Section: A. Demographics — Parent: Root

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

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

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

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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: B. Episode of Care**

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: 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: 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: 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: 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: **Health Insurance Claim Number**

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

Source: Centers for Medicare and Medicaid Services

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: **Patient Enrolled in Research Study**

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

by the study protocol. Participants may receive diagnostic, therapeutic, or other types of interventions.

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

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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: Attending Providers **Parent: Episode Information**

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: The value on arrival at this facility

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: The value on arrival at this facility

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: The value on arrival at this facility

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: The value on arrival at this facility

Supporting Definition:

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

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: Root**

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: Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 - 30), The Society of Thoracic Surgeons

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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: 4291 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.

Note(s):
Code 'No' if the patient's only MI occurred at the transferring facility.

Code 'Yes' if the patient's only MI occurred at the transferring facility but it was treated with PCI or CABG prior to arrival at this facility

Target Value: Any occurrence between birth and arrival at this 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: 4296 Most Recent MI Date

Code System Name	Code
SNOMED CT	22298006

Coding Instruction: Indicate the date of the most recent myocardial infarction.

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

Target Value: The last value between birth and arrival at this 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: 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: 4503 Most Recent Percutaneous Coronary Intervention Date

Code System Name	Code
SNOMED CT	415070008

Coding Instruction: Indicate the date of the most recent percutaneous coronary intervention (PCI) that the patient received prior to this admission.

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

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

Supporting Definition:

Element: 4501 Percutaneous Coronary Intervention of the Left Main Coronary Artery

Code System Name	Code
ACC NCDR	100001255

Coding Instruction: Indicate if the patient's prior PCI included revascularization of the Left Main.

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

Supporting Definition:

Element: 4502 Percutaneous Coronary Intervention of the Left Main Coronary Artery Unknown

Code System Name	Code
ACC NCDR	112000000346

Coding Instruction: Indicate if it is unknown if the patient's prior PCI included revascularization of the Left Main.

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

Supporting Definition:

Element: 6000 Height

Code System Name	Code
LOINC	8302-2

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

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

Supporting Definition:

Element: 6005 Weight

Code System Name	Code
LOINC	3141-9

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

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

Supporting Definition:

Element: 4287 Family History of Premature Coronary Artery Disease

Code System Name	Code
SNOMED CT	134439009

Coding Instruction: Indicate if the patient has a family history of premature coronary artery disease.

Note(s):
If the patient is adopted, or the family history is unknown, code 'No'.

Family history includes any direct blood relatives (parents, siblings, children) who have had any of the following diagnosed at age less than 55 years for male relatives or less than 65 years for female relatives

1. Angina

2. Acute myocardial infarction

3. Sudden cardiac death without obvious cause

4. Coronary artery bypass graft surgery

5. Percutaneous coronary intervention

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

Supporting Definition:

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: 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: 4576 Chronic Lung Disease

Code System Name	Code
SNOMED CT	413839001

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

Note(s):
A history of chronic inhalation reactive disease (asbestosis, mesothelioma, black lung disease or pneumoconiosis) may qualify as chronic lung disease. Radiation induced pneumonitis or radiation fibrosis also qualifies as chronic lung disease. A history of atelectasis is a transient condition and does not qualify.

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

Supporting Definition: **Chronic Lung Disease**

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

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

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: 4521 Most Recent Coronary Artery Bypass Graft Date

Code System Name	Code
SNOMED CT	232717009

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

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

Target Value: The last value 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: 4625 Tobacco Use

Code System Name	Code
SNOMED CT	110483000

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

Target Value: The value on arrival at this facility

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	266919005	Never	The patient has never been a tobacco smoker.
SNOMED CT	8517006	Former	The patient previously smoked daily for at least 1 year but has not smoked within the past 1 year.
SNOMED CT	449868002	Current - Every Day	The patient smokes tobacco daily.
SNOMED CT	428041000124106	Current - Some Days	The patient smokes tobacco but not every day.
SNOMED CT	77176002	Current - Frequency Unknown	The patient smokes tobacco but the frequency is unknown.

Element: 4626 Tobacco Type

Code System Name	Code
SNOMED CT	266918002

Coding Instruction: Indicate the type of tobacco product the patient uses.

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 more than 10 or more cigarettes daily.

Element: 4630 Cardiac Arrest Out of Hospital

Code System Name	Code
ACC NCDR	10001424808

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

Target Value: The value on arrival at this facility

Supporting Definition: **Cardiac Arrest**

Cardiac arrest includes pulseless clinical scenarios that require cardiopulmonary resuscitation (requiring two or more chest compressions, or open heart massage) and/or requiring emergency defibrillation.

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

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

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: 4635 Cardiac Arrest at Transferring Facility

Code System Name	Code
ACC NCDR	100014016

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

Target Value: The value on arrival at this facility

Supporting Definition:

Element: 4555 Diabetes Mellitus

Code System Name	Code
SNOMED CT	73211009

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

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

Supporting Definition: **Diabetes Mellitus**

The American Diabetes Association criteria include documentation of the following:

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

This does not include gestational diabetes.

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

Element: 4560 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.

Note(s):
If a patient is receiving continuous veno-venous hemofiltration (CVVH) as a result of renal failure (and not as treatment to remove

fluid for heart failure), code 'Yes'.

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

Supporting Definition:

Element: 4561 Canadian Study of Health and Aging (CSHA) Clinical Frailty Scale

Code System Name	Code
ACC NCDR	1000142381

Coding Instruction: Indicate the Canadian Study of Health and Aging (CSHA) Clinical Frailty Scale of the patient.

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

Supporting Definition: **Canadian Study of Health and Aging (CSHA)**

1 Very Fit - People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well - People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well - People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable - While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail - These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications).

Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail - People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail - Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail - Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill - Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia
The degree of frailty corresponds to the degree of dementia.
Common symptoms in mild dementia include forgetting the
details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.
In moderate dementia, recent memory is very impaired, even
though they seemingly can remember their past life events well.
They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.

Source:
1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

Code System Name	Code	Selection Text	Definition
ACC NCDR	1000142382	1: Very Fit	CHSA Clinical Frailty Scale 1: Very Fit - People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.
ACC NCDR	1000142383	2: Well	CHSA Clinical Frailty Scale 2: Well - People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.
ACC NCDR	1000142384	3: Managing Well	CHSA Clinical Frailty Scale 3: Managing Well - People whose medical problems are well controlled, but are not regularly active beyond routine walking.
ACC NCDR	1000142385	4: Vulnerable	CHSA Clinical Frailty Scale 4: Vulnerable - While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.
ACC NCDR	1000142386	5: Mildly Frail	CHSA Clinical Frailty Scale 5: Mildly Frail - These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.
ACC NCDR	1000142387	6: Moderately Frail	CHSA Clinical Frailty Scale 6: Moderately Frail - People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.
ACC NCDR	1000142388	7: Severely Frail	CHSA Clinical Frailty Scale 7: Severely Frail - Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).
ACC NCDR	1000142389	8: Very Severely Frail	CHSA Clinical Frailty Scale 8: Very Severely Frail - Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.
ACC NCDR	1000142390	9: Terminally Ill	CHSA Clinical Frailty Scale 9: Terminally Ill - Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Section: E. Procedure Information — Parent: Root

Element: 7000 — Procedure Start Date and Time

Code System Name	Code
ACC NCDR	1000142460

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

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

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: Any occurrence on current procedure

Supporting Definition:

Element: 7005 — Procedure End Date and Time

Code System Name	Code
ACC NCDR	1000142459

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

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

Target Value: N/A

Supporting Definition:

Element: 7045 — Diagnostic Coronary Angiography Procedure

Code System Name	Code
ACC NCDR	100001201

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

Note(s):
In order to code as 'Yes' when PCI is performed during the same cath lab visit, coronary angiography is understood to reflect the patient's initial evaluation within the last 30 days.

Diagnostic coronary angiography is defined as the passage of a catheter into the aortic root or other great vessels for the purpose of angiography of the native coronary arteries or bypass grafts supplying native coronary arteries.

Code 'No' if the patient presents for a staged PCI.

Target Value: The value on current procedure

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.

Target Value: The value on current procedure

Supporting Definition:

Element: 7050 Percutaneous Coronary Intervention (PCI)

Code System Name	Code
SNOMED CT	415070008

Coding Instruction: Indicate if the patient had a percutaneous coronary intervention (PCI) attempted and/or performed during this cath lab visit.

Note(s):

Code 'Yes' when a guidewire is introduced for the purpose of PCI.

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 value on current procedure

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.

Target Value: The value on current procedure

Supporting Definition:

Element: 7060 Diagnostic Left Heart Cath

Code System Name	Code
SNOMED CT	67629009

Coding Instruction: Indicate if the patient had a left heart cath procedure, defined as the passage of a catheter into the left ventricle for the purposes of angiography or measurement of ventricular pressures and/or oxygen saturation.

Note(s): Code 'No' if the left ventricle was only assessed post-intervention (PCI).

Target Value: The value between start of procedure and prior to the intervention

Supporting Definition:

Element: 7061 LVEF % (Diagnostic Left Heart Cath)

Code System Name	Code

LOINC	10230-1

Coding Instruction: Indicate the best estimate of the current left ventricular ejection fraction.

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

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 value between start of procedure and prior to the intervention

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: 7065 Concomitant Procedures Performed

Code System Name	Code
ACC NCDR	100001271

Coding Instruction: Indicate if another procedure was performed in conjunction with a diagnostic coronary angiography and/or PCI procedure.

Target Value: The value on current procedure

Supporting Definition:

Element: 7066 Concomitant Procedures Performed Type

Code System Name	Code
ACC NCDR	100013075

Coding Instruction: Indicate the type of procedure performed in conjunction with a diagnostic coronary angiography and/or PCI procedure.

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

Target Value: The value on current procedure

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: 7325 Arterial Cross Over

Code System Name	Code
ACC NCDR	100014075

Coding Instruction: Indicate if the procedure involved a crossover to a different access site.

Note(s):
Code 'Yes' when the final procedure access site is subsequent to where arterial access for the procedure was first attempted.

Target Value: The value on current procedure

Supporting Definition:

Element: 7332 Closure Method Not Documented

Code System Name	Code
ACC NCDR	112000000349

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

Target Value: All values between start of procedure and next procedure or discharge

Supporting Definition:

Element: 7335 Venous Access

Code System Name	Code
ACC NCDR	1000142421

Coding Instruction: Indicate if a venous access was obtained for the purpose of the diagnostic or PCI procedure.

Target Value: The value on current procedure

Supporting Definition:

Element: 6016 Systolic Blood Pressure

Code System Name	Code
LOINC	8480-6

Coding Instruction: Indicate the systolic blood pressure in mmHg.

Note(s):
Code the first systolic blood pressure obtained in the cath lab procedure room.

Target Value: The first value on current procedure

Supporting Definition:

Element: 7340 Cardiac Arrest at this Facility

Code System Name	Code
ACC NCDR	100014017

Coding Instruction: Indicate if a cardiac arrest event occurred at this facility PRIOR to the cath lab visit.

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

Supporting Definition:

Element: 7214 Fluoroscopy Time

Code System Name	Code

Code System Name	Code
ACC NCDR	100014077

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

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

Supporting Definition:

Element: 7215 Contrast Volume

Code System Name	Code
LOINC	80242-1

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

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

Supporting Definition:

Element: 7210 Cumulative Air Kerma

Code System Name	Code
SNOMED CT	228850003

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

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

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

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

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

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

Element: 7220 Dose Area Product

Code System Name	Code
ACC NCDR	100000994

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

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

Supporting Definition: **Dose Area Product**

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

Also known as KAP (Kerma Area Product).

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

Section: D. Pre-Procedure Information **Parent: E. Procedure Information**

Element: 4001 Heart Failure

Code System Name	Code
SNOMED CT	84114007

Coding Instruction: Indicate if the patient has been diagnosed with heart failure.

Target Value: Any occurrence between birth and current procedure

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: 4011 New York Heart Association Classification

Code System Name	Code
SNOMED CT	420816009

Coding Instruction: Indicate the patient's latest dyspnea or functional class, coded as the New York Heart Association (NYHA) classification.

Target Value: The last value between birth and current procedure

Supporting Definition: **NYHA**

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

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

Code System Name	Code	Selection Text	Definition
SNOMED CT	420300004	Class I	Patients with cardiac disease but without resulting limitations of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnea.
SNOMED CT	421704003	Class II	Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, or dyspnea.
SNOMED CT	420913000	Class III	Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, or dyspnea.
SNOMED CT	422293003	Class IV	Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms are present even at rest or minimal exertion. If any physical activity is undertaken, discomfort is increased.

Element: 4012 Heart Failure Newly Diagnosed

Code System Name	Code
ACC NCDR	1000142464

Coding Instruction: Indicate if the heart failure was newly diagnosed.

Note: Code 'Yes' (newly diagnosed) if there is no documentation of a prior diagnosis of heart failure.

Target Value: The last value between birth and current procedure

Supporting Definition:

Element: 4013 Heart Failure Type

Code System Name	Code
ACC NCDR	1000142465

Coding Instruction: Indicate if the patient has systolic or diastolic heart failure.

Target Value: The last value between birth and current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	418304008	Diastolic	Diastolic Heart Failure or Heart Failure with a normal Ejection Fraction (HFnEF), also known as Heart Failure with a Preserved Ejection Fraction (HFpEF), is when the amount of blood pumped from the heart's left ventricle with each beat (ejection fraction) remains >= 50%.
SNOMED CT	417996009	Systolic	Systolic Heart Failure or Heart Failure with a reduced Ejection Fraction (HFrEF) is when the amount of blood pumped from the heart's left ventricle with each beat (ejection fraction) is <50%.

Element: 4014 Heart Failure Type Unknown

Code System Name	Code
ACC NCDR	1000142465

Coding Instruction: Indicate if it is unknown if the patient has systolic or diastolic heart failure.

Target Value: The last value between birth and current procedure

Supporting Definition:

Section: Diagnostic Test **Parent: D. Pre-Procedure Information**

Element: 5037 Electrocardiac Assessment Method

Code System Name	Code
ACC NCDR	10001424801

Coding Instruction: Indicate the method used for electrocardiac assessment.

Target Value: Last value between 30 days prior to 1st procedure (or previous procedure) and current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	164847006	ECG	
ACC NCDR	10001424802	Telemetry Monitor	
SNOMED CT	86184003	Holter Monitor	
ACC NCDR	10001424803	Other Electrocardiac Assessment	
ACC NCDR	10001424804	None	No Electrocardiac Assessment Performed

Element: 5032 Electrocardiac Assessment Results

Code System Name	Code
ACC NCDR	1000142467

Coding Instruction: Indicate the results of the electrocardiac assessment.

Note(s):
Select all abnormal electocardiac findings supported by physician diagnosis as documented in the medical record.

Target Value: Last value between 30 days prior to 1st procedure (or previous procedure) and current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	253352002:116676008=442021009,17621005	Normal	No evidence that the patient has a clinically relevant electrical dysfunction of the heart (rate, rhythm).
SNOMED CT	263654008	Abnormal	Evidence that the patient has a clinically relevant electrical dysfunction of the heart (rate, rhythm).
ACC NCDR	1000142468	Uninterpretable	A determination cannot be made if the patient has a clinically relevant electrical dysfunction of the heart (rate, rhythm).

Element: 5033 New Antiarrhythmic Therapy Initiated Prior to Cath Lab

Code System Name	Code
ACC NCDR	1000142469

Coding Instruction: Indicate if the patient received a NEW antiarrhythmic therapy PRIOR to evaluation within the cath lab.

Note(s):
New Antiarrhythmic therapy is defined as initiation of a new drug to the patient for the purpose of controlling an abnormal rhythm.

Target Value: Last value between 30 days prior to 1st procedure (or previous procedure) and current procedure

Supporting Definition:

Element: 5034 Electrocardiac Abnormality Type

Code System Name	Code
SNOMED CT	102594003

Coding Instruction: Indicate the findings of the electrocardiac assessment.

Target Value: Last value between 30 days prior to 1st procedure (or previous procedure) and current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	71908006	Ventricular fibrillation (VF)	Fibrillation is an uncontrolled twitching or quivering of muscle fibers occurring in the lower chambers of the heart (ventricles).
SNOMED CT	426525004	Sustained VT	Ventricular tachycardia (VT) that is >30 seconds in duration and/or requires termination due to hemodynamic compromise in <30 seconds.
SNOMED CT	444658006	Non Sustained VT	Three or more consecutive beats of VT that self-terminate in <30 seconds.
ACC NCDR	1000142470	Exercise Induced VT	
SNOMED CT	59931005	T Wave Inversions	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	100014019	New Left Bundle Branch Block	New = Not previously documented
ACC NCDR	1000142476	New Onset Atrial Fib	New = Not previously documented
ACC NCDR	1000142477	New Onset Atrial Flutter	New = Not previously documented
ACC NCDR	1000142471	PVC - Frequent	More than 30 premature ventricular contractions (PVCs) per hour.
ACC NCDR	1000142472	PVC - Infrequent	Less than or equal to 30 premature ventricular contractions (PVCs) per hour.
SNOMED CT	54016002	2nd Degree AV Heart Block Type I	Second-degree atrioventricular block Type 1also known as Wenckebach (Type I Mobitz) is a disease of the of the electrical conduction system of the heart (AV node) characterized by progressive prolongation of the PR interval.
SNOMED CT	28189009	2nd Degree AV Heart Block Type II	Second-degree Atrioventricular block Type 2, also known as "Mobitz II," is usually a disease of the distal conduction system (His-Purkinje System) characterized on a surface ECG by intermittently non-conducted P waves not preceded by PR prolongation and not followed by PR shortening.
SNOMED CT	27885002	3rd Degree AV Heart Block	Third-degree atrioventricular block (AV block), also known as complete heart block, is when the electrical impulse generated in the sinoatrial node (SA node) in the atrium of the heart does stimulate the ventricles to contract.
ACC NCDR	1000142473	Symptomatic Bradyarrhythmia	Heart rate under 60 beats per minute that is associated with symptoms of fatigue, weakness, dizziness, sweating and/or syncope
ACC NCDR	10001424809	ST deviation >= 0.5 mm	
ACC NCDR	1000142474	Other Electrocardiac Abnormality	Electrocardiac abnormality noted but the specific type is not available for selection within the registry.

Element: 6011 Heart Rate

Code System Name	Code
LOINC	8867-4

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

Note(s): During atrial fibrillation code the ventricular rate.

Target Value: Last value between 30 days prior to 1st procedure (or previous procedure) and current procedure

Supporting Definition:

Element: 5036 Non-Sustained Ventricular Tachycardia Type

Code System Name	Code

ACC NCDR	1000142475

Coding Instruction: Indicate the non-sustained ventricular tachycardia type.

Target Value: Last value between 30 days prior to 1st procedure (or previous procedure) and current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	1000142351	Symptomatic	The patient experiences symptoms indicative of non-sustained ventricular tachycardia. This may include: palpitations, dizziness or lightheadedness, shortness of breath, chest pain, or angina, near-fainting or fainting (syncope), weak pulse or no pulse.
ACC NCDR	10001424781	Newly Diagnosed	The patient does not have a documented prior diagnosis of non-sustained ventricular tachycardia.
ACC NCDR	100000351	Other	The patient has been diagnosed with non-sustained ventricular tachycardia but the type is not consistent with selections available.

Element: 5200 Stress Test Performed

Code System Name	Code
ACC NCDR	1000142431

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

Target Value: Last value between birth (or previous procedure) and current procedure

Supporting Definition:

Element: 5220 Cardiac CTA Performed

Code System Name	Code
LOINC	59255-0

Coding Instruction: Indicate if a cardiac computerized tomographic angiography (CTA) was performed.

Target Value: Any occurrence between birth (or previous procedure) and current procedure

Supporting Definition:

Element: 5226 Cardiac CTA Date

Code System Name	Code
LOINC	59255-0

Coding Instruction: Indicate the most recent date a cardiac computerized tomographic angiography (CTA) was performed.

Target Value: Last value between birth (or previous procedure) and current procedure

Supporting Definition:

Element: 5227 Cardiac CTA Results

Code System Name	Code
ACC NCDR	100001257

Coding Instruction: Indicate the results of the cardiac CTA.

Target Value: Last value between birth (or previous procedure) and current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	10001424786	Obstructive CAD	Greater than or equal to 50% luminal diameter narrowing of an epicardial or left main stenosis.
ACC NCDR	10001424787	Non-Obstructive CAD	Less than 50% luminal diameter narrowing of an epicardial or left main stenosis.
ACC NCDR	100001262	Unclear Severity	Coronary artery disease severity is unclear or conflicting.
ACC NCDR	10001424789	No CAD	No evidence of coronary artery disease.
SNOMED CT	128599005	Structural Disease	An abnormality of the heart that is non- coronary, meaning that it does not affect the blood vessels in the heart, but rather involves the valves, walls or chambers.

Element: 5228 Cardiac CTA Results Unknown

Code System Name	Code
ACC NCDR	100001257

Coding Instruction: Indicate if the results of the cardiac CTA are unknown.

Target Value: Last value between birth (or previous procedure) and current procedure

Supporting Definition:

Element: 5256 Agatston Calcium Score Assessed

Code System Name	Code
SNOMED CT	450360000

Coding Instruction: Indicate if the agatston coronary calcium score was assessed.

Target Value: Any occurrence between birth (or previous procedure) and current procedure

Supporting Definition: **Agatston Calcium Score**

After a coronary calcium scan, a calcium score called an Agatston score is provided. The score is based on the amount of calcium found in the coronary (heart) arteries. The test may get an Agatston score for each major artery and a total score.

Source: https://www.nhlbi.nih.gov/health/health-topics/topics/cscan/show

Element: 5255 Agatston Calcium Score

Code System Name	Code
SNOMED CT	450360000

Coding Instruction: Indicate the total agatston coronary calcium score.

Target Value: Last value between birth (or previous procedure) and current procedure

Supporting Definition: **Agatston Calcium Score**

After a coronary calcium scan, a calcium score called an Agatston score is provided. The score is based on the amount of calcium found in the coronary (heart) arteries. The test may get an Agatston score for each major artery and a total score.

Source: https://www.nhlbi.nih.gov/health/health-topics/topics/cscan/show

Element: 5257 Agatston Calcium Score Date

Code System Name	Code
SNOMED CT	450360000

Coding Instruction: Indicate the most recent date of the agatston calcium score.

Target Value: Last value between birth (or previous procedure) and current procedure

Supporting Definition: **Agatston Calcium Score**

After a coronary calcium scan, a calcium score called an Agatston score is provided. The score is based on the amount of calcium

found in the coronary (heart) arteries. The test may get an Agatston score for each major artery and a total score.

Source: https://www.nhlbi.nih.gov/health/health-topics/topics/cscan/show

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Element: 5111 LVEF Assessed (Pre-Procedure)

Code System Name	Code
ACC NCDR	100001027

Coding Instruction: Indicate if the left ventricle was assessed prior to the cath lab visit.

Target Value: Any occurrence between 6 months prior to procedure and the start of the current procedure

Supporting Definition:

Element: 5116 LVEF % (Pre-Procedure)

Code System Name	Code
LOINC	10230-1

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

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

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%

The Left Ventricular Ejection Fraction can be assessed via invasive (i.e. LV gram) or non-invasive (i.e. Echo, MR, CT or Nuclear) testing.

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

Supporting Definition: **Most Recent LVEF %**

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

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

Element: 5263 Prior Diagnostic Coronary Angiography Procedure without intervention

Code System Name	Code
ACC NCDR	10001424782

Coding Instruction: Indicate if the patient had a prior diagnostic coronary angiography procedure without a subsequent intervention.

Note: Code "No" if the most recent cath lab visit involved PCI.

Target Value: Any occurrence between birth (or previous procedure) and current procedure

Supporting Definition:

Element: 5264 Prior Diagnostic Coronary Angiography Procedure Date

Code System Name	Code
ACC NCDR	10001424783

Coding Instruction: Indicate the date of the prior diagnostic coronary angiography.

Target Value: Last value between birth (or previous procedure) and current procedure

Supporting Definition:

Element: 5265 Prior Diagnostic Coronary Angiography Procedure Results

Code System Name	Code
ACC NCDR	10001424784

Coding Instruction: Indicate the results of the prior diagnostic coronary angiography.

Target Value: Last value between birth (or previous procedure) and current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	10001424786	Obstructive CAD	Greater than or equal to 50% luminal diameter narrowing of an epicardial or left main stenosis.
ACC NCDR	10001424787	Non-Obstructive CAD	Less than 50% luminal diameter narrowing of an epicardial or left main stenosis.
ACC NCDR	100001262	Unclear Severity	Coronary artery disease severity is unclear or conflicting.
ACC NCDR	10001424789	No CAD	No evidence of coronary artery disease.
SNOMED CT	128599005	Structural Disease	An abnormality of the heart that is non- coronary, meaning that it does not affect the blood vessels in the heart, but rather involves the valves, walls or chambers.

Element: 5266 Prior Diagnostic Coronary Angiography Procedure Results Unknown

Code System Name	Code
ACC NCDR	10001424784

Coding Instruction: Indicate if the prior diagnostic coronary angiography results are unknown.

Target Value: Last value between birth (or previous procedure) and current procedure

Supporting Definition:

Section: Stress Test **Parent: Diagnostic Test**

Element: 5201 Stress Test Performed Type

Code System Name	Code
ACC NCDR	1000142432

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

Target Value: Last value between birth (or previous procedure) and current procedure

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	18107-3	Stress Echocardiogram	Cardiac ultrasound procedure obtained at rest and during exercise or pharmacologic stress.
LOINC	49569-7	Stress Nuclear	A nuclear stress test measures blood flow to the heart at rest, and during exercise or pharmacologic stress, by comparing the distribution throughout the heart of a radioactive dye injected into the bloodstream.
LOINC	58750-1	Stress Imaging with CMR	Magnetic resonance imaging of the heart at rest and during exercise or pharmacologic stress

Element: 5204 Most Recent Stress Test Date

Code System Name	Code
ACC NCDR	1000142431

Coding Instruction: Indicate the most recent date of the stress test.

Target Value: Last value between birth (or previous procedure) and current procedure

Supporting Definition:

Element: 5202 Stress Test Results

Code System Name	Code
ACC NCDR	10001424303

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

Target Value: Last value between birth (or previous procedure) and current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100013083	Negative	Stress Test: Exercise Stress Test (w/o imaging) • A stress test is negative when the electrocardiogram (ECG) is normal or not suggestive of ischemia. ECGs are not suggestive of ischemia when < 1 mm of horizontal or downsloping ST-segment depression or elevation for >= 60-80 milliseconds after the end of the QRS complex, either during or after exercise. Stress Test: Stress Echocardiogram • The imaging study was normal. There was no change in wall motion during the procedure. Stress Test: Stress Nuclear • The results of the imaging study revealed no myocardial perfusion defects. Stress Test: Stress Imaging with CMR • The results of the imaging study revealed no myocardial perfusion defects.
ACC NCDR	100013093	Positive	Stress Test: Exercise Stress Test (w/o imaging) • A stress test is positive when the electrocardiogram (ECG) suggests ischemia. ECGs suggestive of ischemia can be described as having >= 1 mm of horizontal or downsloping ST-segment depression or elevation for >= 60-80 milliseconds after the end of the QRS complex, either during or after exercise. It is also be suggestive of ischemia if the patient had symptoms of ischemia (i.e.chest pain), arrhythmias, and/or a fall in blood pressure during or immediately after the procedure. Stress Test: Stress Echocardiogram • The imaging study was abnormal. There were changes that reflected wall motion abnormalities during the procedure. Stress Test: Stress Nuclear • The result of the imaging study revealed one or more stress-induced myocardial perfusion defects. Stress Test: Stress Imaging with CMR • The result of the imaging study revealed one or more stress-induced myocardial perfusion defects.
ACC NCDR	100013094	Indeterminate	The results of the study were uninterpretable. They cannot be considered to be positive or negative.
ACC NCDR	100000646	Unavailable	The results of the study were not available.

Element: 5203 Stress Test Risk/Extent of Ischemia

Code System Name	Code
ACC NCDR	1000142434

Coding Instruction: Indicate the risk or extent of ischemia for the non-invasive stress test.

Target Value: Last value between birth (or previous procedure) and current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100013097	Low	Low risk (<1% annual death or MI) 1. Low-risk treadmill score (score >=5) or no new ST segment changes or exercise-induced chest pain symptoms; when achieving maximal levels of exercise 2. Normal or small myocardial perfusion defect at rest or with stress encumbering <5% of the myocardium* 3. Normal stress or no change of limited resting wall motion abnormalities during stress 4. CAC score <100 Agaston units 5. No coronary stenosis >50% on CCTA *Although the published data are limited; patients with these findings will probably not be at low risk in the presence of either a high-risk treadmill score or severe resting LV dysfunction (LVEF <35%).
ACC NCDR	100000584	High	High risk (>3% annual death or MI) 1. Severe resting LV dysfunction (LVEF <35%) not readily explained by noncoronary causes 2. Resting perfusion abnormalities >=10% of the myocardium in patients without prior history or evidence of MI 3. Stress ECG findings including >=2 mm of ST-segment depression at low workload or persisting into recovery, exercise-induced ST-segment elevation, or exercise-induced VT/VF 4. Severe stress-induced LV dysfunction (peak exercise LVEF <45% or drop in LVEF with stress >=10%) 5. Stress-induced perfusion abnormalities encumbering >=10% myocardium or stress segmental scores indicating multiple vascular territories with abnormalities 6. Stress-induced LV dilation 7. Inducible wall motion abnormality (involving >2 segments or 2 coronary beds) 8. Wall motion abnormality developing at low dose of dobutamine (<=10 mg/kg/min) or at a low heart rate (<120 beats/min) 9. CAC score >400 Agatston units 10. Multivessel obstructive CAD (>=70% stenosis) or left main stenosis (>=50% stenosis) on CCTA
ACC NCDR	100013098	Intermediate	Intermediate risk (1% to 3% annual death or MI) 1. Mild/moderate resting LV dysfunction (LVEF 35% to 49%) not readily explained by noncoronary causes 2. Resting perfusion abnormalities in 5% to 9.9% of the myocardium in patients without a history or prior evidence of MI 3. >=1 mm of ST-segment depression occurring with exertional symptoms 4. Stress-induced perfusion abnormalities encumbering 5% to 9.9% of the myocardium or stress segmental scores (in multiple segments) indicating 1 vascular territory with abnormalities but without LV dilation 5. Small wall motion abnormality involving 1 to 2 segments and only 1 coronary bed 6. CAC score 100 to 399 Agatston units 7. One vessel CAD with >=70% stenosis or moderate CAD stenosis (50% to 69% stenosis) in >=2 arteries on CCTA
ACC NCDR	100000646	Unavailable	The results of the study were not available.

Section: Pre-Procedure Medications **Parent: D. Pre-Procedure Information**

Element: 6986 PreProcedure Medication Code

Code System Name	Code
ACC NCDR	100013057

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

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

Target Value: N/A

Supporting Definition:

Element: 6991 PreProcedure Medication Administered

Code System Name	Code
SNOMED CT	432102000

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

Note(s):
Code 'No' if a patient was given a sublingual, IV, or short acting formula of one of these medications.

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

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100001247	Yes	
ACC NCDR	112000000168	No	
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.

Section: SA Questionnaire **Parent: D. Pre-Procedure Information**

Element: 5301 Q1a: Difficulty walking indoors on level ground

Code System Name	Code
ACC NCDR	100013017

Coding Instruction: Indicate the patient's response to the Seattle Angina Questionnaire (SAQ) Question 1a "Over the past four weeks, as a result of your angina, how much difficulty have you had in: walking indoors on level ground?"

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100001173	Extremely limited	
ACC NCDR	100001171	Quite a bit limited	
ACC NCDR	100001170	Moderately limited	
ACC NCDR	100014042	Slightly limited	
ACC NCDR	100001167	Not at all limited	
ACC NCDR	100014041	Limited for other reasons or did not do these activities	

Element: 5302 Q1b: Difficulty gardening, vacuuming or carrying groceries

Code System Name	Code
ACC NCDR	100013018

Coding Instruction: Indicate the patient's response to the Seattle Angina Questionnaire (SAQ) Question 1b "Over the past four weeks, as a result of your angina, how much difficulty have you had in: gardening, vacuuming, or carrying groceries?"

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100001173	Extremely limited	
ACC NCDR	100001171	Quite a bit limited	
ACC NCDR	100001170	Moderately limited	
ACC NCDR	100014042	Slightly limited	
ACC NCDR	100001167	Not at all limited	
ACC NCDR	100014041	Limited for other reasons or did not do these activities	

Element: 5303 Q1c: Difficulty lifting or moving heavy objects (e.g. furniture, children)

Code System Name	Code
ACC NCDR	100013019

Coding Instruction: Indicate the patient's response to the Seattle Angina Questionnaire (SAQ) Question 1c "Over the past four weeks, as a result of your angina, how much difficulty have you had in: lifting or moving heavy objects (e.g. furniture, children)?"

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100001173	Extremely limited	
ACC NCDR	100001171	Quite a bit limited	
ACC NCDR	100001170	Moderately limited	
ACC NCDR	100014042	Slightly limited	
ACC NCDR	100001167	Not at all limited	
ACC NCDR	100014041	Limited for other reasons or did not do these activities	

Element: 5305 Q2: Had chest pain, chest tightness, or angina

Code System Name	Code
ACC NCDR	100013020

Coding Instruction: Indicate the patient's response to the Seattle Angina Questionnaire (SAQ) Question 2 "Over the past four weeks, on average, how many times have you: Had chest pain, chest tightness, or angina?"

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100014043	4 or more times per day	
ACC NCDR	100014044	1 - 3 times per day	
ACC NCDR	100014045	3 or more times per week but not every day	
ACC NCDR	100014046	1 - 2 times per week	
ACC NCDR	100014047	Less than once a week	
ACC NCDR	100014048	None over the past 4 weeks	

Element: 5310 Q3: Had to take nitroglycerin (Tablets or spray) for your chest pain, chest tightness or angina

Code System Name	Code
ACC NCDR	100013021

Coding Instruction: Indicate the patient's response to the Seattle Angina Questionnaire (SAQ) Question 3 "Over the past four weeks, on average, how many times have you: Had to take nitroglycerin (Tablets or spray) for your chest pain, chest tightness or angina?"

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100014043	4 or more times per day	
ACC NCDR	100014044	1 - 3 times per day	
ACC NCDR	100014045	3 or more times per week but not every day	
ACC NCDR	100014046	1 - 2 times per week	
ACC NCDR	100014047	Less than once a week	
ACC NCDR	100014048	None over the past 4 weeks	

Element: 5315 Q4: Chest pain, chest tightness or angina limited your enjoyment of life

Code System Name	Code
ACC NCDR	100013022

Coding Instruction: Indicate the patient's response to the Seattle Angina Questionnaire (SAQ) Question 4 "Over the past four weeks, on average, how many times have you: Chest pain, chest tightness or angina limited your enjoyment of life?"

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100014049	It has extremely limited my enjoyment of life	
ACC NCDR	100014050	It has limited my enjoyment of life quite a bit	
ACC NCDR	100014051	It has moderately limited my enjoyment of life	
ACC NCDR	100014052	It has slightly limited my enjoyment of life	
ACC NCDR	100014053	It has not limited my enjoyment of life at all	

Element: 5320 Q5: How would you feel about this

Code System Name	Code
ACC NCDR	100013023

Coding Instruction: Indicate the patient's response to the Seattle Angina Questionnaire (SAQ) Question 5 "If you had to spend the rest of your life with

your chest pain, chest tightness or angina the way it is right now how would you feel about that?"

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100014054	Not satisfied at all	
ACC NCDR	100014055	Mostly dissatisfied	
ACC NCDR	100001197	Somewhat satisfied	
ACC NCDR	100014057	Mostly satisfied	
ACC NCDR	100014058	Completely satisfied	

Section: Rose Dyspnea Scale — Parent: D. Pre-Procedure Information

Element: 5330 — Rose Dyspnea Scale Question 1

Code System Name	Code
ACC NCDR	100013024

Coding Instruction: Indicate the patient's response to the Rose Dyspnea Scale Questionnaire Question 1 "Do you get short of breath when hurrying on level ground or walking up a slight hill?"

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

Supporting Definition:

Element: 5335 — Rose Dyspnea Scale Question 2

Code System Name	Code
ACC NCDR	100013025

Coding Instruction: Indicate the patient's response to the Rose Dyspnea Scale Questionnaire Question 2 "Do you get short of breath when walking with other people your own age on level ground?"

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

Supporting Definition:

Element: 5340 — Rose Dyspnea Scale Question 3

Code System Name	Code
ACC NCDR	100013026

Coding Instruction: Indicate the patient's response to the Rose Dyspnea Scale Questionnaire Question 3 "Do you get short of breath when walking at your own pace on level ground?"

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

Supporting Definition:

Element: 5345 — Rose Dyspnea Scale Question 4

Code System Name	Code
ACC NCDR	100013027

Coding Instruction: Indicate the patient's response to the Rose Dyspnea Scale Questionnaire Question 4 "Do you get short of breath when washing or dressing?"

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

Supporting Definition:

Section: Closure Methods — Parent: E. Procedure Information

Element: 7330 Closure Device Counter

Code System Name	Code
ACC NCDR	100014083

Coding Instruction: The software assigned closure device counter should start at 1 and be incremented by one for each closure device used during or after the cath lab visit.

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

The closure device counter is reset back to 1 for each new cath lab visit.

Target Value: N/A

Supporting Definition:

Element: 7331 Arterial Access Closure Method

Code System Name	Code
ACC NCDR	100014074

Coding Instruction: Indicate the arterial closure methods used in chronological order regardless of whether or not they provided hemostasis. The same closure method may be repeated.

Note(s):
If multiple access sites were utilized during the procedure, only provide those closure methods used for the site identified in Element Ref# 7320 (Arterial Access Site).

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

Target Value: All values between start of procedure and next procedure or discharge

Supporting Definition:

Element: 7333 Closure Method Unique Device Identifier

Code System Name	Code
ACC NCDR	2.16.840.1.113883.3.3719

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

Target Value: The value on current procedure

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

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

Source: US FDA

Section: Pre-Procedure Labs **Parent: F. Labs**

Element: 6090 PreProcedure Troponin I

Code System Name	Code
LOINC	10839-9

Coding Instruction: Indicate the Troponin I result in ng/mL.

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

Target Value: The last value between date of arrival and current procedure

Supporting Definition: **Troponin I**

The troponin test is used to help diagnose a heart attack, to detect and evaluate mild to severe heart injury, and to distinguish chest pain that may be due to other causes. Troponin values can remain high for 1-2 weeks after a heart attack. The test is not affected by damage to other muscles, so injections, accidents, and drugs that can damage muscle do not affect troponin levels. Troponin may rise following strenuous exercise, although in the absence of signs and symptoms of heart disease, it is usually of no medical significance.

Source: http://s.details.loinc.org/LOINC/42757-5.html?sections=Simple

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Element: 6091 PreProcedure Troponin I Not Drawn

Code System Name	Code
LOINC	10839-9

Coding Instruction: Indicate if the Troponin I was not obtained at your facility.

Target Value: The last value between date of arrival and current procedure

Supporting Definition: **Troponin I**

The troponin test is used to help diagnose a heart attack, to detect and evaluate mild to severe heart injury, and to distinguish chest pain that may be due to other causes. Troponin values can remain high for 1-2 weeks after a heart attack. The test is not affected by damage to other muscles, so injections, accidents, and drugs that can damage muscle do not affect troponin levels. Troponin may rise following strenuous exercise, although in the absence of signs and symptoms of heart disease, it is usually of no medical significance.

Source: http://s.details.loinc.org/LOINC/42757-5.html?sections=Simple

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Element: 6095 Troponin T (Pre-Procedure)

Code System Name	Code
LOINC	6598-7

Coding Instruction: Indicate the Troponin T result in ng/mL.

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

Target Value: The last value between date of arrival and current procedure

Supporting Definition: **Troponin T**

The troponin test is used to help diagnose a heart attack, to detect and evaluate mild to severe heart injury, and to distinguish chest pain that may be due to other causes. Troponin values can remain high for 1-2 weeks after a heart attack. The test is not affected by damage to other muscles, so injections, accidents, and drugs that can damage muscle do not affect troponin levels. Troponin may rise following strenuous exercise, although in the absence of signs and symptoms of heart disease, it is usually of no medical significance.

Source: http://s.details.loinc.org/LOINC/48425-3.html?sections=Simple

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Element: 6096 Troponin T Not Drawn (Pre-Procedure)

Code System Name	Code

LOINC	6598-7

Coding Instruction: Indicate if the Troponin T was not obtained at your facility.

Target Value: The last value between date of arrival and current procedure

Supporting Definition: **Troponin T**

The troponin test is used to help diagnose a heart attack, to detect and evaluate mild to severe heart injury, and to distinguish chest pain that may be due to other causes. Troponin values can remain high for 1-2 weeks after a heart attack. The test is not affected by damage to other muscles, so injections, accidents, and drugs that can damage muscle do not affect troponin levels. Troponin may rise following strenuous exercise, although in the absence of signs and symptoms of heart disease, it is usually of no medical significance.

Source: http://s.details.loinc.org/LOINC/48425-3.html?sections=Simple

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Element: 6050 Creatinine

Code System Name	Code
LOINC	2160-0

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

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

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

Supporting Definition: **Creatinine**

Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine results in the formation of creatinine. It is transferred to the kidneys by blood plasma, whereupon it is eliminated by glomerular filtration and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A rise in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver and pancreas.

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

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Element: 6051 Creatinine Not Drawn

Code System Name	Code
LOINC	2160-0

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

Target Value: N/A

Supporting Definition: **Creatinine**

Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine results in the formation of creatinine. It is transferred to the kidneys by blood plasma, whereupon it is eliminated by glomerular filtration and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A rise in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver and pancreas.

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

---

Element: 6030 Hemoglobin

Code System Name	Code
LOINC	718-7

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

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

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

Supporting Definition: **Hemoglobin**

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

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

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Element: 6031 Hemoglobin Not Drawn

Code System Name	Code
LOINC	718-7

Coding Instruction: Indicate if the hemoglobin was not drawn.

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

Supporting Definition: **Hemoglobin**

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

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

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Element: 6100 Total Cholesterol

Code System Name	Code
LOINC	2093-3

Coding Instruction: Indicate the cholesterol level mg/dL.

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

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.

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Element: 6101 Total Cholesterol Not Drawn

Code System Name	Code
LOINC	2093-3

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

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

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.

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Element: 6105 High-density Lipoprotein

Code System Name	Code
LOINC	2085-9

Coding Instruction: Indicate the high-density lipoprotein (HDL) level mg/dL.

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

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.

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Element: 6106 High-density Lipoprotein Not Drawn

Code System Name	Code
LOINC	2085-9

Coding Instruction: Indicate if the high density lipoprotein (HDL) cholesterol value was not drawn.

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

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.

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Section: Post-Procedure Labs **Parent: F. Labs**

Element: 8515 PostProcedure Troponin I

Code System Name	Code
LOINC	10839-9

Coding Instruction: Indicate the Troponin I result in ng/mL.

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

Target Value: The highest value between 6 hours after current procedure and 24 hours after current procedure

Supporting Definition: **Troponin I**

The troponin test is used to help diagnose a heart attack, to detect and evaluate mild to severe heart injury, and to distinguish chest pain that may be due to other causes. Troponin values can remain high for 1-2 weeks after a heart attack. The test is not affected by damage to other muscles, so injections, accidents, and drugs that can damage muscle do not affect troponin levels. Troponin may rise following strenuous exercise, although in the absence of signs and symptoms of heart disease, it is usually of no medical significance.

Source: http://s.details.loinc.org/LOINC/42757-5.html?sections=Simple

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Element: 8516 PostProcedure Troponin I Not Drawn

Code System Name	Code
LOINC	10839-9

Coding Instruction: Indicate if the Troponin I was not obtained at your facility.

Target Value: The highest value between 6 hours after current procedure and 24 hours after current procedure

Supporting Definition: **Troponin I**

The troponin test is used to help diagnose a heart attack, to detect and evaluate mild to severe heart injury, and to distinguish chest pain that may be due to other causes. Troponin values can remain high for 1-2 weeks after a heart attack. The test is not affected by damage to other muscles, so injections, accidents, and drugs that can damage muscle do not affect troponin levels. Troponin may rise following strenuous exercise, although in the absence of signs and symptoms of heart disease, it is usually of no medical significance.

Source: http://s.details.loinc.org/LOINC/42757-5.html?sections=Simple

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Element: 8520 Troponin T (Post-Procedure)

Code System Name	Code
LOINC	6598-7

Coding Instruction: Indicate the Troponin T result in ng/mL.

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

Target Value: The highest value between 6 hours after current procedure and 24 hours after current procedure

Supporting Definition: **Troponin T**

The troponin test is used to help diagnose a heart attack, to detect and evaluate mild to severe heart injury, and to distinguish chest pain that may be due to other causes. Troponin values can remain high for 1-2 weeks after a heart attack. The test is not affected by damage to other muscles, so injections, accidents, and drugs that can damage muscle do not affect troponin levels. Troponin may rise following strenuous exercise, although in the absence of signs and symptoms of heart disease, it is usually of no medical significance.

Source: http://s.details.loinc.org/LOINC/48425-3.html?sections=Simple

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Element: 8521 Troponin T Not Drawn (Post-Procedure)

Code System Name	Code

LOINC	6598-7

Coding Instruction: Indicate if the Troponin T was not obtained at your facility.

Target Value: The highest value between 6 hours after current procedure and 24 hours after current procedure

Supporting Definition: **Troponin T**

The troponin test is used to help diagnose a heart attack, to detect and evaluate mild to severe heart injury, and to distinguish chest pain that may be due to other causes. Troponin values can remain high for 1-2 weeks after a heart attack. The test is not affected by damage to other muscles, so injections, accidents, and drugs that can damage muscle do not affect troponin levels. Troponin may rise following strenuous exercise, although in the absence of signs and symptoms of heart disease, it is usually of no medical significance.

Source: http://s.details.loinc.org/LOINC/48425-3.html?sections=Simple

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Element: 8510 Creatinine

Code System Name	Code
LOINC	2160-0

Coding Instruction: Indicate the post-procedure creatinine level in mg/dL. If more than one level is available, code the peak level.

Target Value: The highest value between current procedure and 5 days after current procedure or until next procedure or 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: 8511 Creatinine Not Drawn

Code System Name	Code
LOINC	2160-0

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

Target Value: The highest value between current procedure and 5 days after current procedure or until next procedure or 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: 8505 Hemoglobin

Code System Name	Code
LOINC	718-7

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

Target Value: The lowest value between current procedure and 72 hours after current procedure

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: 8506 Hemoglobin Not Drawn

Code System Name	Code
LOINC	718-7

Coding Instruction: Indicate if the hemoglobin was not drawn.

Target Value: The lowest value between current procedure and 72 hours after current procedure

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: G. Cath Lab Visit **Parent: E. Procedure Information**

Element: 7400 Indications for Cath Lab Visit

Code System Name	Code
ACC NCDR	100014000

Coding Instruction: Indicate the patient symptoms or condition prompting the cath lab visit.

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

Target Value: The value on current procedure

Supporting Definition:

Element: 7405 Chest Pain Symptom Assessment

Code System Name	Code
ACC NCDR	100001274

Coding Instruction: Indicate the chest pain symptom assessment as diagnosed by the physician or described by the patient.

Target Value: The value on current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	429559004	Typical Angina	Symptoms meet all three of the characteristics of angina (also known as definite): 1. Substernal chest discomfort with a characteristic quality and duration that is 2. provoked by exertion or emotional stress and 3. relieved by rest or nitroglycerin.
SNOMED CT	371807002	Atypical angina	Symptoms meet two of the three characteristics of typical angina (also known as probable).
ACC NCDR	100001275	Non-anginal Chest Pain	The patient meets one, or none of the typical characteristics of angina.
ACC NCDR	100000932	Asymptomatic	No typical or atypical symptoms or non-anginal chest pain.

Element: 7410 Cardiovascular Instability

Code System Name	Code
ACC NCDR	100014004

Coding Instruction: Indicate if the patient has cardiovascular instability. Cardiovascular instability includes, but is not limited to, persistent ischemic symptoms (such as chest pain or ST elevation), cardiogenic shock, ventricular arrhythmias, symptoms of acute heart failure, or hemodynamic instability (not cardiogenic shock).

Target Value: The value on current procedure

Supporting Definition: **Cardiac Instability**

Cardiac Instability is defined as persistent ischemic symptoms, decompensating heart failure, ventricular arrhythmias, cardiogenic shock and hemodynamic instability (not cardiogenic shock).

Source: ACC/AATS/AHA/ASE/ASNC/SCAI/SCCT/STS 2016 Appropriate Use Criteria for Coronary Revascularization in Patients with Acute Coronary Syndromes: A Report of the American College of Cardiology Appropriate Use Criteria Task Force, American Association for Thoracic Surgery, American Heart Association, American Society of Echocardiography, American Society of Nuclear Cardiology, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Computed Tomography, and the Society of Thoracic Surgeons. www.onlinejacc.org/lookup/doi/10.1016/j.jacc.2016.10.034

Element: 7415 Cardiovascular Instability Type

Code System Name	Code

ACC NCDR 100014005

Coding Instruction: Indicate the cardiovascular instability type.

Target Value: The value on current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100014006	Persistent Ischemic Symptoms (chest pain, STE)	Persistent ischemic symptoms as demonstrated by chest pain, angina and/or ST segment elevation.
SNOMED CT	422773005	Hemodynamic Instability (not cardiogenic shock)	Hemodynamic instability can include periods of reduced, unstable or abnormal blood pressure, and/or hypo-perfusion that does not support normal organ perfusion or function. The hemodynamic compromise (with or without extraordinary supportive therapy) must persist for at least 30 min. Does NOT include cardiogenic shock.
SNOMED CT	44103008	Ventricular arrhythmias	Ventricular arrhythmias are abnormal rapid heart rhythms that originate in the ventricles. Ventricular arrhythmias include ventricular tachycardia and ventricular fibrillation.
SNOMED CT	89138009	Cardiogenic Shock	Cardiogenic shock is defined as a sustained (>30 min) episode of systolic blood pressure <90 mm Hg and/or cardiac index <2.2 L/min per square meter determined to be secondary to cardiac dysfunction and/or the requirement for parenteral inotropic or vasopressor agents or mechanical support (eg, IABP, extracorporeal circulation, VADs) to maintain blood pressure and cardiac index above those specified levels. Note: Transient episodes of hypotension reversed with IV fluid or atropine do not constitute cardiogenic shock. The hemodynamic compromise (with or without extraordinary supportive therapy) must persist for at least 30 min.
ACC NCDR	100014007	Acute Heart Failure Symptoms	Acute heart failure typically have symptoms such as difficulty breathing, leg or feet swelling, pulmonary edema on chest x-ray or jugular venous distension. A low ejection fraction alone, without clinical evidence of heart failure does not qualify.
SNOMED CT	276227005	Refractory Cardiogenic Shock	Refractory cardiogenic shock is defined as acute hypotension with systolic blood pressure <90mmHg (or cardiac index <2.0l/min/m2) for more than 10 minutes despite mechanical support or pharmacologic support with at least two vasopressor agents.

Element: 7420 Ventricular Support

Code System Name	Code
ACC NCDR	100001276

Coding Instruction: Indicate if the patient required any type of ventricular support (i.e. IV vasopressors or mechanical).

Target Value: Any occurrence on current procedure

Supporting Definition:

Element: 7421 Pharmacologic Vasopressor Support

Code System Name	Code
ACC NCDR	100001277

Coding Instruction: Indicate if the patient required pharmacologic vasopressor support.

Target Value: Any occurrence on current procedure

Supporting Definition:

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:

Element: 7424 Mechanical Ventricular Support Timing

Code System Name	Code
ACC NCDR	100014009

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

Target Value: Any occurrence on current procedure

Supporting Definition:

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

Element: 7465 Evaluation for Surgery Type

Code System Name	Code
SNOMED CT	110466009

Coding Instruction: Indicate the type of surgery for which the diagnostic coronary angiography is being performed.

Target Value: The value on current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	64915003	Cardiac Surgery	Any surgery involving the coronary arteries, valves, or a structural repair of the heart.
ACC NCDR	100014022	Non-Cardiac Surgery	Any surgery involving the aortic arch or other body system.

Element: 7466 Functional Capacity

Code System Name	Code
ACC NCDR	1000142418

Coding Instruction: Indicate the functional capacity of the patient as documented by the physician in the medical record.

Note(s):
There should be explicit documentation as part of the pre-op evaluation indicating functional capacity to determine whether the patient should proceed to planned surgery.

Metabolic equivalent of task (MET) is a metabolic unit used to quantify the estimated energy requirements of various activities.

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

Supporting Definition: **Functional Capacity**

Functional capacity (measured in METS) measures the ability (or limitation) of a patient to perform various activities.

Source: Fleisher LA, Beckman JA, Brown KA, et al. 2009 ACCF/AHA Focused Update on Perioperative Beta Blockade Incorporated into the ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery. J Am Coll Cardiol 2009;54:e13-118.

Code System Name	Code	Selection Text	Definition
ACC NCDR	100014023	< 4 METS	1 MET is the equivalent of energy required at rest.
ACC NCDR	100014025	>= 4 METS without Symptoms	>= 4 METS without symptoms of chest pain or anginal equivalent. 4 METS is the equivalent of energy required to walk slowly for two blocks and/or perform light work around the house.
ACC NCDR	100014024	>= 4 METS with Symptoms	>= 4 METS with symptoms of chest pain or anginal equivalent. 4 METS is the equivalent of energy required to walk slowly for two blocks and/or perform light work around the house.

Element: 7467 Functional Capacity Unknown

Code System Name	Code
ACC NCDR	1000142418

Coding Instruction: Indicate if the functional capacity of the patient is unknown.

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

Supporting Definition: **Functional Capacity**

Functional capacity (measured in METS) measures the ability (or limitation) of a patient to perform various activities.

Source: Fleisher LA, Beckman JA, Brown KA, et al. 2009 ACCF/AHA Focused Update on Perioperative Beta Blockade Incorporated into the ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery. J Am Coll Cardiol 2009;54:e13-118.

Element: 7468 Surgical Risk

Code System Name	Code
ACC NCDR	1000142420

Coding Instruction: Indicate the surgical risk category as documented by the physician in the medical record.

Note(s):
There should be explicit documentation by the physician indicating surgical risk to support the risk profile documented. When surgical risk is not documented, select low risk.

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

Supporting Definition: **Surgical Risk**

Surgical risk is assessed based on the patient's history of cardiac and co-morbid diseases, functional capacity, as well as the urgency and magnitude of the surgical procedure. Evaluation of surgical risk is determined by the physician, and outlined according to the ACC/AHA Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery.

Source: Fleisher LA, Beckman JA, Brown KA, et al. 2009 ACCF/AHA Focused Update on Perioperative Beta Blockade Incorporated into the ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery. J Am Coll Cardiol 2009;54:e13-118

Code System Name	Code	Selection Text	Definition
ACC NCDR	112000000375	Low	
ACC NCDR	112000000376	Intermediate	
ACC NCDR	100014029	High Risk: Vascular	High risk vascular surgery includes aortic and other major vascular surgery, and peripheral vascular surgery. This does not include non-surgical vascular procedures that are interventions.
ACC NCDR	100014030	High Risk: Non-Vascular	None

Element: 7469 Solid Organ Transplant Surgery

Code System Name	Code
SNOMED CT	313039003

Coding Instruction: Indicate if the pending surgery involves a solid organ transplant.

Target Value: The value on current procedure

Supporting Definition:

Element: 7470 Solid Organ Transplant Donor

Code System Name	Code
SNOMED CT	51032003

Coding Instruction: Indicate if the patient is the organ donor.

Target Value: The value on current procedure

Supporting Definition:

Element: 7471 Solid Organ Transplant Type

Code System Name	Code
ACC NCDR	100014026

Coding Instruction: Indicate the type of organ transplant surgery performed.

Target Value: The value on current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	32413006	Heart	
SNOMED CT	70536003	Kidney	
SNOMED CT	18027006	Liver	
SNOMED CT	88039007	Lung	
ACC NCDR	100014027	Pancreas	
ACC NCDR	1000142347	Other Organ	

Section: Valvular Disease Stenosis — Parent: G. Cath Lab Visit

Element: 7450 Valvular Disease Stenosis Type

Code System Name	Code
ACC NCDR	100014085

Coding Instruction: Indicate the cardiac valve stenosis severity as diagnosed by the physician.

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	60573004	Aortic Stenosis	
SNOMED CT	79619009	Mitral Stenosis	
SNOMED CT	56786000	Pulmonic Stenosis	
SNOMED CT	49915006	Tricuspid Stenosis	

Element: 7451 Valvular Disease Stenosis Severity

Code System Name	Code
ACC NCDR	100014087

Coding Instruction: Indicate the cardiac valve stenosis severity.

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	112000000377	Mild	
ACC NCDR	112000000378	Moderate	
ACC NCDR	112000000379	Severe	

Section: Valvular Disease Regurgitation — Parent: G. Cath Lab Visit

Element: 7455 Valvular Disease Regurgitation Type

Code System Name	Code
ACC NCDR	100014086

Coding Instruction: Indicate the cardiac valve regurgitation severity as diagnosed by the physician.

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	60234000	Aortic Regurgitation	A condition that occurs when the heart's aortic valve doesn't close tightly, leading to the backward flow of blood from the aorta into the left ventricle. Also called aortic insufficiency.
SNOMED CT	48724000	Mitral Regurgitation	A condition that occurs when the heart's mitral valve doesn't close tightly, causing blood to leak backward, through the mitral valve, each time the left ventricle contracts. Also called mitral valve regurgitation, mitral insufficiency or mitral incompetence.
SNOMED CT	91434003	Pulmonic Regurgitation	A condition that occurs when an incompetent pulmonary valve allows blood to flow backward from the pulmonary artery into the right ventricle during diastole. Also called pulmonic regurgitation, pulmonary insufficiency or pulmonic incompetence.
SNOMED CT	111287006	Tricuspid Regurgitation	A condition that occurs when the tricuspid valve fails to close properly during systole, allowing blood to flow backward into the right atria. Also called tricuspid insufficiency.

Element: 7456 Valvular Disease Regurgitation Severity

Code System Name	Code
ACC NCDR	100014089

Coding Instruction: Indicate the cardiac valve regurgitation severity.

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	112000000380	Mild (1+)	
ACC NCDR	112000000381	Moderate (2+)	
ACC NCDR	1000142345	Moderately Severe (3+)	
ACC NCDR	112000000382	Severe (4+)	

Section: H. Coronary Anatomy **Parent: E. Procedure Information**

Element: 7500 Coronary Circulation Dominance

Code System Name	Code
SNOMED CT	253727002

Coding Instruction: Indicate the dominance of the coronary anatomy (whether the posterior descending artery comes from the right or left vessel system).

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	253729004	Left	The posterior descending artery (PDA) and posterolateral artery (PLA) arises from the left circumflex artery.
SNOMED CT	253728007	Right	The posterior descending artery (PDA) and posterolateral artery (PLA) arises from the right coronary artery.
SNOMED CT	253730009	Co-dominant	The right coronary artery supplies the posterior descending artery (PDA) and the circumflex supplies the posterolateral artery (PLA). Thus, there is approximately equal contribution to the inferior surface of the left ventricle from both the left circumflex and right coronary arteries.

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.

Target Value: The highest 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.

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

Supporting Definition:

Section: Native Vessel **Parent: H. Coronary Anatomy**

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 value on 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):
If the patient has only a PCI (without a diagnostic cath in this lab visit) it is acceptable to use prior cath lab visit information, when coding coronary stenosis, 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: 7511 Native Vessel Adjunctive Measurements Obtained

Code System Name	Code
ACC NCDR	100012979

Coding Instruction: Indicate if an invasive diagnostic measurement was obtained of the native vessel segment.

Target Value: Any occurrence between start of procedure and prior to intervention

Supporting Definition:

Element: 7512 Native Vessel Fractional Flow Reserve Ratio

Code System Name	Code
SNOMED CT	371835003

Coding Instruction: Indicate the fractional flow reserve of the native vessel segment.

Target Value: The lowest value between start of procedure and prior to intervention

Supporting Definition:

Element: 7513 Native Vessel Instantaneous Wave-Free Ratio

Code System Name	Code
ACC NCDR	100012980

Coding Instruction: Indicate the instantaneous wave-free ratio (iFR ratio) of the native vessel segment.

Target Value: The lowest value between start of procedure and prior to intervention

Supporting Definition:

Element: 7514 Native Vessel Intravascular Ultrasonography

Code System Name	Code
SNOMED CT	431945005

Coding Instruction: Indicate the mean luminal area (MLA) measured via IVUS of the native vessel segment.

Target Value: The lowest value between start of procedure and prior to intervention

Supporting Definition:

Element: 7515 Native Vessel Optical Coherence Tomography

Code System Name	Code

SNOMED CT 698254001

Coding Instruction: Indicate the mean luminal area (MLA) measured via OCT of the native vessel segment.

Target Value: The lowest value between start of procedure and prior to intervention

Supporting Definition:

Section: Graft Vessel **Parent: H. Coronary Anatomy**

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 value on 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):
If the patient has only a PCI (without a diagnostic cath in this lab visit) it is acceptable to use prior cath lab visit information, when coding coronary stenosis, 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:

Element: 7531 Graft Vessel Adjunctive Measurements Obtained

Code System Name	Code
ACC NCDR	1000142356

Coding Instruction: Indicate if an invasive diagnostic measurement was obtained of the graft vessel intra-procedure.

Target Value: Any occurrence between start of procedure and prior to intervention

Supporting Definition:

Element: 7532 Graft Vessel Fractional Flow Reserve Ratio

Code System Name	Code
SNOMED CT	371835003

Coding Instruction: Indicate the fractional flow reserve of the graft vessel segment.

Target Value: The lowest value between start of procedure and prior to intervention

Supporting Definition:

Element: 7533 Graft Vessel Instantaneous Wave-Free Ratio

Code System Name	Code
ACC NCDR	100012980

Coding Instruction: Indicate the instantaneous wave-free ratio (iFR ratio) of the graft vessel segment.

Target Value: The lowest value between start of procedure and prior to intervention

Supporting Definition:

Element: 7534 Graft Vessel Intravascular Ultrasonography

Code System Name	Code
SNOMED CT	431945005

Coding Instruction: Indicate the mean luminal area (MLA) measured via IVUS of the graft vessel segment.

Target Value: The lowest value between start of procedure and prior to intervention

Supporting Definition:

Element: 7535 Graft Vessel Optical Coherence Tomography

Code System Name	Code
SNOMED CT	698254001

Coding Instruction: Indicate the mean luminal area (MLA) measured via OCT of the graft vessel segment.

Target Value: The lowest value between start of procedure and prior to intervention

Supporting Definition:

Section: I. PCI Procedure **Parent: E. Procedure Information**

Element: 7800 PCI Status

Code System Name	Code
ACC NCDR	100012986

Coding Instruction: Indicate the status of the PCI. The status is determined at the time the operator decides to perform a PCI.

Target Value: The highest value at start of current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100012987	Elective	The procedure can be performed on an outpatient basis or during a subsequent hospitalization without significant risk of infarction or death. For stable inpatients, the procedure is being performed during this hospitalization for convenience and ease of scheduling and NOT because the patient's clinical situation demands the procedure prior to discharge. If the diagnostic catheterization was elective and there were no complications, the PCI would also be elective.
ACC NCDR	100012988	Urgent	The procedure should be performed on an inpatient basis and prior to discharge because of significant concerns that there is risk of ischemia, infarction and/or death. Patients who are outpatients or in the emergency department at the time that the cardiac catheterization is requested would warrant an admission based on their clinical presentation.
ACC NCDR	100012989	Emergency	The procedure should be performed as soon as possible because of substantial concerns that ongoing ischemia and/or infarction could lead to death. "As soon as possible" refers to a patient who is of sufficient acuity that you would cancel a scheduled case to perform this procedure immediately in the next available room during business hours, or you would activate the on-call team were this to occur during off-hours.
ACC NCDR	100001290	Salvage	The procedure is a last resort. The patient is in cardiogenic shock when the PCI begins (i.e. at the time of introduction into a coronary artery or bypass graft of the first guidewire or intracoronary device for the purpose of mechanical revascularization). Within the last ten minutes prior to the start of the case or during the diagnostic portion of the case, the patient has also received chest compressions for a total of at least sixty seconds or has been on unanticipated extracorporeal circulatory support (e.g. extracorporeal mechanical oxygenation, or cardiopulmonary support).

Element: 7806 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 arrival (or previous procedure) and current procedure

Supporting Definition:

Element: 7807 Hypothermia Induced Timing

Code System Name	Code
ACC NCDR	100013039

Coding Instruction: Indicate when hypothermia was initiated.

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

Target Value: The value on current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100013036	Initiated Pre-PCI, <= 6 hrs post cardiac arrest	Hypothermia was induced less than or equal to 6 hours after the cardiac arrest event and prior to engaging in PCI (guidewire introduced).
ACC NCDR	100013037	Initiated Pre-PCI, > 6 hrs post cardiac arrest	Hypothermia was induced greater than 6 hours after the cardiac arrest event and prior to engaging in PCI (guidewire introduced).
ACC NCDR	100013038	Post PCI	Hypothermia was induced after guidewire introduction for PCI.

Element: 7810 Level of Consciousness (PCI Procedure)

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 value at the start of the PCI

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)

Element: 7815 Decision for PCI with Surgical Consult

Code System Name	Code
ACC NCDR	1000142366

Coding Instruction: Indicate if a cardiac surgical consult was obtained prior to engaging in PCI.

Target Value: The value on current procedure

Supporting Definition:

Element: 7816 Cardiovascular Treatment Decision

Code System Name	Code
ACC NCDR	1000142367

Coding Instruction: Indicate the cardiovascular surgery recommendation and/or patient/family decision.

Target Value: The value on current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	1000142368	Surgery not Recommended	
ACC NCDR	1000142369	Surgery Recommended, Patient/Family Declined	
ACC NCDR	1000142370	Surgery Recommended, Patient/Family Accepted (Hybrid Procedure)	

Element: 7820 PCI for MultiVessel Disease

Code System Name	Code
ACC NCDR	100013007

Coding Instruction: Indicate if the PCI procedure was performed in the presence of multi-vessel disease.

Note(s):
Code 'Yes' if this is the initial (first) PCI procedure for the cath lab indication and the patient has obstructive disease >70% stenosis in >2 coronary vessels and/or disease 50%-70% stenosis in >2 coronary vessels with non-invasive or FFR/IFR evidence of ischemia in that territory and/or left main disease >=50% stenosis
(A coronary vessel is defined as: LAD and any of its branches, LCX and any of its branches, RCA and any of its branches, a true RAMUS branch >2 mm)

Code 'Yes' if this a subsequent, planned staged PCI procedure of a vessel not treated during the initial PCI procedure. The first PCI could have been during a prior admission, or during this admission but must occur within 90 days of the initial PCI procedure.

Target Value: The value on current procedure

Supporting Definition:

Element: 7821 Multi-vessel Procedure Type

Code System Name	Code
ACC NCDR	100013008

Coding Instruction: Indicate the type of multi-vessel PCI procedure that was performed during this lab visit.

Target Value: The value on current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	10001424793	Initial PCI	This PCI procedure is the initial (first) for the cath lab indication
ACC NCDR	10001424794	Staged PCI	This PCI procedure is the subsequent, planned staged PCI procedure for a vessel NOT treated during the initial PCI procedure. The first PCI could have been during a prior admission, or during this admission but must occur within 90 days of the initial PCI procedure.

Element: 7825 Percutaneous Coronary Intervention Indication

Code System Name	Code
ACC NCDR	100000880

Coding Instruction: Indicate the reason the percutaneous coronary intervention PCI is being performed.

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

Target Value: The highest value at start of current procedure

Supporting Definition:

Element: 7826 Acute Coronary Syndrome Symptom Date

Code System Name	Code

ACC NCDR	100013003

Coding Instruction: Indicate the date and time 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 1 week prior to current procedure and current procedure

Supporting Definition:

Element: 7827 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 1 week prior to current procedure and current procedure

Supporting Definition:

Element: 7828 Acute Coronary Syndrome Symptom Time Unknown

Code System Name	Code
ACC NCDR	100013004

Coding Instruction: Indicate if the symptom time was not available.

Target Value: N/A

Supporting Definition:

Element: 7829 Thrombolytics

Code System Name	Code
SNOMED CT	307521008

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

Note(s):
Code 'Yes' only if full dose (not partial dose) thrombolytics were administered.

Target Value: Any occurrence between 1 week prior to arrival at this facility and current procedure

Supporting Definition:

Element: 7830 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 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 1 week prior to arrival at this facility and current procedure

Supporting Definition:

Element: 7831 Syntax Score

Code System Name	Code
ACC NCDR	10001424796

Coding Instruction: Indicate the Syntax Score for the PCI procedure.

Target Value: The highest value at start of current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	10001424799	Low Syntax Score	Syntax score <=22
ACC NCDR	10001424798	Intermediate Syntax Score	Syntax score >22 and <=27
ACC NCDR	10001424797	High Syntax Score	Syntax score >27

Element: 7832 Syntax Score Unknown

Code System Name	Code
ACC NCDR	10001424796

Coding Instruction: Indicate if the Syntax Score for the PCI procedure is unknown.

Target Value: The highest value at start of current procedure

Supporting Definition:

Element: 7835 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 either the first ECG or a subsequent ECG.

Note(s):
Code "Subsequent ECG" if STEMI is noted after the ECG on arrival does not indicate STEMI or STEMI equivalent.

Code "Subsequent ECG" if STEMI is noted on an ECG subsequent to the patients non-cardiac presentation.

Code "Subsequent ECG" if STEMI is noted on an inpatient ECG.

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

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100000578	First ECG	
ACC NCDR	100000579	Subsequent ECG	

Element: 7836 Subsequent ECG with STEMI or STEMI Equivalent Date and Time

Code System Name	Code
ACC NCDR	100012995

Coding Instruction: Indicate the Subsequent ECG date and time.

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 1 day prior to current procedure and current procedure

Supporting Definition:

Element: 7840 Subsequent ECG obtained in Emergency Department

Code System Name	Code
ACC NCDR	100012997

Coding Instruction: Indicate if the subsequent ECG was obtained in the Emergency Department at this facility.

Target Value: The value on current procedure

Supporting Definition:

Element: 7841 Patient Transferred In for Immediate PCI for STEMI

Code System Name	Code
ACC NCDR	100014084

Coding Instruction: Indicate if the patient was transferred from another facility to have a primary PCI for STEMI at this facility.

Target Value: Any occurrence between ACS symptom date/time and current procedure

Supporting Definition:

Element: 7842 Emergency Department Presentation at Referring Facility Date and Time

Code System Name	Code
ACC NCDR	100012999

Coding Instruction: Code the date and time of arrival to the original, transferring facility as documented in the medical record.

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

Target Value: The first value on arrival at referring facility

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	The patient and/or their condition is obstructive to the timing of PCI.

Section: Procedure Medications **Parent: I. PCI Procedure**

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:

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: J. Lesions and Devices **Parent: I. PCI Procedure**

Element: 8000 Lesion Counter

Code System Name	Code
ACC NCDR	1000142441

Coding Instruction: The lesion counter is used to distinguish between multiple lesions on which a PCI is attempted or performed.

When specifying intracoronary devices, list all treated lesions in which the device was utilized.

Note(s):
The software-assigned lesion counter should start at one and be incremented by one for each lesion. The lesion counter is reset back to one for each new PCI lab visit.

At least one lesion must be specified for each PCI procedure.

Target Value: N/A

Supporting Definition:

Element: 8001 Native Lesion Segment Number

Code System Name	Code
ACC NCDR	100012984

Coding Instruction: Indicate the segment(s) that the current lesion spans (a lesion can span one or more segments).

Target Value: N/A

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: 8002 Culprit Stenosis

Code System Name	Code
SNOMED CT	371895000

Coding Instruction: Indicate if the stenosis is considered to be responsible for the acute coronary syndrome.

Note(s):

Code 'No' if the stenosis is not considered to be responsible for the evidence of ischemia.

Target Value: Any occurrence on current procedure

Supporting Definition:

Element: 8003 Culprit Stenosis Unknown

Code System Name	Code
ACC NCDR	112000000347

Coding Instruction: Indicate if the stenosis considered to be responsible for the acute coronary syndrome is unknown.

Target Value: Any occurrence on current procedure

Supporting Definition:

Element: 8004 Stenosis Immediately Prior to Treatment

Code System Name	Code
ACC NCDR	1000142442

Coding Instruction: Indicate the percent diameter stenosis immediately prior to the treatment of this lesion.

Target Value: The highest value on current procedure

Supporting Definition:

Element: 8005 Chronic Total Occlusion

Code System Name	Code
ACC NCDR	100000290

Coding Instruction: Indicate if the segment with 100% pre-procedure stenosis was presumed to be 100% occluded for at least 3 months previous to this procedure AND not related to a clinical event prompting (or leading to) this procedure.

Target Value: Any occurrence on current procedure

Supporting Definition:

Element: 8006 Chronic Total Occlusion Unknown

Code System Name	Code
ACC NCDR	112000000345

Coding Instruction: Indicate if the segment with 100% pre-procedure stenosis was presumed to be 100% occluded for at least 3 months previous to this procedure AND not related to a clinical event prompting (or leading to) this procedure was unknown.

Target Value: Any occurrence on current procedure

Supporting Definition:

Element: 8007 TIMI Flow (Pre-Intervention)

Code System Name	Code
ACC NCDR	112000000348

Coding Instruction: Indicate the pre-intervention TIMI flow.

Note(s): If a lesion spans multiple segments with different TIMI flow, code the lowest TIMI flow within the entire lesion.

Target Value: The lowest value on current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	371867000	TIMI-0	No flow/no perfusion
SNOMED CT	371866009	TIMI-1	Slow penetration without perfusion
SNOMED CT	371864007	TIMI-2	Partial flow/partial perfusion (greater than TIMI-1 but less than TIMI-3).
SNOMED CT	371865008	TIMI-3	Complete and brisk flow/complete perfusion.

Element: 8008 Previously Treated Lesion

Code System Name	Code
ACC NCDR	100013015

Coding Instruction: Indicate if the lesion has been treated before in the current or a prior episode of care.

Note(s):
Code 'No' if the only prior treatment was CABG.

Code 'No' if the only treatment of this lesion occurred during THIS PCI procedure.

Target Value: Any occurrence between birth and the procedure

Supporting Definition:

Element: 8009 Previously Treated Lesion Date

Code System Name	Code
ACC NCDR	100013015

Coding Instruction: Indicate the date the lesion was previously treated.

Target Value: The last value between birth and current procedure

Supporting Definition:

Element: 8010 Treated with Stent

Code System Name	Code
SNOMED CT	36969009

Coding Instruction: Indicate if the previously treated lesion was treated with any type of stent in the current or prior episode of care.

Target Value: Any occurrence between birth and start of the current procedure

Supporting Definition:

Element: 8011 In-stent Restenosis

Code System Name	Code
ACC NCDR	100013013

Coding Instruction: Indicate if the previously treated and stented lesion is being treated for in-stent restenosis.

Note(s): In-stent restenosis is defined as a previously stented lesion that has 50% or greater stenosis.

Target Value: Any occurrence between birth and start of the current procedure

Supporting Definition:

Element: 8012 In-stent Thrombosis

Code System Name	Code
ACC NCDR	100013014

Coding Instruction: Indicate if the previously treated and stented lesion is being treated because of the presence of a thrombus in the stent.

Target Value: Any occurrence between birth and start of the current procedure

Supporting Definition: **Thrombosis in stented Lesion**

The formation of a blood clot inside a previously treated and stented lesion.

Element: 8013 Stent Type

Code System Name	Code
ACC NCDR	100000856

Coding Instruction: Indicate the type of stent used in the previously treated lesion.

Note(s): If a patient has multiple stents in the lesion code 'bioabsorbable' over either of the other two options when it is present.

If a DES and BMS are present in the lesion, code 'DES'.

Target Value: The last value between birth and start of the current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
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.
SNOMED CT	464052002	Bare Metal Stent (BMS)	A bare metal stent (BMS) is a coronary stent without eluting drugs.

Element: 8014 Stent Type Unknown

Code System Name	Code
ACC NCDR	100000856

Coding Instruction: Indicate if the type of stent used in the previously treated lesion is unknown.

Target Value: The last value between birth and start of the current procedure

Supporting Definition:

Element: 8015 Lesion In Graft

Code System Name	Code
ACC NCDR	1000142443

Coding Instruction: Indicated if the lesion is in a coronary artery bypass graft.

Target Value: Any occurrence on current procedure

Supporting Definition:

Element: 8016 Type of CABG Graft

Code System Name	Code
ACC NCDR	100013028

Coding Instruction: Indicate in which type of bypass graft the lesion is located.

Target Value: Any occurrence on current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	261402001	LIMA	Left Internal Mammary Artery
SNOMED CT	181367001	Vein	
ACC NCDR	100013029	Other Artery	Specific artery not available for selection in registry.

Element: 8017 Location in Graft

Code System Name	Code
ACC NCDR	100000862

Coding Instruction: Indicate the location of the most severe stenosis, if the lesion is in the graft.

Target Value: Any occurrence on current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	1000142355	Aortic	At the aortic anastomosis of the graft (<= 3 mm from insertion point).
ACC NCDR	1000142354	Body	In the body of the graft.
ACC NCDR	1000142353	Distal	At the distal anastomosis of the graft (<= 3 mm from insertion point).

Element: 8018 Navigate through Graft to Native Lesion

Code System Name	Code
ACC NCDR	1000142348

Coding Instruction: Indicate if treatment of the native artery lesion required navigating through a graft (to reach the lesion).

Target Value: The value on current procedure

Supporting Definition:

Element: 8019 Lesion Complexity

Code System Name	Code
ACC NCDR	100000866

Coding Instruction: Indicate the complexity of the lesion as defined in the selections below.

Target Value: Any occurrence on current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100000583	Non-High/Non-C	Non-high/non-C lesions are considered Type A or B lesions. They can be characterized as follows: Low Risk or Type A lesions: Discrete (<10 mm length) Concentric Readily accessible Non-angulated segment <45 degrees Smooth contour Little or no calcification Less than totally occlusive Not ostial in location No major branch involvement Absence of thrombus Medium Risk (Type B1) lesions: Tubular (10-20 mm length) Eccentric Moderate tortuosity of proximal segment Moderately angulated segment, 45-90 degrees Irregular contour Moderate to heavy calcification Ostial in location Bifurcation lesions requiring double guidewires Some thrombus present Total occlusion <3 months old Medium Risk (Type B2 lesions): Two or more "B" characteristics.
ACC NCDR	100000584	High/C	Descriptions of a High Lesion Risk (C Lesion): Diffuse (length > 2cm) Excessive tortuosity of proximal segment Extremely angulated segments > 90 degrees Total occlusions > 3 months old and/or bridging collaterals Inability to protect major side branches Degenerated vein grafts with friable lesions

Element: 8020 Lesion Length

Code System Name	Code
ACC NCDR	100013030

Coding Instruction: Indicate the length of the treated lesion in millimeters.

Note(s):
If the lesion length is not available it is acceptable to code the length of the device used to treat the lesion.

If multiple devices are used sequentially, total the individual device lengths.

Information obtained after the baseline angiogram can be used to help determine lesion length (e.g. for total occlusions where the distal vessel can not be visualized).

Target Value: Any occurrence on current procedure

Supporting Definition:

Element: 8021 Severe Calcification

Code System Name	Code
ACC NCDR	1000142350

Coding Instruction: Indicate if there was severe calcification of the lesion.

Note(s): To support coding there must documentation of 'severe calcification' specific to the lesion treated during the PCI procedure, by the interventionalist.

Target Value: The value on current procedure

Supporting Definition: **Severe calcification**

Severe calcification is most commonly defined as radiopacities seen without cardiac motion before contrast injection, usually affecting both sides of the arterial lumen.

Source: Madhavan MV, Tarigopula M, Mintz GS, Maehara A, Stone GW, Généreux P. Coronary Artery Calcification: Pathogenesis and Prognostic Implications. J Am Coll Cardiol. 2014;63(17):1703-1714. doi:10.1016/j.jacc.2014.01.017.

Element: 8022 Bifurcation Lesion

Code System Name	Code
SNOMED CT	371894001

Coding Instruction: Indicate if the treated lesion is at a significant bifurcation, trifucation or more complex branch point.

Note(s):
A significant bifurcation or branch point is a division of a vessel into at least two branches, each of which is >1.5 mm or greater in diameter. In a bifurcation or branch lesion, the plaque extends from at least one of the limbs to the branch point; it need not progress down all the proximal and distal branches. Bifurcations or branch point lesions should be considered one lesion, no matter how many limbs are treated.

Target Value: Any occurrence on current procedure

Supporting Definition:

Element: 8023 Guidewire Across Lesion

Code System Name	Code
ACC NCDR	100000851

Coding Instruction: Indicate if a guidewire successfully crossed the lesion.

Target Value: Any occurrence on current procedure

Supporting Definition:

Element: 8024 Device Deployed

Code System Name	Code
ACC NCDR	1000142349

Coding Instruction: Indicate if a device was deployed during the procedure.

Note(s):
Code 'Yes' if an intracoronary device was used as designed (e.g. a balloon was inflated, a stent was placed, aspiration was attempted with a thrombectomy device, etc.) The success of the device used is not relevant.

If 'Yes' is selected for any lesion, at least one intracoronary device must be specified.

Target Value: The value on current procedure

Supporting Definition:

Element: 8025 Stenosis (Post-Intervention)

Code System Name	Code
ACC NCDR	1000142461

Coding Instruction: Indicate the post-intervention percent stenosis for the treated lesion.

Target Value: The highest value on current procedure

Supporting Definition:

Element: 8026 TIMI Flow (Post-Intervention)

Code System Name	Code

ACC NCDR 100013016

Coding Instruction: Indicate the post-intervention TIMI flow.

Note(s):
If a lesion spans multiple segments with different TIMI flows, coded the lowest TIMI flow within the entire lesion.

Target Value: The lowest value on current procedure

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	371867000	TIMI-0	No flow/no perfusion
SNOMED CT	371866009	TIMI-1	Slow penetration without perfusion
SNOMED CT	371864007	TIMI-2	Partial flow/partial perfusion (greater than TIMI-1 but less than TIMI-3).
SNOMED CT	371865008	TIMI-3	Complete and brisk flow/complete perfusion.

Section: Devices **Parent: I. PCI Procedure**

Element: 8027 Intracoronary Device Counter

Code System Name	Code
ACC NCDR	2.16.840.1.113883.3.3478.4.851

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

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

The intracoronary device counter is reset back to one for each procedure.

Target Value: N/A

Supporting Definition:

Element: 8028 Intracoronary Device(s) Used

Code System Name	Code
ACC NCDR	1000142374

Coding Instruction: Indicate all devices utilized during the current procedure. If a device was utilized on multiple lesions, specify it only once (e.g., if a balloon was used to dilate two separate lesions, list it only once). Every treatment and support device utilized during the procedure should be specified.

Note(s):
Each intracoronary device must be associated with at least one lesion via the Lesion Counter (Element Ref# 8000) if Device Deployed (8024) is 'Yes'. An intracoronary device may be associated with more than one lesion.

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

Target Value: Any occurrence on current procedure

Supporting Definition:

Element: 8029 Intracoronary Unique Device Identifier

Code System Name	Code
ACC NCDR	2.16.840.1.113883.3.3719

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

Target Value: The value on current procedure

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

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

Source: US FDA

Element: 8030 Intracoronary Device Associated Lesion

Code System Name	Code
ACC NCDR	1000142398

Coding Instruction: Indicate all Lesion Counter Numbers (Element Ref# 8000) corresponding to the lesion(s) on which this device was used.

The lesion counter is used to distinguish between multiple lesions on which a PCI procedure is attempted or performed.

Target Value: The value on current procedure

Supporting Definition:

Element: 8031 Intracoronary Device Diameter

Code System Name	Code
ACC NCDR	1000142375

Coding Instruction: Indicate the diameter of the intracoronary device in millimeters.

Target Value: The value on current procedure

Supporting Definition:

Element: 8032 Intracoronary Device Length

Code System Name	Code
ACC NCDR	1000142376

Coding Instruction: Indicate the length of the device in millimeters.

Target Value: The value on current procedure

Supporting Definition:

Section: K. Intra and Post-Procedure Events **Parent: E. Procedure Information**

Element: 9145 Coronary Artery Perforation

Code System Name	Code
SNOMED CT	234010000

Coding Instruction: Indicate if angiographic or clinical evidence of perforation was observed.

Target Value: Any occurrence on current procedure

Supporting Definition: **Perforation**

A coronary artery perforation occurs when there is angiographic or clinical evidence of a dissection or intimal tear that extends through the full thickness of the arterial wall.

Source: NCDR

Element: 9146 Significant Coronary Artery Dissection

Code System Name	Code
ACC NCDR	100000883

Coding Instruction: Indicate if a significant coronary artery dissection was observed.

Note(s):
Typically, dissections described as type A or B are not considered significant dissections because there is no impairment of flow.

Significant dissections are grade C dissections in the presence of ischemia, or grade D-F dissections, all of which are further described as:

type C: persisting contrast medium extravasations;
type D: spiral filling defect with delayed but complete distal flow;
type E: persistent filling defect with delayed antegrade flow;
type F: filling defect with impaired flow and total occlusion

Target Value: Any occurrence on current procedure

Supporting Definition: **Dissection**

Dissection is defined as the appearance of contrast materials outside of the expected luminal dimensions of the target vessel and extending longitudinally beyond the length of the lesion.

Source: NCDR

Element: 9275 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: Any occurrence between start of procedure and until next procedure or discharge

Supporting Definition:

Element: 9276 Number of units of PRBCs transfused

Code System Name	Code
ACC NCDR	100014031

Coding Instruction: Indicate the number of transfusion(s) of packed red blood cells.

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

Supporting Definition:

Element: 9277 Transfusion PCI

Code System Name	Code
ACC NCDR	100014032

Coding Instruction: Indicate if the transfusion occurred during or after PCI.

Note(s):
Code 'No' if the pre-procedure hemoglobin was <=8mg/dL.

Target Value: Any occurrence between start of procedure and 72 hours after current procedure

Supporting Definition:

Element: 9278 Transfusion Surgery

Code System Name	Code
ACC NCDR	100014033

Coding Instruction: Indicate if the transfusion occurred during or after surgery.

Target Value: Any occurrence between start of procedure and 72 hours after current procedure

Supporting Definition:

Section: Intra and Post-Procedure Events **Parent: K. Intra and Post-Procedure Events**

Element: 9001 Intra/Post-Procedure Events

Code System Name	Code
ACC NCDR	1000142478

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

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

Supporting Definition:

Element: 9002 Intra/Post-Procedure Events Occurred

Code System Name	Code
ACC NCDR	1000142479

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

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

Supporting Definition:

Element: 9003 Intra/Post-Procedure 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 start of procedure and until next procedure or discharge

Supporting Definition:

Section: L. Discharge — Parent: Root

Element: 10030 — Interventions this Hospitalization

Code System Name	Code
ACC NCDR	100001283

Coding Instruction: Indicate other interventions (percutaneous or surgical) that occurred during this hospitalization.

Note(s):
This does not include interventions that occurred during the same cath lab visit as a Diagnostic Cath or PCI procedure.

Target Value: Any occurrence between arrival and discharge

Supporting Definition:

Element: 10031 — Intervention Type this Hospitalization

Code System Name	Code
ACC NCDR	100001284

Coding Instruction: Indicate the type of intervention or surgery that occurred.

Target Value: Any occurrence between arrival and discharge

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	232717009	CABG	Coronary artery bypass graft.
ACC NCDR	100014071	Valvular Intervention	A transcatheter valvular intervention.
ACC NCDR	100014068	Cardiac Surgery (non CABG)	A surgical correction of a defect or abnormality of the heart that is non- coronary, meaning that it does not affect the blood vessels in the heart, but rather involves the valves, walls or chambers.
ACC NCDR	100014072	Structural Heart Intervention (non-valvular)	A transcatheter correction of a defect or abnormality of the heart that is non-coronary and non-valvular, meaning that it does not affect the blood vessels or the valves but is limited to the walls or chambers.
ACC NCDR	100014022	Surgery (Non Cardiac)	A surgical intervention not involving the heart.
SNOMED CT	252425004	EP Study	A cardiac electrophysiology study (EP) is a minimally invasive procedure that tests the electrical conduction system of the heart to assess the electrical activity and conduction pathways of the heart. The study is indicated to investigate the cause, location of origin, and best treatment for various abnormal heart rhythms. This type of study is performed by an electrophysiologist and using a single or multiple catheters situated within the heart through a vein or artery. If at any step during the EP study the electrophysiologist finds the source of the abnormal electrical activity, he/she may try to ablate the cells that are misfiring. This is done using high-energy radio frequencies (similar to microwaves) to effectively "cook" the abnormal cells.
ACC NCDR	10001424811	Other	The intervention performed is not available for selection within the registry.

Element: 10035 — CABG Status

Code System Name	Code
ACC NCDR	100014080

Coding Instruction: Indicate the status of the coronary artery bypass graft (CABG) surgery.

Target Value: Any occurrence between arrival and discharge

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100001285	Elective	The patient's cardiac function has been stable in the days or weeks prior to the operation. The procedure could be deferred without increased risk of compromised cardiac outcome.
ACC NCDR	100001286	Urgent	Procedure required during same hospitalization in order to minimize chance of further clinical deterioration. Examples include but are not limited to: worsening sudden chest pain, CHF, acute myocardial infarction (AMI), anatomy, IABP, unstable angina (USA) with intravenous (IV) nitroglycerin (NTG) or rest angina
ACC NCDR	100001287	Emergency	Patients requiring emergency operation will have ongoing refractory (difficulty, complicated, and unmanageable) unrelenting cardiac compromise, with or without hemodynamic instability, and not responsive to any form of therapy except cardiac surgery. An emergency operation is one in which there should be no delay in providing operative intervention. The patient's clinical status includes any of the following: a. Ischemic dysfunction (any of the following): 1. Ongoing ischemia including rest angina despite maximal medical therapy (medical or IABP). 2. Acute Evolving Myocardial Infarction with 24hours before surgery. 3. Pulmonary edema requiring intubation. b. Mechanical dysfunction (either of the following): 1. Shock with circulatory support 2. Shock without circulatory support.
ACC NCDR	100001288	Salvage	The patient is undergoing CPR in route to the operating room or prior to anesthesia induction.

Element: 10036 CABG Indication

Code System Name	Code
ACC NCDR	100001289

Coding Instruction: Indicate the reason coronary artery bypass graft (CABG) surgery is being performed.

Target Value: Any occurrence between arrival and discharge

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100000712	PCI/CABG Hybrid Procedure	Hybrid therapy occurs when both surgical and percutaneous coronary revascularization are planned, with different lesions treated with the different techniques. Examples include LIMA-LAD followed by PCI of the circumflex or RCA; or primary PCI of the infarct culprit RCA followed by CABG for the severe LMCA stenosis. Unplanned revascularization as a result of a complication (e.g., CABG for PCI-related dissection, PCI for acute graft closure) are NOT considered hybrid procedures because these sequential interventions were not part of a considered treatment strategy.
ACC NCDR	100001291	Recommendation from Dx Cath (instead of PCI)	CABG was recommended after diagnostic coronary angiography
ACC NCDR	100001292	PCI Failure	PCI failed to successfully treat the patient and CABG is required, the patient is stable without clinical deterioration.
ACC NCDR	100000709	PCI complication	PCI failed to successfully treat the patient and/or there was a complication, CABG is required and the patient is unstable.

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.

Element: 10060 Creatinine

Code System Name	Code
LOINC	2160-0

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

Target Value: The last value on discharge

Supporting Definition: **Creatinine**

Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine results in the formation of creatinine. It is transferred to the kidneys by blood plasma, whereupon it is eliminated by glomerular filtration and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A rise in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver and pancreas.

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

Element: 10061 Creatinine Not Drawn

Code System Name	Code
LOINC	2160-0

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

Target Value: The last value on discharge

Supporting Definition: **Creatinine**

Creatinine or creatine anhydride, is a breakdown product of creatine phosphate in muscle. The loss of water molecule from creatine results in the formation of creatinine. It is transferred to the kidneys by blood plasma, whereupon it is eliminated by glomerular filtration and partial tubular excretion. Creatinine is usually produced at a fairly constant rate and measuring its serum level is a simple test. A rise in blood creatinine levels is observed only with marked damage to functioning nephrons; therefore this test is not suitable for detecting early kidney disease. Creatine and creatinine are metabolized in the kidneys, muscle, liver and pancreas.

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

Element: 10065 Hemoglobin

Code System Name	Code
LOINC	718-7

Coding Instruction: Indicate the hemoglobin level in g/dL.

Target Value: The last value on 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: 10066 Hemoglobin Not Drawn

Code System Name	Code
LOINC	718-7

Coding Instruction: Indicate if the hemoglobin was not drawn.

Target Value: The last value on 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: 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: 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: 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: 10111 Transferred for CABG

Code System Name	Code
ACC NCDR	100001296

Coding Instruction: Indicate if the patient was transferred for the purpose of performing a coronary artery bypass graft.

Target Value: The value on discharge

Supporting Definition:

Element: 10112 CABG Planned after Discharge

Code System Name	Code
ACC NCDR	10001424792

Coding Instruction: Indicate if the patient has a CABG planned after discharge.

Note: A planned CABG could include a documented plan for the patient to receive a CABG, a patient referral for a CABG or a CABG date scheduled.

Target Value: The value on discharge

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: 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: **Cardiac Rehabilitation Referral**

A referral is defined as an official communication between the health care provider and the patient to recommend and carry out a referral order to an early outpatient cardiac rehab (CR) program. This includes the provision of all necessary information to the patient that will allow the patient to enroll in an early outpatient CR program. This also includes a communication between the health care provider or health care system and the CR program that includes the patient's referral information for the program. A hospital discharge summary or office note may potentially be formatted to include the necessary patient information to communicate to the CR program [the patient's cardiovascular history, testing, and treatments, for instance]. All communications must maintain appropriate confidentiality as outlined by the 1996 Health Insurance Portability and Accountability Act [HIPPA].

Source: Thomas RJ, King M, Lui K, Oldridge N, Piña IL, Spertus J. AACVPR/ACCF/AHA 2010 Update: Performance Measures on Cardiac Rehabilitation for Referral to Cardiac Rehabilitation/Secondary Prevention Services: Endorsed by the American College of Chest Physicians, the American College of Sports Medicine, the American Physical Therapy Association, the Canadian Association of Cardiac Rehabilitation, the Clinical Exercise Physiology Association, the European Association for Cardiovascular Prevention and Rehabilitation, the Inter-American Heart Foundation, the National Association of Clinical Nurse Specialists, the Preventive Cardiovascular Nurses Association, and the Society of Thoracic Surgeons. J Am Coll Cardiol. 2010;56(14):1159-1167. doi:10.1016/j.jacc.2010.06.006.

Code System Name	Code	Selection Text	Definition
ACC NCDR	100014064	No - Reason Not Documented	
ACC NCDR	100014066	No - Medical Reason Documented	
ACC NCDR	100014065	No - Health Care System Reason Documented	
ACC NCDR	100013072	Yes	

Element: 10117 Level of Consciousness (Discharge)

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 from start of procedure to death

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)

Element: 10120 Death During the Procedure

Code System Name	Code
ACC NCDR	100000923

Coding Instruction: Indicate if the patient expired during the procedure.

Note(s): Make sure to only capture 'Death during the procedure' in the procedure appropriate registry.

For example, if the patient had a CathPCI procedure and a TVT procedure in the same episode of care (hospitalization) but different cath lab visits and the death occurred during the TVT procedure, code 'Yes' only in the TVT Registry and not the CathPCI Registry. If the CathPCI procedure and TVT procedure occurred during the same cath lab visit then code 'Yes' in both registries.

Target Value: Any occurrence 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: **Cause of Death**

Underlying cause of death is defined as “the disease or injury which initiated the train of morbid events leading directly to death, or the circumstances of the accident or violence which produced the fatal injury”.

Source: http://www.who.int/topics/mortality/en/

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: 10220 Discharge Medication Reconciliation Completed

Code System Name	Code
ACC NCDR	100013084

Coding Instruction: Indicate if the medication reconciliation was completed as recommended by the Joint Commission's National Patient Safety Goals.

Target Value: The value on discharge

Supporting Definition:

Element: 10221 Discharge Medications Reconciled

Code System Name	Code
ACC NCDR	100013085

Coding Instruction: Indicate the specific medication classes that were reconciled.

Target Value: The value on discharge

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100013086	Prescriptions: Cardiac	
ACC NCDR	100013087	Prescriptions: Non-Cardiac	
ACC NCDR	100013088	Over the Counter (OTC) Medications	
ACC NCDR	100013089	Vitamins/Minerals	
ACC NCDR	100013090	Herbal Supplements	

Section: Discharge Medications — Parent: L. Discharge

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:

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.

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% Simvastatin 10 mg Pravastatin 10-20 mg Lovastatin 20 mg Fluvastatin 20-40 mg Pitavastatin 1 mg
ACC NCDR	100014035	Moderate Intensity Dose	Daily dose lowers LDL-C, on average, by approximately 30% to <50% Atorvastatin 10 (20) mg Rosuvastatin (5) 10 mg Simvastatin 20-40 mg Pravastatin 40 (80) mg Lovastatin 40 mg Fluvastatin XL 80 mg Fluvastatin 40 mg BID
ACC NCDR	100014034	High Intensity Dose	Daily dose lowers LDL-C, on average, by approximately >=50% Atorvastatin (40)-80 mg Rosuvastatin 20 (40) mg

Element: 10206 Patient Rationale for not taking medication

Code System Name	Code
ACC NCDR	100013080

Coding Instruction: Indicate the patient rationale for requesting a medication not be prescribed.

Target Value: The value on discharge

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100013081	Cost	
ACC NCDR	100013082	Alternative Therapy Preferred	
ACC NCDR	100013083	Negative Side Effect	

Section: M. Follow-Up **Parent: Root**

Element: 10999 FollowUp 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 FollowUp 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: 11001 FollowUp Reference Procedure Start Date and Time

Code System Name	Code
ACC NCDR	1000142372

Coding Instruction: Indicate the reference procedure start date and time on the follow-up assessment date.

Target Value: The value on Follow-up

Supporting Definition:

Element: 11002 Follow Up Reference Episode Arrival Date and Time

Code System Name	Code
ACC NCDR	1000142436

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

Target Value: The value on Follow-up

Supporting Definition:

Element: 11015 FollowUp 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.

Target Value: The value on Follow-up

Supporting Definition:

Element: 11003 Method to Determine FollowUp Status

Code System Name	Code
ACC NCDR	100014059

Coding Instruction: Indicate the method(s) used to determine the patient's vital status for follow up.

Target Value: The value on Follow-up

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	183654001	Office Visit	
ACC NCDR	100014062	Phone Call	
ACC NCDR	100014060	Medical Records	
ACC NCDR	1000142362	Social Security Death Master File	
ACC NCDR	100014061	Letter from Medical Provider	
ACC NCDR	1000142363	Hospitalized	
ACC NCDR	100000351	Other	

Element: 11004 FollowUp Status

Code System Name	Code
SNOMED CT	308273005

Coding Instruction: Indicate whether the patient is alive or deceased.

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: 11005 Chest Pain Symptom Assessment

Code System Name	Code
ACC NCDR	100001274

Coding Instruction: Indicate the chest pain symptom assessment as diagnosed by the physician or described by the patient.

Target Value: The value on Follow-up

Supporting Definition:

Code System Name	Code	Selection Text	Definition
SNOMED CT	429559004	Typical Angina	Symptoms meet all three of the characteristics of angina (also known as definite): 1. Substernal chest discomfort with a characteristic quality and duration that is 2. provoked by exertion or emotional stress and 3. relieved by rest or nitroglycerin.
SNOMED CT	371807002	Atypical angina	Symptoms meet two of the three characteristics of typical angina (also known as probable).
ACC NCDR	100001275	Non-anginal Chest Pain	The patient meets one, or none of the typical characteristics of angina.
ACC NCDR	100000932	Asymptomatic	No typical or atypical symptoms or non-anginal chest pain.

Element: 11006 FollowUp Date of Death

Code System Name	Code
ACC NCDR	1000142373

Coding Instruction: Indicate the date of death.

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: **Cause of Death**

Underlying cause of death is defined as “the disease or injury which initiated the train of morbid events leading directly to death, or the circumstances of the accident or violence which produced the fatal injury”.

Source: http://www.who.int/topics/mortality/en/

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: 11008 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: The value on Follow-up

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

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

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

Section: Follow-Up Research Study — Parent: M. Follow-Up

Element: 11009 — 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: The value on Follow-up

Supporting Definition:

Element: 11010 — 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: The value on Follow-up

Supporting Definition:

Section: Follow-Up Events — Parent: M. Follow-Up

Element: 11011 — FollowUp Events

Code System Name	Code
ACC NCDR	1000142377

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

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:

Element: 11012 — FollowUp 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: 11013 — FollowUp Devices Event Occurred In

Code System Name	Code
ACC NCDR	1000142417

Coding Instruction: Indicate the device that the event occurred in.

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

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

Supporting Definition:

Element: 11014 — FollowUp 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: Follow-Up Medications — Parent: M. Follow-Up

Element: 11990 FollowUp Medications Code

Code System Name	Code
ACC NCDR	100013057

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

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

Target Value: N/A

Supporting Definition:

Element: 11995 FollowUp Medications Prescribed

Code System Name	Code
SNOMED CT	432102000

Coding Instruction: Indicated if the medication is prescribed, not prescribed or is not prescribed for either a medical or patient reason

Target Value: The last value between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100001247	Yes - Prescribed	Code 'Yes' if this medication was initiated (or prescribed) or continued at follow-up.
ACC NCDR	100001048	Not Prescribed - No Reason	Code 'No' if this medication was not initiated (or prescribed) or continued at follow-up 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 initiated (or prescribed) or continued at follow-up 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 initiated (or prescribed) or continued at follow-up and there was a reason documented related to the patient's preference.

Element: 11996 FollowUp Medication Dose

Code System Name	Code
ACC NCDR	100014233

Coding Instruction: Indicate the category of the dose of statin prescribed at follow-up.

Target Value: The last value between discharge (or previous follow-up) and current follow-up assessment

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100014036	Low Intensity Dose	Daily dose lowers LDL-C, on average, by <30% Simvastatin 10 mg Pravastatin 10-20 mg Lovastatin 20 mg Fluvastatin 20-40 mg Pitavastatin 1 mg
ACC NCDR	100014035	Moderate Intensity Dose	Daily dose lowers LDL-C, on average, by approximately 30% to <50% Atorvastatin 10 (20) mg Rosuvastatin (5) 10 mg Simvastatin 20-40 mg Pravastatin 40 (80) mg Lovastatin 40 mg Fluvastatin XL 80 mg Fluvastatin 40 mg BID
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: Follow-Up SA Questionnaire — Parent: M. Follow-Up

Element: 11301 — Q1a: Difficulty walking indoors on level ground

Code System Name	Code
ACC NCDR	100013017

Coding Instruction: Indicate the patient's response to the Seattle Angina Questionnaire (SAQ) Question 1a "Over the past four weeks, as a result of your angina, how much difficulty have you had in: walking indoors on level ground?"

Target Value: The value on Follow-up

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100001173	Extremely limited	
ACC NCDR	100001171	Quite a bit limited	
ACC NCDR	100001170	Moderately limited	
ACC NCDR	100014042	Slightly limited	
ACC NCDR	100001167	Not at all limited	
ACC NCDR	100014041	Limited for other reasons or did not do these activities	

Element: 11302 — Q1b: Difficulty gardening, vacuuming or carrying groceries

Code System Name	Code
ACC NCDR	100013018

Coding Instruction: Indicate the patient's response to the Seattle Angina Questionnaire (SAQ) Question 1b "Over the past four weeks, as a result of your angina, how much difficulty have you had in: gardening, vacuuming, or carrying groceries?"

Target Value: The value on Follow-up

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100001173	Extremely limited	
ACC NCDR	100001171	Quite a bit limited	
ACC NCDR	100001170	Moderately limited	
ACC NCDR	100014042	Slightly limited	
ACC NCDR	100001167	Not at all limited	
ACC NCDR	100014041	Limited for other reasons or did not do these activities	

Element: 11303 — Q1c: Difficulty lifting or moving heavy objects (e.g. furniture, children)

Code System Name	Code
ACC NCDR	100013019

Coding Instruction: Indicate the patient's response to the Seattle Angina Questionnaire (SAQ) Question 1c "Over the past four weeks, as a result of your angina, how much difficulty have you had in: lifting or moving heavy objects (e.g. furniture, children)?"

Target Value: The value on Follow-up

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100001173	Extremely limited	
ACC NCDR	100001171	Quite a bit limited	
ACC NCDR	100001170	Moderately limited	
ACC NCDR	100014042	Slightly limited	
ACC NCDR	100001167	Not at all limited	
ACC NCDR	100014041	Limited for other reasons or did not do these activities	

Element: 11305 Q2: Had chest pain, chest tightness, or angina

Code System Name	Code
ACC NCDR	100013020

Coding Instruction: Indicate the patient's response to the Seattle Angina Questionnaire (SAQ) Question 2 "Over the past four weeks, on average, how many times have you: Had chest pain, chest tightness, or angina?"

Target Value: The value on Follow-up

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100014043	4 or more times per day	
ACC NCDR	100014044	1 - 3 times per day	
ACC NCDR	100014045	3 or more times per week but not every day	
ACC NCDR	100014046	1 - 2 times per week	
ACC NCDR	100014047	Less than once a week	
ACC NCDR	100014048	None over the past 4 weeks	

Element: 11310 Q3: Had to take nitroglycerin (Tablets or spray) for your chest pain, chest tightness or angina

Code System Name	Code
ACC NCDR	100013021

Coding Instruction: Indicate the patient's response to the Seattle Angina Questionnaire (SAQ) Question 3 "Over the past four weeks, on average, how many times have you: Had to take nitroglycerin (Tablets or spray) for your chest pain, chest tightness or angina?"

Target Value: The value on Follow-up

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100014043	4 or more times per day	
ACC NCDR	100014044	1 - 3 times per day	
ACC NCDR	100014045	3 or more times per week but not every day	
ACC NCDR	100014046	1 - 2 times per week	
ACC NCDR	100014047	Less than once a week	
ACC NCDR	100014048	None over the past 4 weeks	

Element: 11315 Q4: Chest pain, chest tightness or angina limited your enjoyment of life

Code System Name	Code
ACC NCDR	100013022

Coding Instruction: Indicate the patient's response to the Seattle Angina Questionnaire (SAQ) Question 4 "Over the past four weeks, on average, how many times have you: Chest pain, chest tightness or angina limited your enjoyment of life?"

Target Value: The value on Follow-up

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100014049	It has extremely limited my enjoyment of life	
ACC NCDR	100014050	It has limited my enjoyment of life quite a bit	
ACC NCDR	100014051	It has moderately limited my enjoyment of life	
ACC NCDR	100014052	It has slightly limited my enjoyment of life	
ACC NCDR	100014053	It has not limited my enjoyment of life at all	

Element: 11320 Q5: How would you feel about this

Code System Name	Code
ACC NCDR	100013023

Coding Instruction: Indicate the patient's response to the Seattle Angina Questionnaire (SAQ) Question 5 "If you had to spend the rest of your life with

your chest pain, chest tightness or angina the way it is right now how would you feel about that?"

Target Value: The value on Follow-up

Supporting Definition:

Code System Name	Code	Selection Text	Definition
ACC NCDR	100014054	Not satisfied at all	
ACC NCDR	100014055	Mostly dissatisfied	
ACC NCDR	100001197	Somewhat satisfied	
ACC NCDR	100014057	Mostly satisfied	
ACC NCDR	100014058	Completely satisfied	

Section: Follow-Up Rose Dyspnea Scale — Parent: M. Follow-Up

Element: 11330 — Rose Dyspnea Scale Question 1

Code System Name	Code
ACC NCDR	100013024

Coding Instruction: Indicate the patient's response to the Rose Dyspnea Scale Questionnaire Question 1 "Do you get short of breath when hurrying on level ground or walking up a slight hill?"

Target Value: The value on Follow-up

Supporting Definition:

Element: 11335 — Rose Dyspnea Scale Question 2

Code System Name	Code
ACC NCDR	100013025

Coding Instruction: Indicate the patient's response to the Rose Dyspnea Scale Questionnaire Question 2 "Do you get short of breath when walking with other people your own age on level ground?"

Target Value: The value on Follow-up

Supporting Definition:

Element: 11340 — Rose Dyspnea Scale Question 3

Code System Name	Code
ACC NCDR	100013026

Coding Instruction: Indicate the patient's response to the Rose Dyspnea Scale Questionnaire Question 3 "Do you get short of breath when walking at your own pace on level ground?"

Target Value: The value on Follow-up

Supporting Definition:

Element: 11345 — Rose Dyspnea Scale Question 4

Code System Name	Code
ACC NCDR	100013027

Coding Instruction: Indicate the patient's response to the Rose Dyspnea Scale Questionnaire Question 4 "Do you get short of breath when washing or dressing?"

Target Value: The value on Follow-up

Supporting Definition:

Section: Z. Administration — Parent: Root

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	