) or Barthel ADL index is a scale used	1497-1500.
Element: 14891 Codir	ng Instruction:	Modified Rankin Scale The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sca Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15. Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12) Barthel Index Evaluation Performed Indicate if the Barthel Index Evaluation was performed. The Barthel Index (BI) or Barthel ADL index is a scale used performance in basic activities of daily living (ADL). The value on Follow-up	1497-1500.
Element: 14891 Codir	ng Instruction: Target Value:	Modified Rankin Scale The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sca Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15. Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12) Barthel Index Evaluation Performed Indicate if the Barthel Index Evaluation was performed. The Barthel Index (BI) or Barthel ADL index is a scale used performance in basic activities of daily living (ADL). The value on Follow-up	1497-1500.
Element: 14891 Codir	ng Instruction: Target Value:	Modified Rankin Scale The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a sca Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15. Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12) Barthel Index Evaluation Performed Indicate if the Barthel Index Evaluation was performed. The Barthel Index (BI) or Barthel ADL index is a scale used performance in basic activities of daily living (ADL). The value on Follow-up Barthel Index	1497-1500.





Section: Fo	llow-Up		Parent: Root		
Element: 148	392	Feeding			
	Coding Instruction:		nent that most closely corresponds to the patient's current be obtained from the patient's self-report, from a separate oservation.		
	Target Value:	The value on Follow-up			
	Supporting Definition:	Barthel Index Element			
		Copyright Notice: Used with permissior	۱.		
		Source: Mahoney FI, Barthel D. "Fur	nctional evaluation: the Barthel Index." Maryland State Med	Journal 1965;14:56-	61.
Functional Abili	ity - 1.3.6.1.4.1.19376.1.4.1.6.	.5.801			
Selection	Definition		Source	Code	Code Systen
Unable	Complete assis	st for feeding required.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	289001005	SNOMED C
Needs Help		necessary (with cutting up food, use salt pread butter, etc).	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165223004	SNOMED C
Independent	table when sor must be able to	meone puts the food within reach. They o cut up the food, use salt and pepper, etc. The patient must accomplish this in	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165224005	SNOMED C
Dependent	Patient require	s assistance for bathing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129043005	SNOMED C
Independent	complete spong steps involved	e a bath tub, a shower, or take a ge bath. They must be able to do all the in whichever method is employed er person being present.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129041007	SNOMED C
Needs Help	Patient needs a	assistance with any aspect of grooming.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704440004	SNOMED C
Independent	teeth, and shav must put in bla as get it from d	ash hands and face, comb hair, clean ve. They may use any kind of razor but ide or plug in razor without help as well drawer or cabinet. Female patients must ikeup, if used, but need not braid or style	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704437004	SNOMED C

	hair.			
Dependent	Patient is unable to assist with any dressing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129065005	SNOMED CT
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the work themselves. They must accomplish this in a reasonable time. Women need not be scored on use o a brassiere or girdle unless these are prescribed garments.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61. f	129039006	SNOMED CT
Independent	Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces wher these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.		29035000	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	72042002	SNOMED CT
Inconsistent	Patient needs help in using a suppository or taking an enema or has occasional accidents.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165230005	SNOMED CT
Continent	Patient is able to control bowels and has no accidents. They can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).	Barthel Index." Maryland State Med Journal 1965;14:56-	24029004	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165232002	SNOMED CT
Inconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165233007	SNOMED CT
Continent	Patient is able to control his bladder day and night.	Mahoney FI, Barthel D. "Functional evaluation: the	165234001	SNOMED CT

Effective for Patients Discharged on/after October 01, 2022





Section: Follow-	Up		Parent: Root		
	device and leg	rry patients who wear an external bag must put them on independently, by bag, and stay dry day and night.	Barthel Index." Maryland State Med Journal 1965;14:56- 61.		
Dependent	Patient requires	s full assistance.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129078005	SNOMED CT
Needs Help	Patient needs h clothes or in usi		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165241007	SNOMED CT
Independent	unfasten clothe toilet paper with other stable obj necessary to us	o get on and off toilet, fasten and is, prevent soiling of clothes, and use nout help. They may use a wall bar or ject for support if needed. If it is se a bed pan instead of a toilet, they place it on a chair, empty it, and clean	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129062008	SNOMED CT
Unable		le to assist with any transfer.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	733744002	SNOMED CT
Major Assist Needed	a second perso		f Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002154	ACC NCDR
Minor Assist Needed	Either some mir activity or the pa		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002155	ACC NCDR
Independent	safely approach lift footrests, mo sitting position o position of the	all phases of this activity. Patient can h the bed in his wheelchair, lock brakes ove safely to bed, lie down, come to a on the side of the bed, change the wheelchair, if necessary, to transfer ely, and return to the wheelchair.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	714915006	SNOMED CT
Immobile	Patient is immob	ile.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000001492	ACC NCDR
Wheelchair	wheelchair inde around corners table, bed, toile	not ambulate but can propel a ependently. They must be able to go , turn around, maneuver the chair to a t, etc. They must be able to push a chair ls. Do not score this item if the patient walking		165243005	SNOMED CT
One Person Assist		help or supervision in any of the above least 50 yards with a little help.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	707739007	SNOMED CT
Independent	supervision. Th use crutches, c walker. They m used, assume t the necessary r and dispose of	k at least 50 yards without help or ney may wear braces or prostheses and anes, or a walkerette but not a rolling ust be able to lock and unlock braces if he standing position and sit down, get nechanical aides into position for use, them when he sits. (Putting on and as is scored under dressing.)	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	302042005	SNOMED CT
Unable	Patient is unabl	•,	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	301589003	SNOMED CT
Needs Help	Patient needs h down stairs sat	nelp with or supervision to go up or fely.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165248001	SNOMED CT
Independent	safely without h should use han needed. They n	to go up and down a flight of stairs help or supervision. They may and hdrails, canes, or crutches when must be able to carry canes or crutches I or descend stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165249009	SNOMED CT
Element: 14893		Bathing			
	Coding Instruction:		nent that most closely corresponds to the patient's current be obtained from the patient's self-report, from a separat oservation.		
	Target Value:	The value on Follow-up			
S	supporting Definition:	Barthel Index Element			
		Copyright Notice: Used with permission	۱.		
		Source: Mahoney FI, Barthel D. "Fur	ctional evaluation: the Barthel Index." Maryland State Me	d Journal 1965;14:56-6	61.
			Effec	tive for Patients Dischar	ged on/after October 0





# Section: Follow-Up

# Parent: Root

Selection	Definition	Source	Code	Code System
Unable	Complete assist for feeding required.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	289001005	SNOMED CT
Needs Help	Some help is necessary (with cutting up food, use salt and pepper, spread butter, etc).	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165223004	SNOMED CT
Independent	The patient can feed themselves a meal from a tray or table when someone puts the food within reach. They must be able to cut up the food, use salt and pepper, spread butter, etc. The patient must accomplish this in a reasonable time.	Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165224005	SNOMED CT
Dependent	Patient requires assistance for bathing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129043005	SNOMED CT
Independent	Patient may use a bath tub, a shower, or take a complete sponge bath. They must be able to do all the steps involved in whichever method is employed without another person being present.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129041007	SNOMED CT
Needs Help	Patient needs assistance with any aspect of grooming.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704440004	SNOMED CT
Independent	Patient can wash hands and face, comb hair, clean teeth, and shave. They may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style hair.		704437004	SNOMED CT
Dependent	Patient is unable to assist with any dressing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129065005	SNOMED CT
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the work themselves. They must accomplish this in a reasonable time. Women need not be scored on use of a brassiere or girdle unless these are prescribed garments.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129039006	SNOMED CT
Independent	Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	29035000	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	72042002	SNOMED CT
Inconsistent	Patient needs help in using a suppository or taking an enema or has occasional accidents.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165230005	SNOMED CT
Continent	Patient is able to control bowels and has no accidents. They can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).	Barthel Index." Maryland State Med Journal 1965;14:56-	24029004	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165232002	SNOMED CT
Inconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165233007	SNOMED CT
Continent	Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165234001	SNOMED CT
Dependent	Patient requires full assistance.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129078005	SNOMED CT
Needs Help	Patient needs help because of imbalance or in handling clothes or in using toilet paper.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165241007	SNOMED CT
Independent	Patient is able to get on and off toilet, fasten and unfasten clothes, prevent soiling of clothes, and use toilet paper without help. They may use a wall bar or	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129062008	SNOMED CT





r	ecessary to us	ect for support if needed. If it is e a bed pan instead of a toilet, they			
		place it on a chair, empty it, and clean			
Jnable F	Patient is unable	e to assist with any transfer.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	733744002	SNOMED C
a	second persor		f Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002154	ACC NCD
a	ctivity or the pa	imal help is needed in some step of this titent needs to be reminded or afety of one or more parts of this	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002155	ACC NCD
s li s	afely approach ft footrests, mo itting position o position of the w		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	714915006	SNOMED C
mmobile F	Patient is immobi	le.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-61.	112000001492	ACC NCD
v a tu a	vheelchair inder round corners, able, bed, toilet,	etc. They must be able to push a chair b. Do not score this item if the patient	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165243005	SNOMED C
		elp or supervision in any of the above least 50 yards with a little help.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	707739007	SNOMED C
	upervision. The use crutches, ca valker. They mu used, assume th he necessary m und dispose of t	at least 50 yards without help or ay may wear braces or prostheses and anes, or a walkerette but not a rolling ust be able to lock and unlock braces if ne standing position and sit down, get hechanical aides into position for use, hem when he sits. (Putting on and s is scored under dressing.)	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	302042005	SNOMED C
	Patient is unable		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	301589003	SNOMED C
	Patient needs he lown stairs safe	elp with or supervision to go up or ely.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165248001	SNOMED C
s s r	afely without he hould use hand heeded. They m	o go up and down a flight of stairs elp or supervision. They may and drails, canes, or crutches when tust be able to carry canes or crutches or descend stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165249009	SNOMED C
Element: 14894		Grooming			
Coding			nent that most closely corresponds to the patient's currer be obtained from the patient's self-report, from a separate oservation.		
т	arget Value:	The value on Follow-up			
Supportin	g Definition:	Barthel Index Element			
		Copyright Notice: Used with permission	٦.		

Selection Definition Source Code Code System Unable Mahoney FI, Barthel D. "Functional evaluation: the SNOMED CT Complete assist for feeding required. 289001005 Barthel Index." Maryland State Med Journal 1965;14:56-61. Needs Help Some help is necessary (with cutting up food, use salt Mahoney FI, Barthel D. "Functional evaluation: the 165223004 SNOMED CT and pepper, spread butter, etc). Barthel Index." Maryland State Med Journal 1965;14:56-61 The patient can feed themselves a meal from a tray or Mahoney FI, Barthel D. "Functional evaluation: the 165224005 SNOMED CT Independent table when someone puts the food within reach. They Barthel Index." Maryland State Med Journal 1965;14:56must be able to cut up the food, use salt and pepper, 61.





Section: Follow-Up		Parent: Root		
	spread butter, etc. The patient must accomplish this in a reasonable time.			
Dependent	Patient requires assistance for bathing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129043005	SNOMED CT
Independent	Patient may use a bath tub, a shower, or take a complete sponge bath. They must be able to do all the steps involved in whichever method is employed without another person being present.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129041007	SNOMED CT
Needs Help	Patient needs assistance with any aspect of grooming.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704440004	SNOMED CT
Independent	Patient can wash hands and face, comb hair, clean teeth, and shave. They may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style hair.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704437004	SNOMED CT
Dependent	Patient is unable to assist with any dressing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129065005	SNOMED CT
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the work themselves. They must accomplish this in a reasonable time. Women need not be scored on use of a brassiere or girdle unless these are prescribed garments.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129039006	SNOMED CT
Independent	Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	29035000	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	72042002	SNOMED CT
Inconsistent	Patient needs help in using a suppository or taking an enema or has occasional accidents.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165230005	SNOMED CT
Continent	Patient is able to control bowels and has no accidents. They can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).	Barthel Index." Maryland State Med Journal 1965;14:56-	24029004	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165232002	SNOMED CT
Inconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165233007	SNOMED CT
Continent	Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165234001	SNOMED CT
Dependent	Patient requires full assistance.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129078005	SNOMED CT
Needs Help	Patient needs help because of imbalance or in handling clothes or in using toilet paper.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165241007	SNOMED CT
Independent	Patient is able to get on and off toilet, fasten and unfasten clothes, prevent soiling of clothes, and use toilet paper without help. They may use a wall bar or other stable object for support if needed. If it is necessary to use a bed pan instead of a toilet, they must be able to place it on a chair, empty it, and clean it.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129062008	SNOMED CT
Unable	Patient is unable to assist with any transfer.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	733744002	SNOMED CT
Major Assist Needed	Patient can come to a sitting position without the help o a second person but needs to be lifted out of bed, or if they transfer with a great deal of help.		112000002154	ACC NCDR
Minor Assist Needed	Either some minimal help is needed in some step of this	Mahoney FI, Barthel D. "Functional evaluation: the	112000002155	ACC NCDR





Section: Follow-	Up		Parent: Root		
	• •	atient needs to be reminded or safety of one or more parts of this	Barthel Index." Maryland State Med Journal 1965;14:56- 61.		
Independent	safely approach lift footrests, mo sitting position o position of the	all phases of this activity. Patient can h the bed in his wheelchair, lock brakes ove safely to bed, lie down, come to a on the side of the bed, change the wheelchair, if necessary, to transfer ely, and return to the wheelchair.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	714915006	SNOMED CT
Immobile	Patient is immob	bile.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000001492	ACC NCDR
Wheelchair	wheelchair inde around corners table, bed, toile	not ambulate but can propel a spendently. They must be able to go , turn around, maneuver the chair to a t, etc. They must be able to push a chai Is. Do not score this item if the patient walking		165243005	SNOMED CT
One Person Assist	Patient needs h	help or supervision in any of the above least 50 yards with a little help.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	707739007	SNOMED CT
Independent	Patient can walk at least 50 yards without help or supervision. They may wear braces or prostheses an use crutches, canes, or a walkerette but not a rolling walker. They must be able to lock and unlock braces i used, assume the standing position and sit down, get the necessary mechanical aides into position for use, and dispose of them when he sits. (Putting on and taking off braces is scored under dressing.)		Mahoney FI, Barthel D. "Functional evaluation: the d Barthel Index." Maryland State Med Journal 1965;14:56- 61	302042005	SNOMED CT
Unable	Patient is unabl	e to use stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	301589003	SNOMED CT
Needs Help	Patient needs h down stairs sat	nelp with or supervision to go up or fely.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165248001	SNOMED CT
Independent	safely without h should use han needed. They n	to go up and down a flight of stairs help or supervision. They may and hdrails, canes, or crutches when must be able to carry canes or crutches I or descend stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165249009	SNOMED CT
Element: 14895		Dressing			
	Coding Instruction:	Choose the scoring point for the stater	ment that most closely corresponds to the patient's currer be obtained from the patient's self-report, from a separate bservation.		
	Target Value:	The value on Follow-up			
s	supporting Definition:	Barthel Index Element			
		Copyright Notice: Used with permission	n.		
		Source: Mahoney FI, Barthel D. "Fur	nctional evaluation: the Barthel Index." Maryland State Med	d Journal 1965;14:56-61	1.
Functional Ability - 1.	3.6.1.4.1.19376.1.4.1.6.	5.801			
Selection	Definition		Source	Code	Code System
Unable	Complete assis	t for feeding required.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	289001005	SNOMED CT
Needs Help	Some help is no	ecessary (with cutting up food, use salt	Mahoney FI, Barthel D. "Functional evaluation: the	165223004	SNOMED CT

		01.		
Needs Help	Some help is necessary (with cutting up food, use salt and pepper, spread butter, etc).	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165223004	SNOMED CT
Independent	The patient can feed themselves a meal from a tray or table when someone puts the food within reach. They must be able to cut up the food, use salt and pepper, spread butter, etc. The patient must accomplish this in a reasonable time.	Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165224005	SNOMED CT
Dependent	Patient requires assistance for bathing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129043005	SNOMED CT
Independent	Patient may use a bath tub, a shower, or take a complete sponge bath. They must be able to do all the steps involved in whichever method is employed without another person being present.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129041007	SNOMED CT
Needs Help	Patient needs assistance with any aspect of grooming	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-	704440004	SNOMED CT





Section: Follow-Up		Parent: Root		
Independent	Patient can wash hands and face, comb hair, clean	61. Mahoney FI, Barthel D. "Functional evaluation: the	704437004	SNOMED C
	teeth, and shave. They may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style hair.	Barthel Index." Maryland State Med Journal 1965;14:56- 61.		
Dependent	Patient is unable to assist with any dressing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129065005	SNOMED C
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the work themselves. They must accomplish this in a reasonable time. Women need not be scored on use of a brassiere or girdle unless these are prescribed garments.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129039006	SNOMED C
Independent	Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	29035000	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-61.	72042002	SNOMED CT
Inconsistent	Patient needs help in using a suppository or taking an enema or has occasional accidents.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165230005	SNOMED CT
Continent	Patient is able to control bowels and has no accidents. They can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).	Barthel Index." Maryland State Med Journal 1965;14:56-	24029004	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165232002	SNOMED CT
Inconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165233007	SNOMED CT
Continent	Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165234001	SNOMED CI
Dependent	Patient requires full assistance.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129078005	SNOMED CT
Needs Help	Patient needs help because of imbalance or in handling clothes or in using toilet paper.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165241007	SNOMED CT
Independent	Patient is able to get on and off toilet, fasten and unfasten clothes, prevent soiling of clothes, and use toilet paper without help. They may use a wall bar or other stable object for support if needed. If it is necessary to use a bed pan instead of a toilet, they must be able to place it on a chair, empty it, and clean it.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129062008	SNOMED C1
Unable	Patient is unable to assist with any transfer.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	733744002	SNOMED CT
Major Assist Needed	Patient can come to a sitting position without the help o a second person but needs to be lifted out of bed, or if they transfer with a great deal of help.	f Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002154	ACC NCDF
Minor Assist Needed	Either some minimal help is needed in some step of this activity or the patient needs to be reminded or supervised for safety of one or more parts of this activity.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002155	ACC NCDF
Independent	Independent in all phases of this activity. Patient can safely approach the bed in his wheelchair, lock brakes lift footrests, move safely to bed, lie down, come to a sitting position on the side of the bed, change the position of the wheelchair, if necessary, to transfer back into it safely, and return to the wheelchair.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	714915006	SNOMED CT
Immobile	Patient is immobile.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-61.	112000001492	ACC NCDF





Section: Follow-Up		Parent: Root		
Wheelchair	If a patient cannot ambulate but can propel a wheelchair independently. They must be able to go around corners, turn around, maneuver the chair to a table, bed, toilet, etc. They must be able to push a chair at least 50 yards. Do not score this item if the patient gets score for walking		165243005	SNOMED CT
One Person Assist	Patient needs help or supervision in any of the above but can walk at least 50 yards with a little help.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	707739007	SNOMED CT
Independent	Patient can walk at least 50 yards without help or supervision. They may wear braces or prostheses and use crutches, canes, or a walkerette but not a rolling walker. They must be able to lock and unlock braces if used, assume the standing position and sit down, get the necessary mechanical aides into position for use, and dispose of them when he sits. (Putting on and taking off braces is scored under dressing.)	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	302042005	SNOMED CT
Unable	Patient is unable to use stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	301589003	SNOMED CT
Needs Help	Patient needs help with or supervision to go up or down stairs safely.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165248001	SNOMED CT
Independent	Patient is able to go up and down a flight of stairs safely without help or supervision. They may and should use handrails, canes, or crutches when needed. They must be able to carry canes or crutches as they ascend or descend stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165249009	SNOMED CT
Element: 14896	Bowels			

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

Target Value: The value on Follow-up

#### Supporting Definition: Barthel Index Element

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

Selection	Definition	Source	Code	Code System
Unable	Complete assist for feeding required.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	289001005	SNOMED CT
Needs Help	Some help is necessary (with cutting up food, use salt and pepper, spread butter, etc).	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165223004	SNOMED CT
Independent	The patient can feed themselves a meal from a tray or Mahoney FI, Barthel D. "Functional evaluation: the table when someone puts the food within reach. They Barthel Index." Maryland State Med Journal 1965;1 must be able to cut up the food, use salt and pepper, 61. spread butter, etc. The patient must accomplish this in a reasonable time.		165224005	SNOMED CT
Dependent	Patient requires assistance for bathing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129043005	SNOMED CT
Independent	Patient may use a bath tub, a shower, or take a complete sponge bath. They must be able to do all the steps involved in whichever method is employed without another person being present.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129041007	SNOMED CT
Needs Help	Patient needs assistance with any aspect of grooming	. Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704440004	SNOMED CT
Independent	Patient can wash hands and face, comb hair, clean teeth, and shave. They may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style hair.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704437004	SNOMED CT
Dependent	Patient is unable to assist with any dressing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129065005	SNOMED CT
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-	129039006	SNOMED CT





Section: Follow-Up		Parent: Root		
	work themselves. They must accomplish this in a reasonable time. Women need not be scored on use of a brassiere or girdle unless these are prescribed garments.	61.		
Independent	Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	29035000	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	72042002	SNOMED CT
Inconsistent	Patient needs help in using a suppository or taking an enema or has occasional accidents.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165230005	SNOMED CT
Continent	Patient is able to control bowels and has no accidents. They can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).	Barthel Index." Maryland State Med Journal 1965;14:56-	24029004	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165232002	SNOMED CT
Inconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165233007	SNOMED CT
Continent	Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165234001	SNOMED CT
Dependent	Patient requires full assistance.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129078005	SNOMED CT
Needs Help	Patient needs help because of imbalance or in handling clothes or in using toilet paper.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165241007	SNOMED CT
Independent	Patient is able to get on and off toilet, fasten and unfasten clothes, prevent soiling of clothes, and use toilet paper without help. They may use a wall bar or other stable object for support if needed. If it is necessary to use a bed pan instead of a toilet, they must be able to place it on a chair, empty it, and clean it.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129062008	SNOMED CT
Unable	Patient is unable to assist with any transfer.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	733744002	SNOMED CT
Major Assist Needed	Patient can come to a sitting position without the help of a second person but needs to be lifted out of bed, or if they transfer with a great deal of help.	f Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002154	ACC NCDR
Minor Assist Needed	Either some minimal help is needed in some step of this activity or the patient needs to be reminded or supervised for safety of one or more parts of this activity.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002155	ACC NCDR
Independent	Independent in all phases of this activity. Patient can safely approach the bed in his wheelchair, lock brakes, lift footrests, move safely to bed, lie down, come to a sitting position on the side of the bed, change the position of the wheelchair, if necessary, to transfer back into it safely, and return to the wheelchair.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	714915006	SNOMED CT
Immobile	Patient is immobile.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000001492	ACC NCDR
Wheelchair	If a patient cannot ambulate but can propel a wheelchair independently. They must be able to go around corners, turn around, maneuver the chair to a table, bed, toilet, etc. They must be able to push a chair at least 50 yards. Do not score this item if the patient gets score for walking	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165243005	SNOMED CT
One Person Assist	Patient needs help or supervision in any of the above but can walk at least 50 yards with a little help.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	707739007	SNOMED CT
Independent	Patient can walk at least 50 yards without help or supervision. They may wear braces or prostheses and	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-	302042005	SNOMED CT





Section: Follow-Up		Parent: Root		
	use crutches, canes, or a walkerette but not a rolling walker. They must be able to lock and unlock braces if used, assume the standing position and sit down, get the necessary mechanical aides into position for use, and dispose of them when he sits. (Putting on and taking off braces is scored under dressing.)			
Unable	Patient is unable to use stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	301589003	SNOMED CT
Needs Help	Patient needs help with or supervision to go up or down stairs safely.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165248001	SNOMED CT
Independent	Patient is able to go up and down a flight of stairs safely without help or supervision. They may and should use handrails, canes, or crutches when needed. They must be able to carry canes or crutches as they ascend or descend stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165249009	SNOMED CT
Element: 14897	Bladder			

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

Target Value: The value on Follow-up

Supporting Definition: Barthel Index Element

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

#### Functional Ability - 1.3.6.1.4.1.19376.1.4.1.6.5.801

Selection	Definition	Source	Code	Code System
Unable	Complete assist for feeding required.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	289001005	SNOMED CT
Needs Help	Some help is necessary (with cutting up food, use salt and pepper, spread butter, etc).	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165223004	SNOMED CT
Independent	table when someone puts the food within reach. They must be able to cut up the food, use salt and pepper,	spread butter, etc. The patient must accomplish this in a reasonable time.		SNOMED CT
Dependent	Patient requires assistance for bathing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129043005	SNOMED CT
Independent	Patient may use a bath tub, a shower, or take a complete sponge bath. They must be able to do all the steps involved in whichever method is employed without another person being present.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129041007	SNOMED CT
Needs Help	Patient needs assistance with any aspect of grooming	. Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704440004	SNOMED CT
Independent	Patient can wash hands and face, comb hair, clean teeth, and shave. They may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style hair.		704437004	SNOMED CT
Dependent	Patient is unable to assist with any dressing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129065005	SNOMED CT
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the work themselves. They must accomplish this in a reasonable time. Women need not be scored on use of a brassiere or girdle unless these are prescribed garments.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129039006	SNOMED CT
Independent	Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	29035000	SNOMED CT





Section: Follow-Up		Parent: Root		
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-61.	72042002	SNOMED C
Inconsistent	Patient needs help in using a suppository or taking an enema or has occasional accidents.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165230005	SNOMED C
Continent	Patient is able to control bowels and has no accidents. They can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).	Barthel Index." Maryland State Med Journal 1965;14:56-	24029004	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165232002	SNOMED CT
Inconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165233007	SNOMED CT
Continent	Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165234001	SNOMED CT
Dependent	Patient requires full assistance.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129078005	SNOMED CT
Needs Help	Patient needs help because of imbalance or in handling clothes or in using toilet paper.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165241007	SNOMED CT
Independent	Patient is able to get on and off toilet, fasten and unfasten clothes, prevent soiling of clothes, and use toilet paper without help. They may use a wall bar or other stable object for support if needed. If it is necessary to use a bed pan instead of a toilet, they must be able to place it on a chair, empty it, and clean it.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129062008	SNOMED CT
Unable	Patient is unable to assist with any transfer.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	733744002	SNOMED CT
Major Assist Needed	Patient can come to a sitting position without the help o a second person but needs to be lifted out of bed, or if they transfer with a great deal of help.	f Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002154	ACC NCDR
Minor Assist Needed	Either some minimal help is needed in some step of this activity or the patient needs to be reminded or supervised for safety of one or more parts of this activity.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002155	ACC NCDR
Independent	Independent in all phases of this activity. Patient can safely approach the bed in his wheelchair, lock brakes lift footrests, move safely to bed, lie down, come to a sitting position on the side of the bed, change the position of the wheelchair, if necessary, to transfer back into it safely, and return to the wheelchair.	Mahoney FI, Barthel D. "Functional evaluation: the , Barthel Index." Maryland State Med Journal 1965;14:56- 61.	714915006	SNOMED CT
Immobile	Patient is immobile.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000001492	ACC NCDR
Wheelchair	If a patient cannot ambulate but can propel a wheelchair independently. They must be able to go around corners, turn around, maneuver the chair to a table, bed, toilet, etc. They must be able to push a chair at least 50 yards. Do not score this item if the patient gets score for walking	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165243005	SNOMED CT
One Person Assist	Patient needs help or supervision in any of the above but can walk at least 50 yards with a little help.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	707739007	SNOMED CT
Independent	Patient can walk at least 50 yards without help or supervision. They may wear braces or prostheses and use crutches, canes, or a walkerette but not a rolling walker. They must be able to lock and unlock braces if used, assume the standing position and sit down, get the necessary mechanical aides into position for use, and dispose of them when he sits. (Putting on and taking off braces is scored under dressing.)	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	302042005	SNOMED CT
Unable	Patient is unable to use stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	301589003	SNOMED CT
Needs Help	Patient needs help with or supervision to go up or down stairs safely.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165248001	SNOMED CT





Section: Foll	ow-op		Parent: Root		
Independent	safely without h should use han needed. They n	o go up and down a flight of stairs lelp or supervision. They may and idrails, canes, or crutches when nust be able to carry canes or crutche or descend stairs.	Mahoney FI, Barthel D. "Functional evaluation: the 165249009 Barthel Index." Maryland State Med Journal 1965;14:56- 61. s		SNOMED (
Element: 1489	8	Toilet			
	Coding Instruction:		ement that most closely corresponds to the patient's current n be obtained from the patient's self-report, from a separate observation.		
	Target Value:	The value on Follow-up			
	Supporting Definition:	Barthel Index Element			
		Copyright Notice: Used with permissi	on.		
		Source: Mahoney FI, Barthel D. "Fe	unctional evaluation: the Barthel Index." Maryland State Med	Journal 1965;14:56-6	61.
Functional Ability	/ - 1.3.6.1.4.1.19376.1.4.1.6.	5.801			
Selection	Definition		Source	Code	Code Syste
Unable	Complete assis	t for feeding required.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	289001005	SNOMED (
Needs Help	•	ecessary (with cutting up food, use sa read butter, etc).	It Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165223004	SNOMED (
Independent	The patient can feed themselves a meal from a tray or table when someone puts the food within reach. They		ey Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165224005	SNOMED C
Dependent	Patient requires assistance for bathing.		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129043005	SNOMED
Independent	Patient may use a bath tub, a shower, or take a complete sponge bath. They must be able to do all the steps involved in whichever method is employed without another person being present.		Mahoney FI, Barthel D. "Functional evaluation: the	129041007	SNOMED
Needs Help	Patient needs assistance with any aspect of grooming.		g. Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704440004	SNOMED
Independent	Patient can wash hands and face, comb hair, clean teeth, and shave. They may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style		61. t	704437004	SNOMED (
Dependent	hair. Patient is unabl	e to assist with any dressing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129065005	SNOMED (
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the work themselves. They must accomplish this in a reasonable time. Women need not be scored on use of a brassiere or girdle unless these are prescribed		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129039006	SNOMED C
Independent	garments. Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.		61.	29035000	SNOMED C
Incontinent	Patient has rout	ine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	72042002	SNOMED (
Inconsistent		elp in using a suppository or taking an occasional accidents.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165230005	SNOMED (
Continent	They can use a	suppository or take an enema when for spinal cord injury patients who have	s. Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-	24029004	SNOMED (
Incontinent		tine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-	165232002	SNOMED C





Section: Follow-U	μ	Parent: Root		
		61.		
Inconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165233007	SNOMED C
Continent	Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165234001	SNOMED CT
Dependent	Patient requires full assistance.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129078005	SNOMED C
Needs Help	Patient needs help because of imbalance or in handling clothes or in using toilet paper.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165241007	SNOMED CT
Independent	Patient is able to get on and off toilet, fasten and unfasten clothes, prevent soiling of clothes, and use toilet paper without help. They may use a wall bar or other stable object for support if needed. If it is necessary to use a bed pan instead of a toilet, they must be able to place it on a chair, empty it, and clean it.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129062008	SNOMED CT
Unable	Patient is unable to assist with any transfer.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	733744002	SNOMED CT
Major Assist Needed	Patient can come to a sitting position without the help on a second person but needs to be lifted out of bed, or in they transfer with a great deal of help.	of Mahoney FI, Barthel D. "Functional evaluation: the f Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002154	ACC NCDF
Minor Assist Needed	Either some minimal help is needed in some step of this activity or the patient needs to be reminded or supervised for safety of one or more parts of this activity.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002155	ACC NCDR
Independent	Independent in all phases of this activity. Patient can safely approach the bed in his wheelchair, lock brakes lift footrests, move safely to bed, lie down, come to a sitting position on the side of the bed, change the position of the wheelchair, if necessary, to transfer back into it safely, and return to the wheelchair.	Mahoney FI, Barthel D. "Functional evaluation: the s, Barthel Index." Maryland State Med Journal 1965;14:56- 61.	714915006	SNOMED CT
Immobile	Patient is immobile.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000001492	ACC NCDR
Wheelchair	If a patient cannot ambulate but can propel a wheelchair independently. They must be able to go around corners, turn around, maneuver the chair to a table, bed, toilet, etc. They must be able to push a chai at least 50 yards. Do not score this item if the patient gets score for walking		165243005	SNOMED CT
One Person Assist	Patient needs help or supervision in any of the above but can walk at least 50 yards with a little help.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	707739007	SNOMED CT
Independent	Patient can walk at least 50 yards without help or supervision. They may wear braces or prostheses an use crutches, canes, or a walkerette but not a rolling walker. They must be able to lock and unlock braces ii used, assume the standing position and sit down, get the necessary mechanical aides into position for use, and dispose of them when he sits. (Putting on and taking off braces is scored under dressing.)	Mahoney FI, Barthel D. "Functional evaluation: the d Barthel Index." Maryland State Med Journal 1965;14:56- 61	302042005	SNOMED CT
Unable	Patient is unable to use stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	301589003	SNOMED CT
Needs Help	Patient needs help with or supervision to go up or down stairs safely.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165248001	SNOMED CT
Independent	Patient is able to go up and down a flight of stairs safely without help or supervision. They may and should use handrails, canes, or crutches when needed. They must be able to carry canes or crutches as they ascend or descend stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165249009	SNOMED CT
Element: 14899	Transfers			
<b>∟iement:</b> 14899	Coding Instruction: Choose the scoring point for the state	be obtained from the patient's self-report, from a separat		





# Section: Follow-Up

Target Value: The value on Follow-up

#### Supporting Definition: Barthel Index Element

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

Parent: Root

Selection	Definition	Source	Code	Code System
Unable	Complete assist for feeding required.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	289001005	SNOMED CT
Needs Help	Some help is necessary (with cutting up food, use salt and pepper, spread butter, etc).	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165223004	SNOMED CT
ndependent	The patient can feed themselves a meal from a tray or table when someone puts the food within reach. They must be able to cut up the food, use salt and pepper, spread butter, etc. The patient must accomplish this in a reasonable time.	Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165224005	SNOMED CT
Dependent	Patient requires assistance for bathing. Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.		129043005	SNOMED CT
ndependent	Patient may use a bath tub, a shower, or take a complete sponge bath. They must be able to do all the steps involved in whichever method is employed without another person being present. Wanney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-61.		129041007	SNOMED CT
Needs Help	Patient needs assistance with any aspect of grooming.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704440004	SNOMED CT
Independent	Patient can wash hands and face, comb hair, clean teeth, and shave. They may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style hair.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704437004	SNOMED CT
Dependent	Patient is unable to assist with any dressing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129065005	SNOMED CT
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the work themselves. They must accomplish this in a reasonable time. Women need not be scored on use of a brassiere or girdle unless these are prescribed garments.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129039006	SNOMED CT
Independent	Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	29035000	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	72042002	SNOMED CT
Inconsistent	Patient needs help in using a suppository or taking an enema or has occasional accidents.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165230005	SNOMED CT
Continent	Patient is able to control bowels and has no accidents. They can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).	Barthel Index." Maryland State Med Journal 1965;14:56-	24029004	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165232002	SNOMED CT
Inconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165233007	SNOMED CT
Continent	Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165234001	SNOMED CT
Dependent	Patient requires full assistance.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129078005	SNOMED CT





Section: Follo	w-Up		Parent: Root		
Needs Help	Patient needs h clothes or in usi		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165241007	SNOMED C
independent	unfasten clothe toilet paper with other stable obj necessary to us	o get on and off toilet, fasten and s, prevent soiling of clothes, and use nout help. They may use a wall bar or iect for support if needed. If it is se a bed pan instead of a toilet, they place it on a chair, empty it, and clean	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129062008	SNOMED C
Unable		le to assist with any transfer.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	733744002	SNOMED C
Major Assist Needeo	a second perso		of Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002154	ACC NCD
Minor Assist Needeo	activity or the pa	nimal help is needed in some step of this atient needs to be reminded or safety of one or more parts of this	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002155	ACC NCD
Independent	safely approach lift footrests, mo sitting position o position of the	all phases of this activity. Patient can in the bed in his wheelchair, lock brakes bye safely to bed, lie down, come to a on the side of the bed, change the wheelchair, if necessary, to transfer ely, and return to the wheelchair.	Mahoney FI, Barthel D. "Functional evaluation: the , Barthel Index." Maryland State Med Journal 1965;14:56- 61.	714915006	SNOMED C
Immobile	Patient is immob	ile.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000001492	ACC NCDF
Wheelchair	wheelchair inde around corners table, bed, toile	not ambulate but can propel a pendently. They must be able to go , turn around, maneuver the chair to a t, etc. They must be able to push a chair s. Do not score this item if the patient walking		165243005	SNOMED C
One Person Assist		elp or supervision in any of the above least 50 yards with a little help.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	707739007	SNOMED C
Independent	supervision. Th use crutches, c walker. They m used, assume t the necessary r and dispose of	k at least 50 yards without help or ey may wear braces or prostheses and anes, or a walkerette but not a rolling ust be able to lock and unlock braces if he standing position and sit down, get nechanical aides into position for use, them when he sits. (Putting on and is is scored under dressing.)	Mahoney FI, Barthel D. "Functional evaluation: the d Barthel Index." Maryland State Med Journal 1965;14:56- 61	302042005	SNOMED C
Unable	Patient is unabl	e to use stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	301589003	SNOMED C
Needs Help	Patient needs h down stairs sat	elp with or supervision to go up or fely.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165248001	SNOMED C
Independent	safely without h should use han needed. They n	o go up and down a flight of stairs help or supervision. They may and drails, canes, or crutches when nust be able to carry canes or crutches or descend stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165249009	SNOMED C
Element: 14900		Mobility			
	-	Choose the scoring point for the stater potential, functioning. Information can abilities (such as a relative), or from ol	ment that most closely corresponds to the patient's curre be obtained from the patient's self-report, from a separal bservation.		
	Target Value:	The value on Follow-up			
	Supporting Definition:	Barthel Index Element			
		Copyright Notice: Used with permission	n.		
		Source: Mahoney FI, Barthel D. "Fur	nctional evaluation: the Barthel Index." Maryland State Me	d Journal 1965;14:56-61	
Functional Ability -	1.3.6.1.4.1.19376.1.4.1.6.	5.801			
Selection	Definition		Source	Code	Code System
Unable	Complete assis	t for feeding required.	Mahoney FI, Barthel D. "Functional evaluation: the	289001005	SNOMED C
			Barthel Index." Maryland State Med Journal 1965;14:56- 61.		

61.





Section: Follow-Up		Parent: Root		
Needs Help	Some help is necessary (with cutting up food, use salt and pepper, spread butter, etc).	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165223004	SNOMED C
ndependent	The patient can feed themselves a meal from a tray or table when someone puts the food within reach. They must be able to cut up the food, use salt and pepper, spread butter, etc. The patient must accomplish this in a reasonable time.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165224005	SNOMED C
Dependent	Patient requires assistance for bathing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129043005	SNOMED CT
Independent	Patient may use a bath tub, a shower, or take a complete sponge bath. They must be able to do all the steps involved in whichever method is employed without another person being present.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129041007	SNOMED CT
Needs Help	Patient needs assistance with any aspect of grooming.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704440004	SNOMED CT
Independent	Patient can wash hands and face, comb hair, clean teeth, and shave. They may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style hair.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704437004	SNOMED CT
Dependent	Patient is unable to assist with any dressing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129065005	SNOMED CT
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the work themselves. They must accomplish this in a reasonable time. Women need not be scored on use of a brassiere or girdle unless these are prescribed garments.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129039006	SNOMED CT
Independent	Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	29035000	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	72042002	SNOMED CT
Inconsistent	Patient needs help in using a suppository or taking an enema or has occasional accidents.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165230005	SNOMED CT
Continent	Patient is able to control bowels and has no accidents. They can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).	Barthel Index." Maryland State Med Journal 1965;14:56-	24029004	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165232002	SNOMED CT
Inconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165233007	SNOMED CT
Continent	Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165234001	SNOMED CT
Dependent	Patient requires full assistance.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129078005	SNOMED CT
Needs Help	Patient needs help because of imbalance or in handling clothes or in using toilet paper.		165241007	SNOMED CT
Independent	Patient is able to get on and off toilet, fasten and unfasten clothes, prevent soiling of clothes, and use toilet paper without help. They may use a wall bar or other stable object for support if needed. If it is necessary to use a bed pan instead of a toilet, they must be able to place it on a chair, empty it, and clean it.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129062008	SNOMED CT
Unable	Patient is unable to assist with any transfer.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-	733744002	SNOMED CT





Section: Follow	<i>i</i> -op		Parent: Root		
			61.		
Major Assist Needed	a second perso		f Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002154	ACC NCDF
Minor Assist Needed	activity or the pa	imal help is needed in some step of this atient needs to be reminded or safety of one or more parts of this	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000002155	ACC NCDF
Independent			Mahoney FI, Barthel D. "Functional evaluation: the , Barthel Index." Maryland State Med Journal 1965;14:56- 61.	714915006	SNOMED C
Immobile	Patient is immob	ile.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	112000001492	ACC NCDF
Wheelchair	If a patient cannot ambulate but can propel a wheelchair independently. They must be able to go around corners, turn around, maneuver the chair to a table, bed, toilet, etc. They must be able to push a chair at least 50 yards. Do not score this item if the patient gets score for walking			165243005	SNOMED C
One Person Assist		elp or supervision in any of the above least 50 yards with a little help.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61	707739007	SNOMED C
Independent	supervision. Th use crutches, c walker. They m used, assume th the necessary n and dispose of f	k at least 50 yards without help or ey may wear braces or prostheses and anes, or a walkerette but not a rolling ust be able to lock and unlock braces if ne standing position and sit down, get nechanical aides into position for use, hem when he sits. (Putting on and s is scored under dressing.)	Mahoney FI, Barthel D. "Functional evaluation: the d Barthel Index." Maryland State Med Journal 1965;14:56- 61	302042005	SNOMED C
Unable	Patient is unable to use stairs.		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	301589003	SNOMED C
Needs Help	Patient needs help with or supervision to go up or down stairs safely.		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165248001	SNOMED C
Independent	safely without h should use han needed. They n	o go up and down a flight of stairs elp or supervision. They may and drails, canes, or crutches when nust be able to carry canes or crutches or descend stairs.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165249009	SNOMED C
Element: 14901		Stairs			
	Coding Instruction:	Choose the scoring point for the stater	nent that most closely corresponds to the patient's curre be obtained from the patient's self-report, from a separat oservation.	,	,
	Target Value:	The value on Follow-up			
	Supporting Definition:	Barthel Index Element			
		Copyright Notice: Used with permission	n.		
			nctional evaluation: the Barthel Index." Maryland State Me	d Journal 1965;14:56-6	1.
Functional Ability - <sup>-</sup> Selection	1.3.6.1.4.1.19376.1.4.1.6.5 Definition	0.801	Source	Code	Code System
Unable		for feeding required.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	289001005	SNOMED C
Needs Help	Some help is ne and pepper, spr		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165223004	SNOMED CT
Independent	The patient can feed themselves a meal from a tray or table when someone puts the food within reach. The must be able to cut up the food, use salt and pepper, spread butter, etc. The patient must accomplish this ir		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165224005	SNOMED CT





Section: Follow-Up		Parent: Root		
	complete sponge bath. They must be able to do all the steps involved in whichever method is employed without another person being present.	Barthel Index." Maryland State Med Journal 1965;14:56- 61.		
Needs Help	Patient needs assistance with any aspect of grooming.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704440004	SNOMED CT
Independent	Patient can wash hands and face, comb hair, clean teeth, and shave. They may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style hair.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	704437004	SNOMED CT
Dependent	Patient is unable to assist with any dressing.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129065005	SNOMED CT
Needs Help	Patient needs help in putting on and removing or fastening any clothing. They must do at least half the work themselves. They must accomplish this in a reasonable time. Women need not be scored on use of a brassiere or girdle unless these are prescribed garments.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129039006	SNOMED CT
Independent	Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	29035000	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	72042002	SNOMED CT
Inconsistent	Patient needs help in using a suppository or taking an enema or has occasional accidents.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165230005	SNOMED CT
Continent	Patient is able to control bowels and has no accidents. They can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).	Barthel Index." Maryland State Med Journal 1965;14:56-	24029004	SNOMED CT
Incontinent	Patient has routine incontinence.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165232002	SNOMED CT
Inconsistent	Patient has occasional accidents or can not wait for the bed pan or get to the toilet in time or needs help with an external device.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165233007	SNOMED CT
Continent	Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165234001	SNOMED CT
Dependent	Patient requires full assistance.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129078005	SNOMED CT
Needs Help	Patient needs help because of imbalance or in handling clothes or in using toilet paper.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	165241007	SNOMED CT
Independent	Patient is able to get on and off toilet, fasten and unfasten clothes, prevent soiling of clothes, and use toilet paper without help. They may use a wall bar or other stable object for support if needed. If it is necessary to use a bed pan instead of a toilet, they must be able to place it on a chair, empty it, and clean it.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	129062008	SNOMED CT
Unable	Patient is unable to assist with any transfer.	Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	733744002	SNOMED CT
Major Assist Needed	Patient can come to a sitting position without the help o a second person but needs to be lifted out of bed, or if they transfer with a great deal of help.		112000002154	ACC NCDR
Minor Assist Needed	Either some minimal help is needed in some step of this activity or the patient needs to be reminded or supervised for safety of one or more parts of this activity.		112000002155	ACC NCDR
Independent		Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56- 61.	714915006	SNOMED CT





112000001492 165243005	ACC NCDR SNOMED CT
165243005	SNOMED CT
707739007	SNOMED CT
302042005	SNOMED CT
301589003	SNOMED CT
165248001	SNOMED CT
165249009	SNOMED CT
	302042005 301589003 165248001





Section: Follow-Up Medications		Parent: Follow-Up
Element: 11990	Follow-Up Medications Code	

Coding Instruction: Indicate the assigned identification number associated with the medications the patient was prescribed or received.

Note(s):

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

```
Target Value: N/A
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Vendor Instruction: Follow-Up Medications Code (11990) should not be duplicated in a follow-up

#### Follow-up Medication - 2.16.840.1.113883.3.3478.6.5.203

Code Syster	Code	Source	Definition	Selection
RxNor	321208			Fondaparinux
ACC NCD	100000921		ative	Heparin Derivative
SNOMED C	373294004		r Weight Heparin	Low Molecular Weight He
SNOMED C	96382006		d Heparin	Unfractionated Heparin
RxNor	11289			Warfarin
RxNor	1191			Aspirin
RxNor	226716		lamole	Aspirin/Dipyridamole
RxNor	1537034			Vorapaxar
RxNor	1364430			Apixaban
RxNor	1546356			Dabigatran
RxNor	1599538			Edoxaban
RxNor	1114195			Rivaroxaban
RxNor	1656052			Cangrelor
RxNor	32968			Clopidogrel
ACC NCD	112000001003			Other P2Y12
RxNor	613391			Prasugrel
RxNor	1116632			Ticagrelor
RxNor	10594			Ticlopidine

Element: 14949

#### Follow-up Current Medications at Time of Follow-up

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

Target Value: The value on Follow-up

#### Follow-Up Medication Administration - 1.3.6.1.4.1.19376.1.4.1.6.5.371

Selection	Definition	Source	Code	Code System
Yes			100001247	ACC NCDR
No - No Reason			100001048	ACC NCDR
No - Medical Reason			100001034	ACC NCDR
No - Patient Reason			100001071	ACC NCDR
<b>E</b> I	-	He He Meller Deer		

Element: 14950

Follow-Up Medication Dose

Coding Instruction: Indicate the category of the medication dose.

Target Value: The value on Follow-up

#### Medication Dose - 1.3.6.1.4.1.19376.1.4.1.6.5.321

Selection	Definition	Source	Code	Code System
Aspirin 81 to 100 mg			112000002080	ACC NCDR
Aspirin 101 to 324 mg			112000002081	ACC NCDR
Aspirin 325 mg			317300	RxNorm





		n Therapy Parent: Follow-Up	
Element: 14951		Follow-up Warfarin Discontinued	
	Coding Instruction:	Indicate if the patient discontinued Warfarin at any time since the last follow-up (or since discharge if this is the 45	-day follow-up).
	Target Value:	The value on Follow-up	
Anticoagulation Disc	continuation - 1.3.6.1.4.	1 10376 1 4 1 6 5 820	
Selection	Definition	Source Code	Code Syste
No - Not Discontinued		112000002220	ACC NCI
Yes - Discontinued		11200002221	ACC NCI
Element: 14952		Follow-up Warfarin Discontinued Date	
	Coding Instruction:	Indicate the date the Warfarin was discontinued.	
	Target Value:	The value on Follow-up	
	Vendor Instruction:	Follow-up Warfarin Discontinued Date (14952) must be Greater than the Follow-Up Reference Procedure Start Date	and Time (11001)
Element: 14953		Follow-up Warfarin Resumed	
	Coding Instruction:	Indicate if the patient resumed Warfarin at any time since the last follow-up (or since discharge if this is the 45-day	follow-up).
	Target Value:	The value on Follow-up	
Anticoagulation Res	umption Reason - 1.3.6	.1.4.1.19376.1.4.1.6.5.803	
Selection	Definition	Source Code	Code Syste
No Yes (Thrombotic Event	t)	11200000168 11200002181	ACC NCE ACC NCE
Yes (Other)	()	100001247	ACC NCI
Element: 14954		Follow-up Warfarin Resumed Date	
	Coding Instruction:	Indicate the date the Warfarin was resumed.	
	-	Indicate the date the Warfarin was resumed.	
	Target Value:	The value on Follow-up	d Time (11001)
	Target Value:		d Time (11001)
Element: 14955	Target Value:	The value on Follow-up	d Time (11001)
Element: 14955	Target Value: Vendor Instruction:	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date an Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (or	
<b>Element:</b> 14955	Target Value: Vendor Instruction: Coding Instruction:	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date an Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (this is the 45-day follow-up).	
Element: 14955	Target Value: Vendor Instruction: Coding Instruction: Target Value:	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date an Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (or this is the 45-day follow-up). The value on Follow-up	
Anticoagulation Disc	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4.	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date an Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up ( this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.820	or since discharge if
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	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4.	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date an Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up ( this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.820 Code	or since discharge if Code Syste ACC NCE
Anticoagulation Disc Selection No - Not Discontinued Yes - Discontinued	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4.	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date an Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up ( this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.820 Code 11200002220	or since discharge if Code Syste ACC NCE
Anticoagulation Disc Selection No - Not Discontinued Yes - Discontinued	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date ar Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.820  Source Code 11200002220 11200002221 Follow-up DOAC Therapy Discontinued Date	or since discharge if Code Syste ACC NCE
Anticoagulation Disc Selection No - Not Discontinued Yes - Discontinued	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date ar Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.820	or since discharge if Code Syste ACC NCE
Anticoagulation Disc Selection No - Not Discontinued Yes - Discontinued	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition Coding Instruction: Target Value:	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date ar Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.820  Code 11200002220 11200002220 11200002221 Follow-up DOAC Therapy Discontinued Date Indicate the date the DOAC was discontinued. The value on Follow-up	or since discharge if Code Syste ACC NCE ACC NCE
Anticoagulation Disc Selection No - Not Discontinued Yes - Discontinued	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition Coding Instruction: Target Value:	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date ar Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.820	or since discharge if Code Syste ACC NCE ACC NCE
Anticoagulation Disc Selection No - Not Discontinued Yes - Discontinued Element: 14956	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition Coding Instruction: Target Value:	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date ar Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up ( this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.820 Code 11200002220 11200002220 112000002221 Follow-up DOAC Therapy Discontinued Date Indicate the date the DOAC was discontinued. The value on Follow-up Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proce	or since discharge if Code Syste ACC NCE ACC NCE
Anticoagulation Disc Selection No - Not Discontinued Yes - Discontinued Element: 14956	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition Coding Instruction: Target Value: Vendor Instruction:	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date ar Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.820 Code 11200002220 11200002221 Follow-up DOAC Therapy Discontinued Date Indicate the date the DOAC was discontinued. The value on Follow-up Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proce Time (11001)	or since discharge if Code Syste ACC NCI ACC NCI edure Start Date and
Anticoagulation Disc Selection No - Not Discontinued Yes - Discontinued Element: 14956	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition Coding Instruction: Target Value: Vendor Instruction: Coding Instruction:	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date ar Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up ( this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.820  Code 11200002220 11200002221 Follow-up DOAC Therapy Discontinued Date Indicate the date the DOAC was discontinued. The value on Follow-up Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proce Time (11001) Follow-up DOAC Therapy Resumed Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up ( Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up ( Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up ( Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up ( Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up ( Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up ( Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up ( Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up ( Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up ( Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up ( Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up ( Indicate If the patient resumed Direct Oral Anticoagulant ( Indicate If the patient resumed Direct Oral Anticoagulant ( Indicate If the patient resumed Direct Oral	or since discharge if Code Syste ACC NCE ACC NCE edure Start Date and
Anticoagulation Disc Selection No - Not Discontinued Yes - Discontinued Element: 14956 Element: 14957	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition Coding Instruction: Target Value: Vendor Instruction: Coding Instruction: Target Value: umption Reason - 1.3.6	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date ar Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up ( this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.803 Code Code Code Code Code Code Code Code	or since discharge if Code Syste ACC NCI ACC NCI edure Start Date and nce discharge if this i
Anticoagulation Disc Selection No - Not Discontinued Yes - Discontinued Element: 14956 Element: 14957 Anticoagulation Rest Selection	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition Coding Instruction: Target Value: Vendor Instruction: Coding Instruction: Target Value:	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date ar Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up ( this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.803  Follow-up DOAC Therapy Discontinued Date Indicate the date the DOAC was discontinued Date (14956) must be Greater than the Follow-Up Reference Proce Time (11001) Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proce Time (11001) Follow-up DOAC Therapy Resumed Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (or si the 45-day follow-up). The value on Follow-up St.1.1.19376.1.4.1.6.5.803	or since discharge if Code Syste ACC NCE ACC NCE ACC NCE edure Start Date and nce discharge if this is
Anticoagulation Disc Selection No - Not Discontinued Yes - Discontinued Element: 14956 Element: 14957 Anticoagulation Rest Selection No	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition Coding Instruction: Target Value: Vendor Instruction: Coding Instruction: Target Value: umption Reason - 1.3.6 Definition	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date ar Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up ( this is the 45-day follow-up). The value on Follow-up 112000002220 112000002221 Follow-up DOAC Therapy Discontinued Date Indicate the date the DOAC was discontinued. The value on Follow-up Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proce Time (11001) Follow-up DOAC Therapy Resumed Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (or si the 45-day follow-up). The value on Follow-up Statt.119376.1.4.1.6.5.803 Code Code Code Code Code Code Code Code	or since discharge if Code Syste ACC NCE ACC NCE edure Start Date and nce discharge if this is Code Syste ACC NCE
Anticoagulation Disc Selection No - Not Discontinued Yes - Discontinued Element: 14956 Element: 14957 Anticoagulation Rest Selection	Target Value: Vendor Instruction: Coding Instruction: Target Value: continuation - 1.3.6.1.4. Definition Coding Instruction: Target Value: Vendor Instruction: Coding Instruction: Target Value: umption Reason - 1.3.6 Definition	The value on Follow-up Follow-up Warfarin Resumed Date (14954) must be Greater than the Follow-Up Reference Procedure Start Date ar Follow-up DOAC Therapy Discontinued Indicate if the patient discontinued Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up ( this is the 45-day follow-up). The value on Follow-up 1.19376.1.4.1.6.5.803  Follow-up DOAC Therapy Discontinued Date Indicate the date the DOAC was discontinued Date (14956) must be Greater than the Follow-Up Reference Proce Time (11001) Follow-up NOAC (DOAC) Therapy Discontinued Date (14956) must be Greater than the Follow-Up Reference Proce Time (11001) Follow-up DOAC Therapy Resumed Indicate if the patient resumed Direct Oral Anticoagulant (DOAC) Therapy at any time since the last follow-up (or si the 45-day follow-up). The value on Follow-up St.1.1.19376.1.4.1.6.5.803	or since discharge if Code Syste ACC NCE ACC NCE ACC NCE edure Start Date and nce discharge if this is

Coding Instruction: Indicate the date the DOAC was resumed.





	Up Anticoagulatio	n Therapy Parent: Follow-Up		
	Target Value:	The value on Follow-up		
	Vendor Instruction:	Follow-up NOAC (DOAC) Therapy Resumed Date (14958) must be Greater than the Follow-U (11001)	Jp Reference Procedure	Start Date and Time
lement: 14959		Follow-up Aspirin Therapy Discontinued		
	Coding Instruction:	Indicate if the patient discontinued Aspirin Therapy at any time since the last follow-up (or si	nce discharge if this is th	ne 45-day follow-
	-	up).		
	-	The value on Follow-up		
nticoagulation Disc election	ontinuation - 1.3.6.1.4. Definition	1.19376.1.4.1.6.5.820 Source	Code	Code Syste
o - Not Discontinued	Definition	00000	112000002220	ACC NCI
es - Discontinued			112000002221	ACC NC
Element: 14960		Follow-up Aspirin Therapy Discontinued Date		
	Coding Instruction:	Indicate the date the Aspirin was discontinued.		
	-	The value on Follow-up		
	-		oforonoo Droooduro Stor	Data and Time
	vendor instruction.	Follow-up Aspirin Therapy Discontinued Date (14960) must be Greater than the Follow-Up Re (11001)	elerence Procedure Stan	
lement: 14961		Follow-up Aspirin Therapy Resumed		
	Coding Instruction:	Indicate if the patient resumed Aspirin Therapy at any time since the last follow-up (or since	discharge if this is the 4	5-day follow-up).
	Target Value:	The value on Follow-up		
nticoagulation Res	umption Reason - 1.3.6	6.1.4.1.19376.1.4.1.6.5.803		
election	Definition	Source	Code	Code Syste
o es (Thrombotic Event	A		11200000168 112000002181	ACC NCI
	.)		11200002101	
'es (Other)			100001247	
		Follow-up Aspirin Therapy Resumed Date	100001247	
	Coding Instruction:	Follow-up Aspirin Therapy Resumed Date Indicate the date the Aspirin was resumed.	100001247	
	-		100001247	
	Target Value:	Indicate the date the Aspirin was resumed.		ACC NCI
Element: 14962	Target Value:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up Refer		ACC NCI
Element: 14962	Target Value: Vendor Instruction:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up Refer (11001) Follow-up P2Y12 Therapy Discontinued	ence Procedure Start Da	ACC NCI
Element: 14962	Target Value: Vendor Instruction: Coding Instruction:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up Refer (11001)	ence Procedure Start Da	ACC NCE
Element: 14962 Element: 14963	Target Value: Vendor Instruction: Coding Instruction:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up Refer (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-up (or sin The value on Follow-up	ence Procedure Start Da	ACC NCE
Element: 14962 Element: 14963 nticoagulation Disc election	Target Value: Vendor Instruction: Coding Instruction: Target Value:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up Refer (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-up (or sin The value on Follow-up	ence Procedure Start Da nce discharge if this is th Code	ACC NCE Ite and Time e 45-day follow-up) Code Syste
Element: 14962 Element: 14963 nticoagulation Disc election o - Not Discontinued	Target Value: Vendor Instruction: Coding Instruction: Target Value: ontinuation - 1.3.6.1.4.	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up Refer (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-up (or sin The value on Follow-up 1.19376.1.4.1.6.5.820	ence Procedure Start Dance discharge if this is the Code	ACC NCE te and Time e 45-day follow-up) Code Syste ACC NCE
Element: 14962 Element: 14963 Inticoagulation Discelection o - Not Discontinued	Target Value: Vendor Instruction: Coding Instruction: Target Value: ontinuation - 1.3.6.1.4.	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up Refer (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-up (or sin The value on Follow-up 1.19376.1.4.1.6.5.820	ence Procedure Start Da nce discharge if this is th Code	ACC NCI ite and Time e 45-day follow-up Code Syste ACC NCI
Element: 14962 Element: 14963 Inticoagulation Disc election Io - Not Discontinued	Target Value: Vendor Instruction: Coding Instruction: Target Value: ontinuation - 1.3.6.1.4.	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up Refer (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-up (or sin The value on Follow-up 1.19376.1.4.1.6.5.820	ence Procedure Start Dance discharge if this is the Code	ACC NCI ite and Time e 45-day follow-up; Code Syste ACC NCI
Element: 14962 Element: 14963 Inticoagulation Disc Inticoagulation Disc	Target Value: Vendor Instruction: Coding Instruction: Target Value: <u>ontinuation - 1.3.6.1.4.</u> Definition	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up Refer (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-up (or sin The value on Follow-up 1.19376.1.4.1.6.5.820 Source	ence Procedure Start Dance discharge if this is the Code	ACC NCE te and Time e 45-day follow-up) Code Syste ACC NCE
Element: 14962 Element: 14963 nticoagulation Disc election o - Not Discontinued es - Discontinued	Target Value: Vendor Instruction: Coding Instruction: Target Value: ontinuation - 1.3.6.1.4. Definition	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up Refer (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-up (or sin The value on Follow-up 1.19376.1.4.1.6.5.820 Source Follow-up P2Y12 Therapy Discontinued Date	ence Procedure Start Dance discharge if this is the Code	ACC NCI ite and Time e 45-day follow-up; Code Syste ACC NCI
Element: 14962 Element: 14963 Inticoagulation Disc election Io - Not Discontinued	Target Value: Vendor Instruction: Coding Instruction: Target Value: <u>ontinuation - 1.3.6.1.4.</u> Definition Coding Instruction: Target Value:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up Refer (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-up (or sin The value on Follow-up 1.19376.1.4.1.6.5.820 Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued.	ence Procedure Start Da nce discharge if this is th Code 112000002220 112000002221	ACC NCE te and Time e 45-day follow-up) Code Syste ACC NCE ACC NCE
Element: 14962 Element: 14963 Inticoagulation Disc election o - Not Discontinued es - Discontinued Element: 14964	Target Value: Vendor Instruction: Coding Instruction: Target Value: <u>ontinuation - 1.3.6.1.4.</u> Definition Coding Instruction: Target Value:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up Refer (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-up (or sin The value on Follow-up 1.19376.1.4.1.6.5.820 Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date (14964) must be Greater than the Follow-Up Refer (11001)	ence Procedure Start Da nce discharge if this is th Code 112000002220 112000002221	ACC NCI ite and Time e 45-day follow-up Code Syste ACC NCI
Element: 14962 Element: 14963 Inticoagulation Disc election o - Not Discontinued es - Discontinued Element: 14964	Target Value: Vendor Instruction: Coding Instruction: Target Value: ontinuation - 1.3.6.1.4. Definition Coding Instruction: Target Value: Vendor Instruction:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up Refer (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-up (or sin The value on Follow-up 1.19376.1.4.1.6.5.820 Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date (14964) must be Greater than the Follow-Up Refer (11001) Follow-up P2Y12 Therapy Resumed	ence Procedure Start Da nce discharge if this is th Code 112000002220 112000002221	ACC NCI the and Time e 45-day follow-up; Code Syste ACC NCI ACC NCI
Element: 14962 Element: 14963 Inticoagulation Disc ielection Io - Not Discontinued (es - Discontinued Element: 14964	Target Value: Vendor Instruction: Coding Instruction: Target Value: <u>ontinuation - 1.3.6.1.4.</u> Definition Coding Instruction: Target Value: Vendor Instruction:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up Refer (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-up (or sin The value on Follow-up 1.19376.1.4.1.6.5.820 Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date (14964) must be Greater than the Follow-Up Refer (11001) Follow-up P2Y12 Therapy Resumed Indicate if the patient resumed P2Y12 Therapy at any time since the last follow-up (or since	ence Procedure Start Da nce discharge if this is th Code 112000002220 112000002221	ACC NCE the and Time e 45-day follow-up) Code Syste ACC NCE ACC NCE
Element: 14962 Element: 14963 Inticoagulation Disc ielection Io - Not Discontinued (es - Discontinued Element: 14964	Target Value: Vendor Instruction: Coding Instruction: Target Value: <u>ontinuation - 1.3.6.1.4.</u> Definition Coding Instruction: Target Value: Vendor Instruction:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up Refer (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-up (or sin The value on Follow-up 1.19376.1.4.1.6.5.820 Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date (14964) must be Greater than the Follow-Up Refer (11001) Follow-up P2Y12 Therapy Resumed	ence Procedure Start Da nce discharge if this is th Code 112000002220 112000002221	ACC NCE the and Time e 45-day follow-up) Code Syste ACC NCE ACC NCE
Element: 14962 Element: 14963 Element: 14963 Io - Not Discontinued ies - Discontinued Element: 14964 Element: 14965	Target Value: Vendor Instruction: Coding Instruction: Target Value: ontinuation - 1.3.6.1.4. Definition Coding Instruction: Target Value: Vendor Instruction: Target Value: umption Reason - 1.3.6	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up Refer (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-up (or sin The value on Follow-up 1.19376.1.4.1.6.5.820 Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date (14964) must be Greater than the Follow-Up Re (11001) Follow-up P2Y12 Therapy Resumed Indicate if the patient resumed P2Y12 Therapy at any time since the last follow-up (or since The value on Follow-up	ence Procedure Start Da nce discharge if this is th Code 112000002220 112000002221	ACC NCE te and Time e 45-day follow-up) Code Syste ACC NCE ACC NCE Date and Time 5-day follow-up).
Selection No - Not Discontinued Yes - Discontinued Element: 14964	Target Value: Vendor Instruction: Coding Instruction: Target Value: ontinuation - 1.3.6.1.4. Definition Coding Instruction: Target Value: Vendor Instruction: Coding Instruction: Target Value:	Indicate the date the Aspirin was resumed. The value on Follow-up Follow-up Aspirin Therapy Resumed Date (14962) must be Greater than the Follow-Up Refer (11001) Follow-up P2Y12 Therapy Discontinued Indicate if the patient discontinued P2Y12 Therapy at any time since the last follow-up (or sin The value on Follow-up 1.19376.1.4.1.6.5.820 Source Follow-up P2Y12 Therapy Discontinued Date Indicate the date the P2Y12 was discontinued. The value on Follow-up Follow-up P2Y12 Therapy Discontinued Date (14964) must be Greater than the Follow-Up Ref (11001) Follow-up P2Y12 Therapy Resumed Indicate if the patient resumed P2Y12 Therapy at any time since the last follow-up (or since The value on Follow-up	ence Procedure Start Da nce discharge if this is th Code 112000002220 112000002221	ACC NCD the and Time e 45-day follow-up) Code System ACC NCD ACC NCD Date and Time





Section: Follow-Up Anti	coagulation Therapy P	arent: Follow-Up	
Yes (Other)		100001247	ACC NCDR
Element: 14966	Follow-up P2Y12 Therapy Resumed Date	e	
Coding	Instruction: Indicate the date the P2Y12 was resumed.		

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Target Value: The value on Follow-up

Vendor Instruction: Follow-up P2Y12 Therapy Resumed Date (14966) must be Greater than the Follow-Up Reference Procedure Start Date and Time (11001)



Section: Follow-Up Events

Parent: Follow-Up



#### Element: 14948 Follow-Up Event Coding Instruction: Indicate if any event from the NCDR-provided list had occurred between the time of the last follow-up (or discharge if this is the 45-day follow-up) and the current follow-up. Target Value: The value on Follow-up Vendor Instruction: A Follow-Up - combination of Event Name (14948), Occurred (14276) and Date (14277) - may only be entered/selected once Follow-up Events - 1.3.6.1.4.1.19376.1.4.1.6.5.802 Selection Definition Source Code Code System 56819008 SNOMED CT Endocarditis latrogenic ASD (requiring 112000002179 ACC NCDR intervention) LAA Occlusion Reintervention 112000002200 ACC NCDR Myocardial Infarction 22298006 SNOMED CT PCI 415070008 SNOMED CT Pericarditis 3238004 SNOMED CT Unplanned Cardiac Surgery ACC NCDR 112000001892 ACC NCDR Unplanned Intervention 112000002180

Unplanned Intervention	11200002180	ACC NCDR
Deep Vein Thrombosis	128053003	SNOMED CT
New Requirement for Dialysis	100014076	ACC NCDR
Non-Device Related Readmission	112000002177	ACC NCDR
Systemic Thromboembolism (other than stroke) (Complete Adjudication)	11200002126	ACC NCDR
Device Explant	100001141	ACC NCDR
Device Fracture	112000001891	ACC NCDR
Device Migration	370512004	SNOMED CT
Device Related Readmission	112000002176	ACC NCDR
Device Systemic Embolism	112000002175	ACC NCDR
Device Thrombus	112000001839	ACC NCDR
Hemorrhagic Stroke (Complete Adjudication)	230706003	SNOMED CT
Intracranial Hemorrhage (other than hemorrhagic stroke) (Complete Adjudication)	1386000	SNOMED CT
Ischemic Stroke (Complete Adjudication)	422504002	SNOMED CT
TIA (Complete Adjudication)	266257000	SNOMED CT
Undetermined Stroke (Complete Adjudication)	230713003	SNOMED CT
Access Site Bleeding (Complete Adjudication)	1000142440	ACC NCDR
GI Bleeding (Complete Adjudication)	74474003	SNOMED CT
Hematoma (Complete Adjudication)	385494008	SNOMED CT
Hemothorax (not requiring drainage) (Complete Adjudication)	112000002147	ACC NCDR
Hemothorax (requiring drainage) (Complete Adjudication)	100001011	ACC NCDR
Other Hemorrhage (non- intracranial) (Complete Adjudication)	50960005	SNOMED CT
Pericardial Effusion (requiring open cardiac surgery) (Complete Adjudication)	112000002148	ACC NCDR
Pericardial Effusion with tamponade (requiring percutaneous drainage) (Complete Adjudication)	112000002149	ACC NCDR
Pericardial Effusion without tamponade (requiring percutaneous drainage) (Complete Adjudication)	112000002150	ACC NCDR
Retroperitoneal Bleeding (Complete Adjudication)	95549001	SNOMED CT





Section: Follow-Up Events		Parent: Follow-Up	
Vascular Complications (Complete Adjudication)		213217008	SNOMED CT
AV Fistula (requiring surgical repair) (Complete Adjudication)		11200002141	ACC NCDR
Pseudoaneurysm (requiring endovascular repair) (Complete Adjudication)		11200002144	ACC NCDR
Pseudoaneurysm (requiring surgical repair) (Complete Adjudication)		11200002145	ACC NCDR
Pseudoaneurysm (requiring thrombin injection only) (Complete Adjudication)		11200002146	ACC NCDR
Pulmonary Embolism		59282003	SNOMED CT
Element: 14276	Follow-Up Events Occurred		

Coding Instruction: Indicate if the event occurred.
Target Value: Any occurrence on follow-up

Vendor Instruction: When a Follow-Up Event (14948) is provided then Follow-Up Events Occurred (14276) cannot be Null

Element: 14277

Coding Instruction: Indicate the date the event occurred.

Follow-Up Event Date

Target Value: Any occurrence on follow-up

Vendor Instruction: Follow-Up Event Date (14277) must be Less than or Equal to the Follow-Up Assessment Date (11000)

Follow-Up Event Date (14277) must be Greater than the Follow-Up Reference Procedure Start Date and Time (11001)





Section: Follow-Up Adjudication

# Parent: Follow-Up

Element: 14967

Coding Instruction: Indicate the event being adjudicated.

Adjudication Event

Target Value: The value on Follow-up

Vendor Instruction: An Adjudication - combination of Event (14967) and Date (14386) - may only be entered/selected once

Adjudication Event (14967) cannot be Null if Follow-Up Event (14948) is Equal to (Hemorrhagic Stroke, Intracranial Hemorrhage (other than hemorrhagic stroke), Ischemic Stroke, TIA, Undetermined Stroke, Access Site Bleeding, GI Bleeding, Hematoma, Hemothorax (not requiring drainage), Hemothorax (requiring drainage), Other Hemorrhage (non-intracranial), Pericardial Effusion (requiring open heart surgery), Pericardial Effusion with tamponade (requiring percutaneous drainage), Pericardial Effusion without tamponade (requiring urgical repair), Pesudoaneurysm (requiring surgical repair), Pseudoaneurysm (requiring thrombin injection only)) and Follow-Up Events Occurred (14276) is Yes. Every Follow-up Event (combination of Event (14967) and Event Date (14277)) that requires adjudication must have a corresponding adjudication record (combination of Event (14967) and Event Date (14386).

#### Follow-up Events - 1.3.6.1.4.1.19376.1.4.1.6.5.802

Selection	Definition	Source	Code	Code System
Endocarditis			56819008	SNOMED CT
latrogenic ASD (requiring intervention)			112000002179	ACC NCDR
LAA Occlusion Reinterver	ntion		112000002200	ACC NCDR
Myocardial Infarction			22298006	SNOMED CT
PCI			415070008	SNOMED CT
Pericarditis			3238004	SNOMED CT
Unplanned Cardiac Surge	ery		112000001892	ACC NCDR
Unplanned Intervention			112000002180	ACC NCDR
Deep Vein Thrombosis			128053003	SNOMED CT
New Requirement for Dia	lysis		100014076	ACC NCDR
Non-Device Related Readmission			112000002177	ACC NCDR
Systemic Thromboembolis (other than stroke) (Comp Adjudication)			112000002126	ACC NCDR
Device Explant			100001141	ACC NCDR
Device Fracture			112000001891	ACC NCDR
Device Migration			370512004	SNOMED CT
Device Related Readmissi	ion		112000002176	ACC NCDR
Device Systemic Embolisn			112000002175	ACC NCDR
Device Thrombus			112000001839	ACC NCDR
Hemorrhagic Stroke (Com Adjudication)	plete		230706003	SNOMED CT
Intracranial Hemorrhage ( than hemorrhagic stroke) (Complete Adjudication)			1386000	SNOMED CT
Ischemic Stroke (Complete Adjudication)	e		422504002	SNOMED CT
TIA (Complete Adjudicatio	n)		266257000	SNOMED CT
Undetermined Stroke (Complete Adjudication)	,		230713003	SNOMED CT
Access Site Bleeding (Complete Adjudication)			1000142440	ACC NCDR
GI Bleeding (Complete Adjudication)			74474003	SNOMED CT
Hematoma (Complete Adjudication)			385494008	SNOMED CT
Hemothorax (not requiring drainage) (Complete Adjudication)	)		112000002147	ACC NCDR
Hemothorax (requiring drainage) (Complete Adjudication)			100001011	ACC NCDR
Other Hemorrhage (non- intracranial) (Complete Adjudication)			50960005	SNOMED CT
Pericardial Effusion (requi open cardiac surgery) (Complete Adjudication)	iring		112000002148	ACC NCDR
Pericardial Effusion with			112000002149	ACC NCDR





Section: Follow-Up Adjudication	Parent: Follow-Up	
tamponade (requiring percutaneous drainage) (Complete Adjudication)		
Pericardial Effusion without tamponade (requiring percutaneous drainage) (Complete Adjudication)	11200002150	ACC NCDR
Retroperitoneal Bleeding (Complete Adjudication)	95549001	SNOMED CT
Vascular Complications (Complete Adjudication)	213217008	SNOMED CT
AV Fistula (requiring surgical repair) (Complete Adjudication)	11200002141	ACC NCDR
Pseudoaneurysm (requiring endovascular repair) (Complete Adjudication)	11200002144	ACC NCDR
Pseudoaneurysm (requiring surgical repair) (Complete Adjudication)	11200002145	ACC NCDR
Pseudoaneurysm (requiring thrombin injection only) (Complete Adjudication)	11200002146	ACC NCDR
Pulmonary Embolism	59282003	SNOMED CT

Element: 14386

Adjudication Event Date

Coding Instruction: Indicate the date the clinical event being adjudicated occurred.

Target Value: N/A

Vendor Instruction: When Adjudication Event (14967) is selected, Adjudication Event Date (14386) cannot be Null

The Adjudication Event Date (14386) / Adjudication Event (14967) must match with Follow-Up Event Date (14277) / Follow-Up Event (14948)





	-Up Neurologic	Parent: Follow-Up Adjudication	
Element: 14969		Adjudication Status	
	Coding Instruction:	Indicate whether the patient was alive or deceased on the date the adjudication was performed.	
	-	Any value between discharge or last follow up and the current follow up	
	-	Adjudication Status (14969) cannot be Null if Follow-Up Adjudication Event (14967) is Equal to (Hemorrhagic Stroke, Intraci Hemorrhage, Ischemic Stroke, TIA, Undetermined Stroke)	ranial
djudication Life Sta	tus - 1.3.6.1.4.1.19376. <sup>,</sup>	1.4.1.6.5.726	
Selection	Definition	Source Code	Code Syste
live		438949009	SNOMED
eceased		20 HL7 Disch	narge dispositi
Element: 14970		Adjudication Date of Death	
	Coding Instruction:	Indicate the date the patient was declared deceased.	
	Target Value:	Any value between discharge or last follow up and the current follow up	
	Vendor Instruction:	Adjudication Date of Death (14970) must be Greater than Follow-Up Reference Procedure Start Date and Time (11001)	
		Adjudication Date of Death (14970) must be Greater than or Equal to Follow-Up Adjudication Event Date (14386)	
		Adjudication Date of Death (14970) must be Greater than or Equal to Follow-Up Symptom Onset Date (14976)	
Element: 14976		Symptom Onset Date	
	Coding Instruction:	Indicate the date of symptom onset associated with this event.	
	Target Value:	Any value between discharge or last follow up and the current follow up	
	Vendor Instruction:	Follow-Up Symptom Onset Date (14976) must be Greater than or Equal to Follow-Up Reference Discharge Date (14338)	
		Follow-Up Symptom Onset Date (14976) must be Greater than or Equal to Follow-Up Reference Procedure Start Date Time	(11001)
			(11001)
		Follow-up Symptom Onset Date (14976) must be Less than or Equal to Follow-up Adjudication Event Date (14386)	
Element: 14977		Neurologic Deficit with Rapid Onset	
	Coding Instruction:	Indicate if the patient had a sudden onset of a focal or global neurologic deficit regardless of the duration of symptoms.	
		Rapid onset means sudden or maximal within minutes.	
	Target Value:	Any value between discharge or last follow up and the current follow up	
Element: 14978		Neurologic Deficit Clinical Presentation	
Element: 14978	Coding Instruction:	Neurologic Deficit Clinical Presentation Indicate the clinical presentation of the neurologic deficit.	
Element: 14978	-		
	Target Value:	Indicate the clinical presentation of the neurologic deficit. Any value between discharge or last follow up and the current follow up	
leurologic Deficit Cli	Target Value:	Indicate the clinical presentation of the neurologic deficit.	Code Syste
leurologic Deficit Cli Selection	Target Value: inical Presentation - 1.	Indicate the clinical presentation of the neurologic deficit. Any value between discharge or last follow up and the current follow up 3.6.1.4.1.19376.1.4.1.6.5.716	Code Syste
leurologic Deficit Cli Selection Stroke-related	Target Value: inical Presentation - 1.	Indicate the clinical presentation of the neurologic deficit. Any value between discharge or last follow up and the current follow up 3.6.1.4.1.19376.1.4.1.6.5.716 Source Code	-
Neurologic Deficit Cli Selection Stroke-related Non-Stroke-related	Target Value: inical Presentation - 1.	Indicate the clinical presentation of the neurologic deficit. Any value between discharge or last follow up and the current follow up 3.6.1.4.1.19376.1.4.1.6.5.716  Source Code 100014109	ACC NC
leurologic Deficit Cli Selection Stroke-related Jon-Stroke-related	Target Value: inical Presentation - 1. Definition	Indicate the clinical presentation of the neurologic deficit. Any value between discharge or last follow up and the current follow up 3.6.1.4.1.19376.1.4.1.6.5.716 Source Code 100014109 112000001860 Diagnosis Confirmation by Neurology	ACC NCI
leurologic Deficit Cli Selection Stroke-related Ion-Stroke-related	Target Value: inical Presentation - 1. Definition	Indicate the clinical presentation of the neurologic deficit. Any value between discharge or last follow up and the current follow up 3.6.1.4.1.19376.1.4.1.6.5.716  Source Code 100014109 112000001860	ACC NCI
leurologic Deficit Cli Selection Stroke-related Jon-Stroke-related	Target Value: inical Presentation - 1. Definition	Indicate the clinical presentation of the neurologic deficit. Any value between discharge or last follow up and the current follow up 3.6.1.4.1.19376.1.4.1.6.5.716	ACC NCI
leurologic Deficit Cli Selection Stroke-related Ion-Stroke-related Element: 14979	Target Value: inical Presentation - 1. Definition	Indicate the clinical presentation of the neurologic deficit. Any value between discharge or last follow up and the current follow up 3.6.1.4.1.19376.1.4.1.6.5.716	ACC NCI
Jeurologic Deficit Cli Selection Stroke-related Jon-Stroke-related Element: 14979	Target Value: inical Presentation - 1. Definition Coding Instruction: Target Value:	Indicate the clinical presentation of the neurologic deficit. Any value between discharge or last follow up and the current follow up 3.6.1.4.1.19376.1.4.1.6.5.716	ACC NCI
Veurologic Deficit Cli Selection Stroke-related Von-Stroke-related Element: 14979	Target Value: inical Presentation - 1. Definition Coding Instruction: Target Value: Coding Instruction:	Indicate the clinical presentation of the neurologic deficit. Any value between discharge or last follow up and the current follow up 3.6.1.4.1.19376.1.4.1.6.5.716 Source Code 100014109 112000001860 Diagnosis Confirmation by Neurology Indicate if the diagnosis was confirmed by a neurologist or a neurosurgeon. Any value between discharge or last follow up and the current follow up Brain Imaging Performed	ACC NCI
Jeurologic Deficit Cli Selection Stroke-related Jon-Stroke-related Element: 14979 Element: 14980	Target Value: inical Presentation - 1. Definition Coding Instruction: Target Value: Coding Instruction:	Indicate the clinical presentation of the neurologic deficit. Any value between discharge or last follow up and the current follow up 3.6.1.4.1.19376.1.4.1.6.5.716 Code 100014109 112000001860 Diagnosis Confirmation by Neurology Indicate if the diagnosis was confirmed by a neurologist or a neurosurgeon. Any value between discharge or last follow up and the current follow up Brain Imaging Performed Indicate if neuro imaging (such as CT, MRI, cerebral angiography) was performed in an attempt to confirm the diagnosis. All values between discharge or last follow up and the current follow up	ACC NCI
	Target Value: inical Presentation - 1. Definition Coding Instruction: Target Value: Coding Instruction: Target Value:	Indicate the clinical presentation of the neurologic deficit. Any value between discharge or last follow up and the current follow up 3.6.1.4.1.19376.1.4.1.6.5.716   Code  100014109 112000001860  Diagnosis Confirmation by Neurology  Indicate if the diagnosis was confirmed by a neurologist or a neurosurgeon.  Any value between discharge or last follow up and the current follow up  Brain Imaging Performed  Indicate if neuro imaging (such as CT, MRI, cerebral angiography) was performed in an attempt to confirm the diagnosis.  All values between discharge or last follow up and the current follow up  Brain Imaging Type	ACC NCI
Jeurologic Deficit Cli Selection Stroke-related Jon-Stroke-related Element: 14979 Element: 14980	Target Value:         inical Presentation - 1.         Definition         Coding Instruction:         Target Value:         Coding Instruction:	Indicate the clinical presentation of the neurologic deficit. Any value between discharge or last follow up and the current follow up 3.6.1.4.1.19376.1.4.1.6.5.716 Code 100014109 112000001860 Diagnosis Confirmation by Neurology Indicate if the diagnosis was confirmed by a neurologist or a neurosurgeon. Any value between discharge or last follow up and the current follow up Brain Imaging Performed Indicate if neuro imaging (such as CT, MRI, cerebral angiography) was performed in an attempt to confirm the diagnosis. All values between discharge or last follow up and the current follow up	ACC NCI



# Coder's Data Dictionary v1.4



Cerebial Argography     3258003     SNOMED C       Computed Tangography     112000001862     SNOMED C       Magnetic Resonance Imaging     112000001862     ACC NCDF       Element: 14982     Deficit Type     Indicate the type of deficit identified by the neuroimaging study.     Target Value:     All values between discharge or last follow up and the current follow up       Brain Imaging Finding - 1.3.61.4.1.19376.1.4.1.6.5.717     Sedection     Code     Code System       No deficit     Deficit Type     Code System     Sedection     Sedection       No deficit     Sedection     Sedection     Sedection     Sedection       No deficit     Performance     Code System       No deficit     For patients presenting with an intracranial hemorrhage, indicate the hemorrhage location.     ACC NCDF       Element: 14983     Hemorrhagic Stroke Type     Code System       Element: 14983     Hemorrhagic Stroke Type     Code System       Coding Instruction:     For patients presenting with an intracranial hemorrhage, indicate the hemorrhage location.     Target Value:     All values between discharge or last follow up and the current follow up       Hemorrhagic Stroke Type - 1.3.6.1.4.119376.1.4.1.6.5.794     Subsection     Subsection     Subsection       Statestion     Definition     Source     Code System       Statestind     Definition     Source <t< th=""><th colspan="2">Section: Follow-Up Neurologic</th><th colspan="2">Parent: Follow-Up Adjudication</th></t<>	Section: Follow-Up Neurologic		Parent: Follow-Up Adjudication	
Company Important Sectors Imaging         97.477.00         81.0000 (1402)         81.0000 (1402)         81.0000 (1402)         A.C.C.N.C.S.           Element: 14.962         Deficit Type         11.3000 (1402)         A.C.C.N.C.S.           Element: 14.962         Deficit Type	Selection	Definition	Source Code	Code System
Magnetic Resonance Imaging         1130000160         SUMMED C           Other         11200001682         ACC NOD           Element: 14982         Deficit Type         Section         ACC NOD           Statistic Resonance Imaging Resonance         Index Not	Cerebral Angiography		3258003	SNOMED CT
Office     11200001682     ACC NOD       Element: 14982     Deficit Type     Indicate the upon deficit identified by the neuroimaging study. Target Value:     ACC NOD       Brain Insigning Finding - 1.3.6.1.4.15276.1.4.16.5.7T     Source     Code     Code </td <td>Computed Tomography</td> <td>ý</td> <td>77477000</td> <td>SNOMED CT</td>	Computed Tomography	ý	77477000	SNOMED CT
Element:       1989         Element:       1989         Brin Insurger for Market Status Extension discharge or Isets follow up and the current follow up       Code       Code System         Selection       Definition       Source       Code       Code System         No addali       Hemorrhagic Stroke Type       Source       Code       Code System         Bettering       Hemorrhagic Stroke Type       Source       Code       Code System         Solutandmod       21440004       SNOAED C       Source       Code System         Solutandmod       21440004       SNOAED C       Source       Source       Code System         Solutandmod       214440007       SNOAED C       Source       Code System       Source       Source       Code System         Intrace Type       Subsequent Intracensital Remultingen instructure Iolow up       Source       Code System       Source       Code System       Source       Code System       Source       Code System       Source       Code Syst	Magnetic Resonance In	maging	113091000	SNOMED CT
Coding instruction:       Indicate the type of deficit identified by the neuroimaging atudy;         Balanianging Finding - 1.3.4.1.4.1.58.571       Source       Code       Code System         Selection       9000143       49000143       49000143       49000143       49000143       49000143       49000143       49000143       49000143       49000143       49000143       49000143       49000143       49000143       49000143       49000143       49000145       69000143       49000145       69000143       49000145       69000143       49000145       69000143       49000145       69000143       49000145       69000143       49000145       69000143       49000145       69000143       49000143       49000145       69000143       49000143       49000143       49000143       49000143       49000143       49000143       59000140       590001	Other		112000001862	ACC NCDR
Tare training	Element: 14982		Deficit Type	
Brain Imaging Finding - 1.3.6.1.4.1.18376.1.4.1.6.5.714         Source         Code         Code System           Selection         Definition         50000000         50000000         50000000           Brain Interaction         50560000         500000000         500000000         500000000           Brain Interaction         112000000000         ACC NCDF         5000000000         ACC NCDF           Brain Interaction         For patients presenting with an interactival herrouthage, indicate the herrouthage locator.         Target Value:         All values between discharge or last follow up and the current follow up           Hemorthagic Stroke Type - 1.3.6.1.4.1.13276.1.4.1.6.5.794         Source         Code         Code System           Selection         Source         Code         Code System         Source           Interaction         Interaction:         Indicate System         Source         Code         Code System           Element: 14984         Subsequent Intravenous Recombinant Tissue Plasminogen activator Administered         Source         Coding Instruction:         Indicate if an andoxascular Therapeutic Intervention         Intervention		Coding Instruction:	Indicate the type of deficit identified by the neuroimaging study.	
Selection         Definition         Source         Code         Source         Code         Code <thcode< th=""> <thcode< th="">         Code<td></td><td>Target Value:</td><td>All values between discharge or last follow up and the current follow up</td><td></td></thcode<></thcode<>		Target Value:	All values between discharge or last follow up and the current follow up	
No deficit indication bio deficit biological biologica	Brain Imaging Findin	ıg - 1.3.6.1.4.1.19376.1.4	4.1.6.5.717	
Inferencing Infer		Definition		Code System
Henorthage     5000000000000000000000000000000000000				
Boni     11200002004     ACC NCDF       Element: 14983     Hemorrhagic Stroke Type     ACC NCDF       Coding Instruction:     For patients presenting with an intracranial hemorrhage, indicate the hemorrhage location.     Target Value:     Ard 2000000000000000000000000000000000000				
Element: 14983       Hemorrhagic Stroke Type         Element: 14983       Hemorrhagic Stroke Type         Hemorrhagic Stroke Type - 1.3.6.1.4.1.13276.1.4.1.6.5.794         Selection       Definition         Selection       Definition         Selection       Definition         Subhardhold       27410004         Subhardhold       35488000         Subsequent Intravenscular (IV) recombinant Tissue Plasminogen Activator Administered         Element: 14985       Subsequent Endovascular Therapeutic Intervention         Coding Instruction:       Indicate if intravescular (IV) recombinant tissue plasminogen activator (IPA) was used as a treatment option related to this event.         Target Value:       Avy value between discharge or last follow up and the current follow up         Coding Instruction:       Indicate fine advancular intervention         Element: 14986       Neurologic Symptoms Duration         Element: 14986       Neurologic Symptoms Duration     <	•			
Element: 14986       Neurologic Symptoms Duration         Element: 14987       Trauma         Coding Instruction:       Indicate fi the patient experienced a physical tr	Both		112000002004	ACC NCDR
Target Value: All values between discharge or last follow up and the current follow up         Hemorrhagic Stricke Type - 1.3.6.1.4.1.1937e.1.4.1.6.5.794       Source       Code       Source       Source       Code       Source       Source </td <td>Element: 14983</td> <td></td> <td>Hemorrhagic Stroke Type</td> <td></td>	Element: 14983		Hemorrhagic Stroke Type	
Hemorrhagic Stroke Type 1 3.8.1.4.1.19376.1.4.1.6.5.794         Code         Code         Code         Code         Solution           Selection         Definition         30 vorce         Code         Sylone of Sylo		Coding Instruction:	For patients presenting with an intracranial hemorrhage, indicate the hemorrhage location.	
Selection         Definition         Source         Code         Code         Code         Code         Source           Intracembral         217410004         SNOMED C		Target Value:	All values between discharge or last follow up and the current follow up	
Intracerebul 27410004 SW0ED C Subarandonid 21454007 SW0ED C Subarandonid 21454007 SW0ED C Element: 14984 Subsequent Intravascular (IV) recombinant Tissue Plasminogen Activator Administered Coding Instruction: Indicate if intravascular (IV) recombinant tissue plasminogen Activator Administered Coding Instruction: Indicate if intravascular (IV) recombinant tissue plasminogen activator (trPA) was used as a treatment option related to this event. Target Value: Any value between discharge or last follow up and the current follow up Element: 14985 Subsequent Endovascular Interventional therapy was performed as a treatment option related to this event. Target Value: Any value between discharge or last follow up and the current follow up Element: 14986 Neurologic Symptoms Duration Coding Instruction: Indicate the duration (in hours) of the neurologic symptoms. Target Value: All values between discharge or last follow up and the current follow up Duration - 1.3.6.1.4.1.9375.1.4.1.6.5.795 Selection Definition Source Code Code System 112000002130 ACC NODF Less than 1 Hour 112000002131 ACC NODF Element: 14987 Trauma Coding Instruction: Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event. Target Value: Any value between discharge or last follow up and the current follow up Element: 14987 Trauma Element: 14988 Modified Rankin Scale Coding Instruction: Indicate the patient experienced a physical trauma within 24 hours prior to the neurologic event. Target Value: Any value between discharge or last follow up and the current follow up Supporting Definition: Modified Rankin Scale Coding Instruction: Indicate the patient sfunctional ability according to the modified Rankin Scale (mRS) administered following the event. Target Value: Any value between discharge or last follow up and the current follow up Supporting Definition: Modified Rankin Scale to a standardized neurological examination of patients with disability that provides a scale of global disabilit	Hemorrhagic Stroke	Type - 1.3.6.1.4.1.1937	6.1.4.1.6.5.794	
Subarachnoid       21454007       SNOMED C         Subdural       35468000       SNOMED C         Element: 14984       Subsequent Intravenous Recombinant Tissue Plasminogen Activator Administered         Coding Instruction: Target Value:       Indicate if intravascular (IV) recombinant issue plasminogen activator (rtPA) was used as a treatment option related to this event. Target Value:       Any value between discharge or last follow up and the current follow up         Element: 14985       Subsequent Endovascular Intervention       Subsequent Endovascular Interventional therapy was performed as a treatment option related to this event. Target Value:       Any value between discharge or last follow up and the current follow up         Element: 14986       Neurologic Symptoms Duration       Neurologic Symptoms Duration         Coding Instruction:       Indicate the duration (in hours) of the neurologic symptoms. Target Value:       All values between discharge or last follow up and the current follow up         Duration - 13.6.1.4.1.19376.1.4.1.6.795       Selection       Code       Code System         Selection       Definition       Source       Code System       ACC NCD follow         1.24 Hours       112000002130       ACC NCD follow       A	Selection	Definition	Source Code	Code System
Subdural       3548600       SNOMED C         Element: 14984       Subsequent Intravenous Recombinant Tissue Plasminogen Activator Administered         Coding Instruction:       Indicate if Intravascular (IV) recombinant tissue plasminogen activator (nPA) was used as a treatment option related to this event. Target Value:       Any value between discharge or last follow up and the current follow up         Element: 14985       Subsequent Endovascular Therapeutic Intervention       Indicate if an endovascular Interventional therapy was performed as a treatment option related to this event. Target Value:       Any value between discharge or last follow up and the current follow up         Element: 14986       Neurologic Symptoms Duration       Indicate the duration (in hours) of the neurologic symptoms. Target Value:       All values between discharge or last follow up and the current follow up         Element: 14986       Neurologic Symptoms Duration       Code       Code System         Less than 1 Hour       Source       Code Code System       ACC NCDF         1 24 Hours       112000002130       ACC NCDF         Coding Instruction:       Indicate the patient experienced a physical trauma within 24 hours prior to the neurologic event.       Source Code System         Less than 24 Hours       Target Value:       Any value between discharge or last follow up and the current follow up         Element: 14987       Tarama       Tarama       Target Value:       Any value between discharge or la	Intracerebral		274100004	SNOMED CT
Element: 14984       Subsequent Intravenous Recombinant Tissue Plasminogen Activator Administered         Coding Instruction:       Indicate if Intravascular (IV) recombinent tissue plasminogen activator (IrRA) was used as a treatment option related to this event. Target Value:         Any value between discharge or last follow up and the current follow up         Element: 14985       Subsequent Endovascular Therapeutic Intervention         Coding Instruction:       Indicate if an endovascular interventional therapy was performed as a treatment option related to this event. Target Value:         Any value between discharge or last follow up and the current follow up         Element: 14986       Neurologic Symptoms Duration         Coding Instruction:       Indicate the duration (in hours) of the neurologic symptoms. Target Value:         Target Value:       All values between discharge or last follow up and the current follow up         Duration - 1.3.6.1.4.1.9376.1.4.1.6.5795       Selection         Selection       Definition         Source       Code       Code System         Less than 1 Hour       112000002130       ACC NCDF         1.24 Hours       112000002131       ACC NCDF         I element: 14987       Trauma       Trauma         Element: 14988       Modified Rankin Scale       Indicate if the patient experienced a physical trauma within 24 hours poir to the neurologic event. Target Value:       Any value between	Subarachnoid		21454007	SNOMED CT
Coding Instruction:       Indicate if intravascular (IV) recombinant tissue plasminogen activator (rIPA) was used as a treatment option related to this event.         Target Value:       Any value between discharge or last follow up and the current follow up         Element:       14985         Subsequent Endovascular Interventional therapy was performed as a treatment option related to this event.         Target Value:       Any value between discharge or last follow up and the current follow up         Element:       14986         Neurologic Symptoms Duration         Coding Instruction:       Indicate if an endovascular (in hours) of the neurologic symptoms.         Target Value:       All values between discharge or last follow up and the current follow up         Duration - 1.3.6.1.4.1.19376.1.4.1.6.5.795         Solection       Definition         Source       Code       Code System         Less than 1 Hour       112000002130       ACC NCDF         1.24 Hours       112000002131       ACC NCDF         Greater than 24 Hours       112000002131       ACC NCDF         Coding Instruction:       Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event.       Target Value:         Any value between discharge or last follow up and the current follow up       Element:       14986         Modified Rankin Scale       Modified R	Subdural		35486000	SNOMED CT
Coding Instruction:       Indicate if intravascular (IV) recombinant tissue plasminogen activator (rtPA) was used as a treatment option related to this event.         Target Value:       Any value between discharge or last follow up and the current follow up         Element:       14985         Subsequent Endovascular Therapeutic Intervention         Target Value:       Any value between discharge or last follow up and the current follow up         Element:       14986         Neurologic Symptoms Duration         Coding Instruction:       Indicate if an endovascular (in hours) of the neurologic symptoms.         Target Value:       All values between discharge or last follow up and the current follow up         Duration - 1.3.6.1.4.1.19376.1.4.1.6.5.795         Selection       Definition         Selection       Code       Code System         Less than 1 Hour       112000002130       ACC NCDF         1 - 24 Hours       112000002131       ACC NCDF         Element:       14987       Trauma       112000002131       ACC NCDF         Element:       14987       Trauma       112000002130       ACC NCDF         Coding Instruction:       Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event.       Target Value:       Any value between discharge or last follow up and the current follow up	Element: 14984		Subsequent Intravenous Recombinant Tissue Plasminogen Activator Administered	
Element: 14985       Subsequent Endovascular Therapeutic Intervention         Coding Instruction:       Indicate if an endovascular Therapeutic Intervention         Target Value:       Any value between discharge or last follow up and the current follow up         Element: 14986       Neurologic Symptoms Duration         Indicate the duration (in hours) of the neurologic symptoms. Target Value:       All values between discharge or last follow up and the current follow up         Duration - 1.3.6.1.4.1.9376.1.4.1.6.5.795       Indicate the duration (in hours) of the neurologic symptoms. Target Value:       Code Code System         Element: 14986       Source       Code Code System         Element: 14987       Trauma       11200002130       ACC NODF         Element: 14987       Trauma       Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event. Target Value:       Any value between discharge or last follow up and the current follow up         Element: 14987       Trauma       Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event. Target Value:       Any value between discharge or last follow up and the current follow up         Element: 14988       Modified Rankin Scale       Modified Rankin Scale (mRS) administered following the event.         Target Value:       Any value between discharge or last follow up and the current follow up       Supporting Derlinitis         Modified Rankin Scale		Coding Instruction:		to this event.
Element: 14985       Subsequent Endovascular Therapeutic Intervention         Coding Instruction:       Indicate if an endovascular interventional therapy was performed as a treatment option related to this event.         Target Value:       Any value between discharge or last follow up and the current follow up         Element:       14986         Coding Instruction:       Indicate the duration (in hours) of the neurologic symptoms.         Target Value:       All values between discharge or last follow up and the current follow up         Duration - 1.3.6.1.4.1.19376.1.4.1.6.5.795       Selection         Selection       Definition         Source       Code         Selection       Definition         Source       Code         Coding Instruction:       112000002130         Less than 1 Hour       112000002131         Less than 1 Hours       112000002132         Coding Instruction:       Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event.         Target Value:       Any value between discharge or last follow up and the current follow up         Element:       14987       Trauma         Coding Instruction:       Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event.         Target Value:       Any value between discharge or last follow up and the current f		-		
Coding Instruction:       Indicate if an endovascular interventional therapy was performed as a treatment option related to this event.         Target Value:       Any value between discharge or last follow up and the current follow up         Element:       14986         Neurologic Symptoms Duration       Indicate if an endovascular interventional therapy was performed as a treatment option related to this event.         Target Value:       Any value between discharge or last follow up and the current follow up         Duration - 1.3.6.1.4.1.19376.1.4.1.6.5.795       Selection         Selection       Definition         Selection       Code Code System         Less than 1 Hour       11200002130         1.2.4 Hours       112000002131         Greater than 24 Hours       Trauma         Coding Instruction:       Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event.         Target Value:       Any value between discharge or last follow up and the current follow up         Element:       14987       Trauma         Coding Instruction:       Indicate if a patient experienced a physical trauma within 24 hours prior to the neurologic event.         Target Value:       Any value between discharge or last follow up and the current follow up         Element:       14988       Modified Rankin Scale         Coding Instruction:       Indica			· · · · · · · · · · · · · · · · · · ·	
Element: 14986       Neurologic Symptoms Duration         Coding Instruction:       Indicate the duration (in hours) of the neurologic symptoms.         Target Value:       All values between discharge or last follow up and the current follow up         Duration - 1.3.6.1.4.1.19376.1.4.1.6.5.795       Selection         Selection       Definition       Source         Less than 1 Hour       112000002130       ACC NODF         1 - 24 Hours       112000002132       ACC NODF         Greater than 24 Hours       Trauma       112000002131       ACC NODF         Element: 14987       Trauma       Indicate the patient experienced a physical trauma within 24 hours prior to the neurologic event.       Target Value:       Any value between discharge or last follow up and the current follow up         Element: 14987       Modified Rankin Scale       Modified Rankin Scale       Indicate the patient experienced a physical trauma within 24 hours prior to the neurologic event.       Target Value:       Any value between discharge or last follow up and the current follow up         Element: 14988       Modified Rankin Scale       Modified Rankin Scale       Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the event.         Target Value:       Any value between discharge or last follow up and the current follow up       Supporting Definition:       Modified Rankin Scale is a standardized neurological examination	Element: 14985		Subsequent Endovascular Therapeutic Intervention	
Element: 14986       Neurologic Symptoms Duration         Coding Instruction:       Indicate the duration (in hours) of the neurologic symptoms. Target Value:       All values between discharge or last follow up and the current follow up         Duration - 1.3.6.1.4.1.19376.1.4.1.6.5.795       Source       Code       Code       Code System         Selection       Definition       Source       Code       Code System         Less than 1 Hour       11200002130       ACC NCDF         1 - 24 Hours       11200002131       ACC NCDF         Greater than 24 Hours       Trauma       11200002131       ACC NCDF         Element: 14987       Trauma       Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event. Target Value       Any value between discharge or last follow up and the current follow up         Element: 14988       Modified Rankin Scale       Modified Rankin Scale       Modified Rankin Scale         Supporting Definition       Modified Rankin Scale       The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability. Source: Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.       Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.		Coding Instruction:	Indicate if an endovascular interventional therapy was performed as a treatment option related to this event.	
Coding Instruction:       Indicate the duration (in hours) of the neurologic symptoms. Target Value:       All values between discharge or last follow up and the current follow up         Duration - 1.3.6.1.4.1.6.5.795       Selection       Code       Code       Code System         Selection       Definition       Source       Code       Code System         Less than 1 Hour       11200002130       ACC NCDF         1 - 24 Hours       11200002132       ACC NCDF         Greater than 24 Hours       11200002131       ACC NCDF         Element: 14987       Trauma       Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event.       Target Value:         Any value between discharge or last follow up and the current follow up       Modified Rankin Scale       Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the event.         Target Value:       Any value between discharge or last follow up and the current follow up       Supporting Definition:       Modified Rankin Scale         Modified Rankin Scale       Modified Rankin Scale       Modified Rankin Scale       The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability. Source:         Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.       Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of m		Target Value:	Any value between discharge or last follow up and the current follow up	
Coding Instruction:       Indicate the duration (in hours) of the neurologic symptoms. Target Value:       All values between discharge or last follow up and the current follow up         Duration - 1.3.6.1.4.1.6.5.795       Selection       Code       Code       Code System         Selection       Definition       Source       Code       Code System         Less than 1 Hour       11200002130       ACC NCDF         1 - 24 Hours       11200002132       ACC NCDF         Greater than 24 Hours       11200002131       ACC NCDF         Element: 14987       Trauma       Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event.       Target Value:         Any value between discharge or last follow up and the current follow up       Modified Rankin Scale       Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the event.         Target Value:       Any value between discharge or last follow up and the current follow up       Supporting Definition:       Modified Rankin Scale         Modified Rankin Scale       Modified Rankin Scale       Modified Rankin Scale       The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability. Source:         Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.       Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of m				
Target Value: All values between discharge or last follow up and the current follow up         Duration - 1.3.6.1.4.1.19376.1.4.1.6.5.795         Selection       Code       Code System         Less than 1 Hour       11200002130       ACC NODE         1 - 24 Hours       11200002132       ACC NODE         Greater than 24 Hours       11200002131       ACC NODE         Element: 14987       Trauma         Coding Instruction:       Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event.       Target Value         Element: 14987       Trauma         Element: 14988       Modified Rankin Scale         Coding Instruction:       Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the event.         Target Value       Any value between discharge or last follow up and the current follow up         Element: 14988       Modified Rankin Scale         Rarget Value       Any value between discharge or last follow up and the current follow up         Supporting Definition       Modified Rankin Scale         Target Value       Modified Rankin Scale         Rarget Value       Modified Rankin Scale         Greater than 24 Hours       Modified Rankin Scale is a standardized neurological ex	Element: 14986		Neurologic Symptoms Duration	
Duration - 1.3.6.1.4.119376.1.4.1.6.5.795           Selection         Definition         Source         Code         Code System           Less than 1 Hour         11200002130         ACC NCDF           1 - 24 Hours         112000002132         ACC NCDF           Greater than 24 Hours         112000002131         ACC NCDF           Greater than 24 Hours         112000002131         ACC NCDF           Element: 14987         Trauma         112000002131         ACC NCDF           Element: 14987         Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event.         Target Value         Any value between discharge or last follow up and the current follow up           Element: 14988         Modified Rankin Scale         Modified Rankin Scale         Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the event.         Target Value         Any value between discharge or last follow up and the current follow up           Supporting Definition:         Modified Rankin Scale         Modified Rankin Scale         The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability. Source:           Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.         Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.		Coding Instruction:	Indicate the duration (in hours) of the neurologic symptoms.	
Selection         Definition         Source         Code         Code System           Less than 1 Hour         11200002130         ACC NCDF           1 - 24 Hours         11200002132         ACC NCDF           Greater than 24 Hours         11200002132         ACC NCDF           Element: 14987         Trauma         11200002131         ACC NCDF           Element: 14987         Trauma         Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event.         Target Value:         Any value between discharge or last follow up and the current follow up           Element: 14988         Modified Rankin Scale         Modified Rankin Scale         Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the event.           Target Value:         Any value between discharge or last follow up and the current follow up         Supporting Definition:         Modified Rankin Scale           Supporting Definition:         Modified Rankin Scale         The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.           Source:         Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.           Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.		Target Value:	All values between discharge or last follow up and the current follow up	
Less than 1 Hour       11200002130       ACC NCDF         1 - 24 Hours       11200002132       ACC NCDF         Greater than 24 Hours       112000002131       ACC NCDF         Element: 14987       Trauma       Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event.       Target Value:       Any value between discharge or last follow up and the current follow up         Element: 14988       Modified Rankin Scale       Modified Rankin Scale         Coding Instruction:       Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the event.         Target Value:       Any value between discharge or last follow up and the current follow up         Supporting Definition:       Modified Rankin Scale         The Modified Rankin Scale       The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.         Source:       Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.         Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.	Duration - 1.3.6.1.4.1	.19376.1.4.1.6.5.795		
1 - 24 Hours       11200002132       ACC NCDF         Greater than 24 Hours       11200002131       ACC NCDF         Element: 14987       Trauma       11200002131       ACC NCDF         Element: 14987       Trauma       Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event.       Target Value:       Any value between discharge or last follow up and the current follow up         Element: 14988       Modified Rankin Scale       Modified Rankin Scale       Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the event.         Target Value:       Any value between discharge or last follow up and the current follow up       Modified Rankin Scale         Supporting Definition:       Modified Rankin Scale       The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.         Source:       Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.       Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.	Selection	Definition	Source Code	Code System
Greater than 24 Hours       11200002131       ACC NCDF         Element: 14987       Trauma         Coding Instruction:       Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event.         Target Value:       Any value between discharge or last follow up and the current follow up         Element: 14988       Modified Rankin Scale         Coding Instruction:       Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the event.         Target Value:       Any value between discharge or last follow up and the current follow up         Supporting Definition:       Modified Rankin Scale         The Modified Rankin Scale       The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.         Source:       Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.         Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.				ACC NCDR
Element: 14987       Trauma         Coding Instruction:       Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event.         Target Value:       Any value between discharge or last follow up and the current follow up         Element: 14988       Modified Rankin Scale         Coding Instruction:       Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the event.         Target Value:       Any value between discharge or last follow up and the current follow up         Supporting Definition:       Modified Rankin Scale         The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.         Source:       Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.         Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.				ACC NCDR
Coding Instruction:       Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event.         Target Value:       Any value between discharge or last follow up and the current follow up         Element: 14988       Modified Rankin Scale         Coding Instruction:       Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the event.         Target Value:       Any value between discharge or last follow up and the current follow up         Supporting Definition:       Modified Rankin Scale         The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.         Source:       Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.         Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.	Greater than 24 Hours		112000002131	ACC NCDR
Target Value:       Any value between discharge or last follow up and the current follow up         Element: 14988       Modified Rankin Scale         Coding Instruction:       Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the event.         Target Value:       Any value between discharge or last follow up and the current follow up         Supporting Definition:       Modified Rankin Scale         The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.         Source:       Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.         Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.	Element: 14987		Trauma	
Element: 14988       Modified Rankin Scale         Coding Instruction:       Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the event.         Target Value:       Any value between discharge or last follow up and the current follow up         Supporting Definition:       Modified Rankin Scale         The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.         Source:       Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.         Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.		Coding Instruction:	Indicate if the patient experienced a physical trauma within 24 hours prior to the neurologic event.	
Coding Instruction:       Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the event.         Target Value:       Any value between discharge or last follow up and the current follow up         Supporting Definition:       Modified Rankin Scale         The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.         Source:       Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.         Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.		Target Value:	Any value between discharge or last follow up and the current follow up	
Coding Instruction:       Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the event.         Target Value:       Any value between discharge or last follow up and the current follow up         Supporting Definition:       Modified Rankin Scale         The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.         Source:       Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.         Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.				
Target Value:       Any value between discharge or last follow up and the current follow up         Supporting Definition:       Modified Rankin Scale         The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.         Source:       Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.         Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.	Element: 14988		Modified Rankin Scale	
Supporting Definition:       Modified Rankin Scale         The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability.         Source:       Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.         Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.		Coding Instruction:	Indicate the patient's functional ability according to the modified Rankin Scale (mRS) administered following the event	
The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability. <b>Source:</b> Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15. Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.		Target Value:	Any value between discharge or last follow up and the current follow up	
<b>Source:</b> Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15. Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.	:	Supporting Definition:	Modified Rankin Scale	
				of global disability.
			Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1-	497-1500.
	Rankin Scale Ascos	ement Finding - 1 3 6 1	4 1 19376 1 4 1 6 5 139	





Section: Follow-Up Ne	eurologic	Parent: Follow-Up A	djudication	
Selection	Definition	Source	Code	Code System
0: No symptoms at all			LA6111-4	LOINC
1: No significant disability despite symptoms	Able to carry out all usual duties a	nd activities.	LA6112-2	LOINC
2: Slight disability	Unable to carry out all previous ac look after own affairs without ass	,	LA6113-0	LOINC
3: Moderate disability	Requiring some help, but able to vassistance.	valk without	LA6114-8	LOINC
4: Moderately severe disability	Unable to walk without assistance to own bodily needs without assist		LA6115-5	LOINC
5: Severe disability	Bedridden, incontinent and requiri care and attention.	ng constant nursing	LA10137-0	LOINC
6: Death			419620001	SNOMED CT

Element: 14989

Adjudication Modified Rankin Scale Not Administered

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

Target Value: Any value between discharge or last follow up and the current follow up

#### Supporting Definition: Modified Rankin Scale

The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability. **Source:** Rankin J. Cerebral vascular accidents in patients over the age of 60. Scott Med J. 1957; 2:200-15.

Bonita R, Beaglehole R. Modification of Rankin Scale: Recovery of motor function after stroke. Stroke. 1988;19(12):1497-1500.

Element: 14990		Procedure Related Neurologic Event
	Coding Instruction:	Indicate using the following selections the likelihood in which this event is related to the LAAO procedure based upon the clinician's best clinical judgement.

# Target Value: All values between discharge or last follow up and the current follow up

Selection	Definition	Source	Code	Code System
Certain	The clinical adverse event occurs in a plausible time relationship to the procedure and cannot be explain by concurrent disease or other drugs or devices.		17162000	SNOMED CT
Probable	The clinical adverse event occurs within a reasonal time sequence to the procedure and it is unlikely to l attributed to concurrent disease or other drugs or devices.		112000002134	ACC NCDR
Possible	The clinical adverse event occurs within a reasonal time sequence to the procedure, but the event could also be explained by concurrent disease or other drugs or devices.		371930009	SNOMED CT
Unlikely	The clinical adverse event, based upon its temporal relationship to the procedure, makes a causal relationship improbable. Additionally, other drugs, devices or underlying disease provide plausible explanations.		112000002135	ACC NCDR
Unclassifiable	The clinical adverse event is reported yet more data essential for a proper assessment OR the clinical adverse event is reported yet the causality cannot b judged because information is insufficient or contradictory, and cannot be supplemented or verifi	De	112000002136	ACC NCDR





# Section: Follow-Up Neurologic

# Parent: Follow-Up Neurologic

Element: 15015

Follow-up Device Related Neurologic Event

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

Target Value: Any value between discharge or last follow up and the current follow up

Selection	Definition	Source	Code	Code System
Certain	The clinical adverse event occurs in a plausible time relationship to the procedure and cannot be explaine by concurrent disease or other drugs or devices.	1	17162000	SNOMED CT
Probable	The clinical adverse event occurs within a reasonabl time sequence to the procedure and it is unlikely to be attributed to concurrent disease or other drugs or devices.	-	112000002134	ACC NCDR
Possible	The clinical adverse event occurs within a reasonabl time sequence to the procedure, but the event could also be explained by concurrent disease or other drugs or devices.	e	371930009	SNOMED CT
Unlikely	The clinical adverse event, based upon its temporal relationship to the procedure, makes a causal relationship improbable. Additionally, other drugs, devices or underlying disease provide plausible explanations.		112000002135	ACC NCDR
Unclassifiable	The clinical adverse event is reported yet more data essential for a proper assessment OR the clinical adverse event is reported yet the causality cannot be judged because information is insufficient or contradictory, and cannot be supplemented or verifie	9	112000002136	ACC NCDR





Element: 14971       Adjudication Status         Coding Instruction:       Indicate whether the patient was alive or deceased on the date the adjudication was performed.         Target Value:       Any value between discharge or last follow up and the current follow up         Vendor Instruction:       Adjudication Status (14971) cannot be Null if Adjudication Event (14967) is Equal to (Access Site Bleet)		
Coding Instruction:       Indicate whether the patient was alive or deceased on the date the adjudication was performed.         Target Value:       Any value between discharge or last follow up and the current follow up		
<b>Target Value:</b> Any value between discharge or last follow up and the current follow up		
	ding Cl Bloodin	a Homotomo
Adjudication Life Status - 1.3.6.1.4.1.19376.1.4.1.6.5.726	al Effusion (requ n without tampo rgical repair), Ps	iring open cardiac nade (requiring seudoaneurysm
Selection Definition Source	Code	Code Syster
Alive 4	38949009	SNOMED C
Deceased	20 HL7	Discharge disposition
Element: 14972 Adjudication Date of Death		
Coding Instruction: Indicate the date the patient was declared deceased.		
Target Value: Any value between discharge or last follow up and the current follow up		
Vendor Instruction: Adjudication Date of Death (14972) must be Greater than the Follow-Up Reference Procedure Start I	Date and Time (1	1001)
Adjudication Date of Death (14972) must be Greater than or Equal to Follow-Up Adjudication Event D	ate (14386)	
	· · · ·	
Element: 14991 Invasive Intervention Required		
Coding Instruction: Indicate if there was a surgical or percutaneous intervention required to treat the patient for this blee	ding event.	
Target Value: Any value between discharge or last follow up and the current follow up		
Element: 14992     RBC Transfusion		
Coding Instruction: Indicate if there was at least one transfusion of PRBCs given to treat the patient for this bleeding even	ent.	
Target Value: All values between discharge or last follow up and the current follow up		
Element: 14993         Follow-up number of RBC Units Transfused		
Coding Instruction: Indicate the number of PRBC units transfused for treatment of this bleeding event.		
Target Value: All values between discharge or last follow up and the current follow up		
Element: 14994 Hemoglobin Pre-Transfusion		
Coding Instruction: Indicate the lowest hemoglobin (Hgb) value (g/dL), obtained via lab assay or point of care assay, be bleeding event and prior to the transfusion.	tween the intra	or post procedure
Target Value: All values between discharge or last follow up and the current follow up		
Element: 14995 Diagnostic Imaging Performed		
Coding Instruction: Indicate if imaging (such as CT, MRI) was performed in an attempt to confirm the diagnosis.		
Target Value: All values between discharge or last follow up and the current follow up		
Element: 14996 End Organ Damage		
Coding Instruction: Indicate if the patient was diagnosed with end organ damage after this bleeding event.		
Target Value: All values between discharge or last follow up and the current follow up		
Element: 14975 Bleeding Event Readmission		
Coding Instruction: Indicate if a readmission was associated with a bleeding related diagnosis.		
Target Value: Any value between discharge or last follow up and the current follow up		
Element: 14997 Major Surgery		
Coding Instruction: Indicate if the patient underwent surgery within 30 days prior to this bleeding event.		



Parent: Follow-Up Adjudication



# Section: Follow-Up Bleeding

# Element: 14998 Percutaneous Coronary Intervention Coding Instruction: Indicate if the patient had a percutaneous coronary artery or percutaneous valvular intervention within 30 days prior to this bleeding event. Target Value: Any value between discharge or last follow up and the current follow up Supporting Definition: Percutaneous Coronary Intervention A percutaneous coronary intervention (PCI) is the placement of an angioplasty guide wire, balloon, or other device (e.g. stent, atherectomy, brachytherapy, or thrombectomy catheter) into a native coronary artery or coronary artery bypass graft for the purpose of mechanical coronary revascularization. Source: Medline Plus, 2017 by Merriam-Webster, Incorporated Element: 14999 Procedure Related Bleeding Event Coding Instruction: Indicate using the following selections the likelihood in which this event is related to the LAAO procedure based upon the clinician's best clinical judgement. Target Value: Any value between discharge or last follow up and the current follow up Supporting Definition: Bleeding Event A bleeding event observed and documented in the medical record that was associated with a hematocrit drop of ≥10% and/or a hemoglobin drop of ≥3 g/dL or that required transfusion or surgical intervention. Source: Cannon CP, Brindis RG, Chaitman BR, et al. 2013 ACCF>AHA Key Date Elements and Definitions for Measuring the Clinical Management and Outcomes of Patients with Acute Coronary Syndromes and Coronary Artery Disease. Circulation. 2013;127;1052-1089.

Selection	Definition	Source	Code	Code System
Certain	The clinical adverse event occurs in a plausible tir relationship to the procedure and cannot be expla by concurrent disease or other drugs or devices.		17162000	SNOMED CT
Probable	The clinical adverse event occurs within a reason time sequence to the procedure and it is unlikely tr attributed to concurrent disease or other drugs or devices.	be	112000002134	ACC NCDR
Possible	The clinical adverse event occurs within a reason time sequence to the procedure, but the event cou also be explained by concurrent disease or other drugs or devices.		371930009	SNOMED CT
Unlikely	The clinical adverse event, based upon its tempor relationship to the procedure, makes a causal relationship improbable. Additionally, other drugs, devices or underlying disease provide plausible explanations.	al	112000002135	ACC NCDR
Unclassifiable	The clinical adverse event is reported yet more da essential for a proper assessment OR the clinical adverse event is reported yet the causality canno judged because information is insufficient or contradictory, and cannot be supplemented or ver	t be	112000002136	ACC NCDR





# Section: Follow-Up Bleeding

# Element: 15000 Device Related Bleeding Event Coding Instruction Indicate using the following selections the likelihood in which this event is related to the LAAO device based upon the clinician's best clinical judgement. Target Vaue Any value between discharge or last follow up and the current follow up Supporting Definition Bleeding Event A bleeding event observed and documented in the medical record that was associated with a hematocrit drop of ≥10% and/or a hemoglobin drop of ≥3 g/dL or that required transfusion or surgical intervention.

Source: Cannon CP, Brindis RG, Chaitman BR, et al. 2013 ACCF>AHA Key Date Elements and Definitions for Measuring the Clinical Management and Outcomes of Patients with Acute Coronary Syndromes and Coronary Artery Disease. Circulation. 2013;127;1052-1089.

Parent: Follow-Up Bleeding

Selection	Definition	Source Code	Code System
Certain	The clinical adverse event occurs in a plausible time relationship to the procedure and cannot be explained by concurrent disease or other drugs or devices.	17162000	SNOMED CT
Probable	The clinical adverse event occurs within a reasonabl time sequence to the procedure and it is unlikely to be attributed to concurrent disease or other drugs or devices.		ACC NCDR
Possible	The clinical adverse event occurs within a reasonabl time sequence to the procedure, but the event could also be explained by concurrent disease or other drugs or devices.	e 371930009	SNOMED CT
Unlikely	The clinical adverse event, based upon its temporal relationship to the procedure, makes a causal relationship improbable. Additionally, other drugs, devices or underlying disease provide plausible explanations.	11200002135	ACC NCDR
Unclassifiable	The clinical adverse event is reported yet more data i essential for a proper assessment OR the clinical adverse event is reported yet the causality cannot be judged because information is insufficient or contradictory, and cannot be supplemented or verifie		ACC NCDR





	-Up Systemic Thro	mboembolism Parent: Follow-Up Adjudication		
Element: 14973		Adjudication Status		
	Coding Instruction:	Indicate whether the patient was alive or deceased on the date the adjudication was perform	led	
	-	Any value between discharge or last follow up and the current follow up		
	-		Thromboomholiom (	other then strake))
		Adjudication Status (14973) cannot be Null if Adjudication Event (14967) is Equal to (Systemic	: milomboembolism (	
	ntus - 1.3.6.1.4.1.19376.		Codo	Cada Suatu
Selection	Definition	Source	438949009	Code Syste SNOMED
Deceased				L7 Discharge disposit
Element: 14974		Adjudication Date of Death		
	Coding Instruction:	Indicate the date the patient was declared deceased.		
	-	Any value between discharge or last follow up and the current follow up		
	-	Adjudication Date of Death (14974) must be Greater than the Follow-Up Reference Procedure	Start Date and Time	(11001)
	venuor instruction.	Adjudication Date of Death (14974) must be Greater than or Equal to the Follow-Up Adjudication		
Element: 15016		Death Cause (End-Organ Hypoperfusion OR Systemic Thromboembolization C	OR Intervention)	
	Coding Instruction:	If deceased, indicate if the patient's death cause was due to systemic thromboembolization, or from systemic thromboembolism, or therapeutic intervention to treat systemic thromboembolism	or focal end-organ hy	poperfusion resulting
	Target Value:	Any value between discharge or last follow up and the current follow up		
Element: 15001		Focal End-Organ Hypoperfusion Present		
	Coding Instruction:	Indicate if focal end-organ hypoperfusion resulted from the systemic thromboembolism event.		
	Target Value:	Any value between discharge or last follow up and the current follow up		
Element: 15002		Systemic Thromboembolization Imaging Evidence		
	Coding Instruction:	Indicate if imaging evidence indicated systemic thromboembolism.		
	Target Value:	All values between discharge or last follow up and the current follow up		
Element: 15003		Follow-up Imaging Method		
	Coding Instruction:	Indicate the imaging method to identify systemic thromboembolism.		
	Target Value:	All values between discharge or last follow up and the current follow up		
maging Type - 1.3.6. Selection	1.4.1.19376.1.4.1.6.5.41 Definition	7 Source	Code	Code Syste
election	Demnition	Source	Code	Code Syste
			77343006	SNOMED
ngiography	ý		77343006 77477000	
angiography Computed Tomography				SNOMED
Ingiography Computed Tomography Aagnetic Resonance Ir Jltrasound			77477000 113091000 112000001042	SNOMED SNOMED ACC NC
Ingiography Computed Tomography Aagnetic Resonance Ir Jltrasound			77477000 113091000	SNOMED SNOMED ACC NC
Angiography Computed Tomography Aagnetic Resonance Ir JItrasound Other Imaging		Therapeutic Intervention Performed	77477000 113091000 112000001042	SNOMED SNOMED ACC NC
Angiography Computed Tomography Aagnetic Resonance Ir JItrasound Other Imaging	naging	Therapeutic Intervention Performed Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was perfor thromboembolism.	77477000 113091000 112000001042 112000001862	SNOMED SNOMED ACC NC ACC NC
Angiography Computed Tomography Aagnetic Resonance Ir JItrasound Other Imaging	Coding Instruction:	Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was performed	77477000 113091000 112000001042 112000001862	SNOMED SNOMED ACC NC ACC NC
Angiography Computed Tomography Agnetic Resonance Ir JItrasound Dther Imaging Element: 15004	Coding Instruction: Target Value:	Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was perfor thromboembolism. All values between discharge or last follow up and the current follow up Intervention Type	77477000 113091000 112000001042 112000001862	SNOMED SNOMED ACC NC ACC NC
Angiography Computed Tomography Agnetic Resonance Ir JItrasound Dther Imaging Element: 15004	Coding Instruction: Target Value: Coding Instruction:	Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was perfort thromboembolism. All values between discharge or last follow up and the current follow up Intervention Type Indicate the intervention type.	77477000 113091000 112000001042 112000001862	SNOMED SNOMED ACC NC ACC NC
Angiography Computed Tomography Agnetic Resonance In JItrasound Other Imaging Element: 15004	Coding Instruction: Target Value: Coding Instruction: Target Value:	Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was perfort thromboembolism. All values between discharge or last follow up and the current follow up Intervention Type Indicate the intervention type. All values between discharge or last follow up and the current follow up	77477000 113091000 112000001042 112000001862	SNOMED SNOMED ACC NC ACC NC
Angiography Computed Tomography Agnetic Resonance In JItrasound Other Imaging Element: 15004 Element: 15005	Coding Instruction: Target Value: Coding Instruction: Target Value: .3.6.1.4.1.19376.1.4.1.6	Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was perforthromboembolism. All values between discharge or last follow up and the current follow up Intervention Type Indicate the intervention type. All values between discharge or last follow up and the current follow up 5.797	77477000 113091000 112000001042 112000001862	SNOMED SNOMED ACC NC ACC NC
Angiography Computed Tomography Magnetic Resonance In Jltrasound Dther Imaging Element: 15004 Element: 15005	Coding Instruction: Target Value: Coding Instruction: Target Value:	Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was perfort thromboembolism. All values between discharge or last follow up and the current follow up Intervention Type Indicate the intervention type. All values between discharge or last follow up and the current follow up	77477000 113091000 112000001042 112000001862	SNOMED SNOMED ACC NCI ACC NCI stemic
Angiography Computed Tomography Magnetic Resonance Ir Jltrasound Dther Imaging Element: 15004	Coding Instruction: Target Value: Coding Instruction: Target Value: .3.6.1.4.1.19376.1.4.1.6	Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was perforthromboembolism. All values between discharge or last follow up and the current follow up Intervention Type Indicate the intervention type. All values between discharge or last follow up and the current follow up 5.797	77477000 113091000 11200001042 112000001862 prmed to treat the sys	SNOMED SNOMED SNOMED ACC NCI ACC NCI stemic Stemic
Angiography Computed Tomography Magnetic Resonance In JItrasound Dther Imaging Element: 15004 Element: 15005 ntervention Type - 1 Selection Catheter	Coding Instruction: Target Value: Coding Instruction: Target Value: .3.6.1.4.1.19376.1.4.1.6	Indicate if any pharmacological, catheter, surgical, or other therapeutic intervention was perforthromboembolism. All values between discharge or last follow up and the current follow up Intervention Type Indicate the intervention type. All values between discharge or last follow up and the current follow up 5.797	77477000 113091000 11200001042 112000001862 prmed to treat the system control to treat the system	SNOMED SNOMED ACC NCI ACC NCI stemic code Syste SNOMED





Section: Follow-Up Systemic Thromboembolism

Parent: Follow-Up Adjudication





# Section: Follow-Up Adjudication Medications

Parent: Follow-Up Adjudication

Element: 15006

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

Target Value: All values between discharge or last follow up and the current follow up

Adjudication Medication Code

Vendor Instruction: Adjudication Medication Code (15006) should not be duplicated within an adjudication event

#### Pre-Procedure Medication - 1.3.6.1.4.1.19376.1.4.1.6.5.216

Selection	Definition	Source	Code	Code System
Fondaparinux			321208	RxNorm
Heparin Derivative			100000921	ACC NCDR
Low Molecular Weigh	nt Heparin		373294004	SNOMED CT
Unfractionated Hepar	rin		96382006	SNOMED CT
Warfarin			11289	RxNorm
Aspirin 81 to 100 mg			11200002080	ACC NCDR
Aspirin 101 to 324 mg	g		11200002081	ACC NCDR
Aspirin 325 mg			317300	RxNorm
Aspirin/Dipyridamole			226716	RxNorm
Vorapaxar			1537034	RxNorm
Apixaban			1364430	RxNorm
Dabigatran			1546356	RxNorm
Edoxaban			1599538	RxNorm
Rivaroxaban			1114195	RxNorm
Cangrelor			1656052	RxNorm
Clopidogrel			32968	RxNorm
Other P2Y12			112000001003	ACC NCDR
Prasugrel			613391	RxNorm
Ticagrelor			1116632	RxNorm
Ticlopidine			10594	RxNorm

Element: 15007

Medication Administered

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

Target Value: All values between discharge or last follow up and the current follow up

Vendor Instruction: When an Adjudication Medication Code (15006) is selected, Medication Administered (15007) cannot be Null

Drug Administered - 1.3.6.1.4.1.19376.1.4.1.6.5.711

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





Element: 1000		Participant ID
	Coding Instruction:	Indicate the participant ID of the submitting facility.
	Target Value:	N/A
<b>Flow out: 4040</b>		
Element: 1010		Participant Name Indicate the full name of the facility where the procedure was performed.
	county instruction.	
		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	Coding Instruction	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
Liement. 1050	Coding Instruction:	Vendor identification (agreed upon by mutual selection between the vendor and the NCDR) to identify software vendor. This is entered
	j i i i i	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:	
	-	
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
Elemente 1071		Pagista (Sehama Varsian
Element: 1071	Coding Instruction:	Registry Schema Version Schema version describes the version number of the Registry Transmission Document (RTD) schema to which each record conforms. It
	County instruction.	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:	
Element: 1085		
Liement. 1085	Coding Instruction:	Submission Type 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 2017Cl Base Registry Record file, but the Follow-up data will be transmitted in the 2017Q2 Follow-Up File.



Parent: Root



Target Value: N/A

Submission Type						
Selection	Definition	Source	Code	Code System		
Episode of Care Records Only			1000142424	ACC NCDR		
Follow-Up Records Only			1000142425	ACC NCDR		