Section: A. Demographics — Parent: A. Demographics

Element: 2000 Last Name

Code System Name	Code
ACC NCDR	1000142463

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

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 2010 First Name

Code System Name	Code
ACC NCDR	1000142463

Coding Instruction: Indicate the patient's first name.

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 2020 Middle Name

Code System Name	Code
ACC NCDR	1000142463

Coding Instruction: Indicate the patient's middle name.

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

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

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

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

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 2030 SSN

Code System Name	Code
United States Social Security Number (SSN)	2.16.840.1.113883.4.1

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

Supporting Definition:

Element: 2031 SSN N/A

Code System Name	Code
United States Social Security Number (SSN)	2.16.840.1.113883.4.1

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

Supporting Definition:

Element: 2040 Patient ID

Code System Name	Code
ACC NCDR	2.16.840.1.113883.3.3478.4.842

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

Supporting Definition:

Element: 2045 Other ID

Code System Name	Code
ACC NCDR	2.16.840.1.113883.3.3478.4.843

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

Target Value: N/A

Supporting Definition:

Element: 2050 Birth Date

Code System Name	Code
ACC NCDR	1000142447

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

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 2060 Sex

Code System Name	Code
ACC NCDR	1000142448

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

Target Value: The value on arrival at this facility

Supporting Definition:

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

Element: 2065 Patient Zip Code

Code System Name	Code
ACC NCDR	1000142449

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

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

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 2066 Zip Code N/A

Code System Name	Code

ACC NCDR	1000142449

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

Supporting Definition:

Element: 2070 Race - White

Code System Name	Code
HL7 Race	2106-3

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

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

Target Value: The value on arrival at this facility

Supporting Definition: **White (race)**

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

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

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Element: 2071 Race - Black/African American

Code System Name	Code
HL7 Race	2054-5

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

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

Target Value: The value on arrival at this facility

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

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

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

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Element: 2073 Race - American Indian/Alaskan Native

Code System Name	Code
HL7 Race	1002-5

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

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

Target Value: The value on arrival at this facility

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

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

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

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Element: 2072 Race - Asian

Code System Name	Code
HL7 Race	2028-9

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

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

Target Value: The value on arrival at this facility

Supporting Definition: **Asian (race)**

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

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

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Element: 2080 Race - Asian Indian

Code System Name	Code
HL7 Race	2029-7

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

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

Target Value: The value on arrival at this facility

Supporting Definition: **Asian Indian**

Having origins in any of the original peoples of India.

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

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Element: 2081 Race - Chinese

Code System Name	Code
HL7 Race	2034-7

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

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

Target Value: The value on arrival at this facility

Supporting Definition: **Asian - Chinese**

Having origins in any of the original peoples of China.

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

---

Element: 2082 Race - Filipino

Code System Name	Code
HL7 Race	2036-2

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

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

Target Value: The value on arrival at this facility

Supporting Definition: **Asian - Filipino**

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

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

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Element: 2083 Race - Japanese

Code System Name	Code
HL7 Race	2039-6

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

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

Target Value: The value on arrival at this facility

Supporting Definition: **Asian - Japanese**

Having origins in any of the original peoples of Japan.

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

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Element: 2084 Race - Korean

Code System Name	Code
HL7 Race	2040-4

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

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

Target Value: The value on arrival at this facility

Supporting Definition: **Asian - Korean**

Having origins in any of the original peoples of Korea.

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

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Element: 2085 Race - Vietnamese

Code System Name	Code
HL7 Race	2047-9

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

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

Target Value: The value on arrival at this facility

Supporting Definition: **Asian - Vietnamese**

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

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

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Element: 2086 Race - Other Asian

Code System Name	Code
ACC NCDR	100001130

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

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

Target Value: The value on arrival at this facility

Supporting Definition: **Asian - Other Asian**

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

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

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Element: 2074 Race - Native Hawaiian/Pacific Islander

Code System Name	Code
HL7 Race	2076-8

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

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

Target Value: The value on arrival at this facility

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

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

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

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Element: 2090 Race - Native Hawaiian

Code System Name	Code
HL7 Race	2079-2

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**

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

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

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Element: 2091 Race - Guamanian or Chamorro

Code System Name	Code
HL7 Race	2086-7

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

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

Target Value: The value on arrival at this facility

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

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

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

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Element: 2092 Race - Samoan

Code System Name	Code
HL7 Race	2080-0

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

Note(s):

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

Target Value: The value on arrival at this facility

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

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

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

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Element: 2093 Race - Other Pacific Islander

Code System Name	Code
HL7 Race	2500-7

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

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

Target Value: The value on arrival at this facility

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

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

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

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Element: 2076 Hispanic or Latino Ethnicity

Code System Name	Code
HL7 Ethnicity	2135-2

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 Ethnicity**

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

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

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Element: 2100 Hispanic Ethnicity Type - Mexican, Mexican-American, Chicano

Code System Name	Code
HL7 Ethnicity	2148-5

Coding Instruction: Indicate if the patient is Mexican, Mexican - American, or Chicano 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 Ethnicity - Mexican/Mexican American/Chicano**

Having origins in any of the original peoples of Mexico.

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

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Element: 2101 Hispanic Ethnicity Type - Puerto Rican

Code System Name	Code

HL7 Ethnicity	2180-8

Coding Instruction: Indicate if the patient is Puerto Rican 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 Ethnicity - Puerto Rican**

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

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

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Element: 2102 Hispanic Ethnicity Type - Cuban

Code System Name	Code
HL7 Ethnicity	2182-4

Coding Instruction: Indicate if the patient is Cuban 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 Ethnicity - Cuban**

Having origins in any of the original peoples of Cuba.

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

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Element: 2103 Hispanic Ethnicity Type - Other Hispanic, Latino or Spanish Origin

Code System Name	Code
ACC NCDR	100001131

Coding Instruction: Indicate if the patient is another Hispanic, Latino, or Spanish origin 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 Ethnicity - Other Hispanic/Latino/Spanish Origin**

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

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

Section: Episode Information **Parent: Episode Information**

Element: 2999 Episode Unique Key

Code System Name	Code
ACC NCDR	2.16.840.1.113883.3.3478.4.855

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

Target Value: N/A

Supporting Definition:

Element: 3001 Arrival Date and Time

Code System Name	Code
ACC NCDR	1000142450

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

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

Target Value: N/A

Supporting Definition:

Element: 12217 Admission Date and Time

Code System Name	Code
ACC NCDR	112000000162

Coding Instruction: Indicate the date and time the patient was admitted as an inpatient to your facility for the current episode of care.

Note(s):
Indicate the date and time that the inpatient admission order was written.

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

Target Value: N/A

Supporting Definition:

Element: 3050 Admitting Provider's Last Name

Code System Name	Code
ACC NCDR	1000142451

Coding Instruction: Indicate the last name of the admitting provider.

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

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the physician level, which may assist physicians with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging Provider roles, as supported by the patient medical record.

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 3051 Admitting Provider's First Name

Code System Name	Code
ACC NCDR	1000142451

Coding Instruction: Indicate the first name of the admitting provider.

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

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the physician level, which may assist physicians with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging Provider roles, as supported by the patient medical record.

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 3053 Admitting Provider's NPI

Code System Name	Code
ACC NCDR	1000142451

Coding Instruction: Indicate the National Provider Identifier (NPI) of the provider that admitted the patient. NPI's, assigned by the Centers for Medicare and Medicaid Services (CMS), are used to uniquely identify physicians for Medicare billing purposes.

Note(s):
The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the physician level, which may assist physicians with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging Provider roles, as supported by the patient medical record.

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 3052 Admitting Provider's Middle Name

Code System Name	Code
ACC NCDR	1000142451

Coding Instruction: Indicate the middle name of the admitting provider.

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.

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the physician level, which may assist physicians with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging Provider roles, as supported by the patient medical record.

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 3005 Health Insurance

Code System Name	Code
LOINC	63513-6

Coding Instruction: Indicate if the patient has health insurance.

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 3010 Health Insurance Payment Source

Code System Name	Code
ACC NCDR	100001072

Coding 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, please discuss with your billing department to understand how it should be identified in the registry.

Target Value: The value on arrival at this facility

Supporting Definition:

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

Element: 3015 Health Insurance Claim Number (HIC)

Code System Name	Code
ACC NCDR	100000517

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

Note(s):
Enter the Health Insurance Claim (HIC) number for those patients covered by Medicare. Patients with other insurances will not have a HIC number.

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 12846 Medicare Beneficiary Identifier

Code System Name	Code
Center for medicare and medicaid services, MBI	2.16.840.1.113883.4.927

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:

Element: 3020 Patient Enrolled in Research Study

Code System Name	Code
ACC NCDR	100001095

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

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

Supporting Definition:

Element: 3036 Patient Restriction

Code System Name	Code
ACC NCDR	100000922

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

Note(s):
Documentation must be found in the patient record to support the request of removal of their information.

Target Value: Last value between arrival and discharge from facility

Supporting Definition:

Section: ED Providers **Parent: ED Providers**

Element: 12202 Emergency Department Provider's Last Name

Code System Name	Code
ACC NCDR	112000000145

Coding Instruction: Indicate the last name of the emergency department provider.

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

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the physician level, which may assist physicians with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, Emergency and Discharging Provider roles, as supported by the patient medical record.

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 12201 Emergency Department Provider's First Name

Code System Name	Code
ACC NCDR	112000000145

Coding Instruction: Indicate the first name of the admitting provider.

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

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the physician level, which may assist physicians with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, Emergency and Discharging Provider roles, as supported by the patient medical record.

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 12203 Emergency Department Provider's Middle Name

Code System Name	Code
ACC NCDR	112000000145

Coding Instruction: Indicate the middle name of the emergency department provider.

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.

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the physician level, which may assist physicians with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, Emergency and Discharging Provider roles, as supported by the patient medical record.

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 12204 Emergency Department Provider's NPI

Code System Name	Code
ACC NCDR	112000000145

Coding Instruction: Indicate the National Provider Identifier (NPI) of the provider that will be listed as the physician of record during the Emergency Department visit. NPI's, assigned by the Centers for Medicare and Medicaid Services (CMS), are used to uniquely identify physicians for Medicare billing purposes.

Note(s):
The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the physician level, which may assist physicians with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, Emergency and Discharging Provider roles, as supported by the patient medical record.

Target Value: The value on arrival at this facility

Supporting Definition:

Section: Attending Providers **Parent: Attending Providers**

Element: 3055 Attending Provider's Last Name

Code System Name	Code
ACC NCDR	1000142452

Coding Instruction: Indicate the last name of the attending provider.

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

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the physician level, which may assist physicians with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging Provider roles, as supported by the patient medical record.

Target Value: All values between arrival at this facility and discharge

Supporting Definition:

Element: 3056 Attending Provider's First Name

Code System Name	Code
ACC NCDR	1000142452

Coding Instruction: Indicate the first name of the attending provider.

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

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the physician level, which may assist physicians with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging Provider roles, as supported by the patient medical record.

Target Value: All values between arrival at this facility and discharge

Supporting Definition:

Element: 3057 Attending Provider's Middle Name

Code System Name	Code
ACC NCDR	1000142452

Coding Instruction: Indicate the middle name of the admitting provider.

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.

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the physician level, which may assist physicians with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging Provider roles, as supported by the patient medical record.

Target Value: All values between arrival at this facility and discharge

Supporting Definition:

Element: 3058 Attending Provider's NPI

Code System Name	Code
ACC NCDR	1000142452

Coding Instruction: Indicate the National Provider Identifier (NPI) of the provider that will be listed as the physician of record during the hospitalization. NPI's, assigned by the Centers for Medicare and Medicaid Services (CMS), are used to uniquely identify physicians for Medicare billing purposes.

Note(s):
The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the physician level, which may assist physicians with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging Provider roles, as supported by the patient medical record.

Target Value: All values between arrival at this facility and discharge

Supporting Definition:

Section: Research Study **Parent: Research Study**

Element: 3025 Research Study Name

Code System Name	Code
ACC NCDR	100001096

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

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

Target Value: N/A

Supporting Definition:

Element: 3030 Research Study Patient ID

Code System Name	Code
ACC NCDR	2.16.840.1.113883.3.3478.4.852

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

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

Target Value: N/A

Supporting Definition:

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

Element: 12242 Height

Code System Name	Code
LOINC	8302-2

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

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

Supporting Definition:

Element: 12243 Weight

Code System Name	Code
LOINC	3141-9

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

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

Supporting Definition:

Element: 12246 Atrial Fibrillation

Code System Name	Code
SNOMED CT	49436004

Coding Instruction: Indicate if the patient has a history of atrial fibrillation.

Note(s):
If there is no prior documentation of atrial arrhythmias, it is acceptable to code "No".

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

Supporting Definition: **Atrial Fibrillation**

Atrial Fibrillation is a supraventricular tachyarrhythmia characterized by uncoordinated atrial activity with consequent deterioration of atrial mechanical function. On the electrocardiogram (ECG), atrial fibrillation is characterized by the replacement of consistent P waves with rapid oscillations or fibrillation waves that vary in amplitude, shape and timing, associated with an irregular, frequently rapid ventricular response when atrioventricular conduction is intact.

Source: ACC/AHA 2006 Data Standards for Measuring Clinical Management and Outcomes of Patients with Atrial Fibrillation

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Element: 12247 Atrial Flutter

Code System Name	Code
SNOMED CT	5370000

Coding Instruction: Indicate if the patient has a history of atrial flutter.

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

Supporting Definition: **Atrial Flutter**

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

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

Element: 4615 Hypertension

Code System Name	Code
SNOMED CT	38341003

Coding Instruction: Indicate if the patient has a current diagnosis of hypertension.

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

Supporting Definition: **Hypertension**

Hypertension is defined by any one of the following:
1. History of hypertension diagnosed and treated with medication, diet and/or exercise

2. Prior documentation of blood pressure greater than 140 mm Hg systolic and/or 90 mm Hg diastolic for patients without diabetes or chronic kidney disease, or prior documentation of blood pressure greater than 130 mm Hg systolic and/or 80 mm Hg diastolic on at least two occasions for patients with diabetes or chronic kidney disease

3. Currently on pharmacologic therapy for treatment of hypertension.

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

Element: 4620 Dyslipidemia

Code System Name	Code
SNOMED CT	370992007

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

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

Supporting Definition: **Dyslipidemia**

National Cholesterol Education Program criteria include documentation of the following:
1. Total cholesterol greater than 200 mg/dL (5.18 mmol/l); or

2. Low-density lipoprotein (LDL) greater than or equal to 130 mg/dL (3.37 mmol/l); or,

3. High-density lipoprotein (HDL) less than 40 mg/dL (1.04 mmol/l).

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

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

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Element: 12244 Currently on Dialysis

Code System Name	Code
SNOMED CT	108241001

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

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 12173 Cancer

Code System Name	Code
SNOMED CT	363346000

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

Note(s):
Code for organ based cancers (such as brain, colon, uterine, lung, skin (melanoma) or liver) or Hematologic cancers such as leukemia or lymphoma.

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

Supporting Definition:

Element: 12252 Prior Myocardial Infarction

Code System Name	Code
SNOMED CT	22298006

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

Target Value: Any occurrence between birth and arrival at first facility.

Supporting Definition: **Myocardial Infarction/Prior MI**

Criteria for acute myocardial infarction:
The term acute myocardial infarction (MI) should be used when there is evidence of myocardial necrosis in a clinical setting consistent with acute myocardial ischemia. Under these conditions any one of the following criteria meets the diagnosis for MI:
- Detection of a rise and/or fall of cardiac biomarker values [preferably cardiac troponin (cTn) with at least one value above the 99th percentile upper reference limit (URL) and with at least one of the following:

Symptoms of ischemia.
New or presumed new significant ST-segment-T wave (ST-T) changes or new left bundle branch block (LBBB). Development of pathological Q waves in the ECG.
Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality. Identification of an intracoronary thrombus by angiography or autopsy.

- Cardiac death with symptoms suggestive of myocardial ischemia and presumed new ischemic ECG changes or new LBBB, but death occurred before cardiac biomarkers were obtained, or before cardiac biomarker values would be increased.

- Percutaneous coronary intervention (PCI) related MI is arbitrarily defined by elevation of cTn values (>5 x 99th percentile URL) in patients with normal baseline values (99th percentile URL) or a rise of cTn values >20% if the baseline values are elevated and are stable or falling. In addition, either (i) symptoms suggestive of myocardial ischemia or (ii) new ischemic ECG changes or (iii) angiographic findings consistent with a procedural complication or (iv) imaging demonstration of new loss of viable myocardium or new regional wall motion abnormality are required.

- Stent thrombosis associated with MI when detected by coronary angiography or autopsy in the setting of myocardial ischemia and with a rise and/or fall of cardiac biomarker values with at least one value above the 99th percentile URL.

- Coronary artery bypass grafting (CABG) related MI is arbitrarily defined by elevation of cardiac biomarker values (>10 x 99th percentile URL) in patients with normal baseline cTn values (99th percentile URL). In addition, either (i) new pathological Q waves or new LBBB, or (ii) angiographic documented new graft or new native coronary artery occlusion, or (iii) imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

Any one of the following criteria meets the diagnosis for prior MI:
- Pathological Q waves with or without symptoms in the absence of non-ischemic causes.
- Imaging evidence of a region of loss of viable myocardium that is thinned and fails to contract, in the absence of a non-ischemic cause.
- Pathological findings of a prior MI.

Source: Thygesen K, Alpert JS, Jaffe AS, et al. Third Universal Definition of Myocardial Infarction. J Am Coll Cardiol. 2012;60 (16):1581-1598. doi:10.1016/j.jacc.2012.08.001.

Element: 12245 Diabetes Mellitus

Code System Name	Code
SNOMED CT	73211009

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

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

Supporting Definition: **Diabetes Mellitus**

The American Diabetes Association criteria include documentation of the following:

1. FPG >=126 mg/dL (7.0 mmol/L). Fasting is defined as no caloric intake for at least 8 h.
OR
2. 2-h PG >=200 mg/dL (11.1 mmol/L) during an OGTT. The test should be performed as described by the WHO, using a glucose load containing the equivalent of 75 g anhydrous glucose dissolved in water.
OR
3. A1C >=6.5% (48 mmol/mol). The test should be performed in a laboratory using a method that is NGSP certified and standardized to the DCCT assay.

OR
4. In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose >=200 mg/dL (11.1 mmol/L).

Source: American Diabetes Association Care. 2017;40 Suppl 1:S13.

Element: 12253 Prior Heart Failure

Code System Name	Code
SNOMED CT	84114007

Coding Instruction: Indicate if there is a previous history of heart failure.

Note(s):
A previous hospital admission with principal diagnosis of heart failure is considered evidence of heart failure history.

Target Value: Any occurrence between birth and arrival at first facility.

Supporting Definition: **Heart Failure**

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

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

Element: 4495 Prior Percutaneous Coronary Intervention

Code System Name	Code
SNOMED CT	415070008

Coding Instruction: Indicate if the patient had a percutaneous coronary intervention (PCI), prior to this admission.

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

Supporting Definition:

Element: 12228 Most Recent Percutaneous Coronary Intervention Date

Code System Name	Code
SNOMED CT	415070008

Coding Instruction: Indicate the date of the most recent PCI.

Note: Code 01/01/Year when only the year is known - Leave Blank if Unknown.

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

Supporting Definition:

Element: 4515 Prior Coronary Artery Bypass Graft

Code System Name	Code
SNOMED CT	232717009

Coding Instruction: Indicate if the patient had coronary artery bypass graft (CABG) surgery prior to this admission.

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

Supporting Definition: **Coronary Artery Bypass Graft**

Coronary artery bypass graft surgery is when the native vessels of the heart are bypassed with other vessels (internal mammary artery, radial artery or saphenous vein) to restore normal blood flow to the obstructed coronary arteries.

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.

Element: 4520 Most Recent Coronary Artery Bypass Graft Date

Code System Name	Code
SNOMED CT	232717009

Coding Instruction: Indicate the date of the most recent CABG that the patient received prior to this admission.

Note(s):
If the month or day of the CABG 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 CABG" documented in a record from 2011, then the year 2011 can be utilized and coded as 01/01/2011).

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

Supporting Definition: **Coronary Artery Bypass Graft**

Coronary artery bypass graft surgery is when the native vessels of the heart are bypassed with other vessels (internal mammary artery, radial artery or saphenous vein) to restore normal blood flow to the obstructed coronary arteries.

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.

Element: 4551 Cerebrovascular Disease

Code System Name	Code
SNOMED CT	62914000

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

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

Supporting Definition: **Cerebrovascular Disease**

Current or previous history of any of the following:

- Ischemic stroke: infarction of central nervous system tissue whether symptomatic or silent (asymptomatic).

-TIA: transient episode of neurological dysfunction caused by focal brain, spinal cord, or retinal ischemia without acute infarction. The symptoms typically last less than 24 hours.

- Noninvasive or invasive arterial imaging test demonstrating 50% stenosis of any of the major extracranial or intracranial vessels to the brain.

- Previous cervical or cerebral artery revascularization surgery or percutaneous intervention.

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

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

Element: 12248 Stroke

Code System Name	Code
SNOMED CT	230690007

Coding Instruction: Indicate if the patient was diagnosed with a stroke.

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

Supporting Definition: **Stroke (CVA)**

An ischemic stroke is an acute episode of focal or global neurological dysfunction caused by brain, spinal cord, or retinal vascular injury as a result of infarction of central nervous system tissue. Hemorrhage may be a consequence of ischemic stroke. In this situation, the stroke is an ischemic stroke with hemorrhagic transformation and not a hemorrhagic stroke. A hemorrhagic stroke is

defined as an acute episode of focal or global cerebral or spinal dysfunction caused by intraparenchymal, intraventricular, or subarachnoid hemorrhage (note: subdural hematomas are intracranial hemorrhagic events and not strokes).

Source: Hicks KA, Tcheng JE, Bozkurt B, et al. 2014 ACC/AHA Key Data Elements and Definitions for Cardiovascular Endpoint Events in Clinical Trials: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Data Standards (Writing Committee to Develop Cardiovascular Endpoints Data Standards). J Am Coll Cardiol. 2015;():. Doi:10.1016/j.jacc.2014.12.018.

Element: 12249 Transient Ischemic Attack

Code System Name	Code
SNOMED CT	266257000

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

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

Supporting Definition: **Transient Ischemic Attack (TIA)**

Transient episode of focal neurological dysfunction caused by brain, spinal cord, or retinal ischemia without acute infarction.

Source: Hicks KA, Tcheng JE, Bozkurt B, et al. 2014 ACC/AHA Key Data Elements and Definitions for Cardiovascular Endpoint Events in Clinical Trials: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Data Standards (Writing Committee to Develop Cardiovascular Endpoints Data Standards). J Am Coll Cardiol. 2015;():.Doi:10.1016/j.jacc.2014.12.018.

Element: 4610 Peripheral Arterial Disease

Code System Name	Code
SNOMED CT	399957001

Coding Instruction: Indicate if the patient has a history of peripheral arterial disease (PAD).

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

Supporting Definition: **Peripheral Arterial Disease**

Current or previous history of peripheral arterial disease (includes subclavian, iliac, femoral, and upper- and lower-extremity vessels; excludes renal, coronary, cerebral, and mesenteric vessels and aneurysms). This can include:
* Claudication on exertion
* Amputation for arterial vascular insufficiency
* Vascular reconstruction, bypass surgery, or percutaneous revascularization in the arteries of the extremities
* Positive noninvasive test (e.g., ankle brachial index <= 0.9, ultrasound, MR or CT imaging of >50% diameter stenosis in any peripheral artery (i.e., subclavian, femoral, iliac) or angiographic imaging)

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

Element: 4625 Tobacco Use

Code System Name	Code
SNOMED CT	110483000

Coding Instruction: Indicate the frequency that the patient uses tobacco.

Note(s): Consider use of any tobacco product as equivalent to a cigarette for referenced definitions.

Target Value: The value on arrival at this facility

Supporting Definition: **Meaningful Use Core Measure from CMS**

More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.

Source: CMS - Eligible Professional Meaningful Use Core Measures Measure 9 of 13 Stage 1

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/9_Record_Smoking_Status.pdf

Code System Name	Code	Selection Text	Definition
SNOMED CT	266919005	Never	An individual who has not smoked 100 or more cigarettes during his/her lifetime.
SNOMED CT	8517006	Former	An individual who has smoked at least 100 cigarettes during his/her lifetime but does not currently smoke.
SNOMED CT	449868002	Current - Every Day	An individual who has smoked at least 100 cigarettes during his/her lifetime and still regularly smokes every day.
SNOMED CT	428041000124106	Current - Some Days	An individual who has smoked at least 100 cigarettes during his/her lifetime and still regularly smokes periodically (not every day), yet consistently.
SNOMED CT	77176002	Smoker - Current Status Unknown	An individual known to have smoked at least 100 cigarettes in the past, but whether they currently still smoke is unknown.
SNOMED CT	266927001	Unknown if ever smoked	An individual whose current and prior smoking status is not known.

Element: 4626 Tobacco Type

Code System Name	Code
SNOMED CT	266918002

Coding Instruction: Indicate the frequency that the patient uses tobacco.

Note(s): Consider use of any tobacco product as equivalent to a cigarette for referenced definitions.

Target Value: The value on arrival at this facility

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	65568007	Cigarettes	
SNOMED CT	59978006	Cigars	
SNOMED CT	82302008	Pipe	
SNOMED CT	713914004	Smokeless	

Element: 4627 Smoking Amount

Code System Name	Code
ACC NCDR	100001256

Coding Instruction: Indicate the amount of cigarette smoking reported by the patient.

Target Value: The value on arrival at this facility

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	428061000124105	Light tobacco use (<10/day)	The patient smokes less than 10 cigarettes daily.
SNOMED CT	428071000124103	Heavy tobacco use (>=10 day)	The patient smokes 10 or more cigarettes daily.

Element: 12196 Walking

Code System Name	Code

SNOMED CT	116329008

Coding Instruction: Indicate the level of assistance the patient required with ambulation.

Target Value: The value on arrival at this facility

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	112000000157	Unassisted	
ACC NCDR	112000000158	Assisted	
SNOMED CT	225612007	Wheelchair/Non-Ambulatory	Patient cannot walk - ambulates only by wheelchair.

Element: 12210 Walking Unknown

Code System Name	Code
SNOMED CT	116329008

Coding Instruction: Indicate if the patient's level of assistance with ambulation is unable to be determined.

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 12208 Cognition

Code System Name	Code
ACC NCDR	112000000140

Coding Instruction: Indicate the patients level of cognition.

Note(s):
Cognition is scored on four levels of neuropsychiatric functioning.

Target Value: The value on arrival at this facility

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	449888003	Normal	Normal changes are taking place at the molecular level in the brain, but no symptoms have appeared. Currently, we do not have the tools to diagnose AD at this stage, but research is being done to improve our diagnostic capabilities.
ACC NCDR	112000000154	Mildly Impaired	Family and friends begin to notice difficulties with getting the right word, remembering names, losing or misplacing things, performing everyday tasks, planning and organizing. A medical examination during this Alzheimer's stage may reveal problems with memory and/or concentration.
ACC NCDR	112000000155	Moderately Impaired	Noticeable gaps in cognition, severe short-term memory lapses, disoriented to place and time, need help with many daily tasks, such as getting dressed or cutting food into bite-sized pieces. Most can still feed themselves and attend to their own toilet functions.
ACC NCDR	112000000156	Severely Impaired	At this stage, AD patients no longer have any short-term memory, knowledge of time or place, or understanding of how to perform simple tasks. They may experience major changes in personality, sleep disturbances and develop delusional or compulsive behaviour patterns.

Element: 12209 Cognition Unknown

Code System Name	Code

ACC NCDR	112000000140

Coding Instruction: Indicate if the patient is unable to be assessed for cognition.

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 12250 Basic Activities of Daily Living

Code System Name	Code
ACC NCDR	112000000180

Coding Instruction: Indicate the level of assistance the patient required with activities of daily living.

Target Value: The value on arrival at this facility

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	112000000184	Independent of all ADLs	
ACC NCDR	112000000183	Full Assist >= 1 ADL	If a patient had full assistance on any ADLs, then such patient will be categorized as Full assist >= 1 ADL. For example, when a patient had 3 Partial Assist ADLs and 1 Full Assist ADLs, this patient will be classified as Full Assist>=1 ADL.
ACC NCDR	112000000182	Partial Assist >=1 ADL	

Element: 12251 Basic Activities of Daily Living Unknown

Code System Name	Code
ACC NCDR	112000000180

Coding Instruction: Indicate if the level of assistance the patient required with activities of daily living is unknown.

Target Value: The value on arrival at this facility

Supporting Definition:

Section: Home Medications **Parent: Home Medications**

Element: 12297 Home Medication Code

Code System Name	Code
ACC NCDR	100013057

Coding Instruction: Indicate the medication the patient has been taking routinely at home prior to this hospitalization.

Target Value: N/A

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	41549009	Angiotensin Converting Enzyme Inhibitor	
SNOMED CT	372603003	Aldosterone Antagonist	
RxNorm	11289	Warfarin	
RxNorm	1191	Aspirin	Aspirin administered only through oral and rectal doses should be collected.
SNOMED CT	372913009	Angiotensin II Receptor Blocker	
SNOMED CT	33252009	Beta Blocker	
SNOMED CT	67866001	Insulin	
RxNorm	1656341	Sacubitril and Valsartan	
RxNorm	341248	Ezetimibe	
RxNorm	8703	Fenofibrate	
RxNorm	1364430	Apixaban	
RxNorm	1546356	Dabigatran	
RxNorm	1599538	Edoxaban	
RxNorm	1114195	Rivaroxaban	
ACC NCDR	112000000263	DPP-4 inhibitor	
ACC NCDR	112000000264	GLP-1 Receptor Agonist	
RxNorm	6809	Metformin	
ACC NCDR	112000000265	Other Oral Hypoglycemic	
RxNorm	33738	Pioglitazone	
SNOMED CT	703673007	Sodium glucose cotransporter subtype 2 inhibitor	
SNOMED CT	372711004	Sulfonylurea	
RxNorm	32968	Clopidogrel	
RxNorm	613391	Prasugrel	
RxNorm	1116632	Ticagrelor	
RxNorm	1659152	Alirocumab	
RxNorm	1665684	Evolocumab	
SNOMED CT	96302009	Statin	

Element: 12359 Home Medication Prescribed

Code System Name	Code
SNOMED CT	432102000

Coding Instruction: Indicate if the patient has been taking the medication routinely at home prior to this hospitalization.

Note(s):
"Routinely" refers to the daily use of medications as prescribed, even if the patient misses a dose.

Target Value: Any occurrence between 2 weeks prior to first medical contact and first medical contact

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100013073	No	
ACC NCDR	100013072	Yes	

Section: D. Cardiac Status **Parent: D. Cardiac Status**

Element: 12360 Patient Type

Code System Name	Code
ACC NCDR	112000000214

Coding Instruction: Indicate the (cardiac) patient type.

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	112000000217	Low-Risk Chest Pain	
SNOMED CT	401314000	NSTEMI	
SNOMED CT	401303003	STEMI	
SNOMED CT	4557003	Unstable Angina	

Element: 12447 STEMI Setting

Code System Name	Code
ACC NCDR	112000000302

Coding Instruction: Indicate the setting in which the STEMI occurred.

Target Value: The first value between first medical contact and discharge

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	112000000300	Pre-Admit	Pre-Admit STEMI occurs pre-hospital or any time prior to order for admission. Orders for observation status (or like designation) do not qualify as admitting orders.
ACC NCDR	112000000216	In-Hospital	In-Hospital STEMI occurs after order for admission. The diagnostic ECG occurs after cardiac or non-cardiac admission order.

Element: 12188 Means of Transport to First Hospital

Code System Name	Code
ACC NCDR	112000000131

Coding Instruction: Indicate the means of transportation to the first acute care facility (hospital) where the patient first received treatment.

Note(s):
Patients that transport to hospital by medical personnel via wheelchair or stretcher are to be entered as “Self/Family” transport.

Target Value: N/A

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	112000000254	Self/Family	
ACC NCDR	112000000255	Ambulance	
ACC NCDR	112000000256	Air	

Element: 12197 Emergency Medical Services First Medical Contact Date and Time

Code System Name	Code
ACC NCDR	112000000141

Coding Instruction: Indicate the date and time when the patient was first evaluated by emergency medical services (EMS) prior to arrival at first facility.

Note(s):

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

Target Value: N/A
Supporting Definition:

Element: 12419 Emergency Medical Services First Medical Contact Non System Reason For Delay

Code System Name	Code
ACC NCDR	112000000258

Coding Instruction: Indicate if there is a non system reason for the delay when first evaluated by emergency medical services (EMS).

Target Value: N/A
Supporting Definition:

Element: 12279 Heart Failure

Code System Name	Code
SNOMED CT	84114007

Coding Instruction: Indicate if there is physician documentation or report of heart failure on first medical contact.
Target Value: Any occurrence between first medical contact and arrival at this facility
Supporting Definition: **Heart Failure**

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

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

Element: 12280 Cardiogenic Shock at First Medical Contact

Code System Name	Code
SNOMED CT	89138009

Coding Instruction: Indicate if the patient was in a state of cardiogenic shock on first medical contact.
Target Value: Any occurrence between first medical contact and arrival at this facility
Supporting Definition: **Cardiogenic Shock**

Cardiogenic shock is defined as a sustained (>30 minutes) episode of systolic blood pressure <90 mm Hg, and/or cardiac index <2.2 L/min/m2 determined to be secondary to cardiac dysfunction, and/or the requirement for parenteral inotropic or vasopressor agents or mechanical support (e.g., IABP, extracorporeal circulation, ventricular assist devices) to maintain blood pressure and cardiac index above those specified levels.

Source: Cannon CP, Brindis RG, Chaitman BR, et al. 2013 ACCF/AHA Key Data Elements and Definitions for Measuring the Clinical Management and Outcomes of Patients With Acute Coronary Syndromes and Coronary Artery Disease: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Clinical Data Standards (Writing Committee to Develop Acute Coronary Syndromes and Coronary Artery Disease Clinical Data Standards). J Am Coll Cardiol. 2013;61(9):992-1025. doi:10.1016/j.jacc.2012.10.005.

Element: 12281 Heart Rate

Code System Name	Code
LOINC	8867-4

Coding Instruction: Indicate the first measurement or earliest record of heart rate (in beats per minute).

Note(s):
Arrival at first facility refers to either the time of arrival at your facility or the time of arrival at the transferring facility.

Target Value: The first value between first medical contact and arrival at first facility

Supporting Definition:

Element: 12282 Systolic Blood Pressure

Code System Name	Code
LOINC	8480-6

Coding Instruction: Indicate the first measurement or earliest record of systolic blood pressure (mm Hg).

Note(s):
Arrival at first facility refers to either the time of arrival at your facility or the time of arrival at the transferring facility.

Target Value: The first value between first medical contact and arrival at first facility

Supporting Definition:

Element: 4630 Cardiac Arrest Out of Healthcare Facility

Code System Name	Code
ACC NCDR	10001424808

Coding Instruction: Indicate if a cardiac arrest event occurred outside of any healthcare facility.

Target Value: The value on arrival at this facility

Supporting Definition: **Sudden Cardiac Arrest**

"Sudden" Cardiac arrest is the sudden cessation of cardiac activity. The victim becomes unresponsive with no normal breathing and no signs of circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death. Cardiac arrest should be used to signify an event as described above that is reversed, usually by CPR and/or defibrillation or cardioversion or cardiac pacing.

Source: 2013 ACCF/AHA key data elements and definitions for measuring the clinical management and outcomes of patients with acute coronary syndromes and coronary artery disease.

Element: 4631 Cardiac Arrest Witnessed

Code System Name	Code
ACC NCDR	100014082

Coding Instruction: Indicate if the out-of-hospital cardiac arrest was witnessed by another person.

Target Value: The value on arrival at this facility

Supporting Definition: **Cardiac Arrest Witnessed**

A witnessed arrest is one that is seen or heard by another person.

Source: Cardiac Arrest Registry to Enhand Survival - CARES Complete Data Set for EMS, Hospital and CAD participants and Instruction for Abstracting and Coding Data Elements

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Element: 4632 Cardiac Arrest After Arrival of Emergency Medical Services

Code System Name	Code
ACC NCDR	100014081

Coding Instruction: Indicate if the out-of-hospital cardiac arrest occurred after arrival of Emergency Medical Services (EMS).

Target Value: The value on arrival at this facility

Supporting Definition: **Cardiac Arrest After Arrival of EMS**

Patients who experience a cardiac arrest after the arrival of EMS personnel are in the best circumstances to be resuscitated by trained personnel with the equipment to provide immediate defibrillation.

Source: Cardiac Arrest Registry to Enhand Survival - CARES Complete Data Set for EMS, Hospital and CAD participants and Instruction for Abstracting and Coding Data Elements

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Element: 12283 Bystander Cardiopulmonary Resuscitation

Code System Name	Code
ACC NCDR	112000000186

Coding Instruction: Indicate if a bystander administered cardiopulmonary resuscitation after a cardiac arrest prior to EMS arrival.

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 4633 First Cardiac Arrest Rhythm

Code System Name	Code
ACC NCDR	100014013

Coding Instruction: Indicate if the initial out-of-hospital cardiac arrest rhythm was a shockable rhythm.

Target Value: The value on arrival at this facility

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100013034	Shockable	Pulseless ventricular arrhythmias
ACC NCDR	100013035	Not Shockable	

Element: 4634 First Cardiac Arrest Rhythm Unknown

Code System Name	Code
ACC NCDR	100014013

Coding Instruction: Indicate if the initial out-of-hospital cardiac arrest rhythm was unknown.

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 12285 Resuscitation Date and Time

Code System Name	Code
SNOMED CT	439569004

Coding Instruction: Indicate the date and time of resuscitation (return of spontaneous circulation).

Target Value: The first value between first medical contact and discharge

Supporting Definition:

Element: 4635 Cardiac Arrest at Transferring Healthcare Facility

Code System Name	Code
ACC NCDR	100014016

Coding Instruction: Indicate if the patient had cardiac arrest at the transferring healthcare facility prior to arrival at the current facility.

Target Value: The value on arrival at this facility

Supporting Definition: **Cardiac Arrest**

"Sudden" Cardiac arrest is the sudden cessation of cardiac activity. The victim becomes unresponsive with no normal breathing and no signs of circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death. Cardiac arrest should be used to signify an event as described above that is reversed, usually by CPR and/or defibrillation or cardioversion or cardiac pacing.

Source: 2013 ACCF/AHA key data elements and definitions for measuring the clinical management and outcomes of patients with acute coronary syndromes and coronary artery disease.

Element: 12218 Location of First Evaluation

Code System Name	Code
ACC NCDR	112000000163

Coding Instruction: Indicate the location the patient was first evaluated at your facility.

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	112000000164	ED	Emergency Departments (ED) include traditional ED locations, such as ED-based chest pain units, clinics, and short-stay coronary-care units housed in the ED.
ACC NCDR	112000000165	Cath Lab	Area where diagnostic cardiac catheterizations or percutaneous coronary interventions are performed.
ACC NCDR	100013061	Observation	
ACC NCDR	112000000257	Direct Admit	
ACC NCDR	100000351	Other	Not otherwise specified.

Element: 12361 Transferred out of Emergency Department Date and Time

Code System Name	Code
ACC NCDR	112000000219

Coding Instruction: Indicate the date and time the patient was moved out of the emergency department, either to another location within your facility or to another acute care center.

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

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

Supporting Definition:

Element: 12362 Emergency Department Disposition

Code System Name	Code
ACC NCDR	112000000220

Coding Instruction: Indicate where the patient went from the Emergency Department.

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100013061	Observation	
SNOMED CT	440654001	Inpatient	

Element: 12417 Observation Order Date and Time

Code System Name	Code
ACC NCDR	112000000253

Coding Instruction: Indicate the date and time that the observation bed order was written.

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

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

Supporting Definition:

Element: 12277 Acute Coronary Syndrome Symptom Date

Code System Name	Code

ACC NCDR	100013003

Coding Instruction: Indicate the date the patient noted ischemic symptoms lasting greater than or equal to 10 minutes.

Note(s):
Symptoms may include jaw pain, arm pain, shortness of breath, nausea, vomiting, fatigue/malaise, or other equivalent discomfort suggestive of a myocardial infarction.

Target Value: The last value between 24 hours prior to arrival at first facility and arrival at this facility

Supporting Definition:

Element: 12276 Acute Coronary Syndrome Symptom Time

Code System Name	Code
ACC NCDR	100013004

Coding Instruction: Indicate the time the patient first noted ischemic symptoms lasting greater than or equal to 10 minutes.

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

If the symptom time is not specified in the medical record, it may be recorded as 0700 for morning; 1200 for lunchtime; 1500 for afternoon; 1800 for dinnertime; 2200 for evening and 0300 if awakened from sleep.

Target Value: The last value between 24 hours prior to arrival at first facility and arrival at this facility

Supporting Definition:

Element: 12302 Risk Score Documented

Code System Name	Code
ACC NCDR	112000000189

Coding Instruction: Indicate if a risk score was performed and documented during the hospitalization.

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

Supporting Definition:

Element: 12303 Name of Risk Score Performed

Code System Name	Code
ACC NCDR	112000000190

Coding Instruction: Indicate the name or type of risk score documented.

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	112000000191	TIMI	
ACC NCDR	112000000192	GRACE	
ACC NCDR	112000000193	HEART	
ACC NCDR	10001424796	SYNTAX Score	
ACC NCDR	112000000232	EDACS	
ACC NCDR	100000351	Other	Not otherwise specified.

Element: 12532 Thrombolysis in Myocardial Infarction Score

Code System Name	Code
ACC NCDR	112000000191

Coding Instruction: Indicate the Thrombolysis in Myocardial Infarction (TIMI) Score.

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

Supporting Definition:

Element: 12533 Global Registry of Acute Coronary Events Score

Code System Name	Code
ACC NCDR	112000000192

Coding Instruction: Indicate the Global Registry of Acute Coronary Events (GRACE) Score.

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

Supporting Definition:

Element: 12305 Chest X-ray Performed

Code System Name	Code
LOINC	36572-6

Coding Instruction: Indicate if a chest x-ray was performed.

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

Supporting Definition:

Element: 12444 Non-Invasive Test Performed

Code System Name	Code
ACC NCDR	1000142431

Coding Instruction: Indicate if a non-invasive stress test was performed.

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100013072	Yes	
ACC NCDR	112000000195	No - No Reason	
ACC NCDR	112000000199	No - Medical Reason	Clear documentation of a reason related to the patient's medical issue or concern.
ACC NCDR	112000000197	No - Pt. Reason	Clear documentation of a reason related to the patient's and or family preference.

Element: 12429 Ischemic Symptoms Resolved Before Testing

Code System Name	Code
ACC NCDR	112000000266

Coding Instruction: Indicate if patient's ischemic symptoms resolved prior to the non-invasive testing being performed.

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

Supporting Definition:

Element: 12452 Non-Invasive Test Planned for After Discharge

Code System Name	Code
ACC NCDR	112000000303

Coding Instruction: Indicate if a non-invasive test is scheduled for after discharge.

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

Supporting Definition:

Section: Electrocardiogram **Parent: Electrocardiogram**

Element: 12286 Electrocardiogram Counter

Code System Name	Code
ACC NCDR	112000000187

Coding Instruction: The software assigned electrocardiogram (ECG) counter should start at 1 and be incremented by one for each ECG obtained between first medical contact and discharge.

Note(s):
The ECG counter number should be assigned sequentially in ascending order. Do not skip numbers.

Target Value: N/A

Supporting Definition:

Element: 12278 Electrocardiogram Date and Time

Code System Name	Code
SNOMED CT	164847006

Coding Instruction: Indicate the date and time of the 12-lead electrocardiogram (ECG) was obtained.

Note:
The date/time of the 12-lead ECG with a reading can be documented in the Emergency Medical Services (EMS) record, a physical copy of the 12-lead ECG is not required.

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

Target Value: Any occurrence between 24 hours prior to first medical contact and discharge

Supporting Definition:

Element: 12300 STEMI or STEMI Equivalent First Noted

Code System Name	Code
ACC NCDR	100000180

Coding Instruction: Indicate if a STEMI or STEMI equivalent was noted on the ECG.

Target Value: Any occurrence between first medical contact and discharge

Supporting Definition:

Element: 12383 STEMI Electrocardiogram Findings

Code System Name	Code
ACC NCDR	112000000226

Coding Instruction: Indicate if the ECG findings demonstrated either new or presumed new ST-segment elevation, new left bundle branch block, or isolated posterior myocardial infarction prior to any procedures.

Note(s): Arrival at first facility refers to either the time of arrival at your facility or the time of arrival at the transferring facility.

Target Value: Any occurrence between first medical contact and discharge

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	76388001	ST elevation	ST-segment elevation is defined by new or presumed new sustained ST-segment elevation at the J-point in two contiguous electrocardiogram (ECG) leads with the cut-off points: >=0.2 mV in men or >= 0.15mV in women in leads V2-V3 and/or >= 0.1 mV in other leads and lasting greater than or equal to 20 minutes. If no exact ST-elevation measurement is recorded in the medical chart, physician's written documentation of ST-elevation or Q-waves is acceptable. If only one ECG is performed, then the assumption that the ST elevation persisted at least the required 20 minutes is acceptable.
SNOMED CT	73999000	Isolated posterior MI	Isolated Posterior Myocardial Infarction refers to infarction of the posterobasal wall of the left ventricle. The use of posterior leads V7 to V9 will show ST segment elevation in patients with posterior infarction. If posterior leads were not applied, ST segment depression that is maximal in leads V1-V3, without ST-segment elevation in other leads, may be considered as indicative of posterior ischemia or infarction.
SNOMED CT	164909002	Left bundle branch block	

Element: 12384 Other Electrocardiogram Findings

Code System Name	Code
ACC NCDR	112000000228

Coding Instruction: Indicate if other findings from the electrocardiogram were demonstrated within 24 hours of arrival at first facility. If more than one present, code the findings on which treatment was based.

Note(s): Arrival at first facility refers to either the time of arrival at your facility or the time of arrival at the transferring facility.

Target Value: Any occurrence between first medical contact and 24 hours after arrival at first facility

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	26141007	ST depression (New or Presumed New)	Indicate if there was new or presumed new horizontal or down-sloping ST depression >=0.5 mV in two contiguous leads below the isoelectric line on the electrocardiogram (ECG) within the first 24 hours of presentation. If no exact ST- depression measurement is recorded in the medical chart, physician's written documentation of ST- depression is acceptable.
SNOMED CT	59931005	T-Wave inversion (New or Presumed New)	T wave inversion is defined as secondary to depolarization abnormalities and is selected as an abnormal electrocardiac finding when there is specific physician documentation indicating this is an abnormal finding for the patient.
ACC NCDR	112000000230	Transient ST elevation (Lasting < 20 minutes)	Indicate if there was new or presumed new ST-segment elevation at the J-point in two contiguous electrocardiogram (ECG) leads with the cut-off points: >=0.2 mV in men or >= 0.15mV in women in leads V2-V3 and/or >= 0.1 mV in other leads, and lasting less than 20 minutes, within the first 24 hours of presentation. If no exact ST- elevation measurement is recorded in the medical chart, physician's written documentation of transient ST- elevation is acceptable.
ACC NCDR	112000000231	Old LBBB	
ACC NCDR	100001231	None	

Section: Non-Invasive Tests **Parent: Non-Invasive Tests**

Element: 12445 Non-Invasive Test Performed Type

Code System Name	Code
ACC NCDR	1000142432

Coding Instruction: Indicate the type of non-invasive stress test performed.

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
LOINC	18752-6	Exercise Stress Test (w/o imaging)	Continuous ECG recording/monitoring test (without additional imaging) performed initially at rest and then during exercise, or pharmacologic stress to detect the presence of coronary artery disease, abnormal heart rhythms, abnormal blood pressure response to exercise, or evaluate exercise tolerance and exercise-related symptoms.
LOINC	18106-5	Echocardiogram	
LOINC	82654-5	Nuclear with SPECT	
LOINC	24748-6	Imaging w/ CMR	
LOINC	59255-0	Cardiac CTA	

Element: 12446 Non-Invasive Test Method

Code System Name	Code
ACC NCDR	112000000296

Coding Instruction: Indicate if the non-invasive test was performed at rest or under stress conditions.

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	112000000298	Rest	
ACC NCDR	112000000299	Stress	

Section: Arrival Medications **Parent: Arrival Medications**

Element: 12430 Arrival Medication Code

Code System Name	Code
ACC NCDR	100013057

Coding Instruction: Indicate the assigned identification number associated with the medications the patient was prescribed 24 hours before and after arrival.

Target Value: The first value between 24 hours before and after arrival

Supporting Definition:

Code System Name	Code	Selection Text	Definition
RxNorm	1191	ASA	
SNOMED CT	33252009	Beta Blocker	
RxNorm	32968	Clopidogrel	
RxNorm	613391	Prasugrel	
RxNorm	1116632	Ticagrelor	

Element: 12355 Medications Administered on Arrival

Code System Name	Code
SNOMED CT	432102000

Coding Instruction: Indicate if the medication was administered or contraindicated 24 hours before and after arrival.

Target Value: The first value between 24 hours before and after arrival

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100013073	No	
ACC NCDR	100013072	Yes	
ACC NCDR	100013074	Contraindicated	A contraindication is a specific situation in which a drug should not be used because a clinician deems it may be harmful to the patient. Examples include allergy, adverse drug interaction, comorbid condition, pregnancy.

Element: 12357 Medications Administered on Arrival Dose

Code System Name	Code
ACC NCDR	100014233

Coding Instruction: Indicate the dose of medication administered 24 hours before after arrival.

Target Value: The first value between 24 hours before and after arrival

Supporting Definition:

Element: 12448 Drug Start Date and Time

Code System Name	Code
SNOMED CT	432102000

Coding Instruction: Indicate the date and time the drug was started.

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

Target Value: The first value between 24 hours before and after arrival

Supporting Definition:

Section: E. Arrival Information **Parent: E. Arrival Information**

Element: 12295 Thrombolytic

Code System Name	Code
SNOMED CT	307521008

Coding Instruction: Indicate if the patient received thrombolytic therapy as an urgent treatment for STEMI.

Target Value: Any occurrence between first medical contact and discharge

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100001247	Yes	Code 'Yes' if this medication was initiated (or prescribed).
ACC NCDR	112000000195	No - No Reason	
ACC NCDR	112000000199	No - Medical Reason	Clear documentation of a reason related to the patient's medical issue or concern.
ACC NCDR	100001071	No - Patient Reason	Documentation of a patient reason (eg, initial patient concern with bleeding hazards).

Element: 12296 Thrombolytic Therapy Date and Time

Code System Name	Code
SNOMED CT	307521008

Coding Instruction: Indicate the date and time of either the first bolus or the beginning of the infusion.

Note(s):
If your facility receives a patient transfer with infusion ongoing, record the date and time that infusion was started at the transferring facility.

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

Target Value: Any occurrence between first medical contact and discharge

Supporting Definition:

Element: 14207 Medical Reason for Delay in Thrombolytic

Code System Name	Code
ACC NCDR	112000001729

Coding Instruction: Indicate if there was a medical reason for delay in administering a thrombolytic.

Target Value: Any occurrence between first medical contact and discharge

Supporting Definition: **Medical Reason for Delay in Thrombolytics**

Documentation of a medical reason for delayed fibrinolytic therapy (e.g., cardiopulmonary arrest, initial suspicion of bleeding/stroke or other contraindications to use fibrinolytic therapy, respiratory failure requiring intubation, intra-aortic balloon pump insertion, late presentation >12 h after symptom onset).

Source: Jneid, H., Addison, D., Bhatt, D. L., Fonarow, G. C. Gokak, S., Grady, K. L., Green, L. A., Heidenreich, P. A., Ho, P. M., Jurgens, C. Y., King, M. L., Kumbhani, D. J., Pancholy, S. (in press) 2017 AHA/ACC Clinical Performance and Quality Measures for Adults With ST-Elevation and Non–ST-Elevation Myocardial Infarction. Journal of the American College of Cardiology. doi: 10.1016/j.jacc.2017.06.032

Element: 14208 Patient Reason for Delay in Thrombolytic

Code System Name	Code
ACC NCDR	112000001730

Coding Instruction: Indicate if there was a patient reason for delay in administering a thrombolytic.

Target Value: The first value between first medical contact and discharge

Supporting Definition:

Element: 12198 Emergency Medical Services Dispatch Date and Time

Code System Name	Code
ACC NCDR	112000000142

Coding Instruction: Indicate the date and time the responding unit was notified by dispatch.

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

Target Value: N/A

Supporting Definition:

Element: 12199 Emergency Medical Services Leaving Scene Date and Time

Code System Name	Code
ACC NCDR	112000000143

Coding Instruction: Indicate the date and time the responding unit left the scene with a patient (started moving).

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

Target Value: N/A

Supporting Definition:

Element: 12189 Emergency Medical Services Agency Number

Code System Name	Code
ACC NCDR	112000000132

Coding Instruction: Indicate the emergency medical services agency number.

Target Value: N/A

Supporting Definition:

Element: 12190 Emergency Medical Services Run Number

Code System Name	Code
ACC NCDR	112000000133

Coding Instruction: Indicate the emergency medical services run number.

Target Value: N/A

Supporting Definition: **Incident Number**

The incident number assigned by the 911 Dispatch System.

Source: http://nemsis.org/v3/downloads/datasetDictionaries.html

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Element: 12420 12 -Lead Electrocardiogram performed by Emergency Medical Services

Code System Name	Code
SNOMED CT	164847006

Coding Instruction: Indicate if a 12-Lead electrocardiogram was performed by EMS prior to arrival at the facility.

Target Value: Any occurrence between first medical contact and arrival at this facility

Supporting Definition:

Element: 12200 Emergency Medical Services STEMI Alert

Code System Name	Code
ACC NCDR	112000000144

Coding Instruction: Indicate if the EMS notified the receiving hospital of a possible or positive ST Elevation Myocardial Infarction (STEMI).

Target Value: Any occurrence between first medical contact and arrival at this facility

Supporting Definition:

Element: 12421 Transferred From Outside Facility

Code System Name	Code
ACC NCDR	112000000259

Coding Instruction: Indicate if the patient was transferred directly to your facility within 24 hours after initial presentation to an outside facility.

Target Value: N/A

Supporting Definition:

Element: 12422 Means of Transfer from Outside Hospital

Code System Name	Code
ACC NCDR	112000000131

Coding Instruction: Indicate the means of transportation from the outside facility to your facility.

Target Value: The last value between Transfer from Outside Facility and arrival at this facility

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	112000000255	Ambulance	
ACC NCDR	112000000256	Air Transport	
SNOMED CT	58938008	Wheelchair	
SNOMED CT	89149003	Stretcher	

Element: 12426 Arrival at Outside Facility Date and Time

Code System Name	Code
ACC NCDR	112000000261

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

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

Target Value: N/A

Supporting Definition:

Element: 12427 Transfer From Outside Facility Date and Time

Code System Name	Code
ACC NCDR	112000000259

Coding Instruction: Indicate the date and time the patient left the outside facility.

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

Target Value: N/A

Supporting Definition:

Element: 12402 Transferring Facility American Hospital Association Name

Code System Name	Code

ACC NCDR	112000000604

Coding Instruction: Indicate the name of the facility from which the patient was transferred.

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 12161 Transferring Facility American Hospital Association Number

Code System Name	Code
ACC NCDR	112000000106

Coding Instruction: Indicate the American Hospital Association number of the facility from which the patient was transferred.

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 12531 Number of Transferring Facility Unavailable

Code System Name	Code
ACC NCDR	112000000106

Coding Instruction: Indicate if the number of the facility from which the patient was transferred was not available.

Note(s):
This element should only be used for international sites or for when there is not an American Hospital Association Number available.

Target Value: The value on arrival at this facility

Supporting Definition:

Section: Troponin **Parent: Troponin**

Element: 12255 Troponin Counter

Code System Name	Code
ACC NCDR	112000000185

Coding Instruction: The software assigned Troponin counter should start at 1 and be incremented by one for each Troponin Lab collected and resulted between first medical contact and discharge.

Note(s):
The Troponin counter number should be assigned sequentially in ascending order. Do not skip numbers.

Target Value: Any occurrence between first medical contact and discharge

Supporting Definition:

Element: 12405 Troponin Collected Date and Time

Code System Name	Code
ACC NCDR	112000000185

Coding Instruction: Indicate the date and time the Troponin was collected.

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

Target Value: Any occurrence between first medical contact and discharge

Supporting Definition:

Element: 12406 Troponin Resulted Date and Time

Code System Name	Code
ACC NCDR	112000000237

Coding Instruction: Indicate the date and time the Troponin was resulted.

Target Value: Any occurrence between first medical contact and discharge

Supporting Definition:

Element: 12544 Troponin Test Location

Code System Name	Code
ACC NCDR	112000000386

Coding Instruction: Indicate if the troponin blood sample test was run at the point of care (POC) or in the laboratory.

Target Value: Any occurrence between first medical contact and discharge

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	112000000387	Lab	
ACC NCDR	112000000388	POC	

Element: 12409 Lab Troponin Assay and URL

Code System Name	Code
ACC NCDR	112000000234

Coding Instruction: Indicate the troponin assay used for the troponin sample that was processed in the laboratory.

Target Value: Any occurrence between first medical contact and discharge

Supporting Definition:

Element: 12543 Point of Care Troponin Assay and URL

Code System Name	Code

ACC NCDR	112000000385

Coding Instruction: Indicate the troponin assay used for the troponin sample that was processed at the point of care.

Target Value: Any occurrence between first medical contact and discharge

Supporting Definition:

Element: 12408 Troponin Value

Code System Name	Code
ACC NCDR	112000000185

Coding Instruction: Indicate the initial troponin value with the appropriate unit of measure.

Note(s):
If value is reported using a < symbol (e.g., < 0.02), record the number only (e.g., 0.02).

Target Value: Any occurrence between first medical contact and discharge

Supporting Definition:

Element: 13080 Troponin Units of Measure

Code System Name	Code
ACC NCDR	112000000185

Coding Instruction: Indicate the unit of measure for the troponin value.

Target Value: N/A

Supporting Definition:

Section: Initial Labs Results **Parent: Initial Labs Results**

Element: 12256 Initial Creatinine

Code System Name	Code
LOINC	2160-0

Coding Instruction: Indicate the results of the initial creatinine sample in mg/dL.

Target Value: The first value between first medical contact 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

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Element: 12257 Initial Creatinine Not Drawn

Code System Name	Code
LOINC	2160-0

Coding Instruction: Indicate if an initial creatinine was not drawn.

Target Value: The first value between first medical contact 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

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Element: 12397 Initial Hemoglobin Value

Code System Name	Code
LOINC	718-7

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

Target Value: The first value between first medical contact and discharge

Supporting Definition: **Hemoglobin**

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

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

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Element: 12398 Initial Hemoglobin Not Drawn

Code System Name	Code
LOINC	718-7

Coding Instruction: Indicate if an initial hemoglobin level was not drawn.

Target Value: The first value between first medical contact and discharge

Supporting Definition: Hemoglobin

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

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

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Element: 12264 Initial Hemoglobin A1c Value

Code System Name	Code
LOINC	4548-4

Coding Instruction: Indicate the initial hemoglobin A1C percentage value.

Target Value: The first value between first medical contact and discharge

Supporting Definition: Hemoglobin A1c

Currently (2010), four standardization protocols exist for measuring Hgb A1c:
1. IFCC - designated as a Reference Method or RM (http://www.ifcchba1c.net/)
2. NGSP - the long standing protocol used in the US and most other countries since the DCCT study (http://www.ngsp.org/factors.asp)
3.JDS/JSCC - a protocol used in Japan, Spain and possibly other countries
4. Swedish - used in Sweden at least

Protocols 2-4 are known as Designated Comparison Methods (DCM) and have been connected to the Reference Method and each other through various regression equations.

Because of the high degrees of standardization within protocol it should no longer be necessary to specify a LOINC code with a method such as “HPLC”, “electrophoresis” or anything else. Analytical instruments will be designed so that an Hgb A1c result can be traced back to a specific standardization protocol, so the important distinction will be the standardization protocol as described above and which will be carried in the method field.

A meeting of instrument manufacturers (presumably including Japanese) in Milan, Italy, December 12, 2007, agreed (among other items) that:

-All manufacturers should implement worldwide the traceability to the IFCC reference system for Hgb -A1c.
-All new instruments sold after January 1st, 2011 will report (as a result of an Hgb A1c test) both SI (mmol/mol – no decimals) and NGSP derived units (percentage – one decimal), in agreement with the Consensus Statement.
-Note they only committed to supporting protocol (1) and (2)

Different countries are adopting the international harmonization recommendations in different ways. We have information from the NGSP that the US will continue to report only Hgb A1c/NGSP, with the unit percent – i.e., no change. In Great Britain, labs have already started to report all results both as Hgb A1c (NGSP) in % and Hgb A1c (IFCC) in mmol/mol. In Canada, they are awaiting a recommendation from an expert panel. Any of these measures could be reported in the same units, but the convention for the reporting Hgb A1c under the new IFCC protocol will be to use units of mmol/mol to avoid confusion between the DCCT/NGSP and the IFFCC protocol.

LOINC has defined 59261-8 (Hemoglobin A1c/Hemoglobin.total in Blood) by IFCC protocol.

These protocols produce different results when expressed in the same units. For example, the equivalent of Hgb A1c (NGSP) of 6.5% is Hgb A1c (IFCC) is 4.8%.

The NGSP web site (http://www.ngsp.org/factors.asp) suggests the use of alternate measures, such as glycated albumen, for patients with severe iron deficiency, dialysis patients, and those with SS SC CC because of over or under reading that can occur with these interferences. It also describes the effect of abnormal hemoglobins on results of HbA1c by instrument.

Source: https://s.details.loinc.org/LOINC/4548-4.html?sections=Comprehensive

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Element: 12262 Initial Hemoglobin A1c Not Drawn

Code System Name	Code

Code System Name	Code
LOINC	4548-4

Coding Instruction: Indicate if an initial hemoglobin A1C sample was not collected.

Target Value: The first value between first medical contact and discharge

Supporting Definition: **Hemoglobin A1c**

Currently (2010), four standardization protocols exist for measuring Hgb A1c:
1. IFCC - designated as a Reference Method or RM (http://www.ifcchba1c.net/)
2. NGSP - the long standing protocol used in the US and most other countries since the DCCT study (http://www.ngsp.org/factors.asp)
3.JDS/JSCC - a protocol used in Japan, Spain and possibly other countries
4. Swedish - used in Sweden at least

Protocols 2-4 are known as Designated Comparison Methods (DCM) and have been connected to the Reference Method and each other through various regression equations.

Because of the high degrees of standardization within protocol it should no longer be necessary to specify a LOINC code with a method such as “HPLC”, “electrophoresis” or anything else. Analytical instruments will be designed so that an Hgb A1c result can be traced back to a specific standardization protocol, so the important distinction will be the standardization protocol as described above and which will be carried in the method field.

A meeting of instrument manufacturers (presumably including Japanese) in Milan, Italy, December 12, 2007, agreed (among other items) that:

-All manufacturers should implement worldwide the traceability to the IFCC reference system for Hgb -A1c.
-All new instruments sold after January 1st, 2011 will report (as a result of an Hgb A1c test) both SI (mmol/mol – no decimals) and NGSP derived units (percentage – one decimal), in agreement with the Consensus Statement.
-Note they only committed to supporting protocol (1) and (2)

Different countries are adopting the international harmonization recommendations in different ways. We have information from the NGSP that the US will continue to report only Hgb A1c/NGSP, with the unit percent – i.e., no change. In Great Britain, labs have already started to report all results both as Hgb A1c (NGSP) in % and Hgb A1c (IFCC) in mmol/mol. In Canada, they are awaiting a recommendation from an expert panel. Any of these measures could be reported in the same units, but the convention for the reporting Hgb A1c under the new IFCC protocol will be to use units of mmol/mol to avoid confusion between the DCCT/NGSP and the IFFCC protocol.

LOINC has defined 59261-8 (Hemoglobin A1c/Hemoglobin.total in Blood) by IFCC protocol.

These protocols produce different results when expressed in the same units. For example, the equivalent of Hgb A1c (NGSP) of 6.5% is Hgb A1c (IFCC) is 4.8%.

The NGSP web site (http://www.ngsp.org/factors.asp) suggests the use of alternate measures, such as glycated albumen, for patients with severe iron deficiency, dialysis patients, and those with SS SC CC because of over or under reading that can occur with these interferences. It also describes the effect of abnormal hemoglobins on results of HbA1c by instrument.

Source: https://s.details.loinc.org/LOINC/4548-4.html?sections=Comprehensive

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Element: 12265 Initial International Normalized Ratio

Code System Name	Code
LOINC	34714-6

Coding Instruction: Indicate the international normalized ratio (INR) if the patient is on routine warfarin or coumadin therapy.

Target Value: The first value between first medical contact and discharge

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 evalulate 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.

Source: http://s.details.loinc.org/LOINC/6301-6.html?sections=Simple

Element: 12267 Initial International Normalized Ratio Date and Time

Code System Name	Code
LOINC	34714-6

Coding Instruction: Indicate the date and time the international normalized ratio (INR) sample was collected.

Target Value: The first value between first medical contact and discharge

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 evalulate 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.

Source: http://s.details.loinc.org/LOINC/6301-6.html?sections=Simple

Element: 12403 Initial International Normalized Ratio Not Drawn

Code System Name	Code
LOINC	34714-6

Coding Instruction: Indicate the date and time the international normalized ratio (INR) sample was collected.

Target Value: The first value between first medical contact and discharge

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 evalulate 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.

Source: http://s.details.loinc.org/LOINC/6301-6.html?sections=Simple

Section: Lowest Peak Lab Results **Parent: Lowest Peak Lab Results**

Element: 12260 Peak Creatinine Date and Time

Code System Name	Code
LOINC	2160-0

Coding Instruction: Indicate the date and time of the peak creatinine.

Target Value: The highest value between first medical contact 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

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Element: 12259 Peak Creatinine

Code System Name	Code
LOINC	2160-0

Coding Instruction: Indicate the results of the peak creatinine sample in mg/dL.

Target Value: The highest value between first medical contact 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

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Element: 12261 Peak Creatinine Not Drawn

Code System Name	Code
LOINC	2160-0

Coding Instruction: Indicate if the patient's creatinine level was not collected.

Target Value: The highest value between first medical contact 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

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Element: 12404 Lowest Hemoglobin Value

Code System Name	Code
LOINC	718-7

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

Target Value: The lowest value between first medical contact and discharge

Supporting Definition: **Hemoglobin**

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

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

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Element: 12400 Lowest Hemoglobin Date and Time

Code System Name	Code
LOINC	718-7

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

Target Value: The lowest value between first medical contact and discharge

Supporting Definition: **Hemoglobin**

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

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

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Element: 12399 Lowest Hemoglobin Not Drawn

Code System Name	Code
ACC NCDR	112000000238

Coding Instruction: Indicate if a lowest hemoglobin level was not drawn.

Target Value: The lowest value between first medical contact and discharge

Supporting Definition: **Hemoglobin**

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

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

Section: Lipids **Parent: Lipids**

Element: 12268 Total Cholesterol

Code System Name	Code
LOINC	2093-3

Coding Instruction: Indicate the cholesterol level mg/dL.

Target Value: The last value between 6 months before first medical contact and discharge

Supporting Definition: **Cholesterol**

Cholesterol is a lipidic, waxy alcohol found in the cell membranes and transported in the blood plasma of all animals. It is an essential component of mammalian cell membranes where it establishes proper membrane permeability and fluidity. Cholesterol is the principal sterol synthesized by animals, but small quantities are synthesized in other eukaryotes, such as plants and fungi. It is almost completely absent among prokaryotes, which include bacteria. Cholesterol is classified as a sterol.

Element: 12269 Total Cholesterol Not Drawn

Code System Name	Code
LOINC	2093-3

Coding Instruction: Indicate if the total cholesterol was not drawn.

Target Value: The last value between 6 months before first medical contact and discharge

Supporting Definition: **Cholesterol**

Cholesterol is a lipidic, waxy alcohol found in the cell membranes and transported in the blood plasma of all animals. It is an essential component of mammalian cell membranes where it establishes proper membrane permeability and fluidity. Cholesterol is the principal sterol synthesized by animals, but small quantities are synthesized in other eukaryotes, such as plants and fungi. It is almost completely absent among prokaryotes, which include bacteria. Cholesterol is classified as a sterol.

Element: 12270 High-density Lipoprotein

Code System Name	Code
LOINC	2085-9

Coding Instruction: Indicate the high density lipoprotein (HDL) cholesterol value in mg/dL.

Note(s):
If greater than 24 hours after arrival, then enter the most recent values obtained (within six months) prior to arrival at this facility.

Target Value: The last value between 6 months before first medical contact and discharge

Supporting Definition: **High-density lipoprotein**

High-density lipoprotein (HDL) is one of the five major groups of lipoproteins (chylomicrons, VLDL, IDL, LDL, HDL) which enable lipids like cholesterol and triglycerides to be transported within the water based blood stream. In healthy individuals, about thirty percent of blood cholesterol is carried by HDL. High levels of cholesterol in the blood have been linked to damage to arteries and cardiovascular disease.

Element: 12516 High-density Lipoprotein Not Drawn

Code System Name	Code
LOINC	2085-9

Coding Instruction: Indicate if the HDL level was not drawn.

Target Value: The last value between 6 months before first medical contact and discharge

Supporting Definition: **High-density lipoprotein**

High-density lipoprotein (HDL) is one of the five major groups of lipoproteins (chylomicrons, VLDL, IDL, LDL, HDL) which enable lipids like cholesterol and triglycerides to be transported within the water based blood stream. In healthy individuals, about thirty percent of blood cholesterol is carried by HDL. High levels of cholesterol in the blood have been linked to damage to arteries and cardiovascular disease.

Source: Regenstrief Institute, Inc. All Rights Reserved. To the extent included herein, the LOINC table and LOINC codes are copyright © 1995-2015, Regenstrief Institute, Inc. and the Logical Observation Identifiers Names and Codes (LOINC) Committee.

Element: 12273 LDL Cholesterol

Code System Name	Code
LOINC	2089-1

Coding Instruction: Indicate the low density lipoprotein (LDL) cholesterol value in mg/dL.

Target Value: The last value between 6 months before first medical contact and discharge

Supporting Definition: **Cholesterol in LDL**

A small dense LDL fraction, reported as part of LDL Subclasses panel. Seven LDL subclasses and 3 mid-band fractions can be determined by linear polyacrylamide gel electrophoresis and densitometric scanning.

Source: Regenstrief Institute

Element: 12274 LDL Not Drawn

Code System Name	Code
LOINC	2089-1

Coding Instruction: Indicate if the low density lipoprotein (LDL) cholesterol was not drawn.

Note(s):
If greater than 24 hours after arrival, then enter the most recent values obtained (within six months) prior to arrival at this facility.

Target Value: The last value between 6 months before first medical contact and discharge

Supporting Definition: **Cholesterol in LDL**

A small dense LDL fraction, reported as part of LDL Subclasses panel. Seven LDL subclasses and 3 mid-band fractions can be determined by linear polyacrylamide gel electrophoresis and densitometric scanning.

Source: Regenstrief Institute

Element: 12271 Triglycerides

Code System Name	Code
LOINC	2571-8

Coding Instruction: Indicate the triglycerides value in mg/dL.

Note(s):
If greater than 24 hours after arrival, then enter the most recent values obtained (within six months) prior to arrival at this facility.

Target Value: The last value between 6 months before first medical contact and discharge

Supporting Definition: **Triglyceride**

A triglyceride (TG, triacylglycerol, TAG, or triacylglyceride) is an ester derived from glycerol and three fatty acids. There are many triglycerides, depending on the oil source, some are highly unsaturated, some less so. Triglycerides are the main constituents of vegetable oil (typically more unsaturated) and animal fats (typically more saturated). In humans, triglycerides are a mechanism for storing unused calories, and their high concentrations in blood correlates with the consumption of starchy and fatty foods. High levels of triglycerides in the bloodstream have been linked to atherosclerosis and, by extension, the risk of heart disease and stroke. Diets high in carbohydrates, with carbohydrates accounting for more than 60% of the total energy intake, can increase triglyceride levels.

Source: https://s.details.loinc.org/LOINC/2571-8.html?sections=Comprehensive

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Element: 12272 Triglycerides Not Drawn

Code System Name	Code
LOINC	2571-8

Coding Instruction: Indicate the triglycerides value was not drawn.

Target Value: The last value between 6 months before first medical contact and discharge

Supporting Definition: **Triglyceride**

A triglyceride (TG, triacylglycerol, TAG, or triacylglyceride) is an ester derived from glycerol and three fatty acids. There are many triglycerides, depending on the oil source, some are highly unsaturated, some less so. Triglycerides are the main constituents of vegetable oil (typically more unsaturated) and animal fats (typically more saturated). In humans, triglycerides are a mechanism for storing unused calories, and their high concentrations in blood correlates with the consumption of starchy and fatty foods. High levels of triglycerides in the bloodstream have been linked to atherosclerosis and, by extension, the risk of heart disease and stroke. Diets high in carbohydrates, with carbohydrates accounting for more than 60% of the total energy intake, can increase triglyceride levels.

Source: https://s.details.loinc.org/LOINC/2571-8.html?sections=Comprehensive

Section: G. Procedure Information **Parent: G. Procedure Information**

Element: 12306 Left Ventricular Ejection Fraction Assessed

Code System Name	Code
ACC NCDR	100001027

Coding Instruction: Indicate whether the left ventricular ejection fraction was assessed.

Note(s):
The Left Ventricular Ejection Fraction is the percentage of the blood emptied from the left ventricle at the end of the contraction.

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

Supporting Definition:

Element: 12307 Left Ventricular Ejection Fraction Measurement

Code System Name	Code
LOINC	10230-1

Coding Instruction: Code the best estimate of the current left ventricular ejection fraction closest to discharge.

Note(s):
If a percentage range is reported, report the median of the range (i.e. 50-55%, is reported as 53%).

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

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

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

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

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: 12308 Left Ventricular Ejection Fraction Planned for after Discharge

Code System Name	Code
ACC NCDR	112000000194

Coding Instruction: Indicate if the LVEF assessment is planned for after discharge.

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

Supporting Definition:

Element: 12309 Coronary Angiography

Code System Name	Code
SNOMED CT	33367005

Coding Instruction: Indicate if the patient had a diagnostic coronary angiography procedure.

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

Supporting Definition: **Coronary Angiography**

Coronary angiography is defined as the passage of a catheter into the aortic root or other great vessels for angiography of the native coronary arteries or bypass grafts supplying native coronary arteries. This element would NOT include noninvasive CT angiography.

Source: American College of Cardiology and American Heart Association Task Force on Clinical Data Standards (Writing Committee to Develop Artery Disease: A Report of the American College of Cardiology Foundation/American. Management and Outcomes of Patients With Acute Coronary Syndromes and Coronary 2013 ACCF/AHA Key Data Elements and Definitions for Measuring the Clinical Circulation. 2013;127:1052-1089; originally published online January 28, 2013;

Code System Name	Code	Selection Text	Definition
ACC NCDR	100013072	Yes	
ACC NCDR	112000000195	No - No Reason	
ACC NCDR	112000000199	No - Medical Reason	Clear documentation of a reason related to the patient's medical issue or concern.
ACC NCDR	112000000197	No - Pt. Reason	Clear documentation of a reason related to the patient's and or family preference.
ACC NCDR	112000000198	No - System Reason	

Element: 12311 Catheterization Laboratory Arrival Date and Time

Code System Name	Code
ACC NCDR	112000000200

Coding Instruction: Indicate the date and time the patient arrived to the cath lab where the procedure was being performed, as documented in the medical record.

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

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

Supporting Definition:

Element: 7046 Diagnostic Catheterization Operator Last Name

Code System Name	Code
ACC NCDR	1000142454

Coding Instruction: Indicate the last name of the operator who is performing the diagnostic catheterization.

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

Target Value: The value on current procedure

Supporting Definition:

Element: 7047 Diagnostic Catheterization Operator First Name

Code System Name	Code
ACC NCDR	1000142454

Coding Instruction: Indicate the first name of the operator who is performing the diagnostic catheterization.

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

Target Value: The value on current procedure

Supporting Definition:

Element: 7048 Diagnostic Catheterization Operator Middle Name

Code System Name	Code
ACC NCDR	1000142454

Coding Instruction: Indicate the middle name of the operator who is performing the diagnostic catheterization.

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

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

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

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

Target Value: The value on current procedure

Supporting Definition:

Element: 7049 Diagnostic Catheterization Operator NPI

Code System Name	Code
ACC NCDR	1000142454

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

Note(s):
The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the physician level, which may assist physicians with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging Provider roles, as supported by the patient medical record.

Target Value: The value on current procedure

Supporting Definition:

Element: 12312 Diagnostic Coronary Angiography Date and Time

Code System Name	Code
SNOMED CT	33367005

Coding Instruction: Indicate the date and time the patient had diagnostic coronary angiography.

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

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

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

Supporting Definition: **Coronary Angiography**

Coronary angiography is defined as the passage of a catheter into the aortic root or other great vessels for angiography of the native coronary arteries or bypass grafts supplying native coronary arteries. This element would NOT include noninvasive CT angiography.

Source: American College of Cardiology and American Heart Association Task Force on Clinical Data Standards (Writing Committee to Develop Artery Disease: A Report of the American College of Cardiology Foundation/American. Management and Outcomes of Patients With Acute Coronary Syndromes and Coronary 2013 ACCF/AHA Key Data Elements and Definitions for Measuring the Clinical Circulation. 2013;127:1052-1089; originally published online January 28, 2013;

Element: 7505 Native Vessel with Stenosis >= 50%

Code System Name	Code
ACC NCDR	100001297

Coding Instruction: Indicate if any native vessel had a lesion >= 50%.

Note(s):
Identify the disease found in vessels >=2mm.

Identify disease found in vessels <2mm when PCI is intended for the lesion and/or the patients anatomy is <2mm.

It is acceptable to use prior cath lab visit information, as long as there have been no changes in coronary anatomy. This includes stenosis determined via cardiac catheterization at another facility. This does not include collaterals.

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

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

Supporting Definition:

Element: 7525 Graft Vessel with Stenosis >= 50%

Code System Name	Code
ACC NCDR	100012978

Coding Instruction: Indicate if any graft vessel had a lesion >= 50%.

Note(s):
Identify the disease found in vessels >=2mm.

Identify disease found in vessels <2mm when PCI is intended for the lesion and/or the patients anatomy is <2m.

It is acceptable to use prior cath lab visit information, as long as there have been no changes in coronary anatomy. This includes stenosis determined via cardiac catheterization at another facility. This does not include collaterals.

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

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

Supporting Definition:

Element: 13107 Coronary Artery Bypass Graft

Code System Name	Code
SNOMED CT	232717009

Coding Instruction: Indicate if coronary artery bypass graft (CABG) Surgery was performed.

Target Value: The first value between arrival and discharge

Supporting Definition: **Coronary Artery Bypass Graft**

Coronary artery bypass graft surgery is when the native vessels of the heart are bypassed with other vessels (internal mammary artery, radial artery or saphenous vein) to restore normal blood flow to the obstructed coronary arteries.

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.

Element: 10011 Coronary Artery Bypass Graft Date and Time

Code System Name	Code
SNOMED CT	232717009

Coding Instruction: Indicate the date and time of the coronary artery bypass graft (CABG) surgery.

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

Target Value: The first value between arrival and discharge

Supporting Definition: **Coronary Artery Bypass Graft**

Coronary artery bypass graft surgery is when the native vessels of the heart are bypassed with other vessels (internal mammary artery, radial artery or saphenous vein) to restore normal blood flow to the obstructed coronary arteries.

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.

Section: Native Vessel **Parent: Native Vessel**

Element: 7507 Native Lesion Segment Number

Code System Name	Code
ACC NCDR	100012984

Coding Instruction: Indicate the lesion location using the coronary artery segment diagram of the native lesion.

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	91083009	1 - pRCA	Proximal right coronary artery conduit segment - pRCA
SNOMED CT	450960006	2 - mRCA	Mid-right coronary artery conduit segment - mRCA
SNOMED CT	41879009	3 - dRCA	Distal right coronary artery conduit segment - dRCA
SNOMED CT	53655008	4 - rPDA	Right posterior descending artery segment - rPDA
SNOMED CT	12800002	5 - rPAV	Right posterior atrioventricular segment - rPAV
SNOMED CT	91761002	6 - 1st RPL	First right posterolateral segment - 1st RPL
SNOMED CT	91762009	7 - 2nd RPL	Second right posterolateral segment - 2nd RPL
SNOMED CT	91763004	8 - 3rd RPL	Third right posterolateral segment - 3rd RPL
SNOMED CT	194142006	9 - pDSP	Posterior descending septal perforators segment - pDSP
SNOMED CT	244258000	10 - aMarg	Acute marginal segment(s) - aMarg
SNOMED CT	76862008	11a - Ostial LM	Ostial Left Main Segment - Ostial LM
ACC NCDR	1000142402	11b- Mid-LM	Mid-Left Main Segment - Mid-LM
ACC NCDR	1000142403	11c - Distal LM	Distal Left Main Segment - Distal LM
SNOMED CT	68787002	12 - pLAD	Proximal LAD artery segment - pLAD
SNOMED CT	91748002	13 - mLAD	Mid-LAD artery segment - mLAD
SNOMED CT	36672000	14 - dLAD	Distal LAD artery segment - dLAD
SNOMED CT	91750005	15 - 1st Diag	First diagonal branch segment - 1st Diag
ACC NCDR	1000142404	15a - Lat 1st Diag	Lateral first diagonal branch segment - Lat 1st Diag
SNOMED CT	91751009	16 - 2nd Diag	Second diagonal branch segment - 2nd Diag
ACC NCDR	1000142405	16a - Lat 2nd Diag	Lateral second diagonal branch segment
SNOMED CT	244251006	17 - LAD SP	LAD septal perforator segments - LAD SP
SNOMED CT	52433000	18 - pCIRC	Proximal circumflex artery segment - pCIRC
SNOMED CT	91753007	19 - mCIRC	Mid-circumflex artery segment - mCIRC
SNOMED CT	6511003	19a - dCIRC	Distal circumflex artery segment - dCIRC
SNOMED CT	91754001	20 - 1st OM	First obtuse marginal branch segment - 1st OM
ACC NCDR	1000142406	20a - Lat 1st OM	Lateral first obtuse marginal branch segment - Lat 1st OM
SNOMED CT	91755000	21 - 2nd OM	Second obtuse marginal branch segment - 2nd OM
ACC NCDR	1000142407	21a - Lat 2nd OM	Lateral second obtuse marginal branch segment - Lat 2nd OM
SNOMED CT	91756004	22 - 3rd OM	Third obtuse marginal branch segment - 3rd OM
ACC NCDR	1000142408	22a - Lat 3rd OM	Lateral third obtuse marginal branch segment - Lat 3rd OM
SNOMED CT	75902001	23 - CIRC AV	Circumflex artery AV groove continuation segment - CIRC AV
SNOMED CT	91757008	24 - 1st LPL	First left posterolateral branch segment - 1st LPL
SNOMED CT	91758003	25 - 2nd LPL	Second left posterolateral branch segment - 2nd LPL
SNOMED CT	91759006	26 - 3rd LPL	Third posterolateral descending artery segment - 3rd LPL
SNOMED CT	56322004	27 - LPDA	Left posterolateral descending artery segment - LPDA
SNOMED CT	244252004	28 - Ramus	Ramus intermedius segment - Ramus
ACC NCDR	1000142409	28a - Lat Ramus	Lateral ramus intermedius segment - Lat Ramus

SNOMED CT	91752002	29 - 3rd Diag	Third diagonal branch segment - 3rd Diag
ACC NCDR	1000142410	29a - Lat 3rd Diag	Lateral third diagonal branch segment - Lat 3rd Diag

Element: 7508 Native Coronary Vessel Stenosis

Code System Name	Code
ACC NCDR	100012981

Coding Instruction: Indicate the best estimate of the most severe percent stenosis in the segment of the native coronary vessel identified.

Note(s):

It is acceptable to use prior cath lab visit information, as long as there have been no changes in coronary anatomy. This includes stenosis determined via cardiac catheterization at another facility. This does not include collaterals.

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

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

Supporting Definition:

Section: Graft Vessel **Parent: Graft Vessel**

Element: 7527 Graft Lesion Segment Number

Code System Name	Code
ACC NCDR	100012984

Coding Instruction: Indicate the lesion location using the coronary artery segment diagram of the graft lesion.

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	91083009	1 - pRCA	Proximal right coronary artery conduit segment - pRCA
SNOMED CT	450960006	2 - mRCA	Mid-right coronary artery conduit segment - mRCA
SNOMED CT	41879009	3 - dRCA	Distal right coronary artery conduit segment - dRCA
SNOMED CT	53655008	4 - rPDA	Right posterior descending artery segment - rPDA
SNOMED CT	12800002	5 - rPAV	Right posterior atrioventricular segment - rPAV
SNOMED CT	91761002	6 - 1st RPL	First right posterolateral segment - 1st RPL
SNOMED CT	91762009	7 - 2nd RPL	Second right posterolateral segment - 2nd RPL
SNOMED CT	91763004	8 - 3rd RPL	Third right posterolateral segment - 3rd RPL
SNOMED CT	194142006	9 - pDSP	Posterior descending septal perforators segment - pDSP
SNOMED CT	244258000	10 - aMarg	Acute marginal segment(s) - aMarg
SNOMED CT	76862008	11a - Ostial LM	Ostial Left Main Segment - Ostial LM
ACC NCDR	1000142402	11b- Mid-LM	Mid-Left Main Segment - Mid-LM
ACC NCDR	1000142403	11c - Distal LM	Distal Left Main Segment - Distal LM
SNOMED CT	68787002	12 - pLAD	Proximal LAD artery segment - pLAD
SNOMED CT	91748002	13 - mLAD	Mid-LAD artery segment - mLAD
SNOMED CT	36672000	14 - dLAD	Distal LAD artery segment - dLAD
SNOMED CT	91750005	15 - 1st Diag	First diagonal branch segment - 1st Diag
ACC NCDR	1000142404	15a - Lat 1st Diag	Lateral first diagonal branch segment - Lat 1st Diag
SNOMED CT	91751009	16 - 2nd Diag	Second diagonal branch segment - 2nd Diag
ACC NCDR	1000142405	16a - Lat 2nd Diag	Lateral second diagonal branch segment
SNOMED CT	244251006	17 - LAD SP	LAD septal perforator segments - LAD SP
SNOMED CT	52433000	18 - pCIRC	Proximal circumflex artery segment - pCIRC
SNOMED CT	91753007	19 - mCIRC	Mid-circumflex artery segment - mCIRC
SNOMED CT	6511003	19a - dCIRC	Distal circumflex artery segment - dCIRC
SNOMED CT	91754001	20 - 1st OM	First obtuse marginal branch segment - 1st OM
ACC NCDR	1000142406	20a - Lat 1st OM	Lateral first obtuse marginal branch segment - Lat 1st OM
SNOMED CT	91755000	21 - 2nd OM	Second obtuse marginal branch segment - 2nd OM
ACC NCDR	1000142407	21a - Lat 2nd OM	Lateral second obtuse marginal branch segment - Lat 2nd OM
SNOMED CT	91756004	22 - 3rd OM	Third obtuse marginal branch segment - 3rd OM
ACC NCDR	1000142408	22a - Lat 3rd OM	Lateral third obtuse marginal branch segment - Lat 3rd OM
SNOMED CT	75902001	23 - CIRC AV	Circumflex artery AV groove continuation segment - CIRC AV
SNOMED CT	91757008	24 - 1st LPL	First left posterolateral branch segment - 1st LPL
SNOMED CT	91758003	25 - 2nd LPL	Second left posterolateral branch segment - 2nd LPL
SNOMED CT	91759006	26 - 3rd LPL	Third posterolateral descending artery segment - 3rd LPL
SNOMED CT	56322004	27 - LPDA	Left posterolateral descending artery segment - LPDA
SNOMED CT	244252004	28 - Ramus	Ramus intermedius segment - Ramus
ACC NCDR	1000142409	28a - Lat Ramus	Lateral ramus intermedius segment - Lat Ramus

SNOMED CT	91752002	29 - 3rd Diag	Third diagonal branch segment - 3rd Diag
ACC NCDR	1000142410	29a - Lat 3rd Diag	Lateral third diagonal branch segment - Lat 3rd Diag

Element: 7528 Graft Coronary Vessel Stenosis

Code System Name	Code
ACC NCDR	100012982

Coding Instruction: Indicate the best estimate of the most severe percent stenosis in the segment of the graft vessel identified.

Note(s):
It is acceptable to use prior cath lab visit information, as long as there have been no changes in coronary anatomy. This includes stenosis determined via cardiac catheterization at another facility. This does not include collaterals.

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

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

Supporting Definition:

Element: 7529 CABG Graft Vessel

Code System Name	Code
ACC NCDR	100012983

Coding Instruction: Indicate the vessel that was used for the coronary artery bypass graft.

Target Value: The value on current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	261402001	LIMA	Left Internal Mammary Artery
SNOMED CT	261403006	RIMA	Right Internal Mammary Artery
SNOMED CT	362072009	SVG	Saphenous Vein Graft
SNOMED CT	181332001	Radial	Radial Artery

Element: 7530 CABG Graft Vessel Unknown

Code System Name	Code
ACC NCDR	100012983

Coding Instruction: Indicate if the vessel that was used for the coronary artery bypass graft was unknown.

Target Value: The value on current procedure

Supporting Definition:

Section: H. PCI Procedure **Parent: H. PCI Procedure**

Element: 12325 Percutaneous Coronary Intervention

Code System Name	Code
SNOMED CT	415070008

Coding Instruction: Indicate if the patient had a percutaneous coronary intervention (PCI).

Notes(s):
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.

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

Supporting Definition:

Element: 7051 PCI Operator Last Name

Code System Name	Code
ACC NCDR	1000142455

Coding Instruction: Indicate the last name of the operator who is performing the percutaneous coronary intervention.

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

Target Value: The value on current procedure

Supporting Definition:

Element: 7052 PCI Operator First Name

Code System Name	Code
ACC NCDR	1000142455

Coding Instruction: Indicate the first name of the operator who is performing the percutaneous coronary intervention.

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

Target Value: The value on current procedure

Supporting Definition:

Element: 7053 PCI Operator Middle Name

Code System Name	Code
ACC NCDR	1000142455

Coding Instruction: Indicate the middle name of the operator who is performing the percutaneous coronary intervention.

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

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

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

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

Target Value: The value on current procedure

Supporting Definition:

Element: 7054 PCI Operator NPI

Code System Name	Code
ACC NCDR	1000142455

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

Note(s):
The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the physician level, which may assist physicians with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging Provider roles, as supported by the patient medical record.

Target Value: The value on current procedure

Supporting Definition:

Element: 12327 Stent(s) Placed

Code System Name	Code
SNOMED CT	36969009

Coding Instruction: Indicate if a stent or stents were placed in the affected coronary artery.

Target Value: The first value on current procedure

Supporting Definition:

Element: 12328 Stent Type

Code System Name	Code
ACC NCDR	100000856

Coding Instruction: Indicate the type of stent used during the PCI.

Target Value: The first value on current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	464052002	BMS	A bare metal stent (BMS) is a coronary stent without eluting drugs.
SNOMED CT	411191007	DES	A drug-eluting stent is a coronary stent placed into narrowed, diseased coronary arteries that slowly releases a drug to prevent cell proliferation, thereby preventing fibrosis, that together with clots, could block the stented artery (restenosis).
SNOMED CT	705632009	Bioabsorbable	A bioabsorbable stent is a coronary stent placed into narrowed or diseased coronary arteries that is manufactured from a material that may dissolve or be absorbed by the body.

Element: 12449 Stent Type Unknown

Code System Name	Code
ACC NCDR	100000856

Coding Instruction: Indicate if the type of stent used in the current procedure is unknown.

Target Value: The value on current procedure

Supporting Definition:

Element: 7320 Arterial Access Site

Code System Name	Code
ACC NCDR	100014079

Coding Instruction: Indicate the location of percutaneous entry for the procedure.

Target Value: The last value on current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	7657000	Femoral	
SNOMED CT	17137000	Brachial	
SNOMED CT	45631007	Radial	
ACC NCDR	100013029	Other	Specific artery not available for selection in registry.

Element: 12326 Percutaneous Coronary Intervention Indication

Code System Name	Code
ACC NCDR	100000880

Coding Instruction: Indicate the primary reason PCI was performed or attempted.

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100000570	STEMI – Primary PCI for Acute STEMI	Immediate PCI for STEMI (or STEMI equivalent) PCI is performed emergently and without delay after diagnosis. This includes Unstable <= 12 hours in selection definition.
ACC NCDR	100012991	STEMI - Stable (<= 12 hrs from Sx)	PCI for STEMI (or STEMI equivalent occurs <= 12 hours from symptom. There are no symptoms of recurrent or persistent ischemia, symptoms of heart failure or electrical instability.
ACC NCDR	100000572	STEMI - Stable (> 12 hrs from Sx)	PCI for STEMI (or STEMI equivalent) occurs > 12 hours from symptom. There are no symptoms of recurrent or persistent ischemia, symptoms of heart failure or electrical instability.
ACC NCDR	100000571	STEMI - Unstable (> 12 hrs from Sx)	PCI for STEMI (or STEMI equivalent) > 12 hours from symptom with recurrent or persistent symptoms, symptoms of heart failure or ventricular arrhythmia.
ACC NCDR	100000573	STEMI (after successful lytics)	PCI for STEMI (or STEMI equivalent) after receiving full-dose thrombolysis. There are no symptoms of recurrent or persistent ischemia, symptoms of heart failure or electrical instability.
ACC NCDR	100000574	STEMI - Rescue (After unsuccessful lytics)	Rescue PCI for STEMI (or STEMI equivalent) after failed full-dose thrombolysis for symptoms of recurrent or persistent ischemia, symptoms of heart failure or electrical instability.
SNOMED CT	233821000	New Onset Angina <= 2 months	PCI is performed for the patient's new onset angina (typical or atypical angina) that developed within the previous two months.
ACC NCDR	100012990	NSTE - ACS	PCI for NSTEMI or unstable angina.

Element: 12338 Reason Primary PCI Not Performed

Code System Name	Code
ACC NCDR	112000000211

Coding Instruction: Indicate the one primary reason, documented in the medical record, that primary PCI was not performed as reperfusion therapy.

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	112000000195	No - No Reason	
ACC NCDR	112000000199	No - Medical Reason	Clear documentation of a reason related to the patient's medical issue or concern.
ACC NCDR	112000000197	No - Pt. Reason	

Element: 7422 Mechanical Ventricular Support

Code System Name	Code
ACC NCDR	100014009

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

Target Value: Any occurrence on current procedure

Supporting Definition:

Element: 7423 Mechanical Ventricular Support Device

Code System Name	Code
ACC NCDR	100001278

Coding Instruction: Indicate the mechanical ventricular support device used.

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

Target Value: Any occurrence on current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	1000142428	Cardiopulmonary Support (CPS)	The cardiopulmonary support system is an extracorporeal device that allows for rapid cardiopulmonary support of the critically ill patient in the intensive care unit. It provides immediate and complete support of cardiac and pulmonary functions to maintain perfusion to vital organs in patients who are severely physiologically compromised (eg, in cardiogenic shock, adult respiratory distress syndrome or pulmonary edema).
SNOMED CT	233573008	Extracorporeal membrane oxygenation (ECMO)	Extracorporeal membrane oxygenation (ECMO) or extracorporeal life support (ECLS) is an extracorporeal technique of providing both cardiac and respiratory support to persons whose heart and lungs are unable to provide an adequate amount of gas exchange to sustain life.
ACC NCDR	100014011	Impella: Left Ventricular Support	The Impella device is a minimally invasive, catheter-based cardiac assist device. It is the smallest rotary blood pump in the world. The pump is inserted percutaneously through the femoral artery and into the left ventricle.
ACC NCDR	112000000188	Impella: Right Ventricular Support	
SNOMED CT	442807006	Intra-aortic balloon pump (IABP)	An intra-aortic balloon pump (IABP) is a mechanical device that helps the heart pump blood.
SNOMED CT	232967006	Left ventricular assist device (LVAD)	A ventricular assist device (VAD) is an electromechanical circulatory device that is used to partially or completely replace the function of a failing heart.
SNOMED CT	360065002	Right Ventricular Assist Device (RVAD)	
ACC NCDR	1000142429	Percutaneous Heart Pump (PHP)	A percutaneous heart pump provides hemodynamic support for compromised patients.
ACC NCDR	100014010	TandemHeart	The TandemHeart Percutaneous Ventricular Assist Device (pVAD) differs from other assist devices in that it can be inserted either by cardiovascular surgeons in the operating room or by cardiologists in the cardiac catheterization laboratory. The TandemHeart pVAD is a continuous-flow centrifugal assist device placed outside the body (extracorporeally).

Element: 12333 Catheterization Laboratory Activated

Code System Name	Code
ACC NCDR	112000000210

Coding Instruction: Indicate if the catheterization laboratory was activated due to a patient need for a primary PCI.

Target Value: The first value between first medical contact and discharge

Supporting Definition:

Element: 12334 Catheterization Laboratory Activated Date and Time

Code System Name	Code
ACC NCDR	112000000210

Coding Instruction: Indicate the date and time the catheterization laboratory was activated due to a patient need for a primary PCI.

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

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

Supporting Definition:

Element: 12431 Catheterization Laboratory Activation Canceled

Code System Name	Code
ACC NCDR	112000000239

Coding Instruction: Indicate if the cath lab activation was canceled after being activated.

Target Value: Any occurrence between arrival at this facility and current procedure

Supporting Definition:

Element: 7845 First Device Activation Date and Time

Code System Name	Code
ACC NCDR	100012993

Coding Instruction: Indicate the date and time the first device was activated regardless of type of device used.

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

Use the earliest time from the following:
1. Time of the first balloon inflation.

2. Time of the first stent deployment.

3. Time of the first treatment of lesion (AngjoJet or other thrombectomy/aspiration device, laser, rotational atherectomy).

4. If the lesion cannot be crossed with a guidewire or device (and thus none of the above apply), use the time of guidewire introduction.

This is a process measure about the timeliness of treatment. It is NOT a clinical outcomes measure based on TIMI flow or clinical reperfusion. It does not matter whether the baseline angiogram showed TIMI 3 flow or if the final post-PCI angiogram showed TIMI 0 flow. What is being measured is the time of the first mechanical treatment of the culprit lesion, not the time when TIMI 3 flow was (or was not) restored.

Target Value: The first value on current procedure

Supporting Definition:

Element: 7850 Patient Centered Reason for Delay in PCI

Code System Name	Code
ACC NCDR	100013002

Coding Instruction: Indicate if there was a patient-centered reason for delay in performing the percutaneous coronary intervention (PCI).

Note(s):

A patient-centered reason for delay is an issue/condition understood and documented to originate with the patient. It is not associated with the health care system (i.e. facility, staff or processes, etc.).

To warrant coding 'Yes' the patient-centered reason(s) must be identified in the first 90min after arrival at this facility or in the first 90min after an in-house diagnosis of STEMI and be responsible for affecting the time to PCI.

If the issue is documented in the medical record and the effect on timing self-evident, it can be coded. If the effect on timing/delay to PCI is unclear, then there must be specific documentation by a physician/APN/PA that establishes the linkage between the patient issue/condition and the timing/delay in PCI.

Target Value: The first value on current procedure

Supporting Definition:

Element: 7851 Patient Centered Reason for Delay in PCI Reason

Code System Name	Code
ACC NCDR	100013000

Coding Instruction: Indicate the patient-centered reason for delay in performing the percutaneous coronary intervention (PCI).

Target Value: The first value on current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100000881	Difficult Vascular Access	The patient's anatomy is torturous, obstructive or otherwise prohibitive to the vascular access device. Do not select if the operator is unable to gain access due to inexperience or device selection, etc.
ACC NCDR	100000350	Difficulty crossing the culprit lesion	The patient's anatomy is torturous, obstructive or otherwise prohibitive to guidewire or device access. Do not select if the operator is unable to cross the culprit lesion due to inexperience or device selection, etc.
ACC NCDR	100013001	Cardiac Arrest and/or need for intubation before PCI	
ACC NCDR	100000349	Patient delays in providing consent for PCI	
ACC NCDR	1000142391	Emergent placement of LV support device before PCI	
ACC NCDR	100000351	Other	Not otherwise specified.

Section: PCI Procedure Medications **Parent: PCI Procedure Medications**

Element: 7990 PCI Procedure Medication Code

Code System Name	Code
ACC NCDR	100013057

Coding Instruction: Indicate the assigned identification number associated with the medications the patient 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: The value on current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	400610005	Bivalirudin	
RxNorm	321208	Fondaparinux	
ACC NCDR	100000921	Heparin Derivative	
SNOMED CT	373294004	Low Molecular Weight Heparin	
SNOMED CT	96382006	Unfractionated Heparin	
RxNorm	11289	Warfarin	
RxNorm	1537034	Vorapaxar	
ACC NCDR	1000142427	Glycoprotein IIb IIIa Inhibitors	
RxNorm	1364430	Apixaban	
RxNorm	1546356	Dabigatran	
RxNorm	1599538	Edoxaban	
RxNorm	1114195	Rivaroxaban	
RxNorm	1656052	Cangrelor	
RxNorm	32968	Clopidogrel	
RxNorm	613391	Prasugrel	
RxNorm	1116632	Ticagrelor	

Element: 7995 Procedure Medications Administered

Code System Name	Code
SNOMED CT	432102000

Coding Instruction: Indicate which medications were administered.

Target Value: Any occurrence between 24 hours prior to current procedure and end of current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	432102000	Yes	
ACC NCDR	100014173	No	

Section: I. Episode Events **Parent: I. Episode Events**

Element: 12304 Non-steroidal anti-inflammatory agent therapy

Code System Name	Code
SNOMED CT	713443004

Coding Instruction: Indicate if a non-steroidal anti-inflammatory drug (NSAID) was administered during the hospitalization.

Target Value: Any occurrence between arrival and discharge

Supporting Definition:

Element: 14212 Medical Reason for Administering Non-Steroidal Anti- Inflammatory Drug

Code System Name	Code
ACC NCDR	112000001735

Coding Instruction: Indicate if there was a medical reason the patient was administered an NSAID.

Note: For example patient with refractory arthritis pain that are unresponsive to other analgesics.

Target Value: Any occurrence between arrival and discharge

Supporting Definition:

Element: 12345 Packed Red Blood Cell Transfusion

Code System Name	Code
SNOMED CT	71493000

Coding Instruction: Indicate if there was a transfusion(s) of packed red blood cells.

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

Supporting Definition:

Element: 12354 Packed Red Blood Cell Transfusion Date

Code System Name	Code
SNOMED CT	71493000

Coding Instruction: Indicate the date of the first red blood cell transfusion.

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

Supporting Definition:

Element: 12353 Transfusion Related to CABG

Code System Name	Code
ACC NCDR	112000000212

Coding Instruction: Indicate if any red blood cell/whole blood transfusion was related to CABG.

Note(s):
If any units were given for reasons not related to CABG, check "No." Check "Yes" only if all transfusions given were related to CABG.

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

Supporting Definition:

Element: 12339 Hypothermia Induced

Code System Name	Code
SNOMED CT	308693008

Coding Instruction: Indicate if hypothermia was induced.

Note(s):

Hypothermia Induced is also known as Targeted Temperature Management (TTM).

Target Value: Any occurrence between first medical contact and discharge

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100013072	Yes	
ACC NCDR	112000000195	No - No Reason	
ACC NCDR	112000000199	No - Medical Reason	Clear documentation of a reason related to the patient's medical issue or concern.

Element: 12340 Hypothermia Induced Date and Time

Code System Name	Code
SNOMED CT	308693008

Coding Instruction: Indicate the date and time hypothermia was first induced.

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

Target Value: The first value between first medical contact and discharge

Supporting Definition:

Element: 12410 Location of Hypothermia Induction

Code System Name	Code
ACC NCDR	112000000240

Coding Instruction: Indicate the location where the hypothermia protocol was initiated.

Target Value: Any occurrence between first medical contact and discharge

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	112000000164	ED	Emergency Departments (ED) include traditional ED locations, such as ED-based chest pain units, clinics, and short-stay coronary-care units housed in the ED.
ACC NCDR	112000000165	Cath Lab	Area where diagnostic cardiac catheterizations or percutaneous coronary interventions are performed.
ACC NCDR	112000000241	ICU/CCU	Includes Cardiac or Intensive Care Unit.

Element: 12341 Level of Consciousness

Code System Name	Code
SNOMED CT	365931003

Coding Instruction: Indicate the level of consciousness after resuscitation as measured by the AVPU scale.

Target Value: The highest value between first medical contact and discharge

Supporting Definition: **Level of Consciousness**

The presence of consciousness on admission to hospital and the speed at which consciousness returns following cardiac arrest has been shown to be an indicator of neurological survival following out of hospital cardiac arrest (OHCA).

Source: Deakin, Charles D., Fothergill, Rachael, Moore, Fionna, Watson, Lynne, Whitbread, Mark, Level of consciousness on admission to a Heart Attack Centre is a predictor of survival from out-of-hospital cardiac arrest, Resuscitation (2014) doi: 10.1016/j.resuscitation.2014.02.020.

Code System Name	Code	Selection Text	Definition
SNOMED CT	248234008	(A) Alert	Spontaneously open eyes, responding to voice (although may be confused) and motor function.
SNOMED CT	284592002	(V) Verbal	Responding to verbal stimuli.
ACC NCDR	100013043	(P) Pain	Responding to painful stimuli.
SNOMED CT	422768004	(U) Unresponsive	No eye, voice or motor response to voice or pain.
ACC NCDR	100014234	Unable to Assess	Unable to assess level of consciousness. (Example: Patient Sedated)

Section: Hospitalization Events **Parent: Hospitalization Events**

Element: 12342 Episode Events

Code System Name	Code
ACC NCDR	1000142478

Coding Instruction: Indicate the event that occurred during the hospitalization.

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	49436004	Atrial Fibrillation	Atrial Fibrillation is a supraventricular tachyarrhythmia characterized by uncoordinated atrial activity with consequent deterioration of atrial mechanical function. On the electrocardiogram (ECG), atrial fibrillation is characterized by the replacement of consistent P waves with rapid oscillations or fibrillation waves that vary in amplitude, shape and timing, associated with an irregular, frequently rapid ventricular response when atrioventricular conduction is intact.
ACC NCDR	1000142440	Bleeding - Access Site	Indicate if the patient experienced a confirmed bleeding event at the access site observed and documented in the medical record that was associated with any of the following: 1. Hemoglobin drop of >=3 g/dL; 2. Transfusion of whole blood or packed red blood cells; 3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding (such as surgical closures/exploration of the arteriotomy site, balloon angioplasty to seal an arterial tear, endoscopy with cautery of a GI bleed).
SNOMED CT	74474003	Bleeding - Gastrointestinal	Indicate if the patient experienced a confirmed gastrointestinal bleeding event observed and documented in the medical record that was associated with any of the following: 1. Hemoglobin drop of >=3 g/dL; 2. Transfusion of whole blood or packed red blood cells; 3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding (such as surgical closures/exploration of the arteriotomy site, balloon angioplasty to seal an arterial tear, endoscopy with cautery of a GI bleed).
SNOMED CT	417941003	Bleeding - Genitourinary	Indicate if the patient experienced a confirmed genitourinary bleeding event observed and documented in the medical record that was associated with any of the following: 1. Hemoglobin drop of >=3 g/dL; 2. Transfusion of whole blood or packed red blood cells; 3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding (such as surgical closures/exploration of the arteriotomy site, balloon angioplasty to seal an arterial tear, endoscopy with cautery of a GI bleed).
ACC NCDR	1000142371	Bleeding - Other	Indicate if the patient experienced a confirmed bleeding event not available for selection within the registry that was observed and documented in the medical record that was associated with any of the following: 1. Hemoglobin drop of >=3 g/dL; 2. Transfusion of whole blood or packed red blood

			cells; 3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding (such as surgical closures/exploration of the arteriotomy site, balloon angioplasty to seal an arterial tear, endoscopy with cautery of a GI bleed).
SNOMED CT	95549001	Bleeding - Retroperitoneal	Indicate if the patient experienced a confirmed retroperioneal bleeding event observed and documented in the medical record that was associated with any of the following: 1. Hemoglobin drop of >=3 g/dL; 2. Transfusion of whole blood or packed red blood cells; 3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding (such as surgical closures/exploration of the arteriotomy site, balloon angioplasty to seal an arterial tear, endoscopy with cautery of a GI bleed).
ACC NCDR	112000000213	Bleeding - Surgical Procedure or Intervention Required for Bleeding Event	
SNOMED CT	410429000	Cardiac Arrest	Cardiac arrest is defined as acute cardiac event documented by one of the following: ventricular fibrillation, rapid ventricular tachycardia or bradycardia rhythms with hemodynamic compromise causing loss of consciousness, pulseless rhythms (PEA), or asystole requiring cardiopulmonary resuscitation (two or more chest compressions or open chest massage, emergency temporary pacing, pericardiocentesis, institution of ECMO, or defibrillation) and without these measures death would have almost certainly resulted.
SNOMED CT	89138009	Cardiogenic Shock	
SNOMED CT	84114007	Heart Failure	Heart failure is a complex clinical syndrome that results from any structural or functional impairment of ventricular filling or ejection of blood. The cardinal manifestations of HF are dyspnea and fatigue, which may limit exercise tolerance, and fluid retention, which may lead to pulmonary and/or splanchnic congestion and/or peripheral edema. Some patients have exercise intolerance but little evidence of fluid retention, whereas others complain primarily of edema, dyspnea, or fatigue. Because some patients present without signs or symptoms of volume overload, the term "heart failure" is preferred over "congestive heart failure." There is no single diagnostic test for HF because it is largely a clinical diagnosis based on a careful history and physical examination.
SNOMED CT	52765003	Intubation	
SNOMED CT	22298006	Myocardial Infarction	The term acute myocardial infarction (MI) should be used when there is evidence of myocardial necrosis in a clinical setting consistent with acute myocardial ischemia. Under these conditions any one of the following criteria meets the diagnosis for MI: - Detection of a rise and/or fall of cardiac biomarker values [preferably cardiac troponin (cTn) with at least one value above the 99th percentile upper reference limit (URL) and with at least one of the following: Symptoms of ischemia. New or presumed new significant ST-segment-T wave (ST-T) changes or new left bundle branch block (LBBB). Development of pathological Q waves in the ECG. Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality. Identification of an intracoronary thrombus by angiography or autopsy.

			- Cardiac death with symptoms suggestive of myocardial ischemia and presumed new ischemic ECG changes or new LBBB, but death occurred before cardiac biomarkers were obtained, or before cardiac biomarker values would be increased. - Percutaneous coronary intervention (PCI) related MI is arbitrarily defined by elevation of cTn values (>5 x 99th percentile URL) in patients with normal baseline values (99th percentile URL) or a rise of cTn values >20% if the baseline values are elevated and are stable or falling. In addition, either (i) symptoms suggestive of myocardial ischemia or (ii) new ischemic ECG changes or (iii) angiographic findings consistent with a procedural complication or (iv) imaging demonstration of new loss of viable myocardium or new regional wall motion abnormality are required. - Stent thrombosis associated with MI when detected by coronary angiography or autopsy in the setting of myocardial ischemia and with a rise and/or fall of cardiac biomarker values with at least one value above the 99th percentile URL. - Coronary artery bypass grafting (CABG) related MI is arbitrarily defined by elevation of cardiac biomarker values (>10 x 99th percentile URL) in patients with normal baseline cTn values (99th percentile URL). In addition, either (i) new pathological Q waves or new LBBB, or (ii) angiographic documented new graft or new native coronary artery occlusion, or (iii) imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.
ACC NCDR	100014076	New Requirement for Dialysis	Indicate if the patient experienced acute or worsening renal failure necessitating renal dialysis.
SNOMED CT	230706003	Stroke - Hemorrhagic	Hemorrhage may be a consequence of ischemic stroke. In this situation, the stroke is an ischemic stroke with hemorrhagic transformation and not a hemorrhagic stroke. Hemorrhagic stroke is defined as an acute episode of focal or global cerebral or spinal dysfunction caused by intraparenchymal, intraventricular, or subarachnoid hemorrhage. Note: Subdural hematomas are intracranial hemorrhagic events and not strokes.
SNOMED CT	422504002	Stroke - Ischemic	An ischemic stroke is an acute episode of focal or global neurological dysfunction caused by brain, spinal cord, or retinal vascular injury as a result of infarction of central nervous system tissue.
SNOMED CT	230713003	Stroke - Undetermined	A stroke of undetermined origin is defined as an acute episode of focal or global neurological dysfunction caused by presumed brain, spinal cord, or retinal vascular injury as a result of hemorrhage or infarction but with insufficient information to allow categorization as ischemic or hemorrhagic.
SNOMED CT	266257000	Transient Ischemic Attack (TIA)	Transient episode of focal neurological dysfunction caused by brain, spinal cord, or retinal ischemia without acute infarction.
SNOMED CT	71908006	Ventricular Fibrillation	
SNOMED CT	25569003	Ventricular Tachycardia	Code 'Yes' if a run of greater than or equal to 7 beats of ventricular tachycardia is documented in the record.

Element: 12344 Episode Events Occurred

Code System Name **Code**

ACC NCDR	1000142479

Coding Instruction: Indicate if the episode event did or did not occur.

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

Supporting Definition:

Element: 12343 Episode Event Date and Time

Code System Name	Code
ACC NCDR	10001424780

Coding Instruction: Indicate the date and time the event occurred.

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

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

Supporting Definition:

Section: J. Discharge **Parent: J. Discharge**

Element: 10101 Discharge Date and Time

Code System Name	Code
ACC NCDR	1000142457

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

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

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

0000 - 0559 (midnight to before 6AM) code 0300
0600 - 1159 (6AM - before noon) code 0900
1200 - 1759 (noon to before 8PM) code 1500
1800 - 2359 (8PM to before midnight) code 2100

Target Value: The value on discharge

Supporting Definition:

Element: 10070 Discharge Provider's Last Name

Code System Name	Code
ACC NCDR	1000142453

Coding Instruction: Indicate the last name of the discharge provider.

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

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the physician level, which may assist physicians with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging Provider roles, as supported by the patient medical record.

Target Value: The value on discharge

Supporting Definition:

Element: 10071 Discharge Provider's First Name

Code System Name	Code
ACC NCDR	1000142453

Coding Instruction: Indicate the first name of the discharge provider.

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

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the physician level, which may assist physicians with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging Provider roles, as supported by the patient medical record.

Target Value: The value on discharge

Supporting Definition:

Element: 10072 Discharge Provider's Middle Name

Code System Name	Code
ACC NCDR	1000142453

Coding Instruction: Indicate the middle name of the discharge provider.

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.

The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the physician level, which may assist physicians with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging Provider roles, as supported by the patient medical record.

Target Value: The value on discharge

Supporting Definition:

Element: 10073 Discharge Provider's NPI

Code System Name	Code
ACC NCDR	1000142453

Coding Instruction: Indicate the National Provider Identifier (NPI) of the provider that discharged the patient. NPI's, assigned by the Centers for Medicare and Medicaid Services (CMS), are used to uniquely identify physicians for Medicare billing purposes.

Note(s):
The completion of this data element is voluntary and at the discretion of your facility. NCDR will use the data to provide reporting at the physician level, which may assist physicians with demonstrating value based care as well as support your facility's engagement in quality improvement efforts. If completed, NCDR will defer to your facility's determination of assigning Admitting, Attending, and Discharging Provider roles, as supported by the patient medical record.

Target Value: The value on discharge

Supporting Definition:

Element: 10075 Comfort Measures Only

Code System Name	Code
SNOMED CT	133918004

Coding Instruction: Indicate if there was physician/nurse practitioner/physician assistant documentation that the patient was receiving comfort measures.

Note(s):
Comfort Measures are not equivalent to the following: Do Not Resuscitate (DNR), living will, no code, no heroic measures.

Comfort measures are commonly referred to as palliative care in the medical community and comfort care by the general public. Palliative care includes attention to the psychological and spiritual needs of the patient and support for the dying patient and the patient's family. Usual interventions are not received because a medical decision was made to limit care to comfort measures only.

Target Value: The value on discharge

Supporting Definition: **Comfort Measures Only**

Comfort Measures Only refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient's family. Comfort Measures Only is commonly referred to as ""comfort care"" by the general public. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).

Source: Specifications Manual for Joint Commission National Quality Measures (v2015A)

Element: 12413 Comfort Measures Only Date and Time

Code System Name	Code
SNOMED CT	133918004

Coding Instruction: Indicate the date and time the comfort measures order was written.

Note(s):

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

Target Value: The value on discharge

Supporting Definition: **Comfort Measures Only**

Comfort Measures Only refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient's family. Comfort Measures Only is commonly referred to as ""comfort care"" by the general public. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).

Source: Specifications Manual for Joint Commission National Quality Measures (v2015A)

Element: 12412 Enrolled in Clinical Trial During Hospitalization

Code System Name	Code
ACC NCDR	112000000242

Coding Instruction: Indicate if the patient was participating in a clinical trial during his/her hospitalization.

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

Supporting Definition:

Element: 12456 Type of Clinical Trial

Code System Name	Code
ACC NCDR	112000000306

Coding Instruction: Indicate the type of clinical trial the patient was involved in.

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	112000000243	Precluding the use of aspirin in protocol	
ACC NCDR	112000000245	Related to reperfusion therapy	
ACC NCDR	112000000247	Involving new antiplatelet therapies	
ACC NCDR	112000000249	Involving renin-angiotensin-aldosterone system inhibitor	
ACC NCDR	112000000244	Related to lipid lowering therapy	
ACC NCDR	112000000246	Related to AMI	
ACC NCDR	112000000248	Related to STEMI	

Element: 10105 Discharge Status

Code System Name	Code
LOINC	75527-2

Coding Instruction: Indicate whether the patient was alive or deceased at discharge.

Target Value: The value on discharge

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	438949009	Alive	
HL7 Discharge disposition	20	Deceased	

Element: 10116 Cardiac Rehabilitation Referral

Code System Name	Code
ACC NCDR	100014067

Coding Instruction: Indicate if there was written documentation of a referral for the patient (by the physician, nurse, or other personnel) to an outpatient cardiac rehabilitation program, or a documented medical or patient-centered reason why such a referral was not made.

The program may include a traditional cardiac rehabilitation program based on face-to-face interactions and training sessions or may include other options such as home-based approaches.

Target Value: The value on discharge

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100013072	Yes	
ACC NCDR	100014064	No - Reason Not Documented	
ACC NCDR	100014066	No - Medical Reason Documented	Patient deemed by a medical provider to have a medically unstable, life-threatening condition or has other cognitive or physical impairments that preclude CR participation.
ACC NCDR	100014065	No - Health Care System Reason Documented	Patient is discharged to a nursing care or long-term care facility, or patient lacks medical coverage for CR.
ACC NCDR	112000000520	No - Patient - Oriented Reason	No traditional CR program available to the patient, within 60 min [travel time] from the patient's home, or patient does not have access to an alternative model of CR delivery that meets all criteria for a CR program.

Element: 10110 Discharge Location

Code System Name	Code
LOINC	75528-0

Coding Instruction: Indicate the location to which the patient was discharged.

Target Value: The value on discharge

Supporting Definition:

Code System Name	Code	Selection Text	Definition
HL7 Discharge disposition	01	Home	
HL7 Discharge disposition	62	Discharged/transferred to an Extended care/TCU/rehab	An Extended Care/transitional care/rehab unit (selection 2) typically provides a high level of intensive therapy as well as specialized nursing and physician care. This discharge setting may also be called subacute care or long term acute care (LTACH).
HL7 Discharge disposition	02	Other acute care hospital	
HL7 Discharge disposition	64	Skilled Nursing facility	Skilled nursing facilities are typically for longer anticipated length of stay, as there are fewer requirements placed on subacute programs. An acute rehabilitation unit may be part of a skilled nursing facility (SNF), however, it is the higher level of care (acute rehab).
ACC NCDR	100001249	Other Discharge Location	
HL7 Discharge disposition	07	Left against medical advice (AMA)	The patient was discharged or eloped against medical advice.

Element: 12414 Transfer Date and Time

Code System Name	Code
ACC NCDR	112000000250

Coding Instruction: Indicate the date and time the patient was transferred to another acute-care hospital for further management.

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

Target Value: The value on discharge

Supporting Definition:

Element: 12415 Transfer for Primary Percutaneous Coronary Intervention

Code System Name	Code
ACC NCDR	112000000251

Coding Instruction: Indicate if the patient was transferred to another facility for percutaneous coronary intervention (PCI).

Target Value: The value on time of transfer

Supporting Definition:

Element: 12416 Transfer for Coronary Artery Bypass Graft

Code System Name	Code
ACC NCDR	112000000252

Coding Instruction: Indicate if the patient was transferred to another facility for coronary artery bypass graft (CABG) surgery.

Target Value: The value on time of transfer

Supporting Definition:

Element: 10115 Hospice Care

Code System Name	Code
SNOMED CT	385763009

Coding Instruction: Indicate if the patient was discharged to hospice care.

Target Value: The value on discharge

Supporting Definition:

Element: 12411 Hospice Care Order Date and Time

Code System Name	Code
SNOMED CT	385763009

Coding Instruction: Indicate the date and time the hospice order was written.

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

Target Value: The value on discharge

Supporting Definition:

Element: 10125 Cause of Death

Code System Name	Code
SNOMED CT	184305005

Coding Instruction: Indicate the primary cause of death, i.e. the first significant abnormal event which ultimately led to death.

Target Value: The value on time of death

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100000960	Acute myocardial infarction	Death by any cardiovascular mechanism (e.g., arrhythmia, sudden death, heart failure, stroke, pulmonary embolus, peripheral arterial disease) within 30 days after an acute myocardial infarction, related to the immediate consequences of the MI, such as progressive HF or recalcitrant arrhythmia. There may be other assessable (attributable) mechanisms of cardiovascular death during this time period, but for simplicity, if the cardiovascular death occurs <=30 days of an acute myocardial infarction, it will be considered a death due to myocardial infarction.
ACC NCDR	100000978	Sudden cardiac death	Death that occurs unexpectedly, and not within 30 days of an acute MI.
ACC NCDR	100000964	Heart failure	Death associated with clinically worsening symptoms and/or signs of heart failure.
ACC NCDR	100000977	Stroke	Death after a stroke that is either a direct consequence of the stroke or a complication of the stroke.
ACC NCDR	100000962	Cardiovascular procedure	Death caused by the immediate complication(s) of a cardiovascular procedure.
ACC NCDR	100000961	Cardiovascular hemorrhage	Death related to hemorrhage such as a non-stroke intracranial hemorrhage, non-procedural or non-traumatic vascular rupture (e.g., aortic aneurysm), or hemorrhage causing cardiac tamponade.
ACC NCDR	100000972	Other cardiovascular reason	Cardiovascular death not included in the above categories but with a specific, known cause (e.g., pulmonary embolism, peripheral arterial disease).
ACC NCDR	100000975	Pulmonary	Non-cardiovascular death attributable to disease of the lungs (excludes malignancy).
ACC NCDR	100000976	Renal	Non-cardiovascular death attributable to renal failure.
ACC NCDR	100000963	Gastrointestinal	Non-cardiovascular death attributable to disease of the esophagus, stomach, or intestines (excludes malignancy).
ACC NCDR	100000966	Hepatobiliary	Non-cardiovascular death attributable to disease of the liver, gall bladder, or biliary ducts (exclude malignancy).
ACC NCDR	100000974	Pancreatic	Non-cardiovascular death attributable to disease of the pancreas (excludes malignancy).
ACC NCDR	100000967	Infection	Non-cardiovascular death attributable to an infectious disease.
ACC NCDR	100000968	Inflammatory/Immunologic	Non-cardiovascular death attributable to an inflammatory or immunologic disease process.
ACC NCDR	100000965	Hemorrhage	Non-cardiovascular death attributable to bleeding that is not considered cardiovascular hemorrhage or stroke per this classification.
ACC NCDR	100000971	Non-cardiovascular procedure or surgery	Death caused by the immediate complication(s) of a non-cardiovascular procedure or surgery.
ACC NCDR	100000980	Trauma	Non-cardiovascular death attributable to trauma.
ACC NCDR	100000979	Suicide	Non-cardiovascular death attributable to suicide.
ACC NCDR	100000970	Neurological	Non-cardiovascular death attributable to disease of the nervous system (excludes malignancy).
ACC NCDR	100000969	Malignancy	Non-cardiovascular death attributable to malignancy.
ACC NCDR	100000973	Other non-cardiovascular reason	Non-cardiovascular death attributable to a cause other than those listed in this classification (specify organ system).

Element: 14187 Medical Reason for Not Prescribing High-Dose Statin

Code System Name	Code
ACC NCDR	112000001708

Coding Instruction: Indicate if there was a medical reason the patient was not prescribed a high-dose statin if a moderate or low-dose statin was prescribed.

Target Value: The last value on discharge

Supporting Definition:

Section: Discharge Medications **Parent: Discharge Medications**

Element: 10200 Discharge Medication Code

Code System Name	Code
ACC NCDR	100013057

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	41549009	Angiotensin Converting Enzyme Inhibitor	
SNOMED CT	372603003	Aldosterone Antagonist	
RxNorm	11289	Warfarin	
RxNorm	1191	Aspirin	
SNOMED CT	372913009	Angiotensin II Receptor Blocker	
SNOMED CT	33252009	Beta Blocker	
RxNorm	1656341	Sacubitril and Valsartan	
ACC NCDR	100014161	Non-Statin	
RxNorm	1364430	Apixaban	
RxNorm	1546356	Dabigatran	
RxNorm	1599538	Edoxaban	
RxNorm	1114195	Rivaroxaban	
RxNorm	32968	Clopidogrel	
RxNorm	613391	Prasugrel	
RxNorm	1116632	Ticagrelor	
SNOMED CT	96302009	Statin	

Element: 10205 Discharge Medication Prescribed

Code System Name	Code
SNOMED CT	432102000

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

Note(s):
Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care is 'Yes'.

Target Value: The value on discharge

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100001247	Yes - Prescribed	Code 'Yes' if this medication was initiated (or prescribed) post procedure and for discharge.
ACC NCDR	100001048	Not Prescribed - No Reason	Code 'No' if this medication was not prescribed post procedure or for discharge and there was no mention of a reason why it was not ordered within the medical documentation.
ACC NCDR	100001034	Not Prescribed - Medical Reason	Code 'No Medical Reason' if this medication was not prescribed post procedure or for discharge and there was a reason documented related to a medical issue or medical concern for not prescribing the medicine.
ACC NCDR	100001071	Not Prescribed - Patient Reason	Code 'No, Patient Reason' if this medication was not prescribed post procedure or for discharge and there was a reason documented related to the patient's preference.

Element: 10207 Discharge Medication Dose

Code System Name	Code
ACC NCDR	100014233

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

Target Value: The value on discharge

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100014036	Low Intensity Dose	Daily dose lowers LDL-C, on average, by <30% Fluvastatin 20-40 mg Lovastatin 20 mg Pitavastatin 1 mg Pravastatin 10-20 mg Simvastatin 10 mg
ACC NCDR	100014035	Moderate Intensity Dose	Daily dose lowers LDL-C, on average, by approximately 30% to <50% Atorvastatin 10-20 mg Fluvastatin 40 mg twice daily Fluvastatin XL 80 mg Lovastatin 40 mg Pitavastatin 2-4 mg Pravastatin 40-80 mg Rosuvastatin 5-10 mg Simvastatin 20-40 mg
ACC NCDR	100014034	High Intensity Dose	Daily dose lowers LDL-C, on average, by approximately >=50% Atorvastatin 40-80 mg Rosuvastatin 20-40 mg

Section: K. Follow-Up **Parent: K. Follow-Up**

Element: 10999 Follow-Up Unique Key

Code System Name	Code
ACC NCDR	1000142426

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

Target Value: N/A

Supporting Definition:

Element: 11000 Follow-Up Assessment Date

Code System Name	Code
ACC NCDR	1000142364

Coding Instruction: Indicate the date of the follow-up assessment was performed.

Target Value: The value on Follow-up

Supporting Definition:

Element: 12537 Follow-Up Reference Admission Date Time

Code System Name	Code
ACC NCDR	112000000366

Coding Instruction: Indicate the date and time of admission for the reference episode of care.

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

Target Value: The value on Follow-up

Supporting Definition:

Element: 11015 Follow-Up Reference Episode Discharge Date and Time

Code System Name	Code
ACC NCDR	1000142437

Coding Instruction: Indicate the date and time of discharge for the episode of care that included the reference procedure.

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

Target Value: The value on Follow-up

Supporting Definition:

Element: 11003 Method to Determine Follow-Up Status

Code System Name	Code
ACC NCDR	100014059

Coding Instruction: Indicate the method to determine follow-up status.

Target Value: The value on Follow-up

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	183654001	Office Visit	
ACC NCDR	100014060	Medical Records	
ACC NCDR	100014061	Letter from Medical Provider	
ACC NCDR	100014062	Phone Call	
ACC NCDR	1000142362	Social Security Death Master File	
ACC NCDR	1000142363	Hospitalized	
ACC NCDR	100000351	Other	Not otherwise specified.

Element: 11004 Follow-Up Status

Code System Name	Code
SNOMED CT	308273005

Coding Instruction: Indicate whether the patient was alive or deceased at the date the follow-up was performed.

Target Value: The value on Follow-up

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	438949009	Alive	
HL7 Discharge disposition	20	Deceased	
SNOMED CT	399307001	Lost to follow-up	

Element: 12424 Enrolled in Cardiac Rehabilitation Program

Code System Name	Code
ACC NCDR	112000000260

Coding Instruction: Indicate if the patient enrolled in a cardiac rehab program since discharge.

Target Value: The value on Follow-up

Supporting Definition:

Element: 12425 Attended Cardiac Rehabilitation Program Date

Code System Name	Code
ACC NCDR	112000000260

Coding Instruction: Indicate the date the patient first attended a cardiac rehabilitation program.

Note(s):
It is appropriate to code the date of the first attendance of cardiac rehab.

Target Value: The value on Follow-up

Supporting Definition:

Element: 11006 Follow-Up Date of Death

Code System Name	Code
ACC NCDR	1000142373

Coding Instruction: Indicate the date the patient was declared dead.

Target Value: The value on Follow-up

Supporting Definition:

Element: 11007 Cause of Death

Code System Name	Code
SNOMED CT	184305005

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100000960	Acute myocardial infarction	Death by any cardiovascular mechanism (e.g., arrhythmia, sudden death, heart failure, stroke, pulmonary embolus, peripheral arterial disease) within 30 days after an acute myocardial infarction, related to the immediate consequences of the MI, such as progressive HF or recalcitrant arrhythmia. There may be other assessable (attributable) mechanisms of cardiovascular death during this time period, but for simplicity, if the cardiovascular death occurs <=30 days of an acute myocardial infarction, it will be considered a death due to myocardial infarction.
ACC NCDR	100000978	Sudden cardiac death	Death that occurs unexpectedly, and not within 30 days of an acute MI.
ACC NCDR	100000964	Heart failure	Death associated with clinically worsening symptoms and/or signs of heart failure.
ACC NCDR	100000977	Stroke	Death after a stroke that is either a direct consequence of the stroke or a complication of the stroke.
ACC NCDR	100000962	Cardiovascular procedure	Death caused by the immediate complication(s) of a cardiovascular procedure.
ACC NCDR	100000961	Cardiovascular hemorrhage	Death related to hemorrhage such as a non-stroke intracranial hemorrhage, non-procedural or non-traumatic vascular rupture (e.g., aortic aneurysm), or hemorrhage causing cardiac tamponade.
ACC NCDR	100000972	Other cardiovascular reason	Cardiovascular death not included in the above categories but with a specific, known cause (e.g., pulmonary embolism, peripheral arterial disease).
ACC NCDR	100000975	Pulmonary	Non-cardiovascular death attributable to disease of the lungs (excludes malignancy).
ACC NCDR	100000976	Renal	Non-cardiovascular death attributable to renal failure.
ACC NCDR	100000963	Gastrointestinal	Non-cardiovascular death attributable to disease of the esophagus, stomach, or intestines (excludes malignancy).
ACC NCDR	100000966	Hepatobiliary	Non-cardiovascular death attributable to disease of the liver, gall bladder, or biliary ducts (exclude malignancy).
ACC NCDR	100000974	Pancreatic	Non-cardiovascular death attributable to disease of the pancreas (excludes malignancy).
ACC NCDR	100000967	Infection	Non-cardiovascular death attributable to an infectious disease.
ACC NCDR	100000968	Inflammatory/Immunologic	Non-cardiovascular death attributable to an inflammatory or immunologic disease process.
ACC NCDR	100000965	Hemorrhage	Non-cardiovascular death attributable to bleeding that is not considered cardiovascular hemorrhage or stroke per this classification.
ACC NCDR	100000971	Non-cardiovascular procedure or surgery	Death caused by the immediate complication(s) of a non-cardiovascular procedure or surgery.
ACC NCDR	100000980	Trauma	Non-cardiovascular death attributable to trauma.
ACC NCDR	100000979	Suicide	Non-cardiovascular death attributable to suicide.
ACC NCDR	100000970	Neurological	Non-cardiovascular death attributable to disease of the nervous system (excludes malignancy).
ACC NCDR	100000969	Malignancy	Non-cardiovascular death attributable to malignancy.
ACC NCDR	100000973	Other non-cardiovascular reason	Non-cardiovascular death attributable to a cause other than those listed in this classification (specify organ system).

Section: Follow-Up Events **Parent: Follow-Up Events**

Element: 11011 Follow-Up Events

Code System Name	Code
ACC NCDR	1000142377

Coding Instruction: Indicate the event(s) assessed for the patient.

Note: Multiple instances of the same event may be identified if the event occurred more than once during the target timeframe.

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	112000000308	CABG: Planned	
ACC NCDR	112000000309	CABG: Unplanned	
SNOMED CT	84114007	Heart Failure	Heart failure is a complex clinical syndrome that results from any structural or functional impairment of ventricular filling or ejection of blood. The cardinal manifestations of HF are dyspnea and fatigue, which may limit exercise tolerance, and fluid retention, which may lead to pulmonary and/or splanchnic congestion and/or peripheral edema. Some patients have exercise intolerance but little evidence of fluid retention, whereas others complain primarily of edema, dyspnea, or fatigue. Because some patients present without signs or symptoms of volume overload, the term "heart failure" is preferred over "congestive heart failure." There is no single diagnostic test for HF because it is largely a clinical diagnosis based on a careful history and physical examination.
SNOMED CT	401314000	Myocardial Infarction: NSTEMI	The absence of persistent ST-elevation is suggestive of NSTE-ACS (except in patients with true posterior myocardial infarction (MI), NSTE-ACS can be further subdivided on the basis of cardiac biomarkers of necrosis (e.g., cardiac troponin, Sections 3.2.4 and 3.4). If cardiac biomarkers are elevated and the clinical context is appropriate, the patient is considered to have NSTEMI; otherwise, the patient is deemed to have UA.
SNOMED CT	401303003	Myocardial Infarction: STEMI	A key branch point is ST-segment elevation (ST-elevation) or new left bundle-branch block on the electrocardiogram (ECG), which is an indication for immediate coronary angiography to determine if there is an indication for reperfusion therapy to open a likely completely occluded coronary artery.
ACC NCDR	112000000310	PCI Planned	
ACC NCDR	112000000311	PCI Unplanned	
ACC NCDR	112000000312	Readmission	
SNOMED CT	36225005	Renal Failure	
SNOMED CT	230706003	Stroke - Hemorrhagic	Hemorrhage may be a consequence of ischemic stroke. In this situation, the stroke is an ischemic stroke with hemorrhagic transformation and not a hemorrhagic stroke. Hemorrhagic stroke is defined as an acute episode of focal or global cerebral or spinal dysfunction caused by intraparenchymal, intraventricular, or subarachnoid hemorrhage.

			Note: Subdural hematomas are intracranial hemorrhagic events and not strokes.
SNOMED CT	422504002	Stroke - Ischemic	An ischemic stroke is an acute episode of focal or global neurological dysfunction caused by brain, spinal cord, or retinal vascular injury as a result of infarction of central nervous system tissue.
SNOMED CT	230713003	Stroke - Undetermined	A stroke of undetermined origin is defined as an acute episode of focal or global neurological dysfunction caused by presumed brain, spinal cord, or retinal vascular injury as a result of hemorrhage or infarction but with insufficient information to allow categorization as ischemic or hemorrhagic.

Element: 11012 Follow-Up Events Occurred

Code System Name	Code
ACC NCDR	1000142378

Coding Instruction: Indicate if the event(s) occurred.

Target Value: Any occurrence between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition:

Element: 11014 Follow-Up Event Dates

Code System Name	Code
ACC NCDR	1000142379

Coding Instruction: Identify each date when the specified event occurred.

If an event occurred more than once on the same date, record the event multiple times with the same date.

If an event occurred more than once in the target timeframe but on different dates, record the event multiple times but with unique dates.

Target Value: All values between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition:

Section: L. Administration **Parent: L. Administration**

Element: 1000 Participant ID

Code System Name	Code
ACC NCDR	2.16.840.1.113883.3.3478.4.836

Coding Instruction: Indicate the participant ID of the submitting facility.

Target Value: N/A

Supporting Definition: **Participant ID**

Participant ID is a unique number assigned to each database participant by NCDR. A database participant is defined as one entity that signs a Participation Agreement with the NCDR, submits one data submission file to the harvest, and receives one report on their data.

Each participant's data if submitted to harvest must be in one data submission file for a quarter. If one participant keeps their data in more than one file (e.g. at two sites), then the data must be combined into a single data submission to the system to file for the harvest. If two or more participants share a single purchased software, and enter cases into one database, then the data must be exported into different data submission files, one for each participant ID.

Source: NCDR

Element: 1010 Participant Name

Code System Name	Code
ACC NCDR	2.16.840.1.113883.3.3478.4.836

Coding Instruction: Indicate the full name of the facility where the procedure was performed.

Note(s):
Values should be full, official hospital names with no abbreviations or variations in spelling.

Target Value: N/A

Supporting Definition: **Participant Name**

Indicate the full name of the facility where the procedure was performed. Values should be full, official hospital names with no abbreviations or variations in spelling.

Source: NCDR

Element: 1020 Time Frame of Data Submission

Code System Name	Code
ACC NCDR	1.3.6.1.4.1.19376.1.4.1.6.5.45

Coding Instruction: Indicate the time frame of data included in the data submission. Format: YYYYQQ. e.g.,2016Q1

Target Value: N/A

Supporting Definition:

Element: 1040 Transmission Number

Code System Name	Code
ACC NCDR	1.3.6.1.4.1.19376.1.4.1.6.5.45

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

Supporting Definition:

Element: 1050 Vendor Identifier

Code System Name	Code
ACC NCDR	2.16.840.1.113883.3.3478.4.840

Coding Instruction: Vendor identification (agreed upon by mutual selection between the vendor and the NCDR) to identify software vendor. This is entered into the schema automatically by vendor software. Vendors must use consistent name identification across sites. Changes to vendor name identification must be approved by the NCDR.

Target Value: N/A

Supporting Definition:

Element: 1060 Vendor Software Version

Code System Name	Code
ACC NCDR	2.16.840.1.113883.3.3478.4.847

Coding Instruction: Vendor's software product name and version number identifying the software which created this record (assigned by vendor). Vendor controls the value in this field. This is entered into the schema automatically by vendor software.

Target Value: N/A

Supporting Definition:

Element: 1070 Registry Identifier

Code System Name	Code
ACC NCDR	2.16.840.1.113883.3.3478.4.841

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

Supporting Definition:

Element: 1071 Registry Schema Version

Code System Name	Code
ACC NCDR	1000142438

Coding Instruction: Schema version describes the version number of the Registry Transmission Document (RTD) schema to which each record conforms. It is an attribute that includes a constant value indicating the version of schema file. This is entered into the schema automatically by software.

Target Value: N/A

Supporting Definition:

Element: 1085 Submission Type

Code System Name	Code
ACC NCDR	1000142423

Coding Instruction: Indicate if the data contained in the harvest/data file contains either standard patient episode of care records (arrival date to discharge only) or if it contains patient follow-up records.

A transmission file with all episode of care records (from Arrival to Discharge only) is considered a 'Base Registry Record'.

A file with patient follow-up records (any follow-up assessments performed during the quarter selected) is considered a 'Follow-Up Record'.

Note(s):
Selecting 'Follow-Up Records Only' will transmit all patient records with Follow-up Assessment Dates (Element Ref# 11000) contained in the selected timeframe, regardless of the procedure or discharge date. For example, if a patient has a procedure on 3/30/2017, is discharged on 3/31/2017, and has a follow-up assessment on 5/6/2017, the patient's episode of care data will be transmitted in the 2017Q1 Base Registry Record file, but the Follow-up data will be transmitted in the 2017Q2 Follow-Up File.

Target Value: N/A

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	1000142424	Episode of Care Records Only	
ACC NCDR	1000142425	Follow-Up Records Only	

Element: 12594 Sampling

Code System Name	Code
ACC NCDR	112000000421

Coding Instruction: Indicate if the site is sampling any patient types.

Target Value: N/A

Supporting Definition:

Element: 12595 Sampling Patients Types

Code System Name	Code
ACC NCDR	112000000422

Coding Instruction: Indicate which patient types are being included for sampling.

Target Value: N/A

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	112000000217	Low Risk	
SNOMED CT	4557003	Unstable Angina	