

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

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

Note(s):

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2010 Name: First Name

Coding Instructions: Indicate the patient's first name.

Note(s):

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2020 Name: Middle Name

Coding Instructions: Indicate the patient's middle name.

Note(s):

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

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

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

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2030 Name: SSN

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

Note(s):

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

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

**A. Demographics****Seq. #:** 2031 **Name:** SSN N/A**Coding Instructions:** Indicate if the patient does not have a United States Social Security Number.**Target Value:** The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 2040 **Name:** NCDR Patient ID**Coding Instructions:** Indicate the number created and automatically inserted by the software that uniquely identifies this patient.**Note(s):**

Once assigned to a patient at the participating facility, this number will never be changed or reassigned to a different patient. If the patient returns to the same participating facility or for followup, they will receive this same unique patient identifier.

Target Value: The value on arrival at this facility**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 2045 **Name:** Other ID**Coding Instructions:** An optional patient identifier, such as Medical Record Number, that can be associated with the patient.**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 2050 **Name:** Birth Date**Coding Instructions:** Indicate the patient's date of birth.**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: The value on arrival at this facility**Selections:** (none)**Supporting Definitions:** (none)



A. Demographics

Seq. #: 2060 **Name:** Sex**Coding Instructions:** Indicate the patient's sex at birth.**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

Male

Female

Supporting Definitions: (none)**Seq. #:** 2070 **Name:** Race - White**Coding Instructions:** Indicate if the patient is White.**Note(s):**

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

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

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

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

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

Seq. #: 2071 **Name:** Race - Black or African American**Coding Instructions:** Indicate if the patient is Black or African American.**Note(s):**

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

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

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

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

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

Effective for Patient Discharges January 01, 2015



A. Demographics

Seq. #: 2072 **Name:** Race - Asian**Coding Instructions:** Indicate if the patient is Asian.**Note(s):**

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

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

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

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

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

Seq. #: 2073 **Name:** Race - American Indian or Alaskan Native**Coding Instructions:** Indicate if the patient is American Indian or Alaskan Native.**Note(s):**

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

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

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

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

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



A. Demographics

Seq. #: 2074 **Name:** Race - Native Hawaiian or Pacific Islander**Coding Instructions:** Indicate if the patient is Native Hawaiian or Pacific Islander.**Note(s):**

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

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

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

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

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

Seq. #: 2076 **Name:** Hispanic or Latino Ethnicity**Coding Instructions:** Indicate if the patient is of Hispanic or Latino ethnicity as determined by the patient/family.**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

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

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

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



A. Demographics

Seq. #: 2080 **Name:** Race - Asian-Indian**Coding Instructions:** Indicate if the patient is Asian - Indian as determined by the patient/family.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: Asian-Indian:

Having origins in any of the original peoples of India.

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

Seq. #: 2081 **Name:** Race - Chinese**Coding Instructions:** Indicate if the patient is Chinese as determined by the patient/family.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: Asian - Chinese:

Having origins in any of the original peoples of China.

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

Seq. #: 2082 **Name:** Race - Filipino**Coding Instructions:** Indicate if the patient is Filipino as determined by the patient/family.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: Asian - Filipino:

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

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



A. Demographics

Seq. #: 2083 **Name:** Race - Japanese**Coding Instructions:** Indicate if the patient is Japanese as determined by the patient/family.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: **Asian - Japanese:**

Having origins in any of the original peoples of Japan.

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

Seq. #: 2084 **Name:** Race - Korean**Coding Instructions:** Indicate if the patient is Korean as determined by the patient/family.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: **Asian - Korean :**

Having origins in any of the original peoples of Korea.

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

Seq. #: 2085 **Name:** Race - Vietnamese**Coding Instructions:** Indicate if the patient is Vietnamese as determined by the patient/family.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: **Asian - Vietnamese:**

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

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

**A. Demographics****Seq. #:** 2086 **Name:** Race - Other Asian**Coding Instructions:** Indicate if the patient is of Other Asian descent as determined by the patient/family.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

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

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

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

Seq. #: 2090 **Name:** Race - Native Hawaiian**Coding Instructions:** Indicate if the patient is Native Hawaiian or Pacific Islander as determined by the patient/family.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

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

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

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

Seq. #: 2091 **Name:** Race - Guamanian or Chamorro**Coding Instructions:** Indicate if the patient is Guamanian or Chamorro as determined by the patient/family.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

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

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

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



A. Demographics

Seq. #: 2092 **Name:** Race - Samoan**Coding Instructions:** Indicate if the patient is Samoan as determined by the patient/family.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

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

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

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

Seq. #: 2093 **Name:** Race - Other Pacific Islander**Coding Instructions:** Indicate if the patient is Other Pacific Islander as determined by the patient/family.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

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

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

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

Seq. #: 2100 **Name:** Hispanic Ethnicity Type - Mexican/Mexican American/Chicano**Coding Instructions:** Indicate if the patient is Mexican, Mexican - American, or Chicano as determined by the patient/family.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

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

Having origins in any of the original peoples of Mexico.

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

**A. Demographics****Seq. #: 2101 Name:** Hispanic Ethnicity Type - Puerto Rican**Coding Instructions:** Indicate if the patient is Puerto Rican as determined by the patient/family.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

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

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

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

Seq. #: 2102 Name: Hispanic Ethnicity Type - Cuban**Coding Instructions:** Indicate if the patient is Cuban as determined by the patient/family.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

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

Having origins in any of the original peoples of Cuba.

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

Seq. #: 2103 Name: Hispanic Ethnicity Type - Other Hispanic/Latino/Spanish Origin**Coding Instructions:** Indicate if the patient is another Hispanic, Latino, or Spanish origin as determined by the patient/family.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

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

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

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



A. Demographics

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

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

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

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

**B. Admission****Seq. #: 3000 Name:** Patient Zip Code**Coding Instructions:** Indicate the patient's United States Postal Service zip code of their primary residence.**Note(s):**

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

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: The value on arrival at this facility**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 3001 Name:** Zip Code N/A**Coding Instructions:** Indicate if the patient does not have a United States Postal Service zip code.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:**

No

Yes

Supporting Definitions: (none)**Seq. #: 3100 Name:** Means of Transport to First Facility**Coding Instructions:** Indicate the means of transportation to the facility where the patient first received treatment.**Note(s):**

Patients that transport from Non-EMS First Medical Center to hospital by medical personnel via wheelchair or stretcher are to be entered as "Self/Family" transport.

Target Value: N/A**Selections:**

Self/Family

Ambulance

Mobile ICU

Air

Retired effective v2.4.

Supporting Definitions: (none)

**B. Admission****Seq. #: 3105 Name:** EMS First Medical Contact Date**Coding Instructions:** Indicate the date when the patient was first evaluated by emergency medical services (EMS) prior to arrival at your facility.**Note(s):**

Indicate the date of first medical contact only for patients who were transported by ambulance or air.

This is NOT the date of arrival to your facility.

Target Value: N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 3106 Name:** EMS First Medical Contact Time**Coding Instructions:** Indicate the time when the patient was first evaluated by emergency medical services (EMS) prior to arrival at your facility.**Note(s):**

Indicate the time of first medical contact only for patients who were transported by ambulance or air.

This is NOT the time of arrival to your facility.

Target Value: N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 3107 Name:** EMS First Medical Contact Time Estimated**Coding Instructions:** Indicate if the EMS first medical contact time was estimated.**Target Value:** N/A**Selections:**

No

Yes

Supporting Definitions: (none)**Seq. #: 3108 Name:** EMS First Medical Contact Non System Reason For Delay**Coding Instructions:** Indicate if there is a non system reason for the delay when first evaluated by emergency medical services (EMS).**Target Value:** N/A**Selections:**

No

Yes

Supporting Definitions: (none)

**B. Admission****Seq. #: 3110 Name:** Transferred From Outside Facility

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

Target Value: N/A

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 3111 Name: Non-EMS First Medical Contact Date

Coding Instructions: Indicate the date when the patient was first evaluated by a healthcare professional prior to arrival at your facility.

Note(s):

Indicate the date of first medical contact with a medical professional, prior to arrival at your hospital. This is NOT the time of arrival to your facility. This is NOT the time emergency medical services (EMS) first medical contact.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3112 Name: Non-EMS First Medical Contact Time

Coding Instructions: Indicate the time when the patient was first evaluated by a healthcare professional prior to arrival at your facility.

Note(s):

Indicate the time of first medical contact with a medical professional, prior to arrival at your hospital. This is NOT the time of arrival to your facility. This is NOT the time emergency medical services (EMS) first medical contact.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3113 Name: Non-EMS First Medical Contact Time-Estimated

Coding Instructions: Indicate if the non EMS first medical contact time is estimated.

Target Value: The value on arrival at this facility

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

**B. Admission****Seq. #: 3115 Name:** Means of Transfer**Coding Instructions:** Indicate the means of transportation from the outside facility to your facility.**Note(s):**

Indicate how the patient was moved from the outside facility to your facility-Ambulance or Air

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

<i>Selection Text</i>	<i>Definition</i>
Ambulance	
Mobile ICU	Retired effective v2.4.
Air	

Supporting Definitions: (none)**Seq. #: 3120 Name:** Arrival at Outside Facility Date**Coding Instructions:** Indicate the date the patient arrived at the outside facility.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 3121 Name:** Arrival at Outside Facility Time**Coding Instructions:** Indicate the time the patient arrived at the outside facility.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 3122 Name:** Arrival at Outside Facility Time Estimated**Coding Instructions:** Indicate if the time the patient arrived at the outside facility was estimated.**Target Value:** N/A**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: (none)

**B. Admission****Seq. #: 3125 Name:** Transfer From Outside Facility Date**Coding Instructions:** Indicate the date the patient left the outside facility.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 3126 Name:** Transfer from Outside Facility Time**Coding Instructions:** Indicate the time the patient left the outside facility.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 3127 Name:** Transfer From Outside Facility Time Estimated**Coding Instructions:** Indicate if the time the patient left the outside facility was estimated.**Target Value:** N/A**Selections:**

No

Yes

Supporting Definitions: (none)**Seq. #: 3150 Name:** Name of Transferring Facility**Coding Instructions:** Indicate the name of the facility from which the patient was transferred.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)



B. Admission

Seq. #: 3151 Name: Transferring Facility AHA Number

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3152 Name: EMS Dispatch Date

Coding Instructions: Indicate the date the responding unit was notified by dispatch.

Target Value: N/A

Selections: (none)

Supporting Definitions: **EMS Dispatch Date:**

The date/time the responding unit was notified by dispatch.

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

Seq. #: 3153 Name: EMS Dispatch Time

Coding Instructions: Indicate the time the responding unit was notified by dispatch.

Target Value: N/A

Selections: (none)

Supporting Definitions: **EMS Dispatch Time:**

The date/time the responding unit was notified by dispatch.

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

Seq. #: 3154 Name: EMS Leaving Scene Date

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

Note(s):

Indicate the date the responding unit left the scene with a patient (started moving).

Target Value: N/A

Selections: (none)

Supporting Definitions: **EMS Leaving Scene Date:**

The date/time the responding unit left the scene with a patient (started moving).

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

**B. Admission****Seq. #: 3155 Name: EMS Leaving Scene Time**

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

Target Value: N/A

Selections: (none)

Supporting Definitions: EMS Leaving Scene Time:

The date/time the responding unit left the scene with a patient (started moving).

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

Seq. #: 3156 Name: EMS Agency Number

Coding Instructions: Indicate the emergency medical services agency number.

Target Value: N/A

Selections: (none)

Supporting Definitions: EMS Agency Number:

The state-assigned provider number of the responding agency

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

Seq. #: 3157 Name: EMS Run Number

Coding Instructions: Indicate the emergency medical services run number.

Target Value: N/A

Selections: (none)

Supporting Definitions: Incident Number:

The incident number assigned by the 911 Dispatch System.

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

Seq. #: 3158 Name: Cath Lab Activation Date

Coding Instructions: Indicate the date the Cath Lab was activated.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: Destination Team Pre-Arrival Alert or Activation:

Indication that an alert (or activation) was called by EMS to the appropriate destination healthcare facility team. The alert (or activation) should occur prior to the EMS Unit arrival at the destination with the patient.

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



B. Admission

Seq. #: 3159 **Name:** Cath Lab Activation Time**Coding Instructions:** Indicate the time the Cath Lab was activated.**Target Value:** The value on current procedure**Selections:** (none)**Supporting Definitions:** **Destination Team Pre-Arrival Alert or Activation:**

Indication that an alert (or activation) was called by EMS to the appropriate destination healthcare facility team. The alert (or activation) should occur prior to the EMS Unit arrival at the destination with the patient.

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

Seq. #: 3200 **Name:** Arrival Date**Coding Instructions:** Indicate the date the patient arrived at your facility.**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures AMI-1, AMI-7, AMI-7a, AMI-8, AMI-8a

Target Value: N/A**Selections:** (none)**Supporting Definitions:** (none)

Seq. #: 3201 **Name:** Arrival Time**Coding Instructions:** Indicate the time the patient arrived at your facility.**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures AMI-7, AMI-7a, AMI-8, AMI-8a

Target Value: N/A**Selections:** (none)**Supporting Definitions:** (none)

Seq. #: 3210 **Name:** Admission Date**Coding Instructions:** Indicate the date the patient was admitted as an inpatient to your facility for the current episode of care.**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: N/A**Selections:** (none)**Supporting Definitions:** (none)

**B. Admission****Seq. #: 3220 Name:** Location of First Evaluation**Coding Instructions:** Indicate the location the patient was first evaluated at your facility.**Note(s):**

Added to the Limited Data Set (ARGL) starting with patients discharged January 1, 2015.

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

Selections:	<i>Selection Text</i>	<i>Definition</i>
	ED	Emergency Departments (ED) include traditional ED locations, such as ED-based chest pain units, clinics, and short-stay coronary-care units housed in the ED.
	Cath Lab	Area where diagnostic cardiac catheterizations or percutaneous coronary interventions are performed.
	Other	Locations such as the pre-op or post-op surgical units or general medicine floor/unit. Also includes intensive -care unit, coronary-care unit, general cardiac floor, step-down unit, or a monitored-bed unit that is physically separate from the ED.

Supporting Definitions: (none)**Seq. #: 3221 Name:** Transferred out of Emergency Department Date**Coding Instructions:** Indicate the date the patient was moved out of the emergency department, either to another location within your facility or to another acute care center.**Note(s):**

Added to the Limited Data Set (ARGL) starting with patients discharged January 1, 2015.

Target Value: The first value between arrival at this facility and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 3222 Name:** Transferred Out of Emergency Department Time**Coding Instructions:** Indicate the time the patient was moved out of the emergency department, either to another location within your facility or to another acute care center.**Note(s):**

Added to the Limited Data Set (ARGL) starting with patients discharged January 1, 2015.

Target Value: The first value on Transferred Out of Emergency Department Date**Selections:** (none)**Supporting Definitions:** (none)

**B. Admission****Seq. #: 3300 Name:** Insurance Payor - Private Health Insurance**Coding Instructions:** Indicate if the patient's insurance payor(s) included private health insurance.**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: Private Health Insurance:

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

Source: U.S. Census Bureau

Seq. #: 3301 Name: Insurance Payor - Medicare**Coding Instructions:** Indicate if the patient's insurance payor(s) included Medicare.**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: Medicare:

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

Source: U.S. Census Bureau

**B. Admission****Seq. #:** 3302 **Name:** Insurance Payor - Medicaid**Coding Instructions:** Indicate if the patient's insurance payor(s) included Medicaid.**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: Medicaid:

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

Source: U.S. Census Bureau

Seq. #: 3303 **Name:** Insurance Payor - Military Health Care**Coding Instructions:** Indicate if the patient's insurance payor(s) included Military Health Care.**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: Military Health Care:

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

Source: U.S. Census Bureau

**B. Admission****Seq. #: 3304 Name:** Insurance Payor - State-Specific Plan**Coding Instructions:** Indicate if the patient's insurance payor(s) included a State-specific Plan.**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: State Specific Plan:

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

Source: U.S. Census Bureau

Seq. #: 3305 Name: Insurance Payor - Indian Health Service**Coding Instructions:** Indicate if the patient's insurance payor(s) included the Indian Health Service.**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: Indian Health Service:

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

Source: U.S. Census Bureau

**B. Admission****Seq. #: 3306 Name:** Insurance Payor - Non-US Insurance**Coding Instructions:** Indicate if the patient's insurance payor(s) included any Non-US Insurance.**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: **Non-US Insurance:**

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

Source: U.S. Census Bureau

Seq. #: 3307 Name: Insurance Payor - None**Coding Instructions:** Indicate if the patient has no insurance payor(s).**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: **None:**

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

Source: U.S. Census Bureau

Seq. #: 3310 Name: Provider Last Name**Coding Instructions:** Indicate the admitting primary provider's last name.**Note(s):**

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

Target Value: The value on current admission**Selections:** (none)**Supporting Definitions:** (none)

**B. Admission****Seq. #: 3311 Name: Provider First Name**

Coding Instructions: Indicate the admitting primary providers first name.

Note(s):

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

Target Value: The value on current admission

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3312 Name: Provider Middle Name

Coding Instructions: Indicate the admitting primary provider's middle name.

Note(s):

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

Target Value: The value on current admission

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3315 Name: Admitting Provider NPI

Coding Instructions: Indicate the primary providers National Provider Identifier. NPIs, assigned by the Center for Medicare and Medicaid Services (CMS), are used to uniquely identify physicians for Medicare billing purposes.

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

Seq. #: 3320 Name: Health Insurance Claim Number

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

Note(s):

The HIC is used for Medicare and Medicaid billing.

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

**C. Cardiac Status****Seq. #: 4000 Name:** Symptom Onset Date**Coding Instructions:** Indicate the date the patient first noted ischemic symptoms lasting greater than or equal to 10 minutes.**Note(s):**

If the patient had intermittent ischemic symptoms, record the date and time of the most recent ischemic symptoms prior to hospital presentation. Symptoms may include jaw pain, arm pain, shortness of breath, nausea, vomiting, fatigue/malaise, or other equivalent discomfort suggestive of a myocardial infarction. In the event of stuttering symptoms, Acute Coronary Syndrome (ACS) symptom onset is the time at which symptoms became constant in quality or intensity.

Target Value: The first value between 24 hours prior to arrival at first facility and arrival at this facility**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 4001 Name:** Symptom Onset Time**Coding Instructions:** Indicate the time the patient first noted ischemic symptoms lasting greater than or equal to 10 minutes.**Note(s):**

If the symptom onset 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.

If an estimated symptom onset time is recorded, code 'symptom onset time estimated'.

Target Value: N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 4002 Name:** Symptom Onset Time Estimated**Coding Instructions:** Indicate if the symptom onset time was estimated.**Target Value:** N/A**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: (none)

**C. Cardiac Status****Seq. #: 4003 Name:** Symptom Onset Time Not Available**Coding Instructions:** Indicate if the symptom onset time was not available.**Target Value:** N/A**Selections:***Selection Text**Definition*

No

Yes

Supporting Definitions: (none)**Seq. #: 4010 Name:** First ECG Obtained**Coding Instructions:** Indicate when the first 12-lead electrocardiogram (ECG) was obtained.**Target Value:** The first value between first medical contact and 24 hours after arrival at first facility**Selections:***Selection Text**Definition*

Pre-Hospital

The first electrocardiogram (ECG) was obtained prior to arrival at your hospital, either at a physician's office, during transport by emergency medical services (EMS), air ambulance, or other method of critical care transport.

After First Hospital
Arrival

The first electrocardiogram (ECG) was obtained upon arrival to the first hospital at which the patient presented.

Supporting Definitions: (none)**Seq. #: 4020 Name:** First ECG Date**Coding Instructions:** Indicate the date of the first 12-lead electrocardiogram (ECG).**Target Value:** The first value between first medical contact and 24 hours after arrival at first facility**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 4021 Name:** First ECG Time**Coding Instructions:** Indicate the time of the first 12-lead electrocardiogram (ECG).**Target Value:** The first value on First ECG Date**Selections:** (none)**Supporting Definitions:** (none)



C. Cardiac Status

Seq. #: 4022 **Name:** First ECG Reason For Delay

Coding Instructions: Indicate if there is a non system reason for the delay in the first ECG.

Target Value: The first value on First ECG Date

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 4030 **Name:** STEMI or STEMI Equivalent

Coding Instructions: Indicate if the ECG findings demonstrated a STEMI or STEMI equivalent.

Note(s):

STEMI or STEMI equivalent must be noted prior to any procedures and not more than 24 hours after arrival at first facility. Arrival at first facility refers to either the time of arrival at your facility or the time of arrival at the transferring facility.

This element is referenced in The Joint Commission AMI Core Measures AMI-7, AMI-7a, AMI-8, AMI-8a

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

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

**C. Cardiac Status****Seq. #: 4040 Name:** ECG Findings

Coding Instructions: Indicate if the ECG findings demonstrated either new or presumed new ST-segment elevation, new left bundle branch block, or isolated posterior myocardial infarction prior to any procedures and not more than 24 hours after arrival at first facility.

Note(s):

Arrival at first facility refers to either the time of arrival at your facility or the time of arrival at the transferring facility.

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

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

Supporting Definitions: (none)

Seq. #: 4041 Name: STEMI or STEMI Equivalent First Noted

Coding Instructions: Indicate if a STEMI or STEMI equivalent was noted on either the first ECG or a subsequent ECG.

Note(s):

The subsequent ECG must be performed within 24 hours of arrival at first facility. Arrival at first facility refers to either the time of arrival at your facility or the time of arrival at the transferring facility.

Target Value: The first value between first medical contact and 24 hours after arrival at first facility

Selections:	<i>Selection Text</i>	<i>Definition</i>
	First ECG	
	Subsequent ECG	

Supporting Definitions: (none)

**C. Cardiac Status**

Seq. #: 4042 **Name:** Subsequent ECG with STEMI or STEMI Equivalent Date

Coding Instructions: Indicate the date of any subsequent electrocardiogram (ECG) with ST-segment elevation, left bundle branch block (LBBB), or isolated posterior myocardial infarction (MI).

Target Value: The first value between first medical contact and 24 hours after arrival at first facility

Selections: (none)

Supporting Definitions: (none)

Seq. #: 4043 **Name:** Subsequent ECG with STEMI or STEMI Equivalent Time

Coding Instructions: Indicate the time of any subsequent electrocardiogram (ECG) with ST-segment elevation, left bundle branch block (LBBB), or isolated posterior myocardial infarction (MI).

Note(s):

Arrival at first facility refers to either the time of arrival at your facility or the time of arrival at the transferring facility.

Target Value: The first value on Subsequent ECG with STEMI or STEMI Equivalent Date

Selections: (none)

Supporting Definitions: (none)



C. Cardiac Status

Seq. #: 4044 Name: Other ECG Findings

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

Note(s):

Arrival at first facility refers to either the time of arrival at your facility or the time of arrival at the transferring facility.

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

Selections:	Selection Text	Definition
	New or Presumed New ST Depression	Indicate if there was new or presumed new horizontal or down-sloping ST depression ≥ 0.5 mV in two contiguous leads below the isoelectric line on the electrocardiogram (ECG) within the first 24 hours of presentation. If no exact ST- depression measurement is recorded in the medical chart, physician's written documentation of ST- depression is acceptable.
	New or Presumed New T-Wave Inversion	Indicate if there was a new or presumed new T-wave inversion of at least 0.1 mV in two contiguous leads with prominent R-wave or R/S ratio >1 within the first 24 hours of presentation. If no exact T-wave inversion measurement is recorded in the medical chart, physician's written documentation of T-wave inversion is acceptable.
	Transient ST Elevation Lasting < 20 Minutes	Indicate if there was new or presumed new ST- segment elevation at the J-point in two contiguous electrocardiogram (ECG) leads with the cut-off points: ≥ 0.2 mV in men or ≥ 0.15 mV in women in leads V2-V3 and/or ≥ 0.1 mV in other leads, and lasting less than 20 minutes, within the first 24 hours of presentation. If no exact ST- elevation measurement is recorded in the medical chart, physician's written documentation of transient ST- elevation is acceptable.
	None	Indicate if the first electrocardiogram (ECG) did not reveal ST depression, transient ST- elevation, or T-wave inversion.
	Old LBBB	
	Other	

Supporting Definitions: (none)



C. Cardiac Status

Seq. #: 4100 Name: Heart Failure at First Medical Contact**Coding Instructions:** Indicate if there is physician documentation or report of heart failure on first medical contact.**Target Value:** Any occurrence between first medical contact and arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: Heart failure:

Heart failure is defined as physician documentation or a report of any of the following clinical symptoms of heart failure described as unusual dyspnea on light exertion, recurrent dyspnea occurring in the supine position, fluid retention, or the description of rales, jugular venous distention, pulmonary edema on physical examination, or pulmonary edema on chest x-ray presumed to be cardiac dysfunction.

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

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

Seq. #: 4110 Name: Cardiogenic Shock at First Medical Contact**Coding Instructions:** Indicate if the patient was in a state of cardiogenic shock on first medical contact.**Target Value:** Any occurrence between first medical contact and arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: Cardiogenic shock:

Cardiogenic shock is defined as

1. a sustained (>30 minutes) episode of systolic blood pressure <90 mm Hg determined to be secondary to cardiac dysfunction, and/or

2. a sustained (>30 minutes) episode of cardiac index <2.2 L/min/m² determined to be secondary to cardiac dysfunction, and/or

3. the sustained (>30 minutes) requirement for parenteral inotropic or vasopressor agents or mechanical support (e.g., IABP, extracorporeal circulation, ventricular assist devices) to maintain systolic blood pressure ≥90 mm Hg, and/or

4. the sustained (>30 minutes) requirement for parenteral inotropic or vasopressor agents or mechanical support (e.g., IABP, extracorporeal circulation, ventricular assist devices) to maintain CI ≥2.2 L/min/m²

Source: NCDR

**C. Cardiac Status****Seq. #:** 4115 **Name:** Cocaine Use**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 4120 **Name:** Heart Rate at First Medical Contact**Coding Instructions:** Indicate the first measurement or earliest record of heart rate (in beats per minute).**Note(s):**

Arrival at first facility refers to either the time of arrival at your facility or the time of arrival at the transferring facility.
Measurement from the transferring facility is acceptable.

Target Value: The first value between first medical contact and arrival at first facility**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 4130 **Name:** Systolic Blood Pressure at First Medical Contact**Coding Instructions:** Indicate the first measurement or earliest record of systolic blood pressure (mm Hg).**Note(s):**

Arrival at first facility refers to either the time of arrival at your facility or the time of arrival at the transferring facility.
Measurement from the transferring facility is acceptable.

Target Value: The first value between first medical contact and arrival at first facility**Selections:** (none)**Supporting Definitions:** (none)

**C. Cardiac Status****Seq. #: 4135 Name:** Cardiac Arrest at First Medical Contact**Coding Instructions:** Indicate if the patient was in cardiac arrest when first evaluated by EMS or ED personnel.**Note(s):**

Evaluated by EMS or ED personnel and either (1) received attempts at external defibrillation (by lay responders or emergency personnel) or chest compressions by organized EMS or ED personnel or (2) were pulseless but did not receive attempts to defibrillate or cardiopulmonary resuscitation (CPR) by EMS personnel.

If the patient experienced a cardiac arrest after arrival at this facility, code the event as an 'In-Hospital Clinical Event'. See Section H.

This element does not need to be collected for patients who were discharged prior to April 1, 2011.

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

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes	
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Supporting Definitions: Cardiac Arrest:

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

Source: ACC/AHA/HRS 2006 Key Data Elements and Definitions for Electrophysiological Studies and Procedures

Seq. #: 4140 Name: Cardiac Arrest Pre-Hospital**Coding Instructions:** Indicate if the patient's cardiac arrest was prior to arrival at the outside facility and/or occurred during transfer from the outside facility to this facility.**Note(s):**

This element does not need to be collected for patients who were discharged prior to April 1, 2011.

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

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes	
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Supporting Definitions: (none)



C. Cardiac Status

Seq. #: 4145 **Name:** Cardiac Arrest Outside Facility

Coding Instructions: Indicate if the patient's cardiac arrest occurred during the hospitalization at the first facility.

Note(s):

This element does not need to be collected for patients who were discharged prior to April 1, 2011.

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

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)



D. HistoryAndRisk

Seq. #: 5000 **Name:** Height**Coding Instructions:** Indicate the patient's height in centimeters.**Note(s):**

Measurement from the transferring facility is acceptable.

Target Value: The first value between arrival at this facility and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 5010 **Name:** Weight**Coding Instructions:** Indicate the patient's weight in kilograms.**Note(s):**

Measurement from the transferring facility is acceptable.

Please use the weight that was utilized for calculating medication dosing.

If no dosing occurred, please enter in first documented weight after arrival at first facility.

Target Value: The first value between arrival at first facility and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 5020 **Name:** Current/Recent Smoker (w/in 1 year)**Coding Instructions:** Indicate if the patient has smoked cigarettes anytime during the year prior to arrival at your facility.**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures AMI-4

Target Value: Any occurrence between 1 year prior to arrival at this facility and arrival at this facility**Selections:**

No

Yes

Supporting Definitions: (none)

**D. HistoryAndRisk****Seq. #: 5030 Name:** Hypertension**Coding Instructions:** Indicate if the patient has been diagnosed previously with hypertension.**Target Value:** Any occurrence between birth and arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: Hypertension:

Hypertension is defined by any one of the following:

1. History of hypertension diagnosed and treated with medication, diet and/or exercise
2. Prior documentation of blood pressure greater than 140 mm Hg systolic and/or 90 mm Hg diastolic for patients without diabetes or chronic kidney disease, or prior documentation of blood pressure greater than 130 mm Hg systolic and/or 80 mm Hg diastolic on at least two occasions for patients with diabetes or chronic kidney disease
3. Currently on pharmacologic therapy for treatment of hypertension.

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

Seq. #: 5040 Name: Dyslipidemia**Coding Instructions:** 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**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: 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

**D. HistoryAndRisk****Seq. #: 5050 Name:** Currently on Dialysis**Coding Instructions:** Indicate if the patient is currently undergoing either hemodialysis or peritoneal dialysis on an ongoing basis as a result of renal failure.**Target Value:** The value on arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #: 5060 Name:** Chronic Lung Disease**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #: 5065 Name:** Cancer**Coding Instructions:** Indicate if the patient has a history of cancer.**Target Value:** Any occurrence between birth and arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #: 5066 Name:** Cancer Type**Coding Instructions:** Indicate the type of cancer if the patient has a history of cancer.**Target Value:** Any occurrence between birth and arrival at this facility**Selections:** *Selection Text* *Definition*

Solid Organ

Solid Organ Type Cancer

Hematologic

Hematologic Type Cancer

Supporting Definitions: (none)



D. HistoryAndRisk

Seq. #: 5070 Name: Diabetes Mellitus

Coding Instructions: Indicate if the patient has a history of diabetes mellitus, regardless of duration of disease or need for antidiabetic agents.**Target Value:** Any occurrence between birth and arrival at this facility**Selections:**

Selection Text	Definition
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No	
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Yes	
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Supporting Definitions: Diabetes mellitus:

The American Diabetes Association criteria include documentation of the following:

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

This does not include gestational diabetes.

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

Seq. #: 5071 Name: Diabetes Therapy

Coding Instructions: Indicate the therapy method the patient presented with. Choose the most aggressive therapy.**Note(s):**

Patients placed on a pre-procedure diabetic pathway of insulin drip at admission but were controlled by diet or oral method are not coded as insulin treated.

If a patient had a pancreatic transplant, code "Other", since the insulin from the new pancreas is not exogenous insulin.

Target Value: The value on arrival at this facility**Selections:**

Selection Text	Definition
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None	No treatment for diabetes.
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Diet	Diet treatment only.
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Oral	Oral agent treatment (includes oral agent with/without diet treatment).
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Insulin	Insulin treatment (includes any combination with insulin).
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Other	Other adjunctive treatment, non-oral/insulin/diet.
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Supporting Definitions: (none)



D. HistoryAndRisk

Seq. #: 5080 **Name:** Prior MI**Coding Instructions:** Indicate if the patient has had at least one documented previous myocardial infarction.**Target Value:** Any occurrence between birth and arrival at first facility**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes	
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Supporting Definitions: **MI:**

Any one of the following criteria meets the diagnosis for prior MI:

1. Pathological Q waves with or without symptoms in the absence of non-ischemic causes.
2. 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.
3. Pathological findings of a prior MI.

Source: Expert Consensus Document: Third Universal Definition of Myocardial Infarction J Am Coll Cardiol. October 16, 2012;60(16):1581-1598 doi:10.1016/j.jacc.2012.08.001

Seq. #: 5090 **Name:** Prior Heart Failure**Coding Instructions:** Indicate if there is a previous history of heart failure.**Note(s):**

A previous hospital admission with principal diagnosis of heart failure is considered evidence of heart failure history.

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

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes	
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Supporting Definitions: **Heart Failure:**

Heart failure is defined as physician documentation or a report of any of the following clinical symptoms of heart failure described as unusual dyspnea on light exertion, recurrent dyspnea occurring in the supine position, fluid retention, or the description of rales, jugular venous distention, pulmonary edema on physical examination, or pulmonary edema on chest x-ray presumed to be cardiac dysfunction.

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

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

**D. HistoryAndRisk****Seq. #: 5100 Name:** Prior PCI**Coding Instructions:** Indicate if the patient had a previous percutaneous coronary intervention (PCI) of any type (balloon angioplasty, stent or other).**Note(s):**

Timeframe does NOT include the current admission.

Target Value: Any occurrence between birth and arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: **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.

Source: NCDR

Seq. #: 5101 Name: Most Recent PCI Date**Coding Instructions:** If the patient had a previous percutaneous coronary intervention (PCI) of any type (balloon angioplasty, stent or other), indicate the date.**Note(s):**

If month or day are unknown enter 01.

Target Value: The last value between birth and arrival at this facility**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 5110 Name:** Prior CABG**Coding Instructions:** Indicate whether the patient had a coronary artery bypass graft (CABG).**Note(s):**

Timeframe does NOT include the current admission.

Target Value: Any occurrence between birth and arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)



D. HistoryAndRisk

Seq. #: 5111 Name: Most Recent CABG Date**Coding Instructions:** If the patient had a previous coronary artery bypass graft (CABG), indicate the date.**Note(s):**

If month or day are unknown enter 01.

Target Value: The last value between birth and arrival at this facility**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 5120 Name:** Atrial Fibrillation or Flutter**Coding Instructions:** Indicate whether atrial fibrillation or flutter was present prior to arrival.**Note(s):**

If there is no prior documentation of atrial arrhythmias, it is acceptable to code "No"

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

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Supporting Definitions: **Atrial Fibrillation:**

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

Atrial Flutter is characterized by a sawtooth pattern of regular atrial activation called flutter waves on the ECG, particularly visible in leads II, III, aVF and v1.

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

**D. HistoryAndRisk****Seq. #: 5130 Name: Cerebrovascular Disease****Coding Instructions:** Indicate if the patient has a history of cerebrovascular disease.**Target Value:** Any occurrence between birth and arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: 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)

Seq. #: 5131 Name: Prior Stroke**Coding Instructions:** Indicate if the patient has had a stroke.**Target Value:** Any occurrence between birth and arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: Stroke:

A stroke is an acute episode of focal or global neurological dysfunction caused by brain, spinal cord, or retinal vascular injury as a result of hemorrhage or infarction.

Source: Standardized Definitions for Cardiovascular Endpoints in Clinical Trials (FDA Draft)



D. HistoryAndRisk

Seq. #: 5132 **Name:** Prior Transient Ischemic Attack**Coding Instructions:** Indicate if the patient has a history of TIAs.**Note(s):**

This element should not be collected for patients who were discharged prior to January 1, 2015. (Added in v2.4.)

Target Value: Any occurrence between birth and arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 5140 **Name:** Peripheral Arterial Disease**Coding Instructions:** Indicate if the patient has a history of peripheral arterial disease (includes upper and lower extremity).**Note(s):**

Does not include venous conditions (e.g. DVT).

Target Value: Any occurrence between birth and arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: **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)



D. HistoryAndRisk

Seq. #: 5200 Name: Walking

Coding Instructions: Indicate the level of assistance the patient required with ambulation.**Target Value:** The value on arrival at this facility**Selections:** *Selection Text* *Definition*

Unassisted

Assisted

Wheelchair/Non-ambulatory

Unknown

Supporting Definitions: (none)

Seq. #: 5205 Name: Cognition

Coding Instructions: Indicate the patients level of cognition.**Note(s):**

Cognition is scored on three levels of neuropsychiatric functioning: Normal, Mildly impaired due to dementia or depression, and Moderate/severely impaired due to dementia or depression. Mildly impaired cognitive function includes mild dementia, not limiting simple exchanges, and mild depression. Such mild impairments may be only identified by family or may be a comorbid diagnosis treated with medications yet requiring minimal support. Short term memory loss is often present from the beginning of this spectrum. Moderate or severely impaired cognitive impairment includes notable short term memory loss, disorientation, and/or confusion which limits the ability to participate in simple exchanges. Moderate to severe cognitive impairment may also result from severe depression which has many of the same manifestations and consequences.

Target Value: The value on arrival at this facility**Selections:** *Selection Text* *Definition*

Normal

Mildly Impaired

Mod/Severly impaired

Unknown

Supporting Definitions: (none)



D. HistoryAndRisk

Seq. #: 5210 Name: Basic ADLs

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

Target Value: The value on arrival at this facility

Selections: *Selection Text* *Definition*

Independent of all ADLs
Partial Assist =1 ADL
Full Assist >1 ADL
Unknown

Supporting Definitions: (none)



E. Medications

Seq. #: 6000 **Name:** Aspirin at Home**Coding Instructions:** Indicate if the patient has been taking aspirin routinely at home prior to this hospitalization.**Note(s):**

"Routinely" refers to the daily use of medications as prescribed, even if the patient misses a dose.

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

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes	
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Supporting Definitions: (none)**Seq. #:** 6010 **Name:** Aspirin in First 24 Hours**Coding Instructions:** Indicate if aspirin was administered in the first 24 hours before or after first medical contact, regardless of location of care (e.g., transferring facility or EMS).**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures AMI-1.

Aspirin administered only through oral and rectal doses should be collected.

Target Value: Any occurrence between 24 hours before first medical contact and 24 hours after first medical contact**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes	
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Contraindicated	
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Blinded	
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Retired effective v2.4.

Supporting Definitions: (none)**Seq. #:** 6011 **Name:** Aspirin First 24 Hours - Start Date**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)



E. Medications

Seq. #: 6012 **Name:** Aspirin First 24 Hours - Start Time**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6020 **Name:** Aspirin at Discharge**Coding Instructions:** Indicate if aspirin was continued or prescribed.**Note(s):**

Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care(11110) is 'Yes'. (Updated in v2.4).

This element is referenced in The Joint Commission AMI Core Measures AMI-2.

Target Value: Any occurrence on discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	
Contraindicated	
Blinded	Retired effective v2.4.

Supporting Definitions: (none)**Seq. #:** 6021 **Name:** Aspirin at Discharge - Dose**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)

**E. Medications****Seq. #: 6022 Name:** Aspirin Dose At Discharge**Coding Instructions:** Indicate the dose of aspirin prescribed at discharge.**Note(s):**

Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care(11110) is 'Yes'. (Updated in v2.4).

This element should not be collected for patients who were discharged prior to January 1, 2015 (Added in v2.4).

Target Value: Any occurrence on discharge**Selections:** *Selection Text* *Definition*

75-100 mg

>100 mg

Supporting Definitions: (none)**Seq. #: 6050 Name:** Clopidogrel at Home**Coding Instructions:** Indicate if the patient has been taking clopidogrel routinely at home prior to this hospitalization.**Note(s):**

"Routinely" refers to the daily use of medications as prescribed, even if the patient misses a dose.

Target Value: Any occurrence between 2 weeks prior to first medical contact and first medical contact**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #: 6060 Name:** Clopidogrel in First 24 Hours**Coding Instructions:** Indicate if clopidogrel was administered, regardless of location of care (e.g., transferring facility or EMS).**Target Value:** Any occurrence between first medical contact and 24 hours after first medical contact**Selections:** *Selection Text* *Definition*

No

Yes

Contraindicated

Blinded

Retired effective v2.4.

Supporting Definitions: (none)

**E. Medications****Seq. #: 6061 Name: Clopidogrel in First 24 Hours - Start Date**

Coding Instructions: Indicate the date the initial dose of clopidogrel was administered, regardless of location of care (e.g., transferring facility or EMS). If administered more than once, code the first date/time it was administered.

Target Value: The first value between first medical contact and 24 hours after first medical contact

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6062 Name: Clopidogrel in First 24 Hours - Start Time

Coding Instructions: Indicate the time the initial dose of clopidogrel was administered, regardless of location of care (e.g., transferring facility or EMS). If administered more than once, code the first date/time it was administered.

Target Value: The first value on Clopidogrel in First 24 Hours Start Date

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6063 Name: Clopidogrel in First 24 Hours - Dose

Coding Instructions: Indicate the initial dose of clopidogrel.

Target Value: The first value between first medical contact and 24 hours after first medical contact

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6070 Name: Clopidogrel at Discharge

Coding Instructions: Indicate if clopidogrel was continued or prescribed.

Note(s):

Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care(11110) is 'Yes'. (Updated in v2.4).

Target Value: Any occurrence on discharge

Selections:

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Contraindicated

Blinded

Retired effective v2.4.

Supporting Definitions: (none)

**E. Medications****Seq. #:** 6071 **Name:** Clopidogrel at Discharge - Dose**Coding Instructions:** Indicate the dose of clopidogrel prescribed at discharge.**Note(s):**

Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care(11110) is 'Yes'. (Updated in v2.4).

Target Value: The highest value on discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6072 **Name:** Clopidogrel at Discharge - Recommended Duration of Therapy**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6100 **Name:** Ticlopidine at Home**Coding Instructions:** Indicate if the patient has been taking ticlopidine routinely at home.**Note(s):**

"Routinely" refers to the daily use of medications as prescribed, even if the patient misses a dose.

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

No

Yes

Supporting Definitions: (none)



E. Medications

Seq. #: 6110 **Name:** Ticlopidine in First 24 Hours**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes	
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Contraindicated	
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Blinded	
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	Retired effective v2.4.
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Supporting Definitions: (none)**Seq. #:** 6111 **Name:** Ticlopidine in First 24 Hours - Start Date**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6112 **Name:** Ticlopidine in First 24 Hours - Start Time**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6113 **Name:** Ticlopidine in First 24 Hours - Dose**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)



E. Medications

Seq. #: 6120 **Name:** Ticlopidine at Discharge**Coding Instructions:** Indicate if ticlopidine was continued or prescribed.**Note(s):**

Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care(11110) is 'Yes'. (Updated in v2.4).

Target Value: Any occurrence on discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes	
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Contraindicated	
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Blinded	
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	Retired effective v2.4.
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Supporting Definitions: (none)**Seq. #:** 6121 **Name:** Ticlopidine at Discharge - Dose**Coding Instructions:** Indicate the total daily dose of ticlopidine prescribed.**Note(s):**

Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care(11110) is 'Yes'. (Updated in v2.4).

Target Value: The highest value on discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6122 **Name:** Ticlopidine at Discharge - Recommended Duration of Therapy**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)

**E. Medications****Seq. #:** 6150 **Name:** Prasugrel at Home**Coding Instructions:** Indicate if the patient has been taking Prasugrel routinely at home prior to this hospitalization.**Note(s):**

"Routinely" refers to the daily use of medications as prescribed, even if the patient misses a dose.

Target Value: Any occurrence between 2 weeks prior to first medical contact and first medical contact**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 6160 **Name:** Prasugrel in First 24 Hours**Coding Instructions:** Indicate if Prasugrel was administered, regardless of location of care (e.g. transferring facility or EMS).**Target Value:** Any occurrence between first medical contact and 24 hours after first medical contact**Selections:** *Selection Text* *Definition*

No

Yes

Contraindicated

Blinded

Retired effective v2.4.

Supporting Definitions: (none)**Seq. #:** 6161 **Name:** Prasugrel in First 24 Hours - Start Date**Coding Instructions:** Indicate the date the initial dose of Prasugrel was administered, regardless of location of care (e.g. transferring facility or EMS). If administered more than once, code the first date/time it was administered.**Target Value:** The first value between first medical contact and 24 hours after first medical contact**Selections:** (none)**Supporting Definitions:** (none)



E. Medications

Seq. #: 6162 **Name:** Prasugrel in First 24 Hours - Start Time**Coding Instructions:** Indicate the time the initial dose of Prasugrel was administered, regardless of location of care (e.g. transferring facility or EMS). If administered more than once, code the first date/time it was administered.**Target Value:** The first value on Prasugrel in First 24 Hours Start Date**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6163 **Name:** Prasugrel in First 24 Hours - Dose**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6170 **Name:** Prasugrel at Discharge**Coding Instructions:** Indicate if Prasugrel was continued or prescribed at discharge.**Note(s):**

Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care(11110) is 'Yes'. (Updated in v2.4).

Target Value: Any occurrence on discharge**Selections:**

No

Yes

Contraindicated

Blinded

Retired effective v2.4.

Supporting Definitions: (none)

**E. Medications****Seq. #:** 6171 **Name:** Prasugrel at Discharge - Dose**Coding Instructions:** Indicate the dose of Prasugrel prescribed at discharge.**Note(s):**

Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care(11110) is 'Yes'. (Updated in v2.4).

Target Value: The value on discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6172 **Name:** Prasugrel at Discharge - Recommended Duration of Therapy**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6180 **Name:** Ticagrelor at Home**Coding Instructions:** Indicate if the patient has been taking Ticagrelor routinely at home prior to this hospitalization.**Note(s):**

This element should not be collected for patients who were discharged prior to January 1, 2013. (Added in v2.3.)

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

No

Yes

Supporting Definitions: (none)

**E. Medications****Seq. #: 6185 Name:** Ticagrelor in First 24 Hours

Coding Instructions: Indicate if Ticagrelor was administered, regardless of location of care (e.g. transferring facility or EMS).

Note(s):

This element should not be collected for patients who were discharged prior to January 1, 2013. (Added in v2.3.)

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

Selections: *Selection Text* *Definition*

No

Yes

Contraindicated

Blinded

Retired effective v2.4.

Supporting Definitions: (none)

Seq. #: 6186 Name: Ticagrelor in First 24 Hours - Start Date

Coding Instructions: Indicate the date the initial dose of Ticagrelor was administered, regardless of location of care (e.g. transferring facility or EMS). If administered more than once, code the first date/time it was administered.

Note(s):

This element should not be collected for patients who were discharged prior to January 1, 2013. (Added in v2.3.)

Target Value: The first value between first medical contact and 24 hours after first medical contact

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6187 Name: Ticagrelor in First 24 Hours - Start Time

Coding Instructions: Indicate the time the initial dose of Ticagrelor was administered, regardless of location of care (e.g. transferring facility or EMS). If administered more than once, code the first date/time it was administered.

Note(s):

This element should not be collected for patients who were discharged prior to January 1, 2013. (Added in v2.3.)

Target Value: The first value on Ticagrelor in First 24 Hours Start Date

Selections: (none)

Supporting Definitions: (none)

**E. Medications****Seq. #:** 6190 **Name:** Ticagrelor at Discharge**Coding Instructions:** Indicate if Ticagrelor was continued or prescribed at discharge.**Note(s):**

Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care(11110) is 'Yes'. (Updated in v2.4).

This element should not be collected for patients who were discharged prior to January 1, 2013. (Added in v2.3.)

Target Value: Any occurrence on discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	
Contraindicated	
Blinded	Retired effective v2.4.

Supporting Definitions: (none)**Seq. #:** 6200 **Name:** Warfarin at Home**Coding Instructions:** Indicate if the patient has been taking warfarin routinely at home.**Note(s):**

"Routinely" refers to the daily use of medications as prescribed, even if the patient misses a dose.

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

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: (none)



E. Medications

Seq. #: 6220 **Name:** Warfarin at Discharge**Coding Instructions:** Indicate if warfarin was continued or prescribed.**Note(s):**

Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care(11110) is 'Yes'. (Updated in v2.4).

Target Value: Any occurrence on discharge**Selections:** *Selection Text* *Definition*

No

Yes

Contraindicated

Blinded

Retired effective v2.4.

Supporting Definitions: (none)**Seq. #:** 6225 **Name:** Dabigatran at Home**Coding Instructions:** Indicate if the patient has been taking dabigatran routinely at home prior to this hospitalization.**Target Value:** Any occurrence between 2 weeks prior to first medical contact and first medical contact**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 6226 **Name:** Dabigatran at Discharge**Coding Instructions:** Indicate if dabigatran was continued or prescribed.**Note(s):**

Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care(11110) is 'Yes'. (Added in v2.4).

Target Value: Any occurrence on discharge**Selections:** *Selection Text* *Definition*

No

Yes

Contraindicated

Supporting Definitions: (none)

**E. Medications****Seq. #:** 6230 **Name:** Rivaroxaban at Home**Coding Instructions:** Indicate if the patient has been taking rivaroxaban routinely at home prior to this hospitalization.**Target Value:** Any occurrence between 2 weeks prior to first medical contact and first medical contact**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 6231 **Name:** Rivaroxaban at Discharge**Coding Instructions:** Indicate if rivaroxaban was continued or prescribed.**Note(s):**

Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care(11110) is 'Yes'. (Added in v2.4).

Target Value: Any occurrence on discharge**Selections:** *Selection Text* *Definition*

No

Yes

Contraindicated

Supporting Definitions: (none)**Seq. #:** 6240 **Name:** Apixaban at Home**Coding Instructions:** Indicate if the patient has been taking apixaban routinely at home prior to this hospitalization.**Target Value:** Any occurrence between 2 weeks prior to first medical contact and first medical contact**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)



E. Medications

Seq. #: 6241 **Name:** Apixaban at Discharge**Coding Instructions:** Indicate if apixaban was continued or prescribed at discharge.**Note(s):**

Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care(11110) is 'Yes'. (Added in v2.4).

Target Value: Any occurrence on discharge**Selections:** *Selection Text* *Definition*

No

Yes

Contraindicated

Supporting Definitions: (none)**Seq. #:** 6250 **Name:** Beta Blocker at Home**Coding Instructions:** Indicate if the patient has been taking a beta blocker routinely at home prior to this hospitalization.**Note(s):**

"Routinely" refers to the daily use of medications as prescribed, even if the patient misses a dose

Target Value: Any occurrence between 2 weeks prior to first medical contact and first medical contact**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 6260 **Name:** Beta Blocker First 24 Hrs**Coding Instructions:** Indicate if a beta blocker was administered, regardless of location of care (e.g., transferring facility or EMS).**Note(s):**

Only oral beta blocker doses are recommended to be collected.

Target Value: Any occurrence between first medical contact and 24 hours after first medical contact**Selections:** *Selection Text* *Definition*

No

Yes

Contraindicated

Blinded

Retired effective v2.4.

Supporting Definitions: (none)



E. Medications

Seq. #: 6261 **Name:** Beta Blocker First 24 Hrs Start Date**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6262 **Name:** Beta Blocker First 24 Hours Start Time**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6270 **Name:** Beta Blocker at Discharge**Coding Instructions:** Indicate if a beta blocker was continued or prescribed.**Note(s):**

Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care(11110) is 'Yes'. (Updated in v2.4).

This element is referenced in The Joint Commission AMI Core Measures AMI-5.

Target Value: Any occurrence on discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	
Contraindicated	
Blinded	Retired effective v2.4.

Supporting Definitions: (none)



E. Medications

Seq. #: 6300 **Name:** ACE Inhibitor at Home**Coding Instructions:** Indicate if the patient had been taking ACE inhibitors routinely at home prior to this hospitalization.**Note(s):**

"Routinely" refers to the daily use of medication as prescribed, even if the patient misses a dose

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

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Supporting Definitions: (none)**Seq. #:** 6310 **Name:** ACE Inhibitor First 24 Hours**Coding Instructions:** Indicate if an ACE inhibitor was administered, regardless of location of care (e.g., transferring facility or EMS).**Target Value:** Any occurrence between first medical contact and 24 hours after first medical contact**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Contraindicated

Blinded

Retired effective v2.4.

Supporting Definitions: (none)**Seq. #:** 6320 **Name:** ACE Inhibitor at Discharge**Coding Instructions:** Indicate if an ACE inhibitor was continued or prescribed.**Note(s):**

Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care(11110) is "Yes". (Updated in v2.4).

This element is referenced in The Joint Commission AMI Core Measures AMI-3.

Target Value: Any occurrence on discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Contraindicated

Blinded

Retired effective v2.4.

Supporting Definitions: (none)



E. Medications

Seq. #: 6350 **Name:** Angiotensin Receptor Blocker at Home**Coding Instructions:** Indicate if the patient has been taking an angiotensin receptor blocker routinely at home prior to this hospitalization.**Note(s):**

"Routinely" refers to the daily use of medications as prescribed, even if the patient misses a dose

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

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: (none)**Seq. #:** 6360 **Name:** Angiotensin Receptor Blocker First 24 Hours**Coding Instructions:** Indicate if an angiotensin receptor blocker was administered, regardless of location of care (e.g., transferring facility or EMS).**Target Value:** Any occurrence between first medical contact and 24 hours after first medical contact**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	
Contraindicated	
Blinded	Retired effective v2.4.

Supporting Definitions: (none)**Seq. #:** 6370 **Name:** Angiotensin Receptor Blocker at Discharge**Coding Instructions:** Indicate if an angiotensin receptor blocker was continued or prescribed.**Note(s):**

Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care(11110) is "Yes". (Updated in v2.4).

This element is referenced in The Joint Commission AMI Core Measures AMI-3.

Target Value: Any occurrence on discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	
Contraindicated	
Blinded	Retired effective v2.4.

Supporting Definitions: (none)

**E. Medications****Seq. #:** 6400 **Name:** Aldosterone Blocking Agent at Home**Coding Instructions:** Indicate if the patient has been taking an aldosterone blocking agent routinely at home prior to this hospitalization.**Target Value:** Any occurrence between 2 weeks prior to first medical contact and first medical contact**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 6410 **Name:** Aldosterone Blocking Agent First 24 Hours**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** *Selection Text* *Definition*

No

Yes

Contraindicated

Blinded

Retired effective v2.4.

Supporting Definitions: (none)**Seq. #:** 6420 **Name:** Aldosterone Blocking Agent at Discharge**Coding Instructions:** Indicate if an aldosterone blocking agent was continued or prescribed.**Note(s):**

Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care(11110) is 'Yes'. (Updated in v2.4).

If the patient's Potassium (K+) level is greater than 5 meq/L then code as contraindicated.

Target Value: Any occurrence on discharge**Selections:** *Selection Text* *Definition*

No

Yes

Contraindicated

Blinded

Retired effective v2.4.

Supporting Definitions: (none)



E. Medications

Seq. #: 6450 **Name:** Statin at Home**Coding Instructions:** Indicate if the patient has been taking a statin routinely at home prior to this hospitalization.**Note(s):**

"Routinely" refers to the daily use of medications as prescribed, even if the patient misses a dose.

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

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Supporting Definitions: (none)**Seq. #:** 6460 **Name:** Statin First 24 Hrs**Coding Instructions:** Indicate if a statin was administered, regardless of location of care (e.g., transferring facility or EMS).**Target Value:** Any occurrence between first medical contact and 24 hours after first medical contact**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Contraindicated

Blinded

Retired effective v2.4.

Supporting Definitions: (none)**Seq. #:** 6470 **Name:** Statin at Discharge**Coding Instructions:** Indicate if a statin was continued or prescribed.**Note(s):**

Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care(11110) is 'Yes'. (Updated in v2.4).

Target Value: Any occurrence on discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Contraindicated

Blinded

Retired effective v2.4.

Supporting Definitions: (none)



E. Medications

Seq. #: 6471 **Name:** Statin Dose at Discharge**Coding Instructions:** Indicate the dose of statin prescribed at discharge.**Note(s):**

Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care(11110) is 'Yes'. (Added in v2.4).

This element should not be collected for patients who were discharged prior to January 1, 2015. (Added in v2.4.)

Target Value: Any occurrence on discharge

Selections:	<i>Selection Text</i>	<i>Definition</i>
	Intensive statin therapy	Intensive statin therapy includes rosuvastatin 20 to 40 mg or atorvastatin 40 to 80 mg for high intensity.
	Less than intensive statin therapy	Less than intensive statin therapy includes any statin dose not considered intensive.

Supporting Definitions: (none)**Seq. #:** 6500 **Name:** Non-Statins Lipid-lowering Agent at Home**Coding Instructions:** Indicate if the patient has been routinely taking a non-statin lipid-lowering agent.**Note(s):**

"Routinely" refers to the daily use of medications as prescribed, even if the patient misses a dose.

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

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	

Supporting Definitions: (none)**Seq. #:** 6510 **Name:** Non-Statins Lipid-lowering Agent First 24 Hrs**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	
	Contraindicated	
	Blinded	Retired effective v2.4.

Supporting Definitions: (none)



E. Medications

Seq. #: 6520 **Name:** Non-Statins Lipid-lowering Agent at Discharge**Coding Instructions:** Indicate if a non-statin lipid-lowering agent was continued or prescribed.**Note(s):**

Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Left against medical advice (AMA)" or are receiving Hospice Care(11110) is 'Yes'. (Updated in v2.4).

Target Value: Any occurrence on discharge**Selections:** *Selection Text* *Definition*

No

Yes

Contraindicated

Blinded

Retired effective v2.4.

Supporting Definitions: (none)**Seq. #:** 6800 **Name:** GP IIb/IIIa Inhibitor Administered**Coding Instructions:** Indicate if a GP IIb/IIIa inhibitor was administered.**Target Value:** Any occurrence between arrival and discharge**Selections:** *Selection Text* *Definition*

No

Yes

Contraindicated

Blinded

Retired effective v2.4.

Supporting Definitions: (none)**Seq. #:** 6801 **Name:** GP IIb/IIIa Inhibitor Type**Coding Instructions:** Indicate the type of GP IIb/IIIa inhibitor administered.**Target Value:** The first value between arrival and discharge**Selections:** *Selection Text* *Definition*

Eptifibatide

Tirofiban

Abciximab

Supporting Definitions: (none)



E. Medications

Seq. #: 6802 **Name:** GP IIb/IIIa Inhibitor Start Date

Coding Instructions: Indicate the date a GP IIb/IIa inhibitor infusion was initiated.

Target Value: The first value between arrival and discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6803 **Name:** GP IIb/IIIa Inhibitor Start Time

Coding Instructions: Indicate the time a GP IIb/IIa inhibitor infusion was initiated.

Target Value: The first value on GP IIb/IIIa Inhibitor Start Date

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6804 **Name:** GP IIb/IIIa Inhibitor Stop Date

Coding Instructions: This element has been retired effective ACTION v2.4.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6805 **Name:** GP IIb/IIIa Inhibitor Stop Time

Coding Instructions: This element has been retired effective ACTION v2.4.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)



E. Medications

Seq. #: 6806 **Name:** GP IIb/IIIa Dose**Coding Instructions:** Indicate the dose of GP IIb/IIIa administered.**Target Value:** The first value between arrival and discharge**Selections:** *Selection Text* *Definition*

Full

Reduced

Other

Supporting Definitions: (none)**Seq. #:** 6850 **Name:** Anticoagulants Administered**Coding Instructions:** Indicate if an anticoagulant was administered.**Target Value:** Any occurrence between first medical contact and discharge**Selections:** *Selection Text* *Definition*

No

Yes

Contraindicated

Blinded

Retired effective v2.4.

Supporting Definitions: (none)**Seq. #:** 6851 **Name:** IV Unfractionated Heparin**Coding Instructions:** Indicate if unfractionated heparin was administered.**Note(s):**

Exclude UFN doses given during CABG in OR.

Target Value: Any occurrence between first medical contact and discharge**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)



E. Medications

Seq. #: 6852 **Name:** Unfractionated Heparin Start Date**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6853 **Name:** Unfractionated Heparin Start Time**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6854 **Name:** Unfractionated Heparin Initial Bolus**Coding Instructions:** Indicate if an initial bolus of unfractionated heparin was administered.**Target Value:** Any occurrence between first medical contact and discharge**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 6855 **Name:** Unfractionated Heparin Dose of Initial Bolus**Coding Instructions:** Indicate the dose of the initial bolus of unfractionated heparin.**Target Value:** The first value between first medical contact and discharge**Selections:** (none)**Supporting Definitions:** (none)

**E. Medications****Seq. #:** 6856 **Name:** Unfractionated Heparin Initial Infusion**Coding Instructions:** Indicate if an initial infusion was administered.**Target Value:** Any occurrence between first medical contact and discharge**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 6857 **Name:** Unfractionated Heparin Dose of Initial Infusion**Coding Instructions:** Indicate the dose of the initial infusion of unfractionated heparin.**Target Value:** The first value between first medical contact and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6858 **Name:** Unfractionated Heparin Initial Bolus Start Date**Coding Instructions:** Indicate the date the initial UFH bolus was given.**Target Value:** The first value between first medical contact and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6859 **Name:** Unfractionated Heparin Initial Bolus Start Time**Coding Instructions:** Indicate the time of the initial UFH bolus.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)

**E. Medications****Seq. #:** 6860 **Name:** Enoxaparin**Coding Instructions:** Indicate if enoxaparin (Lovenox) was administered.**Target Value:** Any occurrence between first medical contact and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes	
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Supporting Definitions: (none)**Seq. #:** 6861 **Name:** Enoxaparin Start Date**Coding Instructions:** Indicate the date of administration of enoxaparin (Lovenox).**Target Value:** The first value between first medical contact and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6862 **Name:** Enoxaparin Start Time**Coding Instructions:** Indicate the time of administration of enoxaparin (Lovenox).**Target Value:** The first value on Enoxaparin Start Date**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6863 **Name:** Enoxaparin Initial Subcutaneous Dose**Coding Instructions:** Indicate the initial subcutaneous dose of enoxaparin (Lovenox) in milligrams administered.**Note(s):**

Do not include intravenous (IV) low molecular weight heparin.

Target Value: The first value between first medical contact and discharge**Selections:** (none)**Supporting Definitions:** (none)

**E. Medications****Seq. #:** 6864 **Name:** Enoxaparin Initial IV Bolus**Coding Instructions:** Indicate if an IV bolus of enoxaparin (Lovenox) was administered.**Target Value:** Any occurrence between first medical contact and discharge**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 6865 **Name:** Enoxaparin Frequency of Injections Per Day**Coding Instructions:** Indicate the prescribed frequency of subcutaneous injections of enoxaparin (Lovenox).**Target Value:** The value between first medical contact and discharge**Selections:** *Selection Text* *Definition*

q12h

q24h

None

Supporting Definitions: (none)**Seq. #:** 6866 **Name:** Unfractionated Heparin Initial Infusion Start Date**Coding Instructions:** Indicate the date of the initial UFH infusion.**Target Value:** The first value between first medical contact and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6867 **Name:** Unfractionated Heparin Initial Infusion Start Time**Coding Instructions:** Indicate the time of the initial UFH infusion.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)

**E. Medications****Seq. #: 6870 Name:** Dalteparin**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes	
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Supporting Definitions: (none)**Seq. #: 6871 Name:** Dalteparin Start Date**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 6872 Name:** Dalteparin Start Time**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 6873 Name:** Dalteparin Dose**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)



E. Medications

Seq. #: 6875 **Name:** Bivalirudin**Coding Instructions:** Indicate if bivalirudin (Angiomax) was administered.**Target Value:** Any occurrence between arrival and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes	
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Supporting Definitions: (none)**Seq. #:** 6876 **Name:** Bivalirudin Date**Coding Instructions:** Indicate the date of the first administration of bivalirudin (Angiomax).**Target Value:** The first value between arrival and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6877 **Name:** Bivalirudin Time**Coding Instructions:** Indicate the time of the first administration of bivalirudin (Angiomax).**Target Value:** The first value on Bivalirudin Date**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6880 **Name:** Fondaparinux**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes	
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Supporting Definitions: (none)



E. Medications

Seq. #: 6881 **Name:** Fondaparinux Date**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6882 **Name:** Fondaparinux Time**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6885 **Name:** Argatroban**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 6886 **Name:** Argatroban Date**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)



E. Medications

Seq. #: 6887 **Name:** Argatroban Time

Coding Instructions: This element has been retired effective ACTION v2.4.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6890 **Name:** Lepirudin

Coding Instructions: This element has been retired effective ACTION v2.4.

Target Value: N/A

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6891 **Name:** Lepirudin Date

Coding Instructions: This element has been retired effective ACTION v2.4.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6892 **Name:** Lepirudin Time

Coding Instructions: This element has been retired effective ACTION v2.4.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)



E. Medications

Seq. #: 6895 **Name:** Other Parenteral Anticoagulants Given

Coding Instructions: Indicate if an anticoagulant was given that is not listed.

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

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)



F. Procedures And Tests

Seq. #: 7000 Name: Noninvasive Stress Testing**Coding Instructions:** Indicate if the patient underwent exercise or pharmacologic stress testing with or without echocardiographic or nuclear imaging.**Target Value:** Any occurrence between arrival at first facility and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes	
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Supporting Definitions: (none)**Seq. #: 7001 Name:** Noninvasive Stress Testing Date**Coding Instructions:** Indicate the date of exercise or pharmacologic stress testing with or without echocardiographic or nuclear imaging.**Target Value:** The first value between arrival at first facility and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 7010 Name:** LVEF**Coding Instructions:** Code the best estimate of the current left ventricular ejection fraction closest to discharge.**Note(s):**

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

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

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

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%

This element is referenced in The Joint Commission AMI Core Measures AMI-3

Target Value: The last value between arrival at first facility and discharge**Selections:** (none)**Supporting Definitions:** **LVEF :**

The Left Ventricular Ejection Fraction is the percentage of the blood emptied from the left ventricle at the end of the contraction.

Source: ACC Clinical Data Standards, The Society of Thoracic Surgeons



F. Procedures and Tests

Seq. #: 7011 **Name:** LVEF Not Assessed**Coding Instructions:** Indicate whether the left ventricular ejection fraction was assessed.**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures AMI-3

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

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Supporting Definitions: (none)**Seq. #:** 7012 **Name:** LVEF Planned for after Discharge**Coding Instructions:** Indicate if the LVEF assessment is planned for after discharge.**Target Value:** The last value between arrival at this facility and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Supporting Definitions: (none)**Seq. #:** 7020 **Name:** Diagnostic Coronary Angiography**Coding Instructions:** Indicate if the patient had a diagnostic coronary angiography procedure.**Target Value:** Any occurrence between arrival at first facility and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Supporting Definitions: **Diagnostic Coronary Angiography:**

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.

Source: NCDR

**F. Procedures and Tests****Seq. #: 7021 Name:** Diagnostic Coronary Angiography Date**Coding Instructions:** Indicate the date the patient had diagnostic coronary angiography.**Note(s):**

The start date for the diagnostic coronary angiography can be either the initial guidewire date or the lidocaine/anesthesia date.

Target Value: The first value between arrival at first facility and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 7022 Name:** Diagnostic Coronary Angiography Time**Coding Instructions:** Indicate the time the patient had diagnostic coronary angiography.**Note(s):**

The start time for the diagnostic coronary angiography can be either the initial guidewire time or the lidocaine/anesthesia time.

Target Value: The first value on Diagnostic Coronary Angiography Date**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 7023 Name:** Left Main Stenosis Percent**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 7024 Name:** Left Main Not Available**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: (none)



F. Procedures and Tests

Seq. #: 7025 **Name:** Proximal LAD Stenosis Percent**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 7026 **Name:** Proximal LAD Not Available**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: (none)**Seq. #:** 7027 **Name:** Mid/Distal LAD, Diag Branches Stenosis Percent**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 7028 **Name:** Mid/Distal LAD, Diag Branches Not Available**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: (none)



F. Procedures and Tests

Seq. #: 7029 **Name:** CIRC, OMs, LPDA and LPL Branches Stenosis Percent

Coding Instructions: This element has been retired effective ACTION v2.4.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7030 **Name:** CIRC, OMs, LPDA and LPL Branches Not Available

Coding Instructions: This element has been retired effective ACTION v2.4.

Target Value: N/A

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 7031 **Name:** RCA, RPDA, RPL, AM Branches Stenosis Percent

Coding Instructions: This element has been retired effective ACTION v2.4.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7032 **Name:** RCA, RPDA, RPL, AM Branches Not Available

Coding Instructions: This element has been retired effective ACTION v2.4.

Target Value: N/A

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)



F. Procedures and Tests

Seq. #: 7033 **Name:** Ramus Stenosis Percent**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 7034 **Name:** Ramus Not Available**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: (none)**Seq. #:** 7035 **Name:** Diagnostic Cath Contraindication**Coding Instructions:** Indicate if a catheterization was not performed because it was contraindicated.**Note(s):**

Contraindications may include patient refusal, advanced age, not a candidate for revascularization, do not resuscitate, active bleeding, and clinical contraindications/severe comorbidities.

Target Value: Any occurrence between arrival at first facility and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: (none)**Seq. #:** 7040 **Name:** Diagnostic Coronary Angiography Provider Last Name**Coding Instructions:** Indicate the last name of the primary provider for the diagnostic coronary angiography.**Note(s):**

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

Target Value: The value on current procedure**Selections:** (none)**Supporting Definitions:** (none)

**F. Procedures and Tests****Seq. #:** 7045 **Name:** Diagnostic Coronary Angiography Provider First Name**Coding Instructions:** Indicate the first name of the primary provider for the diagnostic coronary angiography.**Note(s):**

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

Target Value: The value on current procedure**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 7050 **Name:** Diagnostic Coronary Angiography Provider Middle Name**Coding Instructions:** Indicate the middle name of the primary provider for the diagnostic coronary angiography.**Note(s):**

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

Target Value: The value on current procedure**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 7055 **Name:** Diagnostic Coronary Angiography Provider NPI**Coding Instructions:** Indicate the primary providers National Provider Identifier. NPIs, assigned by the Center for Medicare and Medicaid Services (CMS), are used to uniquely identify physicians for Medicare billing purposes.**Target Value:** The value on current procedure**Selections:** (none)**Supporting Definitions:** (none)



F. Procedures and Tests

Seq. #: 7060 **Name:** Number of Diseased Vessels**Coding Instructions:** Indicate the number of diseased vessels found during the diagnostic catheterization.**Note(s):**

"Major" is defined as vessels that are ≥ 2.0 mm; Left Main Disease is counted as TWO vessels (LAD and Circumflex, which may include a RAMUS intermedius). For example, Left Main and RCA would count as three total. Presence of Left Main Disease $\geq 50\%$ is also coded in Sequence #7065 as 'Yes.'

When qualifying disease is identified in more than 3 vessels please code '3.'

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

<i>Selection Text</i>	<i>Definition</i>
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None

One

Two

Three

Supporting Definitions: (none)**Seq. #:** 7065 **Name:** Left Main Coronary Artery Stenosis $\geq 50\%$ **Coding Instructions:** Indicate whether or not the left main coronary artery is 50 percent or more stenotic.**Note(s):**

Left Main Disease is counted as TWO vessels (LAD and Circumflex, which may include a RAMUS intermedius)."

Target Value: The last value between arrival at this facility and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Supporting Definitions: (none)



F. Procedures and Tests

Seq. #: 7070 **Name:** Left Main Stenosis Graft is Present**Coding Instructions:** Indicate if a graft is present when the left main stenosis is greater than or equal to 50 percent.**Note(s):**

Code this element if Prior CABG (5110) is 'Yes'.

Code the selection based on diagnostic angiography report of the presence or absence of stenosis in the coronary artery bypass graft.

Code 'graft not patent' for graft stenosis $\geq 50\%$.Code 'graft patent' for graft stenosis $< 50\%$.**Target Value:** Any occurrence on current procedure**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes - graft patent	
Yes - graft not patent	

Supporting Definitions: (none)**Seq. #:** 7075 **Name:** Proximal LAD Stenosis $\geq 70\%$ **Coding Instructions:** Indicate if the left anterior descending coronary artery is greater than or equal to 70 percent stenotic.**Target Value:** The highest value between arrival at this facility and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: (none)



F. Procedures and Tests

Seq. #: 7080 **Name:** Proximal LAD Graft is Present**Coding Instructions:** Indicate if a graft is present when the proximal LAD is greater than or equal to 70 percent stenotic.**Note(s):**

Code this element if Prior CABG (5110) is 'Yes'.

Code the selection based on diagnostic angiography report of the presence or absence of stenosis in the coronary artery bypass graft.

Code 'graft not patent' for graft stenosis $\geq 50\%$.Code 'graft patent' for graft stenosis $< 50\%$.**Target Value:** Any occurrence on current procedure**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes - graft patent	
Yes - graft not patent	

Supporting Definitions: (none)**Seq. #:** 7100 **Name:** PCI**Coding Instructions:** Indicate if the patient had a percutaneous coronary intervention (PCI).**Target Value:** Any occurrence between arrival at this facility and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: **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.

Source: NCDR

Seq. #: 7101 **Name:** Cath Lab Arrival Date**Coding Instructions:** Indicate the date the patient arrived to the cath lab where the PCI was being performed, as documented in the medical record.**Target Value:** The first value between arrival at this facility and discharge**Selections:** (none)**Supporting Definitions:** (none)



F. Procedures and Tests

Seq. #: 7102 Name: Cath Lab Arrival Time

Coding Instructions: Indicate the time the patient arrived to the cath lab where the PCI was being performed, as documented in the medical record.

Target Value: The first value on Cath Lab Arrival Date

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7103 Name: First Device Activation Date

Coding Instructions: Indicate the date the first device was activated regardless of type of device used.

Note(s):

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 between arrival at this facility and discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7104 Name: First Device Activation Time

Coding Instructions: Indicate the time the first device was activated regardless of type of device used. 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 (AngioJet 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.

Note(s):

This element is referenced in The Joint Commission AMI Core Measures AMI-8, AMI-8a

Target Value: The first value on First Device Activation Date

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7105 Name: Stent(s) Placed

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

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

Selections:

<i>Selection Text</i>	<i>Definition</i>
-----------------------	-------------------

No

Yes

Supporting Definitions: (none)

**F. Procedures and Tests****Seq. #: 7106 Name: Bare Metal Stent Implanted**

Coding Instructions: Indicate if one or more bare metal stents were implanted during PCI.

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

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 7107 Name: Drug Eluting Stent Implanted

Coding Instructions: Indicate if one or more drug eluting stents were implanted during PCI.

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

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 7108 Name: Other Stents Implanted

Coding Instructions: Indicate if one or more other (not bare metal or drug eluting) stents were implanted during PCI.

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

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)



F. Procedures and Tests

Seq. #: 7109 **Name:** PCI Indication**Coding Instructions:** Indicate the primary reason PCI was performed or attempted.**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures AMI-8, AMI-8a

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

Selections:	<i>Selection Text</i>	<i>Definition</i>
	Primary PCI for STEMI	Primary PCI for patient with STEMI (or STEMI equivalent).
	Rescue PCI (after failed full-dose lytic)	Rescue PCI for STEMI (or STEMI equivalent) after failed full-dose lytics.
	PCI for NSTEMI	Includes patients with Non-STEMI.
	Stable, successful reperfusion for STEMI, or completed infarction post-STEMI	Retired effective v2.4.
	Other	
	PCI for STEMI (stable after successful full-dose lytic)	PCI for STEMI (or STEMI equivalent) who is stable after receiving full-dose lytic.
	PCI for STEMI (unstable, >12 hrs from symptom onset)	PCI for STEMI (or STEMI equivalent) more than 12 hours from symptom onset with recurrent or persistent symptoms, symptoms of heart failure or ventricular arrhythmia.
	PCI for STEMI (stable, >12 hrs from symptom onset)	Patient with STEMI (or STEMI equivalent) who is stable, and is more than 12 hours from symptom onset. The patient does not have any symptoms of recurrent or persistent ischemia, symptoms of heart failure, or electrical instability.

Supporting Definitions: (none)



F. Procedures and Tests

Seq. #: 7110 **Name:** Non-system Reason for Delay in PCI**Coding Instructions:** Indicate if there is documentation of a non-system reason for a delay in doing the first percutaneous coronary intervention (PCI) after hospital arrival by a physician/advanced practice nurse/physician assistant (physician/APN/PA).**Note(s):**

System reasons for delay are NOT acceptable.

The effect on timing/delay of PCI must be documented in order to be an acceptable reason for delay. If unable to determine whether a documented reason is system in nature, or if physician /APN/PA documentation does not establish a linkage between event(s)/condition(s) and the timing/delay in PCI/reperfusion/cath/transfer to cath lab, select "None"

This element is referenced in The Joint Commission AMI Core Measures AMI-8, AMI-8a.

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

<i>Selection Text</i>	<i>Definition</i>
Difficult vascular access	
Cardiac arrest and/or need for intubation before PCI	
Patient delays in providing consent for the procedure	
Difficulty crossing the culprit lesion during the PCI procedure	
Other	
None	

Supporting Definitions: (none)**Seq. #:** 7112 **Name:** Arterial Access Site**Coding Instructions:** Indicate the primary location of percutaneous entry. Code the site used to perform the majority of the procedure if more than one site was used.**Target Value:** The first value between arrival at this facility and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
Femoral	Either a cutdown or percutaneous puncture of either femoral artery.
Brachial	Either a cutdown or percutaneous puncture of either brachial artery.
Radial	Percutaneous radial approach.
Other	Entry other than femoral, brachial, or radial approaches to the arterial system.

Supporting Definitions: (none)

**F. Procedures and Tests****Seq. #: 7113 Name:** PCI Provider Last Name**Coding Instructions:** Indicate the providers last name.**Note(s):**

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

Target Value: The value on current procedure**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 7114 Name:** PCI Procedure Provider First Name**Coding Instructions:** Indicate the provider's first name.**Note(s):**

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

Target Value: The value on current procedure**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 7115 Name:** PCI Procedure Provider Middle Name**Coding Instructions:** Indicate the provider's middle name.**Note(s):**

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

Target Value: The value on current procedure**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 7116 Name:** PCI Procedure Provider NPI**Coding Instructions:** Indicate the provider's National Provider Identifier. NPIs, assigned by the Center for Medicare and Medicaid Services (CMS), are used to uniquely identify physicians for Medicare billing purposes.**Target Value:** The value on arrival at this facility**Selections:** (none)**Supporting Definitions:** (none)



F. Procedures And Tests

Seq. #: 7200 Name: CABG

Coding Instructions: Indicate if the patient had a CABG (coronary artery bypass graft surgery).

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

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 7201 Name: CABG Date

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

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7202 Name: CABG Time

Coding Instructions: Indicate the time of the coronary artery bypass graft (CABG) surgery.

Note(s):

The time of the procedure is the time to the nearest minute (using 24-hour clock), that the skin incision, or its equivalent was made to start the surgical procedure.

Target Value: The first value on CABG Date

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7205 Name: Treated with In-Hospital Hypothermia Protocol

Coding Instructions: Indicate if an in-hospital hypothermia protocol was initiated.

Target Value: Any occurrence between first medical contact and discharge

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)



F. Procedures And Tests

Seq. #: 7206 **Name:** In-Hospital hypothermia protocol initiated Location

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

Target Value: Any occurrence between first medical contact and discharge

Selections: *Selection Text* *Definition*

Pre-Hospital

ER

Cath Lab

ICU/CCU

Supporting Definitions: (none)

**G. Reperfusion****Seq. #: 8000 Name:** Reperfusion Candidate**Coding Instructions:** Indicate if the STEMI patient is a reperfusion candidate for primary PCI or Thrombolytic therapy.**Target Value:** Any occurrence between first medical contact and discharge**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #: 8010 Name:** Primary Reason Not Indicated**Coding Instructions:** This element has been superceded by 8011, 8030 and 8035 in version 2.2 Indicate the one primary reason, documented in the medical record, that reperfusion therapy (thrombolytic therapy or primary PCI) was not indicated.**Target Value:** The first value between first medical contact and discharge**Selections:** *Selection Text* *Definition*Non-compressible
vascular puncture(s)Active bleeding on
arrival or within 24
hoursKnown bleeding
diathesisRecent bleeding
within previous 4
weeks

History of CVA

Recent
surgery/traumaIntracranial
neoplasm, AV
malformation, or
aneurysmSevere uncontrolled
hypertensionNo ST
elevation/LBBB

ST elevation resolved

MI diagnosis unclear

MI symptoms onset >
12 hours

Chest pain resolved

No chest pain

Suspected aortic
dissection



Significant closed
head or facial trauma
within previous 3
months

Prior allergic reaction
to thrombolytics or IV
contrast

Current use of oral
anticoagulants

Active peptic ulcer

Quality of life decision

Comorbid disease

Traumatic CPR that
precludes
thrombolytics

Anatomy not suitable
to primary PCI

Spontaneous
reperfusion
(documented by cath
only)

Patient/family refusal

DNR at time of
treatment decision

Ischemic stroke w/in
3 months, except
acute ischemic stroke
w/in 3 hours

Any prior intracranial
hemorrhage

Pregnancy

Other (not listed)

Supporting Definitions: (none)

**G. Reperfusion****Seq. #: 8011 Name:** Primary Reason No Reperfusion**Coding Instructions:** Indicate the one primary reason, documented in the medical record, that reperfusion therapy (thrombolytic therapy or primary PCI) was not indicated.**Note(s):**

This element does not need to be collected for patients who were discharged prior to April 1, 2011.

Added to the Limited Data Set (ARGL) starting with patients discharged October 1, 2013.

Target Value: The first value between first medical contact and discharge**Selections:** *Selection Text* *Definition*

No ST elevation/LBBB	
ST elevation resolved	
MI diagnosis unclear	
MI symptoms onset >12 hours	
Chest pain resolved	
No chest pain	
Other	

Supporting Definitions: (none)**Seq. #: 8015 Name:** Primary PCI**Coding Instructions:** Indicate if the patient received primary PCI as an urgent treatment for STEMI.**Note(s):**

This element does not need to be collected for patients who were discharged prior to April 1, 2011.

Target Value: Any occurrence between first medical contact and discharge**Selections:** *Selection Text* *Definition*

No	
Yes	

Supporting Definitions: (none)



G. Reperfusion

Seq. #: 8020 **Name:** Thrombolytics**Coding Instructions:** Indicate if the patient received thrombolytic therapy as an urgent treatment for STEMI.**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures AMI-7, AMI-7a, AMI-8, AMI-8a

Target Value: Any occurrence between first medical contact and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
-----------------------	-------------------

No

Yes

Supporting Definitions: (none)**Seq. #:** 8021 **Name:** Strength of Thrombolytic Dose**Coding Instructions:** Indicate the strength of dose of the thrombolytic.**Target Value:** The first value between first medical contact and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
-----------------------	-------------------

Full Dose

Reduced Dose

Supporting Definitions: (none)**Seq. #:** 8022 **Name:** Type of Thrombolytics**Coding Instructions:** Indicate the type of thrombolytic first administered.**Target Value:** The first value between first medical contact and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
-----------------------	-------------------

Tenecteplase

Alteplase

Retired effective v2.4.

Reteplase

Streptokinase

Retired effective v2.4.

Other

Supporting Definitions: (none)

**G. Reperfusion****Seq. #: 8023 Name: Thrombolytic Therapy Date**

Coding Instructions: Indicate the date of either the first bolus or the beginning of the thrombolytic infusion.

Note(s):

This element is referenced in The Joint Commission AMI Core Measures AMI-7, AMI-7a

If your facility receives a patient transfer with infusion ongoing, record the date that infusion was started at transferring facility.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8024 Name: Thrombolytic Therapy Time

Coding Instructions: Indicate the 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 time that infusion was started at transferring facility.

This element is referenced in The Joint Commission AMI Core Measures AMI-7, AMI-7a.

Target Value: The first value on Thrombolytic Therapy Date

Selections: (none)

Supporting Definitions: (none)

Seq. #: 8025 Name: Non-System Reason for Delay

Coding Instructions: Indicate if there is documentation of a non-system reason for delay in initiating thrombolytic therapy greater than 30 minutes from the time of first facility arrival (including an ambulance capable of administering thrombolytic therapy).

Note(s):

A patient being transferred into your facility is not considered a non-system reason for delay.

This element is referenced in The Joint Commission AMI Core Measures AMI-7, AMI-7a.

Target Value: Any occurrence between first medical contact and discharge

Selections:

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Supporting Definitions: (none)



G. Reperfusion

Seq. #: 8026 Name: Lytic Ineligible and require prolonged transfer for Primary PCI**Coding Instructions:** Indicate if the patient was Lytic ineligible and required prolonged transfer time for primary PCI.**Note(s):**

Prolonged transfer time is defined as greater than 60 minutes.

Target Value: Any occurrence on current admission**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #: 8030 Name:** Reason Primary PCI Not Performed**Coding Instructions:** Indicate the one primary reason, documented in the medical record, that primary PCI was not performed as reperfusion therapy.**Note(s):**

This element does not need to be collected for patients who were discharged prior to April 1, 2011.

Added to the Limited Data Set (ARGL) starting with patients discharged October 1, 2013.

Target Value: The first value between first medical contact and discharge**Selections:** *Selection Text* *Definition*Non-compressible
vascular puncture(s)Active bleeding on
arrival or within 24
hours

Quality of life decision

Anatomy not suitable
to primary PCISpontaneous
reperfusion
(documented by cath
only)

Patient/family refusal

DNR at time of
treatment decisionPrior allergic reaction
to IV contrast

Other

Not performed (not a
PCI center)No reason
documentedThrombolytic
Administered**Supporting Definitions:** (none)



G. Reperfusion

Seq. #: 8035 **Name:** Reason Thrombolytics Not Administered**Coding Instructions:** Indicate the one primary reason, documented in the medical record, that thrombolytics were not administered as reperfusion therapy.**Note(s):**

This element does not need to be collected for patients who were discharged prior to April 1, 2011.

Added to the Limited Data Set (ARGL) starting with patients discharged October 1, 2013.

Target Value: The first value between first medical contact and discharge**Selections:** *Selection Text* *Definition*

Known bleeding diathesis	
Recent bleeding within 4 weeks	
Recent surgery/trauma	
Intracranial neoplasm, AV malformation, or aneurysm	
Severe uncontrolled hypertension	
Suspected aortic dissection	
Significant close head or facial trauma within previous 3 months	
Active peptic ulcer	
Traumatic CPR that precludes thrombolytics	
Ischemic stroke w/in 3 months except acute ischemic stroke within 3 hours	
Any prior intracranial hemorrhage	
Pregnancy	
Prior allergic reaction to thrombolytics	
DNR at time of treatment decision	
Other	
Expected DTB < 90 minutes	
No reason documented	

Supporting Definitions: (none)



H. In Hospital Clinical Events

Seq. #: 9000 Name: Reinfarction

Coding Instructions: Indicate if there are clinical signs and symptoms of a new infarction or repeat infarction.**Target Value:** Any occurrence between arrival at this facility and discharge**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: Reinfarction:

Reinfarction occurs when there are clinical signs and symptoms of ischemia that is distinct from the presenting ischemic event and meeting at least one of the following criteria:

1. Spontaneous (Prior to or without revascularization, >24 hours after PCI and/or >72 hours after CABG)
 - a. New, significant Q waves in at least two contiguous leads of an ECG that were not present with the presenting ischemic event
 - b. Patients whose most recent cardiac markers drawn prior to reinfarction which were normal require an increase in CK-MB or troponin above the ULN which is at least $\geq 25\%$ above the most recent value.
 - c. Patients whose most recent cardiac markers prior to reinfarction were above the upper limit of normal require an increase in CK-MB or troponin by $\geq 50\%$ above the most recent value.
2. Within 24 hours after PCI:
 - a. Patients with normal CK-MB values (pre-procedure) who then develop an increase in CK-MB to a value at least 3 times the upper limit of normal for your laboratory (i.e., above 3 times the 99th percentile upper reference limit for a normal population) are indicative of peri-procedural myocardial necrosis. ECG changes or symptoms are not required to qualify.
Note: Some patients presenting with acute coronary syndrome will not have biomarker elevations prior to the PCI. Elevated biomarker after PCI in these cases do not necessarily mean a reinfarction occurred.
 - b. Patients with elevated baseline (pre-procedure) cardiac biomarkers (CK-MB): there are two possible scenarios. In these scenarios, ECG changes or symptoms are not required to qualify.
 - i. Patients with cardiac markers above the upper limit of normal (pre-procedure) assumed to be in the midst of an acute myocardial infarction. In these patients, it is not possible to distinguish necrosis that resulted from the PCI vs. necrosis arising from the presenting acute MI, and these pts require an increase in CK-MB that must also be $\geq 50\%$ above the most recent value.
 - ii. Patients with elevated biomarkers with a characteristic rise and fall in biomarker levels pre-procedure most likely have completed their presenting infarct. Further rises in CK-MB must be $\geq 50\%$ above the most recent value to be coded as reinfarction.
 - c. Patients with new, significant Q waves in at least two contiguous leads of an ECG that were not present with the presenting ischemic event
3. Within the first 72 hours following CABG: A CABG-related myocardial infarction is defined by an increase of biomarkers greater than 5 times the upper limit of normal for your laboratory (i.e., above 5 times the 99th percentile upper reference limit for a normal population) compared with the pre-CABG biomarker value closest to the time of surgery plus one of the following:
 - a. new pathological Q waves or new LBBB;
 - b. angiographically documented new occlusion or thrombosis of a graft or native coronary artery since the pre-operative angiogram;
 - c. imaging evidence of new loss of viable myocardium at rest in the absence of a non-ischemic cause.

Note: Patients with cardiac biomarkers above the upper limit of normal pre-CABG require the increase in CK-MB to be $\geq 50\%$ above the most recent value.

Source: Joint ESC-ACC-AHA-WHF 2007 Task Force consensus document "Universal Definition of Myocardial Infarction"



H. In Hospital Clinical Events

Seq. #: 9001 **Name:** Reinfarction Date**Coding Instructions:** Indicate the date when the clinical signs and symptoms of the new myocardial infarction first occurred.**Target Value:** The first value between arrival at this facility and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 9010 **Name:** Cardiogenic Shock**Coding Instructions:** Indicate if the patient had a new onset or acute recurrence of cardiogenic shock in your facility.**Note(s):**

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 minutes.

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

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: **Cardiogenic Shock:**

Cardiogenic shock is defined as

1. a sustained (>30 minutes) episode of systolic blood pressure <90 mm Hg determined to be secondary to cardiac dysfunction, and/or
2. a sustained (>30 minutes) episode of cardiac index <2.2 L/min/m² determined to be secondary to cardiac dysfunction, and/or
3. the sustained (>30 minutes) requirement for parenteral inotropic or vasopressor agents or mechanical support (e.g., IABP, extracorporeal circulation, ventricular assist devices) to maintain systolic blood pressure ≥90 mm Hg, and/or
4. the sustained (>30 minutes) requirement for parenteral inotropic or vasopressor agents or mechanical support (e.g., IABP, extracorporeal circulation, ventricular assist devices) to maintain CI ≥2.2 L/min/m²

Source: NCDR

Seq. #: 9011 **Name:** Cardiogenic Shock Date**Coding Instructions:** Indicate the date when a diagnosis of cardiogenic shock was made.**Target Value:** The first value between arrival at this facility and discharge**Selections:** (none)**Supporting Definitions:** (none)



H. In Hospital Clinical Events

Seq. #: 9020 **Name:** Heart Failure**Coding Instructions:** Indicate if there is physician documentation or report of either new onset or acute reoccurrence of heart failure.**Target Value:** Any occurrence between arrival at this facility and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes	
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Supporting Definitions: **Heart Failure:**

Heart failure is defined as physician documentation or report of any of the following clinical symptoms of heart failure: unusual dyspnea on light exertion; recurrent dyspnea occurring in the supine position; fluid retention; the description of rales, jugular venous distension, pulmonary edema on physical exam; or pulmonary edema on chest x-ray. A previous hospital admission with principal diagnosis of heart failure is considered evidence of heart failure history. A low ejection fraction without clinical evidence of heart failure does not qualify as heart failure.

Source: ACC Data Standards, The Society of Thoracic Surgeons

Seq. #: 9021 **Name:** Heart Failure Date**Coding Instructions:** Indicate the date of the new onset or acute reoccurrence of heart failure.**Target Value:** The first value between arrival at this facility and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 9030 **Name:** CVA/Stroke**Coding Instructions:** Indicate if the patient experienced a stroke or cerebrovascular accident (CVA) in your facility.**Target Value:** Any occurrence between arrival at this facility and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes	
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Supporting Definitions: **Stroke:**

A stroke is an acute episode of focal or global neurological dysfunction caused by brain, spinal cord, or retinal vascular injury as a result of hemorrhage or infarction.

Source: Standardized Definitions for Cardiovascular Endpoints in Clinical Trials (FDA Draft)



H. In Hospital Clinical Events

Seq. #: 9031 Name: CVA/Stroke Date**Coding Instructions:** Indicate the date of onset of stroke or cerebrovascular accident (CVA) symptoms. If a stroke occurs during sleep, last awake time may be used.**Target Value:** The first value between arrival at this facility and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 9032 Name:** Hemorrhagic Stroke**Coding Instructions:** Indicate if the patient experienced a hemorrhagic stroke with documentation on imaging.**Target Value:** Any occurrence between arrival at this facility and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: **Hemorrhagic Stroke:**

Hemorrhage may be a consequence of ischemic stroke. In this situation, the stroke is an ischemic stroke with hemorrhagic transformation and not a hemorrhagic stroke.

Hemorrhagic stroke is defined as an acute episode of focal or global cerebral or spinal dysfunction caused by intraparenchymal, intraventricular, or subarachnoid hemorrhage.

Note: Subdural hematomas are intracranial hemorrhagic events and not strokes.

Source: Standardized Definitions for Cardiovascular Endpoints in Clinical Trials (FDA Draft) Cardiovascular Trials



H. In Hospital Clinical Events

Seq. #: 9035 **Name:** Cardiac Arrest**Coding Instructions:** Indicate if the patient experienced an episode of cardiac arrest in your facility.**Note(s):**

Evaluated by EMS or ED personnel and either (1) received attempts at external defibrillation (by lay responders or emergency personnel) or chest compressions by organized EMS or ED personnel or (2) were pulseless but did not receive attempts to defibrillate or cardiopulmonary resuscitation (CPR) by EMS personnel.

This element does not need to be collected for patients who were discharged prior to April 1, 2011.

Target Value: Any occurrence between arrival at this facility and discharge**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: **Cardiac Arrest:**

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

Source: ACC/AHA/HRS 2006 Key Data Elements and Definitions for Electrophysiological Studies and Procedures

Seq. #: 9037 **Name:** Cardiac Arrest Date**Coding Instructions:** Indicate the date of the cardiac arrest.**Note(s):**

This element does not need to be collected for patients who were discharged prior to April 1, 2011.

Target Value: The first value between arrival at this facility and discharge**Selections:** (none)**Supporting Definitions:** (none)



H. In Hospital Clinical Events

Seq. #: 9040 Name: Suspected Bleeding Event

Coding Instructions: Indicate if there was a suspected or confirmed bleeding event observed and documented in the medical record that was associated with any of the following:

1. Hemoglobin drop of ≥ 3 g/dL;
2. Transfusion of whole blood or packed red blood cells;
3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding (such as surgical closures/exploration of the arteriotomy site, balloon angioplasty to seal an arterial tear, endoscopy with cauterization of a GI bleed).

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

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 9041 Name: Suspected Bleeding Event Date

Coding Instructions: Indicate the date of the suspected bleeding event.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 9042 Name: Suspected Bleeding Event Location - Access Site

Coding Instructions: Indicate if a bleeding event occurred at the PCI access site.

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

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

**H. In Hospital Clinical Events****Seq. #:** 9043 **Name:** Suspected Bleeding Event Location - Retroperitoneal**Coding Instructions:** Indicate if the patient had a retroperitoneal bleeding event.**Target Value:** Any occurrence between arrival at this facility and discharge**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 9044 **Name:** Suspected Bleeding Event Location - GI**Coding Instructions:** Indicate if the patient had a GI bleeding event.**Target Value:** Any occurrence between arrival at this facility and discharge**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 9045 **Name:** Suspected Bleeding Event Location - GU**Coding Instructions:** Indicate if the patient had a GU bleeding event.**Target Value:** Any occurrence between arrival at this facility and discharge**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 9046 **Name:** Suspected Bleeding Event Location - Other**Coding Instructions:** Indicate if the patient had a bleeding event in a location not specified elsewhere.**Target Value:** Any occurrence between arrival at this facility and discharge**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

**H. In Hospital Clinical Events****Seq. #: 9047 Name:** Surgical Procedure or Intervention Required

Coding Instructions: Indicate if the suspected bleeding event observed required procedural intervention or surgery at the bleeding site to reverse, stop or correct the bleeding (e.g. surgical closures, exploration of the arteriotomy site, balloon angioplasty to seal an arterial tear, or endoscopy with cautery of a GI bleed).

Note(s):

Prolonged pressure does not qualify as an intervention, but ultrasonic guided compression after making a diagnosis of pseudoaneurysm does qualify

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

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 9050 Name: RBC/Whole Blood Transfusion

Coding Instructions: Indicate if there was a transfusion of either whole blood or packed red blood cells.

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

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 9051 Name: First Transfusion Date

Coding Instructions: Indicate the date of the first whole blood or red blood cell transfusion.

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

Selections: (none)

Supporting Definitions: (none)



H. In Hospital Clinical Events

Seq. #: 9052 **Name:** Transfusion Related to CABG**Coding Instructions:** Indicate if any red blood cell/whole blood transfusion was related to CABG.**Note(s):**

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

Target Value: Any occurrence between arrival at this facility and discharge**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 9060 **Name:** Atrial Fibrillation**Coding Instructions:** Indicate if the patient experienced atrial fibrillation.**Target Value:** Any occurrence between arrival at this facility and discharge**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: **Atrial Fibrillation:**

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

Atrial Flutter is characterized by a sawtooth pattern of regular atrial activation called flutter waves on the ECG, particularly visible in leads II, III, aVF and v1.

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

Seq. #: 9065 **Name:** Atrial Fibrillation Date**Coding Instructions:** Indicate the date the patient experienced episode of atrial fibrillation.**Target Value:** Any occurrence between arrival at this facility and discharge**Selections:** (none)**Supporting Definitions:** (none)



H. In Hospital Clinical Events

Seq. #: 9070 **Name:** VTach/VFib**Coding Instructions:** Indicate if the patient experienced VTach and/or VFib.

Ventricular tachycardia is three or more fast heart beats (greater than 100 bpm) that originates in one of the ventricles. Ventricular fibrillation occurs when the heart's electrical activity becomes disordered and the ventricles contract in a rapid, unsynchronized way.

Significant VT that was clinically relevant greater than 7 beat run of VT that requires treatment or intervention.

Note(s):

Code 'Yes' if a run of greater than or equal to 7 beats of ventricular tachycardia is documented in the record.

Code 'Yes' to any noted instance of ventricular fibrillation.

Target Value: Any occurrence between arrival at this facility and discharge**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: VTach Arrest:

VT is a cardiac arrhythmia of 3 or more consecutive complexes in duration emanating from the ventricles at a rate 100 bpm (cycle length: 600 ms).

Source: JACC Vol. 48, No. 11, 2006 ACC/AHA/HR Clinical Data Standards December 5, 2006:2360-96

Seq. #: 9075 **Name:** VTach/VFib Date**Coding Instructions:** Indicate the date the patient experienced VTach and/or VFib.**Target Value:** Any occurrence between arrival at this facility and discharge**Selections:** (none)**Supporting Definitions:** (none)



H. In Hospital Clinical Events

Seq. #: 9080 **Name:** New Requirement for Dialysis**Coding Instructions:** Indicate if the patient experienced acute or worsening renal failure necessitating renal dialysis.**Note(s):**

If a patient is on receiving continuous veno-venous hemofiltration (CVVH) as a result of renal failure (and not as treatment to remove fluid for heart failure), code yes.

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes	
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Supporting Definitions: (none)**Seq. #:** 9085 **Name:** New Requirement for Dialysis Date**Coding Instructions:** Indicate the date of acute or worsening renal failure leading to a new requirement for dialysis.**Target Value:** The first value between arrival at this facility and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 9090 **Name:** Mechanical Support**Coding Instructions:** Indicate if the patient required the use of other mechanical ventricular support. This includes use of cardiopulmonary bypass, left ventricular assist device (LVAD) and/or extracorporeal membrane oxygenation (ECMO).**Target Value:** Any occurrence between arrival at this facility and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes	
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Supporting Definitions: (none)



H. In Hospital Clinical Events

Seq. #: 9095 **Name:** Mechanical Support Device

Coding Instructions: Indicate the type of mechanical support device.

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

Selections: *Selection Text* *Definition*

IABP

Impella

Tandem Heart

ECMO

LVAD

Other

Supporting Definitions: (none)



I. Laboratory Results

Seq. #: 10000 **Name:** Positive Cardiac Markers w/in First 24 Hours**Coding Instructions:** Indicate if any positive cardiac markers were present within the first 24 hours after first medical contact.**Note(s):**

Qualifying cardiac biomarkers include the following:

1. Troponin I or T: Level is elevated if the lab value exceeds the upper limit of normal (ULN) according to the individual hospital's laboratory parameters.
2. Creatine kinase-myocardial band (CK-MB): Level is elevated if the lab value exceeds the ULN according to the individual hospital's laboratory parameters.
3. Positive bedside troponin assay: Level is elevated if the lab value exceeds the ULN according to the individual hospital's laboratory parameters.

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

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes	
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Supporting Definitions: (none)**Seq. #:** 10010 **Name:** Initial Troponin Collected**Coding Instructions:** Indicate if an initial troponin sample was collected.**Note(s):**

The initial sample refers to the first sample obtained within the first 24 hours of care.

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

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes - I	
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Yes - T	
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Supporting Definitions: (none)**Seq. #:** 10011 **Name:** Initial Troponin Date**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)



I. Laboratory Results

Seq. #: 10012 **Name:** Initial Troponin Time

Coding Instructions: This element has been retired effective ACTION v2.4.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10013 **Name:** Initial Troponin Value

Coding Instructions: Indicate the initial troponin value in ng/mL.

Note(s):

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

Target Value: The first value between first medical contact and 24 hours after arrival at first facility

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10014 **Name:** Initial Troponin URL

Coding Instructions: Indicate the URL (Upper Reference Limit) for the initial troponin sample in ng/mL.

Note(s):

If you are unsure of which Upper Reference Limit value to report from a troponin assay, contact your lab manager to determine which value is consistent with the supporting definition.

The initial sample value refers to the first sample obtained within the first 24 hours of care.

Target Value: N/A

Selections: (none)

Supporting Definitions: **Upper Reference Limit (URL):**

Defined as the 99th percentile of troponin levels for a normal reference population.

Source: Joint ESC-ACC-AHA-WHF 2007 Task Force consensus document "Universal Definition of Myocardial Infarction"



I. Laboratory Results

Seq. #: 10020 **Name:** Initial CK-MB Collected**Coding Instructions:** Indicate if an initial CK-MB sample was collected.**Note(s):**

The initial sample refers to the first sample obtained within the first 24 hours of care.

Target Value: Any occurrence between first medical contact and 24 hours after arrival at first facility**Selections:***Selection Text**Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 10021 **Name:** Initial CK-MB Date**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 10022 **Name:** Initial CK-MB Time**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 10023 **Name:** Initial CK-MB Value**Coding Instructions:** Indicate the initial CK-MB value.**Note(s):**

If a CK-MB value was not calculated at baseline for normal CPK results, record a value of 0 (zero).

The initial sample value refers to the first sample obtained within the first 24 hours of care.

Target Value: The first value between first medical contact and 24 hours after arrival at first facility**Selections:** (none)**Supporting Definitions:** (none)

**I. Laboratory Results****Seq. #:** 10024 **Name:** Initial CK-MB Unit**Coding Instructions:** Indicate the initial CK-MB sample unit of measure.**Note(s):**

The initial sample value refers to the first sample obtained within the first 24 hours of care.

Target Value: The first value between first medical contact and 24 hours after arrival at first facility**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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IU/L

%

(mg/mL)/IU

ng/mL

Supporting Definitions: (none)**Seq. #:** 10025 **Name:** Initial CK-MB ULN**Coding Instructions:** Indicate the ULN (upper limit of normal) for the initial CK-MB sample.**Note(s):**

If a range is given for ULN values, record the highest number in the range.

Examples: If the reference range given is 0.0-1.5, record ULN as 1.5. If the reference range given is < 1.5, record ULN as 1.5 as well.

The initial sample value refers to the first sample obtained within the first 24 hours of care.

Target Value: N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 10030 **Name:** Peak Troponin Collected**Coding Instructions:** Indicate if the peak troponin, I or T, was collected.**Note(s):**

If the initial value was also the peak value, record results in both initial and peak sections.

Target Value: Any occurrence between first medical contact and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No

Yes - I

Yes - T

Supporting Definitions: (none)



I. Laboratory Results

Seq. #: 10031 Name: Peak Troponin Date

Coding Instructions: This element has been retired effective ACTION v2.4.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10032 Name: Peak Troponin Time

Coding Instructions: This element has been retired effective ACTION v2.4.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10033 Name: Peak Troponin Value

Coding Instructions: Indicate the peak troponin value in ng/mL.

Note(s):

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

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10034 Name: Peak Troponin URL

Coding Instructions: Indicate the URL (Upper Reference Limit) for the peak troponin sample in ng/mL.

Note(s):

If you are unsure of which Upper Reference Limit value to report from a troponin assay, contact your lab manager to determine which value is consistent with the supporting definition.

If the initial value was also the peak value, record results in both initial and peak sections.

Target Value: N/A

Selections: (none)

Supporting Definitions: **Upper Reference Limit (URL):**

Defined as the 99th percentile of troponin levels for a normal reference population.

Source: Joint ESC-ACC-AHA-WHF 2007 Task Force consensus document "Universal Definition of Myocardial Infarction"



I. Laboratory Results

Seq. #: 10035 **Name:** Peak Troponin Value Same as Initial**Coding Instructions:** Indicate if the peak Troponin value is equal to the initial value.**Target Value:** N/A**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 10040 **Name:** Peak CK-MB Collected**Coding Instructions:** Indicate if the peak CK-MB was collected.**Note(s):**

If the initial value was also the peak value, record results in both initial and peak sections.

Target Value: Any occurrence between first medical contact and discharge**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 10041 **Name:** Peak CK-MB Date**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 10042 **Name:** Peak CK-MB Time**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)



I. Laboratory Results

Seq. #: 10043 **Name:** Peak CK-MB Value**Coding Instructions:** Indicate the peak CK-MB value.**Note(s):**

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

If the initial value was also the peak value, record results in both initial and peak sections.

Target Value: The highest value between first medical contact and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 10044 **Name:** Peak CK-MB Unit**Coding Instructions:** Indicate the peak CK-MB sample unit of measure.**Target Value:** N/A**Selections:***Selection Text**Definition*

IU/L

%

(mg/mL)/IU

ng/mL

Supporting Definitions: (none)**Seq. #:** 10045 **Name:** Peak CK-MB ULN**Coding Instructions:** Indicate the ULN (upper limit of normal) for the peak CK-MB sample.**Note(s):**

If a range is given for ULN values, record the highest number in the range.

Examples: If the reference range given is 0.0-1.5, record ULN as 1.5. If the reference range given is < 1.5, record ULN as 1.5 as well.

The peak sample value refers to the highest sample obtained.

Target Value: N/A**Selections:** (none)**Supporting Definitions:** (none)

**I. Laboratory Results****Seq. #:** 10046 **Name:** Peak CK-MB Value Same As Initial**Coding Instructions:** Indicate if the peak CK-MB value is equal to the initial CK-MB value.**Target Value:** N/A**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 10100 **Name:** Initial Creatinine Collected**Coding Instructions:** Indicate if an initial creatinine was collected.**Target Value:** Any occurrence between first medical contact and discharge**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 10101 **Name:** Initial Creatinine Date**Coding Instructions:** Indicate the date the initial creatinine was collected.**Target Value:** The first value between first medical contact and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 10102 **Name:** Initial Creatinine Time**Coding Instructions:** Indicate the time the initial creatinine was collected.**Target Value:** The first value on Initial Creatinine Date**Selections:** (none)**Supporting Definitions:** (none)



I. Laboratory Results

Seq. #: 10103 Name: Initial Creatinine Value**Coding Instructions:** Indicate the results of the initial creatinine sample in mg/dL.**Note(s):**

If patient was transferred in, data available from the transferring facility should take precedence.

The initial creatinine sample may be obtained either at this facility or at the transferring facility.

Target Value: The first value between first medical contact and discharge**Selections:** (none)**Supporting Definitions:** (none)

Seq. #: 10110 Name: Peak Creatinine Collected**Coding Instructions:** Indicate if a peak creatinine was collected.**Note(s):**

If the initial value was also the peak value, record results in both initial and peak sections.

Target Value: Any occurrence between first medical contact and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes	
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Supporting Definitions: (none)

Seq. #: 10111 Name: Peak Creatinine Date**Coding Instructions:** Indicate the date of the peak creatinine.**Target Value:** The value between first medical contact and discharge**Selections:** (none)**Supporting Definitions:** (none)

Seq. #: 10112 Name: Peak Creatinine Time**Coding Instructions:** Indicate the time of the peak creatinine.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)

**I. Laboratory Results****Seq. #: 10113 Name:** Peak Creatinine Value

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

Note(s):

If the initial value was also the peak value, record results in both initial and peak sections.

When there are multiple values that are identical, enter the date and time of the 1st of the multiple identical values measured.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10114 Name: Peak Creatinine Value Same As Initial

Coding Instructions: Indicate if the peak Creatinine value is equal to the initial value.

Target Value: N/A

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 10150 Name: Initial Hemoglobin Collected

Coding Instructions: Indicate if a baseline hemoglobin was collected.

Target Value: Any occurrence between first medical contact and discharge

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 10151 Name: Initial Hemoglobin Date

Coding Instructions: Indicate the date the initial hemoglobin sample was collected (not the date results reported).

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

Selections: (none)

Supporting Definitions: (none)

**I. Laboratory Results****Seq. #:** 10152 **Name:** Initial Hemoglobin Time**Coding Instructions:** Indicate the time the baseline hemoglobin sample was collected (not the time results reported).**Target Value:** The first value on Initial Hemoglobin Date**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 10153 **Name:** Initial Hemoglobin Value**Coding Instructions:** Indicate the initial hemoglobin (HGB) value in g/dL.**Target Value:** The first value between first medical contact and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 10200 **Name:** Lowest Recorded Hemoglobin Collected**Coding Instructions:** Indicate if there was a lowest recorded hemoglobin.**Target Value:** Any occurrence between first medical contact and discharge**Selections:**

No

Yes

Supporting Definitions: (none)**Seq. #:** 10201 **Name:** Lowest Recorded Hemoglobin Date**Coding Instructions:** Indicate the date the lowest recorded hemoglobin sample was collected (not the date results reported).**Target Value:** The value between first medical contact and discharge**Selections:** (none)**Supporting Definitions:** (none)



I. Laboratory Results

Seq. #: 10202 **Name:** Lowest Recorded Hemoglobin Time**Coding Instructions:** Indicate the time the lowest recorded hemoglobin sample was collected (not the time results reported).**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 10203 **Name:** Lowest Recorded Hemoglobin Value**Coding Instructions:** Indicate the lowest recorded hemoglobin (HGB) value in g/dL.**Note(s):**

When there are multiple values that are identical, enter the date and time of the 1st of the multiple identical values measured.

Target Value: The lowest value between first medical contact and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 10204 **Name:** Lowest Recorded Hemoglobin Same as Initial**Coding Instructions:** Indicate if the lowest recorded hemoglobin value is the same as the initial.**Target Value:** N/A**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Supporting Definitions: (none)**Seq. #:** 10250 **Name:** Initial Hemoglobin A1c**Coding Instructions:** Indicate if an initial hemoglobin A1C sample was collected.**Target Value:** Any occurrence between first medical contact and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Supporting Definitions: (none)

**I. Laboratory Results****Seq. #:** 10251 **Name:** Initial Hemoglobin A1c Date**Coding Instructions:** Indicate the date of the hemoglobin A1C sample.**Target Value:** The first value between first medical contact and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 10252 **Name:** Initial Hemoglobin A1c Time**Coding Instructions:** Indicate the time the hemoglobin A1C sample was collected.**Target Value:** The first value on Initial Hemoglobin A1c Date**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 10253 **Name:** Initial Hemoglobin A1c Value**Coding Instructions:** Indicate the hemoglobin A1C percentage value.**Target Value:** The first value between first medical contact and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 10300 **Name:** Initial INR**Coding Instructions:** Indicate if an initial international normalized ratio (INR) was collected.**Target Value:** The first value between first medical contact and discharge**Selections:**

No

Yes

Supporting Definitions: (none)

**I. Laboratory Results****Seq. #: 10301 Name: INR Date**

Coding Instructions: Indicate the date the international normalized ratio (INR) sample was collected.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10302 Name: INR Time

Coding Instructions: Indicate the time the international normalized ratio (INR) sample was collected.

Target Value: The first value on INR Date

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10303 Name: INR Value

Coding Instructions: Indicate the international normalized ratio (INR) value.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 10350 Name: Lipid Panel Performed

Coding Instructions: Indicate if a lipid panel (TC, HDL, LDL, Triglycerides) was performed.

Target Value: Any occurrence between 6 months before first medical contact and discharge

Selections:

<i>Selection Text</i>	<i>Definition</i>
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No	
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Yes	
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Supporting Definitions: (none)

**I. Laboratory Results****Seq. #: 10351 Name:** Lipid Panel Date**Coding Instructions:** Indicate the date the lipids panel sample was collected (not the date results reported).**Note(s):**

Lipids obtained with the first 24 hours of this admission should take precedence.

If greater than 24 hours of admission, then enter the most recent values obtained (within six months) prior to this admission.

Target Value: The last value between 6 months before first medical contact and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 10352 Name:** Lipid Panel Time**Coding Instructions:** Indicate the time the sample was collected (not the time results reported).**Note(s):**

Lipids obtained within the first 24 hours of arrival at this facility should take precedence.

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

Target Value: The last value on Lipid Panel Date**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 10353 Name:** Total Cholesterol**Coding Instructions:** Indicate the total cholesterol value in mg/dL.**Note(s):**

Lipids obtained within the first 24 hours of arrival at this facility should take precedence.

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

If an exact value could not be determined by the lab because it is too high or low (e.g., > 300 mg/dL, < 20 mg/dL, or no value was reported), do not indicate a value for this element and indicate "Yes" for Lipid Panel Value Out of Range.

Target Value: The last value between 6 months before first medical contact and discharge**Selections:** (none)**Supporting Definitions:** (none)



I. Laboratory Results

Seq. #: 10354 Name: HDL Cholesterol**Coding Instructions:** Indicate the high density lipoprotein (HDL) cholesterol value in mg/dL.**Note(s):**

If an exact value could not be determined by the lab because it is too high or low (e.g., > 300 mg/dL, < 20 mg/dL, or no value was reported), do not indicate a value for this element and indicate "Yes" for Lipid Panel Value Out of Range.

Lipids obtained with the first 24 hours of this admission should take precedence.

Target Value: The last value between 6 months before first medical contact and discharge**Selections:** (none)**Supporting Definitions:** (none)

Seq. #: 10355 Name: LDL Cholesterol**Coding Instructions:** Indicate the low density lipoprotein (LDL) cholesterol value in mg/dL.**Note(s):**

Lipids obtained within the first 24 hours of arrival at this facility should take precedence.

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

If an exact value could not be determined by the lab because it is too high or low (e.g., > 300 mg/dL, < 20 mg/dL, or no value was reported), do not indicate a value for this element and indicate "Yes" for Lipid Panel Value Out of Range.

Target Value: The last value between 6 months before first medical contact and discharge**Selections:** (none)**Supporting Definitions:** (none)

Seq. #: 10356 Name: Triglycerides**Coding Instructions:** Indicate the triglycerides value in mg/dL.**Note(s):**

Lipids obtained within the first 24 hours of arrival at this facility should take precedence.

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

If an exact value could not be determined by the lab because it is too high or low (e.g., > 300 mg/dL, < 20 mg/dL, or no value was reported), do not indicate a value for this element and indicate "Yes" for Lipid Panel Value Out of Range.

If the value is presented as a decimal, round up to the nearest whole number.

Target Value: The last value between 6 months before first medical contact and discharge**Selections:** (none)**Supporting Definitions:** (none)

**I. Laboratory Results****Seq. #: 10360 Name: Lipid Panel Values Out of Range**

Coding Instructions: Indicate if one or more cholesterol values from the most recent lipid panel cannot be determined. This occurs when a value is so high or low that the laboratory cannot return a valid measurement.

Note(s):

Lipid panel element(s) (e.g. Total Cholesterol, HDL, LDL, and/or Triglycerides) for which an exact value could not be determined should be left blank (e.g., if the reported value is > 300, leave blank, do not code 300) .

Added to the Limited Data Set (ARGL) starting with patients discharged January 1, 2015.

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

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 10400 Name: BNP Collected

Coding Instructions: Indicate if a BNP was obtained during this admission.

Target Value: Any occurrence between first medical contact and discharge

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 10401 Name: BNP

Coding Instructions: Indicate the initial BNP value in pg/mL.

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

Selections: (none)

Supporting Definitions: (none)



I. Laboratory Results

Seq. #: 10405 **Name:** NT-proBNP Collected

Coding Instructions: Indicate if an NT-pro BNP was obtained during this admission.

Target Value: Any occurrence between first medical contact and discharge

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 10406 **Name:** Initial NT-proBNP Value

Coding Instructions: Indicate the initial NT-proBNP value in pg/mL.

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

Selections: (none)

Supporting Definitions: (none)

**J. Discharge****Seq. #: 11000 Name:** Discharge Date

Coding Instructions: Indicate the month, day, and year the patient was discharged from acute care, left against medical advice, or expired during this admission.

Note(s):

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11003 Name: Discharge Provider Last Name

Coding Instructions: Indicate the provider's last name.

Note(s):

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

Target Value: The value on current admission

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11004 Name: Discharge Provider First Name

Coding Instructions: Indicate the providers first name.

Note(s):

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

Target Value: The value on current admission

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11005 Name: Discharge Provider Middle Name

Coding Instructions: Indicate the providers middle name.

Note(s):

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

Target Value: The value on current admission

Selections: (none)

Supporting Definitions: (none)

**J. Discharge****Seq. #: 11006 Name:** Discharge Provider NPI

Coding Instructions: Indicate the discharge provider's National Provider Identifier. NPIs, assigned by the Center for Medicare and Medicaid Services (CMS), are used to uniquely identify physicians for Medicare billing purposes.

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11010 Name: Comfort Measures Only

Coding Instructions: 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: Any occurrence between arrival at this facility and discharge

Selections:

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Supporting Definitions: (none)

Seq. #: 11020 Name: Clinical Trial

Coding Instructions: Indicate if the patient signed an informed consent to participate in a clinical trial during his/her hospitalization, even if the investigational medication, device, or procedure was never initiated.

Note(s):

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

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

Selections:

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Supporting Definitions: (none)

**J. Discharge****Seq. #: 11100 Name:** Discharge Status

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

Target Value: The value on discharge

Selections: *Selection Text* *Definition*

Alive

Deceased

Supporting Definitions: (none)

Seq. #: 11101 Name: Smoking Counseling

Coding Instructions: Indicate if there was documentation in the medical record that smoking cessation advice or counseling was given during this admission.

Note(s):

This element is referenced in The Joint Commission AMI Core Measures AMI-4.

Code this element if Current/Recent Smoker (w/in 1 year) (5020) is Yes.

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

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 11102 Name: Dietary Modification Counseling

Coding Instructions: This element has been retired effective ACTION v2.4.

Target Value: N/A

Selections: *Selection Text* *Definition*

No

Yes

N/A

Supporting Definitions: (none)



J. Discharge

Seq. #: 11103 **Name:** Exercise Counseling

Coding Instructions: This element has been retired effective ACTION v2.4.

Target Value: N/A

Selections: *Selection Text* *Definition*

No

Yes

Ineligible

Supporting Definitions: (none)



J. Discharge

Seq. #: 11104 Name: Cardiac Rehabilitation Referral

Coding Instructions: 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.

Note(s):

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: Any occurrence between arrival at this facility and discharge

Selections: *Selection Text* *Definition*

No Referral

Yes

Ineligible Retired effective v2.4.

No-Medical Reason

No-Patient
Reason/Preference

No-Health Care
System Reason

Supporting Definitions: Referral:

A referral is defined as an official communication between the healthcare provider and the patient to recommend and carry out a referral order to an early outpatient 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 written or electronic communication between the healthcare provider or healthcare system and the cardiac rehabilitation program that includes the patient's enrollment 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 (e.g., the patient's cardiovascular history, testing, and treatments). All communications must maintain appropriate confidentiality as outlined by the 1996 Health Insurance Portability and Accountability Act (HIPAA).

Exclusion criteria:

- Patient factors (e.g., patient to be discharged to a nursing care facility for long-term care).
- Medical factors (e.g., patient deemed by provider to have a medically unstable, life-threatening condition).
- Health care system factors (e.g., no cardiac rehabilitation program available within 60 minutes of travel time from the patient's home).

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.

**J. Discharge****Seq. #: 11105 Name:** Discharge Location**Coding Instructions:** Indicate the location to which the patient was discharged.**Target Value:** The value on discharge

Selections:	<i>Selection Text</i>	<i>Definition</i>
	Home	
	Extended Care/TCU/Rehab	
	Other acute care hospital	
	Skilled nursing facility	
	Hospice	Retired effective v2.4.
	Other	
	Left against medical advice	The patient was discharged or eloped against medical advice

Supporting Definitions: (none)**Seq. #: 11106 Name:** Transfer Time**Coding Instructions:** Indicate the time the patient was transferred to another acute-care hospital for further management.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 11107 Name:** Transfer for PCI**Coding Instructions:** Indicate if the patient was transferred to another facility for percutaneous coronary intervention (PCI).**Target Value:** The value on time of transfer

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	

Supporting Definitions: (none)

**J. Discharge****Seq. #: 11108 Name:** Transfer for CABG

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

Target Value: The value on time of transfer

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 11110 Name: Hospice Care

Coding Instructions: Indicate if the patient was receiving hospice services.

Target Value: The value on discharge

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 11150 Name: Cause of Death

Coding Instructions: Indicate the cause of death.

Target Value: The value on time of death

Selections: *Selection Text* *Definition*

Cardiac

Non-Cardiac

Supporting Definitions: (none)

Seq. #: 11151 Name: Time of Death

Coding Instructions: Indicate the time of death

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)



J. Discharge

Seq. #: 11200 **Name:** Auxiliary 3

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 11201 **Name:** Auxiliary 4

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)



K. Optional

Seq. #: 12000 Name: Point of Origin

Coding Instructions: Indicate the point of inpatient origin for this admission to your facility.**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-9

Target Value: N/A

Selections:	<i>Selection Text</i>	<i>Definition</i>
	Non-Health Care Facility	The patient was admitted to this facility upon order of a physician. Usage note: Includes patients coming from home, a physician's office, or workplace.
	Clinic	The patient was admitted to this facility as a transfer from a freestanding or non-freestanding clinic.
	Transfer From a Hospital (Different Facility)	The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient or outpatient. Usage note: Excludes transfers from hospital inpatient in the same facility (see Code D).
	Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)	The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.
	Transfer from Another Health Care Facility	The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list.
	Emergency Room	The patient was admitted to this facility after receiving services in this facility's emergency room.
	Court/Law Enforcement	The patient was admitted to this facility upon the direction of court of law, or upon the request of a law enforcement agency. Usage note: includes transfers from incarceration facilities.
	Information Not Available	The means by which the patient was admitted to this hospital is unknown.
	D: Transfer from One Distinct Unit of the Hospital to Another Distinct Unit of the Same Hospital	The patient was admitted to this facility as a transfer from hospital inpatient within this hospital resulting in a separate claim to the payer. Usage Note: For purposes of this code, "Distinct Unit" is defined as a unique unit or level of care at the hospital requiring the issuance of a separate claim to the payer. Examples could include observation services, psychiatric units, rehabilitation units, a unit in a critical access hospital, or a swing bed located in an acute hospital.
	E: Transfer from Ambulatory Surgery Center	The patient was admitted to this facility as a transfer from an ambulatory surgery center.
	F: Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program	The patient was admitted to this facility as a transfer from hospice.

Supporting Definitions: (none)



K. Optional

Seq. #: 12010 **Name:** Transfer from Another ED**Coding Instructions:** Was the patient received as a transfer from an emergency department of another hospital?**Note(s):**

Use the following definitions for 'No' and 'Yes':

N (No): Patient not received as a transfer from another hospital emergency department or unable to determine from medical record documentation.

Y (Yes): Patient received as a transfer from another hospital emergency department.

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: N/A**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: (none)**Seq. #:** 12020 **Name:** CMS Comfort Measures Timing**Coding Instructions:** When is the earliest physician/APN/PA documentation of comfort measures only?**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5 and AMI-9.

Target Value: N/A**Selections:**

<i>Selection Text</i>	<i>Definition</i>
Day 0 or 1	The earliest day the physician/APN/PA documented comfort measures only was the day of arrival (Day 0) or day after arrival (Day 1).
Day 2 or after	The earliest day the physician/APN/PA documented comfort measures only was two or more days after arrival day (Day 2+).
Timing unclear	There is physician/APN/PA documentation of comfort measures only during this hospital stay, but whether the earliest documentation of comfort measures only was on day 0 or 1 OR after day 1 is unclear.
Not Documented/UTD	There is no physician/APN/PA documentation of comfort measures only, or unable to determine from medical record documentation if there is physician/APN/PA documentation of comfort measures only during this hospital stay.

Supporting Definitions: (none)



K. Optional

Seq. #: 12090 Name: ICD-9-CM Principal Diagnosis Code

Coding Instructions: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code associated with the diagnosis established after study to be chiefly responsible for occasioning the admission of the patient for this hospitalization.

Note(s):

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12100 Name: ICD-9-CM Principal Procedure Code

Coding Instructions: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code that identifies the principal procedure performed during this hospitalization. The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

Note(s):

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12101 Name: ICD-9-CM Principal Procedure Date

Coding Instructions: The month, day, and year when the principal procedure was performed.

Note(s):

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12110 Name: ICD-9-CM Other Diagnosis Code 1

Coding Instructions: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes associated with the diagnosis for this hospitalization.

Note(s):

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)



K. Optional

Seq. #: 12111 Name: ICD-9-CM Other Diagnosis Code 2

Coding Instructions: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes associated with the diagnosis for this hospitalization.

Note(s):

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12112 Name: ICD-9-CM Other Diagnosis Code 3

Coding Instructions: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes associated with the diagnosis for this hospitalization.

Note(s):

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12120 Name: ICD-9-CM Other Procedure Code 1

Coding Instructions: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes identifying all significant procedures other than the principal procedure.

Note(s):

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 12121 Name: ICD-9-CM Other Procedure Code 2

Coding Instructions: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes identifying all significant procedures other than the principal procedure.

Note(s):

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

**K. Optional****Seq. #: 12122 Name:** ICD-9-CM Other Procedure Date 1**Coding Instructions:** The month, day, and year when the associated procedure(s) was (were) performed.**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 12123 Name:** ICD-9-CM Other Procedure Date 2**Coding Instructions:** The month, day, and year when the associated procedure(s) was (were) performed**Note(s):**

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 12130 Name:** Physician 1**Coding Instructions:** The first physician identifier.**Note(s):**

This element is referenced as optional in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 12131 Name:** Physician 2**Coding Instructions:** The second physician identifier.**Note(s):**

This element is referenced as optional in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: N/A**Selections:** (none)**Supporting Definitions:** (none)



K. Optional

Seq. #: 12140 **Name:** CMS Discharge Status

Coding Instructions: The place or setting to which the patient was discharged.

Note(s):

This element is referenced in The Joint Commission AMI Core Measures, AMI-1 through AMI-5. AMI-7, 7a, 8, 8a and AMI-9.

Target Value: N/A



Selections:	<i>Selection Text</i>	<i>Definition</i>
	D/C - Home or Self Care	
	D/C - Short Term General Hospital	
	D/C - Skilled Nursing Facility (SNF)	Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Covered Skilled Care
	D/C - Intermediate Care Facility	
	D/C - Institution Not Defined Elsewhere in This Code List	
	D/C - Home Under Care of Organized Home Health Service Organization	D/C - Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care
	Left Against Medical Advice or Discontinued Care	
	Expired	
	Expired in a Medical Facility (e.g. Hospital, SNF, ICF, or Freestanding Hospice)	
	D/C - Federal Health Care Facility	
	Hospice - Home	
	Hospice - Medical Facility	
	D/C - Hospital-based Medicare-approved Swing Bed	
	D/C - Inpatient Rehabilitation Facility (IRF)	D/C - Inpatient Rehabilitation Facility (IRF) Including Rehabilitation-distinct Part Units of a Hospital
	D/C - Medicare-certified Long Term Care Hospital (LTCH)	
	D/C - Nursing Facility Certified Under Medicaid but Not Certified Under Medicare	
	D/C - Psychiatric Hospital or a Psychiatric-distinct Part Unit of a Hospital	
	D/C - Critical Access Hospital (CAH)	

Supporting Definitions: (none)



Z. Administration

Seq. #: 1000 **Name:** Participant ID**Coding Instructions:** Indicate the Participant ID of the submitting facility.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** **Participant ID:**

Participant ID is a unique number assigned to each database participant by the 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 gets back one report on their data.

Each Participant's data if submitted to harvest must be in one data submission file. 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 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

Seq. #: 1010 **Name:** Participant Name**Coding Instructions:** Indicate the full name of the facility.**Note(s):**

Values should be full, official hospital names with no abbreviations or variations in spelling.

Target Value: N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 1015 **Name:** Participant Medicare Provider Number**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 1016 **Name:** Participant NPI**Coding Instructions:** This element has been retired effective ACTION v2.4.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)



Z. Administration

Seq. #: 1020 Name: Timeframe of Data Submission**Coding Instructions:** Indicate the timeframe of data included in the data submission. Format: YYYYQQ. e.g., 2005Q4**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)

Seq. #: 1040 Name: Transmission Number**Coding Instructions:** A unique number created and automatically inserted by the software. It identifies the number of times the software has created data submission files. The transmission number should be incremented by one every time the data submission files are exported. The transmission number should never be repeated.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)

Seq. #: 1050 Name: Vendor Identifier**Coding Instructions:** Vendor Identification (agreed upon by mutual selection between the vendor and the NCDR) to identify software vendor. Vendors must use consistent name identification across sites. Changes to Vendor Name Identification must be approved by the NCDR.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)

Seq. #: 1060 Name: Vendor Software Version**Coding Instructions:** Vendor's software product name and version number identifying the software which created this record (assigned by vendor). Vendor controls the value in this field. Version passing certification/harvest testing will be noted at the NCDR.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)



Z. Administration

Seq. #: 1070 Name: Registry Identifier

Coding Instructions: The NCDR Registry Identifier describes the data registry to which these records apply. It is implemented in the software at the time the data is collected and the records are created. This is entered into the schema automatically by software.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1080 Name: Registry Version

Coding Instructions: Registry Version describes the version number of the Data Specifications/Dictionary, to which each record conforms. It identifies which fields should have data, and what are the valid data for each field. It is the version implemented in the software at the time the data is collected and the records are created. This is entered into the schema automatically by software.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1200 Name: Auxiliary 0

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

A. Demographics

Seq. #: 2000 Name: Last Name

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

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2010 Name: First Name

Coding Instructions: Indicate the patient's first name.

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2020 Name: Middle Name

Coding Instructions: Indicate the patient's middle name.

Note(s):

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

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

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

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2030 Name: SSN

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

Note(s):

If the patient does not have a US Social Security Number (SSN), leave blank and check 'SSN NA'.

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2031 Name: SSN N/A

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

Target Value: The value on arrival at this facility

Selections:	<i>Selection Text</i>	<i>Definition</i>
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	No	
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	Yes	
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Supporting Definitions: (none)

A. Demographics

Seq. #: 2040 Name: Patient ID

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

Note(s):

Once assigned to a patient at the participating facility, this number will never be changed or reassigned to a different patient. If the patient returns to the same participating facility or for followup, they will receive this same unique patient identifier.

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2045 Name: Other ID

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2050 Name: Birth Date

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

Target Value: The value on arrival at this facility

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2060 Name: Sex

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

Target Value: The value on arrival at this facility

Selections:	Selection Text	Definition
	Male	
	Female	

Supporting Definitions: (none)

Seq. #: 2070 Name: Race - White

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

Note(s):

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

Target Value: The value on arrival at this facility

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: **White (Race):**

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

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

A. Demographics

Seq. #: 2071 **Name:** Race - Black or African American**Coding Instructions:** Indicate if the patient is Black or African American as determined by the patient/family.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:**

No

Yes

Supporting Definitions: Black/African American (Race):

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

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

Seq. #: 2072 **Name:** Race - Asian**Coding Instructions:** Indicate if the patient is Asian as determined by the patient/family.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:**

No

Yes

Supporting Definitions: Asian (Race):

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

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

Seq. #: 2073 **Name:** Race - American Indian or Alaskan Native**Coding Instructions:** Indicate if the patient is American Indian or Alaskan Native as determined by the patient/family.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:**

No

Yes

Supporting Definitions: American Indian or Alaskan Native (Race):

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

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

A. Demographics

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

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

Note(s):

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

Target Value: The value on arrival at this facility

Selections:	Selection Text	Definition
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	No	
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	Yes	
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Supporting Definitions: Native Hawaiian or Pacific Islander (Race):

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

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

Seq. #: 2076 Name: Hispanic or Latino Ethnicity

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

Target Value: The value on arrival at this facility

Selections:	Selection Text	Definition
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	No	
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	Yes	
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Supporting Definitions: Hispanic or Latino Ethnicity:

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

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

Seq. #: 2500 Name: Auxiliary 1

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2501 Name: Auxiliary 2

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

B. Episode of Care

Seq. #: 3000 Name: Arrival Date**Coding Instructions:** Indicate the date the patient arrived at your facility.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 3001 Name:** Arrival Time**Coding Instructions:** Indicate the time patient arrived at your facility.**Note(s):**

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

If the patient came to your facility for an elective or outpatient procedure and the time was not documented, code the scheduled time of arrival.

Target Value: N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 3005 Name:** Patient Zip Code**Coding Instructions:** Indicate the patient's United States Postal Service zip code of their primary residence.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 3006 Name:** Zip Code N/A**Coding Instructions:** Indicate if the patient does not have a United States Postal Service zip code.**Note(s):**

This includes patients who do not have a U.S residence or are homeless.

Target Value: The value on arrival at this facility**Selections:**

No

Yes

Supporting Definitions: (none)**Seq. #: 3010 Name:** Admit Source**Coding Instructions:** Indicate the source of admission for the patient to your facility.**Target Value:** The value on arrival at this facility**Selections:**

Emergency department

The patient came to the facility for this episode of care via the emergency department (excludes transfers from other facilities).

Transfer in from another acute care facility

The patient was transferred from another acute care facility (even if he/she was transferred to the emergency department) for this episode of care.

Other

The patient came to the facility for this episode of care by any other means. This includes elective admissions, and transfers from non-acute care facilities.

Supporting Definitions: (none)

B. Episode of Care

Seq. #: 3020 Name: Insurance Payors - Private Health Insurance**Coding Instructions:** Indicate if the patient's insurance payor(s) included private health insurance.**Note(s):**

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

Target Value: The value on arrival at this facility**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Supporting Definitions: Private Health Insurance:

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

Source: U.S.Census Bureau

Seq. #: 3021 Name: Insurance Payors - Medicare**Coding Instructions:** Indicate if the patient's insurance payor(s) included Medicare.**Target Value:** The value on arrival at this facility**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Supporting Definitions: Medicare:

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

Source: U.S.Census Bureau

Seq. #: 3022 Name: Insurance Payors - Medicaid**Coding Instructions:** Indicate if the patient's insurance payor(s) included Medicaid.**Target Value:** The value on arrival at this facility**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Supporting Definitions: Medicaid:

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

Source: U.S.Census Bureau

Seq. #: 3023 Name: Insurance Payors - Military Health Care**Coding Instructions:** Indicate if the patient's insurance payor(s) included Military Health Care.**Target Value:** The value on arrival at this facility**Selections:**

<i>Selection Text</i>	<i>Definition</i>
-----------------------	-------------------

No

Yes

Supporting Definitions: 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).

Source: U.S.Census Bureau

B. Episode of Care

Seq. #: 3024 Name: Insurance Payors - State-Specific Plan

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

Target Value: The value on arrival at this facility

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: **State Specific Plan:**

State-specific plan - Some states have their own health insurance programs for low-income uninsured individuals. These health plans may be known by different names in different states. (Non-Medicaid)

Source: U.S.Census Bureau

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

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

Target Value: The value on arrival at this facility

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: **Indian Health Service:**

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

Source: U.S.Census Bureau

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

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

Target Value: The value on arrival at this facility

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: **Non-US Insurance:**

Non-U.S. Insurance refers to individuals with a payor that does not originate in the United States.

Source: U.S.Census Bureau

Seq. #: 3027 Name: Insurance Payors - None

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

Target Value: The value on arrival at this facility

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: **None:**

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

Source: NCDR

B. Episode of Care

Seq. #: 3030 Name: Health Insurance Claim Number**Coding Instructions:** Indicate the patient's Health Insurance Claim (HIC) number.**Note(s):**

The HIC is used for medicare and medicaid billing.

Target Value: The value on arrival at this facility**Selections:** (none)**Supporting Definitions:** **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: Center for Medicare and Medicaid Services

Seq. #: 3040 Name: Auxiliary 7**Coding Instructions:** Reserved for future NCDR use**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)

Seq. #: 3045 Name: Auxiliary 8**Coding Instructions:** Reserved for future NCDR use**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)

C. History And Risk Factors

Seq. #: 4000 Name: Current/Recent Smoker (w/in 1 year)**Coding Instructions:** Indicate if the patient has smoked cigarettes anytime during the year prior to arrival at your facility.**Target Value:** Any occurrence between 1 year prior to arrival at this facility and arrival at this facility

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: (none)**Seq. #: 4005 Name:** Hypertension**Coding Instructions:** Indicate if the patient has a current diagnosis of hypertension.**Target Value:** Any occurrence between birth and arrival at this facility

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: **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

Seq. #: 4010 Name: Dyslipidemia**Coding Instructions:** 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

Selections:	Selection Text	Definition
	No	
	Yes	

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

C. History And Risk Factors

Seq. #: 4015 **Name:** Family History of Premature CAD**Coding Instructions:** 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 unavailable, code "No".

Target Value: Any occurrence between birth and arrival at this facility**Selections:** *Selection Text* *Definition*

No

Yes

Supporting Definitions: Family Hx Premature CAD Direct Relatives:

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
- Source: NCDR, The Society of Thoracic Surgeons

C. History And Risk Factors

Seq. #: 4020 Name: Prior MI

Coding Instructions: 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. Admit Source (3010) must be "Transfer in from another acute care facility."

Target Value: Any occurrence between birth and arrival at this facility**Selections:***Selection Text**Definition*

No

Yes

Supporting Definitions: MI:

A myocardial infarction is evidenced by any of the following:

1. A rise and fall of cardiac biomarkers (preferably troponin) with at least one of the values in the abnormal range for that laboratory [typically above the 99th percentile of the upper reference limit (URL) for normal subjects] together with at least one of the following manifestations of myocardial ischemia:

a. Ischemic symptoms.

b. ECG changes indicative of new ischemia (new ST-T changes, new left bundle branch block, or loss of R wave voltage).

c. Development of pathological Q waves in 2 or more contiguous leads in the ECG (or equivalent findings for true posterior MI).

d. Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

e. Documentation in the medical record of the diagnosis of acute myocardial infarction based on the cardiac biomarker pattern in the absence of any items enumerated in a-d due to conditions that may mask their appearance (e.g., peri-operative infarct when the patient cannot report ischemic symptoms; baseline left bundle branch block or ventricular pacing).

2. ECG changes associated with prior myocardial infarction can include the following (with or without prior symptoms):

a. Any Q-wave in leads V2-V3 ≥ 0.02 seconds or QS complex in leads V2 and V3.

b. Q-wave ≥ 0.03 seconds and ≥ 0.1 mV deep or QS complex in leads I, II, aVL, aVF, or V4-V6 in any two leads of a contiguous lead grouping (I, aVL, V6; V4-V6; II, III, and aVF).

c. R-wave ≥ 0.04 seconds in V1-V2 and R/S ≥ 1 with a concordant positive T-wave in the absence of a conduction defect.

3. Imaging evidence of a region with new loss of viable myocardium at rest in the absence of a non-ischemic cause. This can be manifest as:

a. Echocardiographic, CT, MR, ventriculographic or nuclear imaging evidence of left ventricular thinning or scarring and failure to contract appropriately (i.e., hypokinesis, akinesis, or dyskinesis).

b. Fixed (non-reversible) perfusion defects on nuclear radioisotope imaging (e.g., MIBI, thallium).

4. Medical records documentation of prior myocardial infarction.

Source: Joint ESC-ACC-AHA-WHF 2007 Task Force consensus document "Universal Definition of Myocardial Infarction".

C. History And Risk Factors

Seq. #: 4025 Name: Prior Heart Failure**Coding Instructions:** Indicate if there is a previous history of heart failure.**Note(s):**

A previous hospital admission with principal diagnosis of heart failure is considered evidence of heart failure history.

Target Value: Any occurrence between birth and arrival at this facility**Selections:***Selection Text**Definition*

No

Yes

Supporting Definitions: Heart Failure:

Heart failure is defined as physician documentation or report of any of the following clinical symptoms of heart failure described as unusual dyspnea on light exertion, recurrent dyspnea occurring in the supine position, fluid retention; or the description of rales, jugular venous distension, pulmonary edema on physical exam, or pulmonary edema on chest x-ray. A low ejection fraction alone, without clinical evidence of heart failure does not qualify as heart failure.

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

Seq. #: 4030 Name: Prior Valve Surgery/Procedure**Coding Instructions:** Indicate if the patient had a previous surgical replacement and/or repair of a cardiac valve, by any approach prior to arrival.**Note(s):**

This also includes percutaneous valve procedures and valvuloplasty.

Target Value: Any occurrence between birth and arrival at this facility**Selections:***Selection Text**Definition*

No

Yes

Supporting Definitions: (none)**Seq. #: 4035 Name:** Prior PCI**Coding Instructions:** Indicate if the patient had a previous percutaneous coronary intervention.**Note(s):**

Timeframe does NOT include PCIs performed after arrival.

Target Value: Any occurrence between birth and arrival at this facility**Selections:***Selection Text**Definition*

No

Yes

Supporting Definitions: PCI:

Percutaneous coronary intervention (PCI) is the placement of an angioplasty guide wire, balloon, or other device (e.g. stent, atherectomy, brachytherapy, or thrombectomy catheter) into a native coronary artery or coronary artery bypass graft for the purpose of mechanical coronary revascularization.

Source: NCDR

C. History And Risk Factors

Seq. #: 4040 Name: Most Recent PCI Date**Coding Instructions:** Indicate the date of the most recent PCI.**Note(s):**

If month or day are unknown enter 01.

Target Value: The last value between birth and arrival at this facility**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 4045 Name:** Prior CABG**Coding Instructions:** Indicate if the patient had a previous coronary artery bypass graft (CABG) surgery.**Note(s):**

Timeframe does NOT include CABG performed after arrival.

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

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: (none)**Seq. #: 4050 Name:** Most Recent CABG Date**Coding Instructions:** Indicate the date of the most recent coronary artery bypass graft (CABG) surgery.**Note(s):**

If month or day are unknown enter 01.

Target Value: The last value between birth and arrival at this facility**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 4055 Name:** Height**Coding Instructions:** Indicate the patient's height in centimeters.**Target Value:** The first value between arrival at this facility and discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 4060 Name:** Weight**Coding Instructions:** Indicate the patient's weight in kilograms.**Target Value:** The last value between arrival at this facility and first procedure**Selections:** (none)**Supporting Definitions:** (none)

C. History And Risk Factors

Seq. #: 4065 **Name:** Currently on Dialysis**Coding Instructions:** 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 on 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: The value on arrival at this facility

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	

Supporting Definitions: (none)**Seq. #:** 4070 **Name:** Cerebrovascular Disease**Coding Instructions:** Indicate if the patient has a history of cerebrovascular disease.**Target Value:** Any occurrence between birth and arrival at this facility

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	

Supporting Definitions: Cerebrovascular Disease:

Cerebrovascular Disease documented by any one of the following:

1. Cerebrovascular Accident (CVA): Patient has a history of stroke, i.e., loss of neurological function with residual symptoms at least 24 hrs after onset, presumed to be from vascular etiology.
2. Transient Ischemic Attack (TIA): Patient has a history of loss of neurological function that was abrupt in onset but with complete return of function within 24 hrs, presumed to be due to vascular etiology
3. Non-invasive/invasive carotid test with > 79% occlusion.
4. Previous carotid artery surgery/intervention for carotid artery stenosis.

This does not include neurological disease processes such as metabolic and/or anoxic ischemic encephalopathy.

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

C. History And Risk Factors

Seq. #: 4075 Name: Peripheral Arterial Disease

Coding Instructions: Indicate if the patient has a history of peripheral arterial disease (PAD) (includes upper and lower extremity, renal, mesenteric, and abdominal aortic systems).

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

Selections:

Selection Text	Definition
No	
Yes	

Supporting Definitions: PAD:

Peripheral arterial disease can include:

1. Claudication, either with exertion or at rest.
2. Amputation for arterial vascular insufficiency.
3. Vascular reconstruction, bypass surgery, or percutaneous intervention to the extremities (excluding dialysis fistulas and vein stripping).
4. Documented aortic aneurysm with or without repair.
5. Positive non-invasive test (e.g., ankle brachial index ≤ 0.9); ultrasound, magnetic resonance, computed tomography, or angiographic imaging of $> 50\%$ diameter stenosis in any peripheral artery (e.g., renal, subclavian, femoral, iliac).

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For purposes of the Registry, peripheral arterial disease excludes disease in the carotid and cerebrovascular arteries.

Source: ACC Clinical Data Standards, The Society of Thoracic Surgeons

Seq. #: 4080 Name: Chronic Lung Disease

Coding Instructions: 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) qualifies 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

Selections:

Selection Text	Definition
No	
Yes	

Supporting Definitions: Chronic Lung Disease:

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

Source: NCDR

Seq. #: 4085 Name: Diabetes Mellitus

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

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

Selections:

Selection Text	Definition
No	
Yes	

Supporting Definitions: Diabetes Mellitus:

Diabetes mellitus is diagnosed by a physician or can be defined as a fasting blood sugar greater than 7 mmol/l or 126 mg/dL. It does not include gestational diabetes.

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

C. History And Risk Factors

Seq. #: 4090 Name: Diabetes Therapy

Coding Instructions: Indicate the most aggressive therapy the patient presented with.**Note(s):**

Patients placed on a pre-procedure diabetic pathway of insulin drip after arrival but were not on insulin therapy (treated by diet or oral method) are not coded as insulin treatment.

If a patient had a pancreatic transplant, code "other", since the insulin from the new pancreas is not exogenous insulin.

Target Value: The value on arrival at this facility

Selections:	<i>Selection Text</i>	<i>Definition</i>
	None	No treatment for diabetes
	Diet	Diet treatment only
	Oral	Oral agent treatment (includes oral agent with/without diet treatment)
	Insulin	Insulin treatment (includes any combination with insulin)
	Other	Other adjunctive treatment, non-oral/insulin/diet

Supporting Definitions: (none)

D. Cath Lab Visit

Seq. #: 5000 Name: CAD Presentation

Coding Instructions: Indicate the patient's coronary artery disease (CAD) presentation. Choose the worst status.**Note(s):**

If the patient presents with atypical symptoms of myocardial ischemia (i.e. only shortness of breath, upper abdominal pain, left arm pain, etc.) that is known and documented to be myocardial ischemia, and is considered to be an anginal equivalent, code the selection that fits their presentation. If these symptoms are not thought to be or have not been proven to be the anginal equivalent, code "Symptom unlikely to be ischemic."

If this is a subsequent episode of care (within 7 days), do not code the CAD Presentation from the previous episode of care.

For STEMI and NSTEMI, code the highest value within 1 week of the current procedure.

If this is a repeat visit to the cath lab during the same episode of care, code the CAD presentation based on the patient's clinical status prior to the subsequent procedure.

Target Value: The highest value between 7 days prior to arrival and current procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No symptom, no angina	No symptoms, No angina.
	Symptom unlikely to be ischemic	Pain, pressure or discomfort in the chest, neck or arms NOT clearly exertional or NOT otherwise consistent with pain or discomfort of myocardial ischemic origin. This includes patients with non-cardiac pain (e.g. pulmonary embolism, musculoskeletal, or esophageal discomfort), or cardiac pain not caused by myocardial ischemia (e.g., acute pericarditis).
	Stable angina	Angina without a change in frequency or pattern for the 6 weeks prior to this cath lab visit. Angina is controlled by rest and/or oral or transcutaneous medications.
	Unstable angina	There are three principal presentations of unstable angina: 1. Rest angina (occurring at rest and prolonged, usually >20 minutes); 2. New-onset angina (within the past 2 months, of at least Canadian Cardiovascular Society Class III severity); or 3. Increasing angina (previously diagnosed angina that has become distinctly more frequent, longer in duration, or increased by 1 or more Canadian Cardiovascular Society class to at least CCS III severity).
	Non-STEMI	The patient was hospitalized for a non-ST elevation myocardial infarction (STEMI) as documented in the medical record. Non-STEMIs are characterized by the presence of both criteria: a. Cardiac biomarkers (creatinine kinase-myocardial band, Troponin T or I) exceed the upper limit of normal according to the individual hospital's laboratory parameters with a clinical presentation which is consistent or suggestive of ischemia. ECG changes and/or ischemic symptoms may or may not be present. b. Absence of ECG changes diagnostic of a STEMI (see STEMI).

D. Cath Lab Visit

ST-Elevation MI (STEMI) or equivalent

The patient presented with a ST elevation myocardial infarction (STEMI) or its equivalent as documented in the medical record. STEMI is characterized by the presence of both criteria:

a. ECG evidence of STEMI: New or presumed new ST-segment elevation or new left bundle branch block not documented to be resolved within 20 minutes. ST-segment elevation is defined by new or presumed new sustained ST-segment elevation at the J-point in two contiguous electrocardiogram (ECG) leads with the cut-off points: ≥ 0.2 mV in men or ≥ 0.15 mV in women in leads V2-V3 and/or ≥ 0.1 mV in other leads and lasting greater than or equal to 20 minutes. If no exact ST-elevation measurement is recorded in the medical chart, physician's written documentation of ST-elevation or Q-waves is acceptable. If only one ECG is performed, then the assumption that the ST elevation persisted at least the required 20 minutes is acceptable. Left bundle branch block (LBBB) refers to new or presumed new LBBB on the initial ECG.

b. Cardiac biomarkers (creatinine kinase-myocardial band, Troponin T or I) exceed the upper limit of normal according to the individual hospital's laboratory parameters a clinical presentation which is consistent or suggestive of ischemia.

Note: For purposes of the Registry, ST elevation in the posterior chest leads (V7 through V9), or ST depression that is maximal in V1-3, without ST-segment elevation in other leads, demonstrating posterobasal myocardial infarction, is considered a STEMI equivalent and qualifies the patient for reperfusion therapy.

Supporting Definitions: (none)

Seq. #: 5005 Name: Symptom Onset Date

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

Note(s):

If the patient had intermittent ischemic symptoms, record the date and time of the most recent ischemic symptoms prior to hospital presentation. Symptoms may include jaw pain, arm pain, shortness of breath, nausea, vomiting, fatigue/malaise, or other equivalent discomfort suggestive of a myocardial infarction. In the event of stuttering symptoms, Acute Coronary Syndrome (ACS) symptom onset is the time at which symptoms became constant in quality or intensity.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5006 Name: Symptom Onset Time

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

Note(s):

If an estimated symptom onset time is recorded, code "Symptom Onset Time Estimated" as "Yes."

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

If the symptom onset 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 first value on Symptom Onset Date

Selections: (none)

Supporting Definitions: (none)

D. Cath Lab Visit

Seq. #: 5007 Name: Symptom Onset Time Estimated**Coding Instructions:** Indicate if the symptom onset time was estimated.**Target Value:** N/A

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	

Supporting Definitions: (none)**Seq. #: 5008 Name:** Symptom Onset Time Not Available**Coding Instructions:** Indicate if the symptom onset time was not available.**Target Value:** N/A

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	

Supporting Definitions: (none)**Seq. #: 5010 Name:** Thrombolytics**Coding Instructions:** 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

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	

Supporting Definitions: (none)**Seq. #: 5015 Name:** Thrombolytic Therapy Date**Coding Instructions:** Indicate the date 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.

Target Value: The first value between 1 week prior to arrival at this facility and current procedure**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 5016 Name:** Thrombolytic Therapy Time**Coding Instructions:** Indicate the 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 (0000 hours).

Target Value: The first value on Thrombolytic Therapy Date**Selections:** (none)**Supporting Definitions:** (none)

D. Cath Lab Visit

Seq. #: 5020 Name: Anginal Classification w/in 2 Weeks

Coding Instructions: Indicate the patients anginal classification or symptom status within the past 2 weeks.

Note(s):

If this is a subsequent episode of care (within 2 weeks), do not code the Anginal Classification w/in 2 Weeks(5020) from the previous episode of care.

The anginal classification or symptom status is classified as the highest grade of angina or chest pain by the Canadian Cardiovascular Society Classification System (CCS).

Target Value: The highest value between 2 weeks prior to current procedure and current procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No symptoms, no angina	The patient has no symptoms, no angina.
	CCS I	Ordinary physical activity does not cause angina; for example walking or climbing stairs, angina occurs with strenuous or rapid or prolonged exertion at work or recreation.
	CCS II	Slight limitation of ordinary activity; for example, angina occurs walking or stair climbing after meals, in cold, in wind, under emotional stress or only during the few hours after awakening, walking more than two blocks on the level or climbing more than one flight of ordinary stairs at a normal pace and in normal conditions.
	CCS III	Marked limitation of ordinary activity; for example, angina occurs walking one or two blocks on the level or climbing one flight of stairs in normal conditions and at a normal pace.
	CCS IV	Inability to carry on any physical activity without discomfort - angina syndrome may be present at rest.

Supporting Definitions: (none)

Seq. #: 5025 Name: Anti-Anginal Medication w/in 2 Weeks

Coding Instructions: Indicate if the patient has taken or has been prescribed anti-anginal medication within the past 2 weeks.

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 was started on an oral form of an anti-anginal medication after admission but prior to this cath lab visit.

If any anti-anginal medication was prescribed for this patient, but you are unsure if they were prescribed specifically to treat anginal symptoms, code 'yes'.

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

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	

Supporting Definitions: (none)

Seq. #: 5026 Name: Beta Blockers

Coding Instructions: Indicate if the patient has taken or has been prescribed a beta blocker to treat anginal symptoms.

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 was started on an oral form of a beta-blocker after admission but prior to this cath lab visit.

If this medication was prescribed for this patient, but you are unsure if it has been prescribed specifically to treat anginal symptoms, code 'yes'.

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

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	

Supporting Definitions: (none)

D. Cath Lab Visit

Seq. #: 5027 Name: Calcium Channel Blockers

Coding Instructions: Indicate if the patient has taken or has been prescribed a calcium channel blocker to treat anginal symptoms.

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 was started on an oral form of a calcium channel blocker after admission but prior to this cath lab visit.

If this medication was prescribed for this patient, but you are unsure if it has been prescribed specifically to treat anginal symptoms, code 'yes'.

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

Selections:

Selection Text	Definition
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No

Yes

Supporting Definitions: (none)

Seq. #: 5028 Name: Long Acting Nitrates

Coding Instructions: Indicate if the patient has taken or has been prescribed long acting nitrates to treat anginal symptoms.

Note(s):

Nitropatch or Nitropaste are included as Long Acting Nitrates.

Code 'no' if a patient was given a sublingual, IV, or short acting formula of one of these medications.

Code 'yes' if the patient was started on an oral form of the anti-anginal medication (including Nitropaste or Nitropatch) after admission but prior to this cath lab visit.

If this medication was prescribed for this patient, but you are unsure if it has been prescribed specifically to treat anginal symptoms, code 'yes'.

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

Selections:

Selection Text	Definition
----------------	------------

No

Yes

Supporting Definitions: (none)

Seq. #: 5029 Name: Ranolazine

Coding Instructions: Indicate if the patient has taken or has been prescribed Ranolazine to treat anginal symptoms.

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 was started on an oral form of Ranolazine after admission but prior to this cath lab visit.

If this medication was prescribed for this patient, but you are unsure if it has been prescribed specifically to treat anginal symptoms, code 'yes'.

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

Selections:

Selection Text	Definition
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No

Yes

Supporting Definitions: (none)

D. Cath Lab Visit

Seq. #: 5030 Name: Other Anti-Anginal Agent

Coding Instructions: Indicate if the patient has taken or has been prescribed any other anti-anginal medications to treat anginal symptoms.

Note(s):

Excludes short acting anti-anginals such as nitroglycerin sublingual tablets or spray that is used to relieve an acute episode of chest pain.

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

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: (none)

Seq. #: 5040 Name: Heart Failure w/in 2 Weeks

Coding Instructions: Indicate if there is physician documentation or report that the patient has been in a state of heart failure within the past 2 weeks.

Note(s):

If this is a subsequent episode of care (within 2 weeks), do not code the Heart Failure w/in 2 Weeks(5040) from the previous episode of care.

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

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: Heart failure:

Heart failure is defined as physician documentation or report of any of the following clinical symptoms of heart failure described as unusual dyspnea on light exertion, recurrent dyspnea occurring in the supine position, fluid retention; or the description of rales, jugular venous distension, pulmonary edema on physical exam, or pulmonary edema on chest x-ray presumed to be cardiac dysfunction. A low ejection fraction alone, without clinical evidence of heart failure does not qualify as heart failure.

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

Seq. #: 5045 Name: NYHA Class w/in 2 Weeks

Coding Instructions: Indicate the patient's worst dyspnea or functional class, coded as the New York Heart Association (NYHA) classification within the past 2 weeks.

Target Value: The highest value between 2 weeks prior to current procedure and current procedure

Selections:	Selection Text	Definition
	Class I	Patient has cardiac disease but without resulting limitations of ordinary physical activity. Ordinary physical activity (e.g., walking several blocks or climbing stairs) does not cause undue fatigue, palpitation, dyspnea, or anginal pain. Limiting symptoms may occur with marked exertion.
	Class II	Patient has cardiac disease resulting in slight limitation of ordinary physical activity. Patient is comfortable at rest. Ordinary physical activity such as walking more than two blocks or climbing more than one flight of stairs results in limiting symptoms (e.g., fatigue, palpitation, dyspnea, or anginal pain).
	Class III	Patient has cardiac disease resulting in marked limitation of physical activity. Patient is comfortable at rest. Less than ordinary physical activity (e.g., walking one to two level blocks or climbing one flight of stairs) causes fatigue, palpitation, dyspnea, or anginal pain.
	Class IV	Patient has symptoms at rest that increase with any physical activity. Patient has cardiac disease resulting in inability to perform any physical activity without discomfort. Symptoms may be present even at rest. If any physical activity is undertaken, discomfort is increased.

Supporting Definitions: (none)

D. Cath Lab Visit

Seq. #: 5050 Name: Cardiomyopathy or Left Ventricular Systolic Dysfunction

Coding Instructions: Indicate if a reason for the cath lab visit is evaluation of cardiomyopathy and/or evaluation of left ventricular systolic dysfunction (i.e. depressed LV ejection fraction).

Target Value: Any occurrence between arrival and current procedure

Selections:	Selection Text	Definition
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	No	
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	Yes	
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Supporting Definitions: (none)

Seq. #: 5055 Name: Pre-operative Evaluation Before Non-Cardiac Surgery

Coding Instructions: Indicate if a reason for the cath lab visit is pre-operative evaluation before non-cardiac surgery.

Target Value: Any occurrence between arrival and current procedure

Selections:	Selection Text	Definition
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	No	
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	Yes	
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Supporting Definitions: (none)

Seq. #: 5060 Name: Cardiogenic Shock w/in 24 Hours

Coding Instructions: Indicate if the patient has been in a state of cardiogenic shock within 24 hrs of procedure.

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

Selections:	Selection Text	Definition
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	No	
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	Yes	
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Supporting Definitions: **Cardiogenic Shock:**

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

Source: Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 - 30)

Seq. #: 5065 Name: Cardiac Arrest w/in 24 Hours

Coding Instructions: Indicate if the patient has had an episode of cardiac arrest within 24 hours of procedure.

Note(s):

Cardiac arrest includes pulseless clinical scenarios that can be brady arrests or tachy arrests requiring cardiopulmonary resuscitation (requiring two or more chest compressions, or open chest massage) and/or requiring emergency defibrillation.

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

Selections:	Selection Text	Definition
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	No	
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	Yes	
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Supporting Definitions: (none)

D. Cath Lab Visit

Seq. #: 5100 Name: Stress or Imaging Studies

Coding Instructions: Indicate if an exercise stress test, stress echocardiogram, stress testing with SPECT MPI, stress testing with CMR, cardiac CTA or coronary calcium scoring was performed.

Note(s):

For any subsequent procedures during this episode of care, only code new imaging or stress test results that were performed after the previous procedure until the current procedure.

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

Selections:

Selection Text	Definition
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5200 Name: Standard Exercise Stress Test

Coding Instructions: Indicate if a standard exercise stress test (without imaging) was performed.

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

Selections:

Selection Text	Definition
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5201 Name: Stress Test Results

Coding Instructions: Indicate the results of the exercise stress test.

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

Selections:

Selection Text	Definition
Negative	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.
Positive	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 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. If more than one study was performed with conflicting results and one study suggested coronary artery disease, code yes.
Indeterminant	The results of the stress test were indeterminant. They cannot be considered positive or negative.
Unavailable	The results of the stress test are not available.

Supporting Definitions: (none)

D. Cath Lab Visit

Seq. #: 5202 Name: Risk/Extent of Ischemia (Stress Test)

Coding Instructions: Indicate the risk score of the standard exercise stress test. The risk score is derived by the Duke Treadmill score which is an exercise treadmill score that predicts prognosis in coronary artery disease. It is calculated as follows:

Treadmill score = exercise time - (5 x ST-segment deviation in millimeters*) - (4 x treadmill angina index**)

* ST-segment deviation can be measured at 60 to 80 ms after the J point. If the amount of exercise-induced ST-segment deviation is less than 1 mm, the value entered into the score for ST deviation is 0.

** The treadmill anginal index has a value of 0 if there was no exercise angina, 1 if exercise angina occurred, and 2 if angina was the reason the patient stopped exercising.

Exercise time is based on a standard Bruce protocol.

The Duke Treadmill Score was published by Daniel, Mark, et. al, in the Annals of Internal Medicine, June 1987, Vol 106, #6

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

Selections:	<i>Selection Text</i>	<i>Definition</i>
	Low Risk	Low-risk treadmill score (score >=5).
	Intermediate Risk	Low risk equates with a less than 1% annual mortality rate. Intermediate risk treadmill score (-11 < score < 5).
	High Risk	Intermediate risk equates with a 1-3% annual mortality rate. High risk treadmill score (score <= -11).
	Unavailable	High risk equates with a greater than 3% annual mortality rate. The results of the test are unavailable.

Supporting Definitions: (none)

Seq. #: 5210 Name: Stress Echocardiogram

Coding Instructions: Indicate if a stress echocardiogram was performed.

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

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	

Supporting Definitions: (none)

Seq. #: 5211 Name: Stress Echo Imaging Results

Coding Instructions: Indicate the imaging results of the stress echocardiogram.

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

Selections:	<i>Selection Text</i>	<i>Definition</i>
	Negative	The imaging study was normal. There was no change in wall motion during the procedure.
	Positive	The imaging study was abnormal. There were changes that reflected wall motion abnormalities during the procedure.
	Indeterminant	The results of the study were uninterpretable. They cannot be considered positive or negative.
	Unavailable	The results of the imaging study was not available.

Supporting Definitions: (none)

D. Cath Lab Visit

Seq. #: 5212 Name: Risk/Extent of Ischemia (Stress Echo)**Coding Instructions:** Indicate the risk or extent of ischemia of the stress echocardiogram.**Target Value:** The last value between 6 months prior to current procedure and current procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
Low risk		1. Low-risk treadmill score (score ≥ 5).
		2. Normal stress echocardiographic wall motion or no change of limiting resting wall motion abnormalities during stress*.
Intermediate risk		*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 left ventricular dysfunction (LVEF $< 35\%$).
		Low risk equates with a less than 1% annual mortality rate
		1. Mild/moderate resting left ventricular dysfunction (LVEF = 35% to 49%)
High risk		2. Intermediate-risk treadmill score ($-11 < \text{score} < 5$).
		3. Limited stress echocardiographic ischemia with a wall motion abnormality only at higher doses of dobutamine involving less than or equal to two segments.
		Intermediate risk equates with a 1%-3% annual mortality rate.
		1. Severe resting left ventricular dysfunction (exercise LVEF $< 35\%$).
		2. High-risk treadmill score (score ≤ -11).
Unavailable		3. Severe exercise left ventricular dysfunction (exercise LVEF $< 35\%$).
		4. Echocardiographic wall motion abnormality (involving greater than two segments) developing at low dose of dobutamine (≤ 10 mg/kg/min) or at a low heart rate (< 120 beats/min).
		5. Stress echocardiographic evidence of extensive ischemia.
		High risk equates with a greater than 3% annual mortality rate.
		Results of test not available.

Supporting Definitions: (none)**Seq. #: 5220 Name:** Stress Testing with SPECT MPI**Coding Instructions:** Indicate if stress testing with single photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI) was performed.**Target Value:** The last value between 6 months prior to current procedure and current procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
No		
Yes		

Supporting Definitions: (none)**Seq. #: 5221 Name:** SPECT MPI Imaging Results**Coding Instructions:** Indicate the imaging results of the SPECT MPI study.**Target Value:** The last value between 6 months prior to current procedure and current procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
Negative		The results of the imaging study revealed no myocardial perfusion defects.
		The result of the imaging study revealed one or more stress-induced myocardial perfusion defects.
Positive		The results of the study were uninterpretable. They cannot be considered positive or negative.
		The results of the study were not available.
Indeterminant		
Unavailable		

Supporting Definitions: (none)

D. Cath Lab Visit

Seq. #: 5222 Name: Risk/Extent of Ischemia (SPECT MPI)**Coding Instructions:** Indicate the risk or extent of ischemia of the stress testing with SPECT MPI.**Target Value:** The last value between 6 months prior to current procedure and current procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
Low Risk		1. Low-risk treadmill score (score ≥ 5).
		2. Normal or small myocardial perfusion defect at rest or with stress.*
Intermediate Risk		*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 left ventricular dysfunction (LVEF $< 35\%$).
		Low risk equates with a less than 1% annual mortality rate.
High Risk		1. Mild/moderate resting left ventricular dysfunction (LVEF=35% to 49%).
		2. Intermediate-risk treadmill score ($-11 < \text{score} < 5$)
Unavailable		3. Stress-induced moderate perfusion defect without LV dilation or increased lung intake (thallium-201)
		Intermediate risk equates with a 1%-3% annual mortality rate.
		1. Severe resting left ventricular dysfunction (exercise LVEF $< 35\%$)
		2. High-risk treadmill score (score ≤ -11)
		3. Severe exercise left ventricular dysfunction (exercise LVEF $< 35\%$)
		4. Stress-induced large perfusion defect (particularly if anterior)
		5. Stress-induced multiple perfusion defects of moderate size
		6. Large, fixed perfusion defect with LV dilation or increased lung uptake (thallium-201)
		7. Stress-induced moderate perfusion defect with LV dilation or increased lung uptake (thallium-201)
		High risk equates with a greater than 3% annual mortality rate.
		The results of the study were not available.

Supporting Definitions: (none)**Seq. #: 5230 Name:** Stress Test with CMR**Coding Instructions:** Indicate if a stress test with cardiac magnetic resonance (CMR) was performed.**Target Value:** The last value between 6 months prior to current procedure and current procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
No		
Yes		

Supporting Definitions: (none)

D. Cath Lab Visit

Seq. #: 5231 Name: CMR Imaging Results**Coding Instructions:** Indicate the imaging results of the cardiac magnetic resonance (CMR) study.**Target Value:** The last value between 6 months prior to current procedure and prior to procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
	Negative	The results of the imaging study revealed no myocardial perfusion defects.
	Positive	The result of the imaging study revealed one or more stress-induced myocardial perfusion defects.
	Indeterminant	The results of the study were uninterpretable. They cannot be considered positive or negative.
	Unavailable	The results of the study were not available.

Supporting Definitions: (none)**Seq. #: 5232 Name:** Risk/Extent of Ischemia (Stress Test with CMR)**Coding Instructions:** Indicate the risk or extent of ischemia of the stress test with cardiac magnetic resonance (CMR).**Target Value:** The last value between 6 months prior to current procedure and prior to procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
	Low Risk	<ol style="list-style-type: none"> 1. Low-risk treadmill score (score ≥ 5). 2. Normal or small myocardial perfusion defect at rest or with stress.* <p>*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 left ventricular dysfunction (LVEF $<35\%$).</p> <p>Low risk equates with a less than 1% annual mortality rate.</p>
	Intermediate Risk	<ol style="list-style-type: none"> 1. Mild/moderate resting left ventricular dysfunction (LVEF=35% to 49%). 2. Intermediate-risk treadmill score ($-11 < \text{score} < 5$) 3. Stress-induced moderate perfusion defect without LV dilation or increased lung intake (thallium-201) <p>Intermediate risk equates with a 1%-3% annual mortality rate.</p>
	High Risk	<ol style="list-style-type: none"> 1. Severe resting left ventricular dysfunction (exercise LVEF $<35\%$) 2. High-risk treadmill score (score ≤ -11) 3. Severe exercise left ventricular dysfunction (exercise LVEF $<35\%$) 4. Stress-induced large perfusion defect (particularly if anterior) 5. Stress-induced multiple perfusion defects of moderate size 6. Large, fixed perfusion defect with LV dilation or increased lung uptake (thallium-201) 7. Stress-induced moderate perfusion defect with LV dilation or increased lung uptake (thallium-201) <p>High risk equates with a greater than 3% annual mortality rate.</p>
	Unavailable	The results of the study were not available.

Supporting Definitions: (none)

D. Cath Lab Visit

Seq. #: 5240 Name: Cardiac CTA**Coding Instructions:** Indicate if a cardiac computerized tomographic angiography (CTA) was performed.**Target Value:** The last value between 6 months prior to current procedure and current procedure

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: (none)**Seq. #: 5241 Name:** Cardiac CTA Results**Coding Instructions:** Indicate the results of the cardiac computerized tomographic angiography (CTA).**Note(s):**

For purposes of coding the results of a cardiac CTA, a coronary artery is defined as one of the 3 major vessels of the heart. These vessels are the right coronary artery, the left anterior descending coronary artery and the circumflex coronary artery and their associated branches. A left main coronary artery with stenosis $\geq 50\%$ is considered two vessel disease because it feeds both the left anterior descending and circumflex arteries.

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

Selections:	Selection Text	Definition
	No disease	There was $<50\%$ stenosis in all coronary artery branches.
	1 Vessel disease	There was $\geq 50\%$ stenosis in one coronary artery.
	2 Vessel disease	There was $\geq 50\%$ stenosis in two coronary arteries (or $\geq 50\%$ stenosis in the left main coronary artery).
	3 Vessel disease	There was $\geq 50\%$ stenosis in three coronary arteries (or $\geq 50\%$ stenosis in the left main coronary artery and $\geq 50\%$ stenosis in the right coronary artery).
	Indeterminant	The results of the study were uninterpretable due to technical or patient-related issues.
	Unavailable	The results of the study were unavailable.

Supporting Definitions: (none)**Seq. #: 5250 Name:** Coronary Calcium Score**Coding Instructions:** Indicate if a coronary calcium score is available.**Target Value:** The last value between 6 months prior to current procedure and current procedure

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: (none)**Seq. #: 5251 Name:** Calcium Score**Coding Instructions:** Indicate the coronary calcium score.**Target Value:** The last value between 6 months prior to current procedure and current procedure**Selections:** (none)**Supporting Definitions:** (none)

D. Cath Lab Visit

Seq. #: 5300 Name: Date of Procedure**Coding Instructions:** Indicate the date of the procedure.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 5301 Name:** Time of Procedure**Coding Instructions:** Indicate the time the procedure(s) was initiated.**Note(s):**

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

If an arterial sheath is already in place, use the time of the introduction of a catheter or the time the sheath was exchanged.

Target Value: N/A**Selections:** (none)**Supporting Definitions: Time of Procedure:**

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).

Source: NCDR

Seq. #: 5305 Name: PCI**Coding Instructions:** Indicate if the patient had a percutaneous coronary intervention (PCI).**Target Value:** N/A**Selections:***Selection Text**Definition*

No

Yes

Supporting Definitions: 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.

Source: NCDR

Seq. #: 5310 Name: Diagnostic Cath**Coding Instructions:** Indicate if the patient had a left heart catheterization or diagnostic coronary angiography procedure at this facility.**Target Value:** N/A**Selections:***Selection Text**Definition*

No

Yes

Supporting Definitions: (none)

D. Cath Lab Visit

Seq. #: 5315 Name: Other Procedure (in conj w/Dx Cath or PCI)

Coding Instructions: Indicate if an "other procedure" was performed in conjunction with a left heart cath, diagnostic coronary angiography, or PCI procedure.

Note(s):

Other procedures include, but are not limited to right heart caths, EtOH ablations, septal closures, and other (renal, abdominal, peripheral or carotid) angiograms and/or endovascular interventions.

The intent of "other procedure" is to capture those procedures that would add additional fluoro time and/or contrast volume to the diagnostic cath and/or PCI procedure.

Do not code "other procedure" unless the procedure is performed in conjunction with a left heart cath, diagnostic coronary angiography, or PCI procedure.

Target Value: N/A

Selections:

Selection Text	Definition
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5320 Name: Fluoroscopy Time

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

Note(s):

It is acceptable to code either Fluoroscopy Time (5320) or Fluoroscopy Dose (5321) or both.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5321 Name: Fluoroscopy Dose

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

Note(s):

It is acceptable to code either Fluoroscopy Time (5320) or Fluoroscopy Dose (5321) or both.

The dose recorded should include the total dose for the lab visit.

One gray is the absorption of one joule of radiation energy by one kilogram of matter

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5325 Name: Contrast Volume

Coding Instructions: 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 procedure and end of procedure

Selections: (none)

Supporting Definitions: (none)

D. Cath Lab Visit

Seq. #: 5330 Name: IABP

Coding Instructions: Indicate if the patient required the use of an Intra-Aortic Balloon Pump (IABP).

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

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: (none)

Seq. #: 5335 Name: IABP Timing

Coding Instructions: Indicate when the Intra-Aortic Balloon Pump was placed.

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

Selections:	Selection Text	Definition
	In place at start of procedure	An intra-aortic balloon pump was in place at the start of the procedure.
	Inserted during procedure and prior to PCI	An intra-aortic balloon pump was inserted during the procedure, but prior to the PCI procedure.
	Inserted after PCI has begun	An intra-aortic balloon pump was inserted after the PCI procedure begun.

Supporting Definitions: (none)

Seq. #: 5340 Name: Other Mechanical Ventricular Support

Coding Instructions: Indicate if the patient required the use of other mechanical ventricular support. This includes use of cardiopulmonary bypass, left ventricular assist device (LVAD) and/or extracorporeal membrane oxygenation (ECMO).

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

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: (none)

Seq. #: 5345 Name: Other Mechanical Ventricular Support Timing

Coding Instructions: Indicate when the other mechanical ventricular support was placed.

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

Selections:	Selection Text	Definition
	In place at start of procedure	Mechanical ventricular support was in place at the start of the procedure.
	Inserted during procedure and prior to PCI	Mechanical ventricular support was inserted during the procedure, but prior to the PCI.
	Inserted after PCI has begun	Mechanical ventricular support was inserted after the PCI begun.

Supporting Definitions: (none)

Seq. #: 5350 Name: Arterial Access Site

Coding Instructions: Indicate the primary location of percutaneous entry. Code the site used to perform the majority of the procedure if more than one site was used.

Target Value: The last value on current procedure

Selections:	Selection Text	Definition
	Femoral	Either a cutdown or percutaneous puncture of either femoral artery.
	Brachial	Either a cutdown or percutaneous puncture of either brachial artery
	Radial	Percutaneous radial approach.
	Other	Entry other than femoral, brachial, or radial approaches to the arterial system.

Supporting Definitions: (none)

D. Cath Lab Visit

Seq. #: 5355 Name: Arterial Access Closure Method

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

Target Value: The total between start of procedure and discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5356 Name: Closure Method Not Documented

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

Target Value: Any occurrence between current procedure and discharge

Selections:

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5360 Name: Closure Device Counter

Coding Instructions: 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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5400 Name: Auxiliary 3

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5405 Name: Auxiliary 4

Coding Instructions: Reserved for future use.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

E. Diagnostic Cath

Seq. #: 6000 **Name:** Diagnostic Cath Operator Last Name**Coding Instructions:** Indicate the diagnostic catheterization operator's last name.**Note(s):**

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

Target Value: The value on current procedure**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6005 **Name:** Diagnostic Cath Operator First Name**Coding Instructions:** Indicate the diagnostic catheterization operator's first name.**Note(s):**

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

Target Value: The value on current procedure**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6010 **Name:** Diagnostic Cath Operator Middle Name**Coding Instructions:** Indicate the diagnostic catheterization operator's middle name.**Note(s):**

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

Target Value: The value on current procedure**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6015 **Name:** Diagnostic Cath Operator NPI**Coding Instructions:** Indicate the primary diagnostic cath operator's National Provider Identifier. NPIs, assigned by the Center for Medicare and Medicaid Services (CMS), are used to uniquely identify physicians for Medicare billing purposes.**Target Value:** The value on current procedure**Selections:** (none)**Supporting Definitions:** (none)**Seq. #:** 6020 **Name:** Diagnostic Coronary Angiography Procedure**Coding Instructions:** Indicate if the patient had a diagnostic coronary angiography procedure.**Target Value:** N/A**Selections:**

Selection Text

Definition

No

Yes

Supporting Definitions: **Diagnostic Coronary Angiography:**

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.

Source: NCDR

E. Diagnostic Cath

Seq. #: 6025 Name: Left Heart Cath Procedure

Coding Instructions: 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.

Target Value: N/A

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6030 Name: Cardiac Transplant Evaluation

Coding Instructions: Indicate if a reason for the cath lab visit is evaluation for, or routine follow-up after an organ transplant.

Target Value: Any occurrence between arrival and current procedure

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6035 Name: Cardiac Transplant Type

Coding Instructions: Indicate if the reason for the cath lab visit is evaluation for, or routine follow-up after a cardiac transplant.

Target Value: Any occurrence between arrival and current procedure

Selections: *Selection Text* *Definition*

Donor for cardiac transplant

Candidate to receive a cardiac transplant

Post-cardiac transplant follow-up

Supporting Definitions: (none)

Seq. #: 6040 Name: Diagnostic Cath Status

Coding Instructions: Indicate the status of the diagnostic catheterization. The status is determined when the decision is made to activate the cath lab.

Target Value: The highest value on current procedure

Selections: *Selection Text* *Definition*

Elective

The procedure can be performed on an outpatient basis or during a subsequent hospitalization without significant risk of 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.

Urgent

The procedure is being 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.

Emergency

The procedure is being 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.

Salvage

The procedure is a last resort. The patient is in cardiogenic shock at the start of the procedure. Within the last ten minutes prior to the start of the procedure the patient has also received chest compressions for a total of at least sixty seconds or has been on unanticipated extracorporeal circulatory support (e.g. extracorporeal membrane oxygenation, cardiopulmonary support)

Supporting Definitions: (none)

E. Diagnostic Cath

Seq. #: 6045 **Name:** Rx Recommendation**Coding Instructions:** Indicate the primary treatment that was recommended as a result of the diagnostic cath.**Target Value:** Any occurrence on current procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
	None	Due to the outcome of the cath, no treatment recommendations were required.
	Medical therapy and/or counseling	Medical therapy and/or counseling refers to patients who only receive pharmacologic therapy and/or recommendations for cardiac risk factor reduction.
	PCI without planned CABG	
	CABG	Includes both CABG and planned hybrid CABG/PCI procedures.
	Other cardiac therapy without CABG or PCI	Other cardiac therapy includes any procedure or intervention (not including PCI, CABG, and not receiving only medical/pharmacological therapy).

Supporting Definitions: (none)

F. Coronary Anatomy

Seq. #: 6100 Name: Dominance**Coding Instructions:** 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 1 month prior to current procedure and current procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
	Left	The posterior descending artery (PDA) and posterolateral artery (PLA) arises from the left circumflex artery.
	Right	The posterior descending artery (PDA) and posterolateral artery (PLA) arises from the right coronary artery.
	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.

Supporting Definitions: (none)**Seq. #: 6110 Name:** Left Main Stenosis Percent**Coding Instructions:** Indicate the best estimate of most severe percent stenosis in the left main coronary artery.**Note(s):**

If no stenosis, enter 0%.

If the patient has only a PCI (without a diagnostic cath in the same 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.

Target Value: The highest value between 1 month prior to current procedure and current procedure**Selections:** (none)**Supporting Definitions: Stenosis:**

Stenosis: 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.

Source: NCDR

Seq. #: 6111 Name: Left Main Not Available**Coding Instructions:** Indicate if best estimate of percent stenosis in the left main coronary artery is not available.**Target Value:** N/A

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	

Supporting Definitions: (none)

F. Coronary Anatomy

Seq. #: 6120 Name: Proximal LAD Stenosis Percent

Coding Instructions: Indicate the best estimate of most severe percent stenosis in the proximal left anterior descending (LAD) coronary artery. This does not include collateral circulation.

Note(s):

If the patient has only a PCI (without a diagnostic cath in the same 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.

If no stenosis, enter 0%.

This does not include collaterals.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: Stenosis:

Stenosis: 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.

Source: NCDR

Seq. #: 6121 Name: Proximal LAD Not Available

Coding Instructions: Indicate if best estimate of percent stenosis in the proximal left anterior descending coronary artery branches is not available.

Target Value: N/A

Selections:

Selection Text	Definition
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No

Yes

Supporting Definitions: (none)

Seq. #: 6130 Name: Mid/Distal LAD, Diag Branches Stenosis Percent

Coding Instructions: Indicate the best estimate of most severe percent stenosis in the mid/distal left anterior descending (LAD), including all diagonal coronary artery branches that are ≥ 2.0 mm in diameter as determined by angiography.

Note(s):

The mid LAD is considered to be the LAD starting at the 1st diagonal vessel.

If the patient has only a PCI (without a diagnostic cath in the same 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.

If no stenosis, enter 0%.

This does not include collaterals.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: Stenosis:

Stenosis: 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.

Source: NCDR

F. Coronary Anatomy

Seq. #: 6131 Name: Mid/Distal LAD, Diagonals Stenosis Not Available**Coding Instructions:** Indicate if best estimate of percent stenosis in the mid/distal left anterior descending (LAD) coronary artery including all diagonal coronary artery branches is not available.**Target Value:** N/A**Selections:**

<i>Selection Text</i>	<i>Definition</i>
-----------------------	-------------------

No

Yes

Supporting Definitions: (none)**Seq. #: 6140 Name:** CIRC, OMs, LPDA, LPL Branches Stenosis Percent**Coding Instructions:** Indicate the best estimate of most severe percent stenosis in the circumflex (CIRC), obtuse marginals (OMs), and depending on dominance, the left posterolateral (LPL) and left posterior descending artery (LPDA) branches of ≥ 2.0 mm in diameter as determined by angiography.**Note(s):**

If the patient has only a PCI (without a diagnostic cath in the same 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.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure**Selections:** (none)**Supporting Definitions: Stenosis:**

Stenosis: 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.

Source: NCDR

Seq. #: 6141 Name: CIRC, OMs, LPDL, LPL Branches Stenosis Not Available**Coding Instructions:** Indicate if best estimate of percent stenosis in the circumflex (CIRC), obtuse marginals (OMs), the left posterolateral (LPL) and/or left posterior descending artery (LPDA) branches is not available.**Target Value:** N/A**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Supporting Definitions: (none)

F. Coronary Anatomy

Seq. #: 6150 **Name:** RCA, RPDA, RPL, AM Branches Stenosis Percent

Coding Instructions: Indicate the best estimate of most severe percent stenosis in the right coronary artery (RCA), acute marginal (AM) branches, and depending on dominance, the right posterior descending artery (RPDA), and right posteriolateral (RPL) branches of ≥ 2.0 mm in diameter as determined by angiography.

Note(s):

If the patient has only a PCI (without a diagnostic cath in the same 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.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: Stenosis:

Stenosis: 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.

Source: NCDR

Seq. #: 6151 **Name:** RCA, RPDA, RPL, AM Branches Stenosis Not Available

Coding Instructions: Indicate if the best estimate of percent stenosis in the right coronary artery (RCA), right posterior descending artery (RPDA), right posteriolateral (RPL) branches, and acute marginal (AM) branches is not available.

Target Value: N/A

Selections:

Selection Text	Definition
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6160 **Name:** Ramus Stenosis Percent

Coding Instructions: Indicate the best estimate of most severe percent stenosis in the ramus artery (if present) of ≥ 2.0 mm in diameter as determined by angiography.

Note(s):

If the patient has only a PCI (without a diagnostic cath in the same 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.

If no stenosis, enter 0%

Target Value: The highest value between 1 month prior to current procedure and current procedure

Selections: (none)

Supporting Definitions: Stenosis:

Stenosis: 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.

Source: NCDR

F. Coronary Anatomy

Seq. #: 6161 **Name:** Ramus Stenosis Not Available**Coding Instructions:** Indicate if the best estimate of percent stenosis in the ramus artery is not available, or the ramus is not present.**Target Value:** N/A

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	

Supporting Definitions: (none)**Seq. #:** 6170 **Name:** Proximal LAD Graft Stenosis Percent**Coding Instructions:** Indicate the best estimate of most severe percent stenosis in a graft supplying the proximal left anterior descending (LAD) coronary artery branch territory as determined by angiography. If no stenosis, enter 0%.**Note(s):**

Leave blank if CABG Date is greater than Procedure Date/Time or Prior CABG is "No".

If the patient has only a PCI (without a diagnostic cath in the same 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.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure**Selections:** (none)**Supporting Definitions:** **Stenosis:**

Stenosis: 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.

Source: NCDR

Seq. #: 6171 **Name:** Proximal LAD Graft Stenosis Not Available**Coding Instructions:** Indicate if the best estimate of percent stenosis in a graft supplying the proximal left anterior descending (LAD) coronary artery branch territory is not available.**Target Value:** N/A

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	

Supporting Definitions: (none)

F. Coronary Anatomy

Seq. #: 6180 Name: Mid/Distal LAD, Diag Branches Graft Stenosis Percent**Coding Instructions:** Indicate the best estimate of most severe percent stenosis in a graft supplying the mid/distal left anterior descending (LAD) coronary artery territory, including all diagonal branches, as determined by angiography.**Note(s):**

Leave blank if CABG Date is greater than Procedure Date/Time or Prior CABG is "No".

If the patient has only a PCI (without a diagnostic cath in the same 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.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure**Selections:** (none)**Supporting Definitions: Stenosis:**

Stenosis: 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.

Source: NCDR

Seq. #: 6181 Name: Mid/Distal LAD, Diag Branches Graft Stenosis Not Available**Coding Instructions:** Indicate if the best estimate of percent stenosis in a graft supplying the mid/distal left anterior descending (LAD) coronary artery territory, including all diagonal branches, is not available.**Target Value:** N/A**Selections:**

No

Yes

Supporting Definitions: (none)**Seq. #: 6190 Name:** CIRC, OMs, LPDA, LPL Branches Graft Stenosis Percent**Coding Instructions:** Indicate the best estimate of most severe percent stenosis in a graft supplying the circumflex coronary artery territory as determined by angiography.**Note(s):**

Leave blank if CABG Date is greater than Procedure Date/Time or Prior CABG is "No".

If the patient has only a PCI (without a diagnostic cath in the same 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.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure**Selections:** (none)**Supporting Definitions: Stenosis:**

Stenosis: 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.

Source: NCDR

F. Coronary Anatomy

Seq. #: 6191 **Name:** CIRC, OMs, LPDA, LPL Branches Graft Stenosis Not Available**Coding Instructions:** Indicate if the best estimate of percent stenosis in a graft supplying the circumflex coronary artery territory is not available.**Target Value:** N/A**Selections:**

No

Yes

Supporting Definitions: (none)**Seq. #:** 6200 **Name:** RCA, RPDA, RPL, AM Branches Graft Stenosis Percent**Coding Instructions:** Indicate the best estimate of most severe percent stenosis in a graft supplying the right coronary artery territory as determined by angiography.**Note(s):**

Leave blank if CABG Date is greater than Procedure Date/Time or Prior CABG is "No".

If the patient has only a PCI (without a diagnostic cath in the same 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.

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure**Selections:** (none)**Supporting Definitions:** **Stenosis:**

Stenosis: 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.

Source: NCDR

Seq. #: 6201 **Name:** RCA, RPDA, RPL, AM Branches Graft Stenosis Not Available**Coding Instructions:** Indicate if the best estimate of percent stenosis in a graft supplying the right coronary artery territory is not available.**Target Value:** N/A**Selections:**

No

Yes

Supporting Definitions: (none)

F. Coronary Anatomy

Seq. #: 6210 **Name:** Ramus Graft Stenosis Percent**Coding Instructions:** Indicate the best estimate of most severe percent stenosis supplying a graft to the ramus coronary artery as determined by angiography.**Note(s):**

Leave blank if CABG Date is greater than Procedure Date/Time or Prior CABG is "No".

If the patient has only a PCI (without a diagnostic cath in the same 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

If no stenosis, enter 0%.

Target Value: The highest value between 1 month prior to current procedure and current procedure**Selections:** (none)**Supporting Definitions: Stenosis:**

Stenosis: 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.

Source: NCDR

Seq. #: 6211 **Name:** Ramus Graft Stenosis Not Available**Coding Instructions:** Indicate if the best estimate of percent stenosis in a graft supplying the ramus coronary artery is not available.**Target Value:** N/A

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: (none)

G. PCI Procedure

Seq. #: 7000 Name: PCI Operator Last Name

Coding Instructions: Indicate the PCI operator's last name. If the name exceeds 50 characters, enter the first 50 letters only.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7005 Name: PCI Operator First Name

Coding Instructions: Indicate the PCI operator's first name. If the name exceeds 50 characters, enter the first 50 letters only.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7010 Name: PCI Operator Middle Name

Coding Instructions: PCI operator's middle name. If the name exceeds 50 characters, enter the first 50 letters only.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7015 Name: PCI Operator NPI

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

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

G. PCI Procedure

Seq. #: 7020 Name: PCI Status

Coding Instructions: 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 on current procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
	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.
	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.
	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.
	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).

Supporting Definitions: (none)

Seq. #: 7025 Name: Pre-PCI Left Ventricular Ejection Fraction

Coding Instructions: Code the best estimate of current left ventricular ejection fraction.**Note(s):**

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

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.

If an ejection fraction is not measured during this admission and prior to the PCI, and their clinical status has not changed, it is acceptable to code an ejection fraction that was obtained prior to arrival.

Target Value: The last value between 6 months prior to current procedure and prior to the intervention**Selections:** (none)**Supporting Definitions:** LVEF:

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

Source: ACC Clinical Data Standards, The Society of Thoracic Surgeons

G. PCI Procedure

Seq. #: 7026 **Name:** Pre-PCI Left Ventricular Ejection Fraction Not Assessed**Coding Instructions:** Indicate whether the left ventricular ejection fraction was not assessed.**Target Value:** The last value between 6 months prior to current procedure and prior to the intervention**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: (none)**Seq. #:** 7030 **Name:** Cardiogenic Shock at Start of PCI**Coding Instructions:** Indicate if the patient is in cardiogenic shock at the start of the PCI procedure.**Note(s):**

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 minutes.

Target Value: Any occurrence on current procedure**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: **Cardiogenic Shock:**

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

Source: Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 - 30)

G. PCI Procedure

Seq. #: 7035 Name: PCI Indication

Coding Instructions: Indicate the reason the PCI is being performed.**Target Value:** Any occurrence on current procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
	Immediate PCI for STEMI	Immediate PCI for patient with STEMI (or STEMI equivalent).
	PCI for STEMI (Unstable, >12 hrs from Sx onset)	PCI for STEMI (or STEMI equivalent) more than 12 hours from symptom onset with recurrent or persistent symptoms, symptoms of heart failure or ventricular arrhythmia.
	PCI for STEMI (Stable, >12 hrs from Sx onset)	Patient with STEMI (or STEMI equivalent) who is stable, and is more than 12 hours from symptom onset. The patient does not have any symptoms of recurrent or persistent ischemia, symptoms of heart failure, or electrical instability.
	PCI for STEMI (Stable after successful full-dose Thrombolysis)	PCI for STEMI (or STEMI equivalent) who is stable after receiving full-dose thrombolysis.
	Rescue PCI for STEMI (after failed full-dose lytics)	Rescue PCI for STEMI (or STEMI equivalent) after failed full-dose lytics.
	PCI for high risk Non-STEMI or unstable angina	Includes patients with unstable angina or Non-STEMI who have high risk features for short-term risk of death or nonfatal MI. High risk features includes at least one of the following: <ol style="list-style-type: none"> History - accelerating tempo of ischemic symptoms in preceding 48 hours. Character of pain - prolonged ongoing (greater than 20 minutes) rest pain. Clinical findings: <ol style="list-style-type: none"> Pulmonary edema, most likely due to ischemia New or worsening mitral regurgitation murmur S3 or new worsening rales Hypotension, bradycardia, tachycardia Age greater than 75 years ECG <ol style="list-style-type: none"> Angina at rest with transient ST-segment changes greater than 0.5 mm Bundle-branch block, new or presumed new Sustained ventricular tachycardia Cardiac markers - NSTEMI patients with elevated cardiac TnT, TnI, or CK-MB.
	Staged PCI	The second PCI of a planned, staged procedure (the first PCI could have been during a prior admission, or during this admission).
	Other	Includes patients that don't fit into any of the above categories. This can include patients with elective or urgent status, status/post cardiac arrest or cardiogenic shock but without ECG or biomarker evidence of acute infarction.

Supporting Definitions: (none)

Seq. #: 7040 Name: STEMI or STEMI Equivalent First Noted

Coding Instructions: Indicate if a STEMI or STEMI equivalent was noted on either the first ECG or a subsequent ECG.**Note(s):**

Code "Subsequent ECG" if the ECG on arrival does not indicate STEMI or STEMI equivalent.

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

Selections:	<i>Selection Text</i>	<i>Definition</i>
	First ECG	
	Subsequent ECG	

Supporting Definitions: (none)

G. PCI Procedure

Seq. #: 7045 Name: Subsequent ECG with STEMI or STEMI Equivalent Date

Coding Instructions: If patient is undergoing immediate PCI for STEMI or equivalent and ST elevation occurred on an ECG subsequent to the first ECG performed upon arrival, indicate the date the subsequent ECG was performed.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7046 Name: Subsequent ECG with STEMI or STEMI Equivalent Time

Coding Instructions: If patient is undergoing immediate PCI for STEMI or equivalent and ST elevation occurred on an ECG subsequent to the first ECG performed upon arrival, indicate the time the subsequent ECG was performed.

Please note that a time other than arrival time can only be used for patients whose initial ECG does not show ST elevation.

Note(s):

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

Target Value: The first value on Subsequent ECG with STEMI or STEMI Equivalent Date

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7050 Name: First Device Activation Date

Coding Instructions: Indicate the date the first device was activated regardless of type of device used.

Target Value: The first value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7051 Name: First Device Activation Time

Coding Instructions: Indicate the time the first device was activated regardless of type of device used.

Note(s):

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 (AngioJet 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.

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

Target Value: The first value on First Device Activation Date

Selections: (none)

Supporting Definitions: (none)

G. PCI Procedure

Seq. #: 7055 Name: Patient Transferred in for Immediate PCI for STEMI**Coding Instructions:** Indicate if the patient was transferred from another facility to have immediate PCI for STEMI at this facility.**Target Value:** Any occurrence between date of symptom onset and current procedure**Selections:**

No

Yes

Supporting Definitions: (none)**Seq. #: 7060 Name:** Emergency Department Presentation at Referring Facility Date**Coding Instructions:** Code the date of arrival to the original, transferring facility as documented in the medical record.**Note(s):**

If the initial onset of ST elevation MI symptoms or STEMI equivalent occurred after initial ECG and presentation to the transferring facility, it is acceptable to code the date (time) of symptom onset or subsequent ECG to the original, transferring facility, as documented in the medical record.

Target Value: The first value between date of symptom onset and current procedure**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 7061 Name:** Emergency Department Presentation at Referring Facility Time**Coding Instructions:** Code the time of arrival to the original, transferring facility as documented in the medical record.**Note(s):**

If the initial onset of ST elevation MI symptoms or STEMI equivalent occurred after initial ECG and presentation to the transferring facility, it is acceptable to code the time of symptom onset or subsequent ECG to the original, transferring facility, as documented in the medical record.

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

Target Value: The first value on Emergency Department Presentation at Referring Facility Date**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 7065 Name:** Non-system Reason for Delay in PCI**Coding Instructions:** Indicate if there is documentation of a non-system reason for a delay in performing the percutaneous coronary intervention (PCI). Documentation must be from a physician/advanced practice nurse/physician assistant (physician/APN/PA).**Note(s):**

The effect on timing/delay of PCI must be documented in order to be an acceptable reason for delay. If unable to determine whether a documented reason is system in nature, or if physician/APN/PA documentation does not establish a linkage between event(s)/condition(s) and the timing/delay in PCI/reperfusion/cath/transfer to cath lab, select "None."

System reasons for delay are NOT acceptable.

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

Difficult vascular access

cardiac arrest and/or need for intubation before PCI.

Patient delays in providing consent for the procedure.

Difficulty crossing the culprit lesion during the PCI.

Other

None

Supporting Definitions: (none)

G. PCI Procedure

Seq. #: 7245 **Name:** Significant Dissection**Coding Instructions:** Indicate if a significant 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

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	

Supporting Definitions: 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

Seq. #: 7250 **Name:** Perforation**Coding Instructions:** Indicate if angiographic or clinical evidence of perforation was observed.**Note(s):**

This does not include pre-existing AV fistula and other coronary anomalies.

Target Value: Any occurrence on current procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	

Supporting Definitions: 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

H. Lesion and Devices

Seq. #: 7100 **Name:** Lesion Counter**Coding Instructions:** 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**Selections:** (none)**Supporting Definitions: Lesion:**

A target lesion is defined as a stenosis within a coronary artery or coronary artery bypass graft on which mechanical coronary revascularization is attempted during the current procedure.

Source: NCDR

H. Lesion and Devices

Seq. #: 7105 Name: Segment Number

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

Use the following numeric reference points to identify segments where procedures were attempted and its proximal reference number.

- 1 Proximal right coronary artery conduit segment - pRCA
- 2 Mid-right coronary artery conduit segment - mRCA
- 3 Distal right coronary artery conduit segment - dRCA
- 4 Right posterior descending artery segment - rPDA
- 5 Right posterior atrioventricular segment - rPAV
- 6 First right posterolateral segment - 1st RPL
- 7 Second right posterolateral segment - 2nd RPL
- 8 Third right posterolateral segment - 3rd RPL
- 9 Posterior descending septal perforators segment - pDSP
- 10 Acute marginal segment(s) - aMarg
- 11 Left main coronary artery segment - LM
- 12 Proximal LAD artery segment - pLAD
- 13 Mid-LAD artery segment - mLAD
- 14 Distal LAD artery segment - dLAD
- 15 First diagonal branch segment - 1st Diag
- 15a Lateral first diagonal branch segment - Lat 1st Diag
- 16 Second diagonal branch segment - 2nd Diag
- 16a Lateral second diagonal branch segment - Lat 2nd Diag
- 17 LAD septal perforator segments - LAD SP
- 18 Proximal circumflex artery segment - pCIRC
- 19 Mid-circumflex artery segment - mCIRC
- 19a Distal circumflex artery segment - dCIRC
- 20 First obtuse marginal branch segment - 1st OM
- 20a Lateral first obtuse marginal branch segment - Lat 1st OM
- 21 Second obtuse marginal branch segment - 2nd OM
- 21a Lateral second obtuse marginal branch segment - Lat 2nd OM
- 22 Third obtuse marginal branch segment - 3rd OM
- 22a Lateral third obtuse marginal branch segment - Lat 3rd OM
- 23 Circumflex artery AV groove continuation segment - CIRC AV
- 24 First left posterolateral branch segment - 1st LPL
- 25 Second left posterolateral branch segment - 2nd LPL
- 26 Third posterolateral descending artery segment - 3rd LPL
- 27 Left posterolateral descending artery segment - LPDA
- 28 Ramus intermedius segment - Ramus
- 28a Lateral ramus intermedius segment - Lat Ramus
- 29 Third diagonal branch segment - 3rd Diag
- 29a Lateral third diagonal branch segment - Lat 3rd Diag

Note(s):

A segment is a defined region of a coronary artery, as illustrated in the CathPCI Registry coronary anatomy segment diagram.

If the target lesion is in a bypass graft, indicate the segment location of the first anastomosis distal to the lesion (and if it's above a Y graft, indicate the segment location of the most important distal vessel).

If a PCI of a left subclavian supplying a LIMA is performed, it is not considered a PCI.

Target Value: N/A**Selections:** (none)**Supporting Definitions: Lesion:**

A target lesion is defined as a stenosis within a coronary artery or coronary artery bypass graft on which mechanical coronary revascularization is attempted.

Source: NCDR

H. Lesion and Devices

Seq. #: 7110 Name: Culprit Lesion

Coding Instructions: Indicate the lesion that is considered to be responsible for the acute coronary syndrome.

Note(s):

"No" should be coded if there is no apparent lesion that could be responsible for evidence of ischemia.

"Unknown" should be coded if the culprit segment was not known.

The physician should use his/her judgment in choosing the primary lesion. In cases in which this is difficult to determine (despite correlation of ECG changes and angiographic data), the lesion supplying the largest territory of myocardium should be selected.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	Definition
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No

Yes

Unknown

Supporting Definitions: (none)

Seq. #: 7115 Name: Stenosis Immediately Prior to Rx

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

Target Value: The highest value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7120 Name: Chronic Total Occlusion

Coding Instructions: 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

Selections:

Selection Text	Definition
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No

Yes

Supporting Definitions: (none)

Seq. #: 7125 Name: IVUS

Coding Instructions: Indicate if intravascular ultrasound was performed to confirm the percent stenosis.

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

Selections:

Selection Text	Definition
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No

Yes

Supporting Definitions: (none)

Seq. #: 7130 Name: Fractional Flow Reserve

Coding Instructions: Indicate if fractional flow reserve was performed to confirm the percent stenosis. Myocardial fractional flow reserve is a lesion-specific index of stenosis severity.

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

Selections:

Selection Text	Definition
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No

Yes

Supporting Definitions: (none)

H. Lesion and Devices

Seq. #: 7135 Name: Fractional Flow Reserve Ratio**Coding Instructions:** Indicate the fractional flow reserve ratio.**Target Value:** The lowest value between beginning of procedure and prior to intervention**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 7140 Name:** Pre-Procedure TIMI Flow**Coding Instructions:** Indicate the pre-procedure TIMI flow value.**Note(s):**

If a lesion spans multiple segments with different TIMI flows, coded the lowest TIMI flow within the entire lesion.

Target Value: Any occurrence on current procedure

Selections:	Selection Text	Definition
	TIMI - 0	No flow/no perfusion
	TIMI - 1	Slow penetration without perfusion
	TIMI - 2	Partial flow/partial perfusion (greater than TIMI-1 but less than TIMI-3.
	TIMI - 3	Complete and brisk flow/complete perfusion.

Supporting Definitions: (none)**Seq. #: 7145 Name:** Previously Treated Lesion**Coding Instructions:** Indicate if the lesion has been treated before in the current or a prior episode of care.**Target Value:** Any occurrence between birth and current procedure

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: (none)**Seq. #: 7150 Name:** Previously Treated Lesion Timeframe**Coding Instructions:** If this lesion was previously treated during another PCI procedure, then indicate the timeframe in calendar months or years.**Target Value:** Any occurrence between birth and current procedure

Selections:	Selection Text	Definition
	< 1 month	
	1-5 months	
	6-12 months	
	1-2 years	
	>2 years	
	Time unknown	

Supporting Definitions: (none)**Seq. #: 7155 Name:** Treated with Stent**Coding Instructions:** 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 current procedure

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: (none)

H. Lesion and Devices

Seq. #: 7160 Name: In-stent Restenosis

Coding Instructions: Indicate if the previously treated and stented lesion is being treated for in-stent restenosis. In-stent restenosis is defined as a previously stented lesion that has 50% or greater stenosis

Target Value: Any occurrence between birth and current procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
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	No	
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	Yes	
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Supporting Definitions: (none)

Seq. #: 7165 Name: In-stent Thrombosis

Coding Instructions: 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 current procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
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	No	
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	Yes	
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Supporting Definitions: (none)

Seq. #: 7170 Name: Stent Type

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

Note(s):

If a patient has two types of stents in the lesion (drug eluting and non-drug eluting), code "Drug eluting stent".

Target Value: Any occurrence between birth and current procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
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	Drug eluting stent	
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	Non drug eluting stent	
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	Stent type unknown	
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The patient has a stent but it is not known whether it was drug eluting or non drug eluting.

Supporting Definitions: (none)

Seq. #: 7175 Name: Lesion In Graft

Coding Instructions: If the treated lesion is in a coronary arter bypass graft, indicate the type of graft.

Target Value: Any occurrence on current procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
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	Not in graft	
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Lesion is not in a coronary artery bypass graft.

	Vein	
--	------	--

Lesion is in a vein graft.

	LIMA graft	
--	------------	--

Lesion is in a left internal mammary artery graft.

	Other artery	
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Lesion is in an "other" arterial graft (not including LIMA grafts). Radial artery grafts or other free arterial conduit grafts (e.g. free IMA) should be coded as an other arterial graft.

Supporting Definitions: (none)

H. Lesion and Devices

Seq. #: 7180 Name: Location in Graft**Coding Instructions:** If the lesion is in a graft, indicate the location of the most severe stenosis in the graft.**Target Value:** Any occurrence on current procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
	Aortic	The most severe stenosis is at the aortic anastomosis of the graft (≤ 3 mm from insertion point).
	Body	The most severe stenosis is in the body of the graft.
	Distal	The most severe stenosis is at the distal anastomosis of the graft (≤ 3 mm from insertion point).

Supporting Definitions: (none)**Seq. #: 7185 Name:** Lesion Complexity**Coding Instructions:** Indicate the complexity of the lesion as defined in the selections below.**Target Value:** Any occurrence on current procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
	Non-High/Non-C Lesion	<p>Non-high/non-C lesions are considered Type A or B lesions. They can be characterized as follows:</p> <p>Low Risk or Type A lesions: Descrete (<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</p> <p>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</p>
	High/C Lesion	<p>Medium Risk (Type B2 lesions): Two or more "B" characteristics.</p> <p>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</p>

Supporting Definitions: (none)

H. Lesion and Devices

Seq. #: 7190 Name: Lesion Length**Coding Instructions:** Indicate the length of the treated lesion in millimeters.**Note(s):**

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**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 7195 Name:** Thrombus Present**Coding Instructions:** Indicate if there was a thrombus present.**Note(s):**

Thrombus is suggested by certain angiographic features: haziness, reduced contrast density or contrast persistence, irregular lesion contours, or globular filling defects.

Target Value: Any occurrence on current procedure**Selections:**

No

Yes

Supporting Definitions: (none)**Seq. #: 7200 Name:** Bifurcation Lesion**Coding Instructions:** Indicate if the lesion is at a significant bifurcation, trifurcation 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**Selections:**

No

Yes

Supporting Definitions: (none)**Seq. #: 7205 Name:** Guidewire Across Lesion**Coding Instructions:** Indicate if a guidewire successfully crossed the lesion.**Target Value:** Any occurrence on current procedure**Selections:**

No

Yes

Supporting Definitions: (none)**Seq. #: 7210 Name:** Stenosis Post-Procedure**Coding Instructions:** Indicate the post-procedure percent stenosis for the treated lesion.**Target Value:** The highest value on current procedure**Selections:** (none)**Supporting Definitions:** (none)

H. Lesion and Devices

Seq. #: 7215 Name: Post-Procedure TIMI Flow**Coding Instructions:** Indicate the post-procedure 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: Any occurrence on current procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
	TIMI - 0	No flow/no perfusion
	TIMI - 1	Slow penetration without perfusion
	TIMI - 2	Partial flow/partial perfusion (greater than TIMI-1 but less than TIMI-3.
	TIMI - 3	Complete and brisk flow/complete perfusion.

Supporting Definitions: (none)**Seq. #: 7220 Name:** Device Deployed**Coding Instructions:** Indicate if a device was deployed during the procedure.**Note(s):**

If Device Deployed (7220) is 'Yes' for any lesion, at least one intracoronary device must be specified.

Target Value: Any occurrence on current procedure

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	

Supporting Definitions: (none)**Seq. #: 7225 Name:** Intracoronary Device(s) Used**Coding Instructions:** 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 (7100) if Device Deployed (7220) is 'Yes'. An intracoronary device may be associated with more than one lesion.

The devices available for selection in your application are controlled by the intracoronary device downloadable file. This file and its updates will be maintained by the ACC and will be made available on the Internet for downloading and importing into your application.

Target Value: Any occurrence on current procedure**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 7230 Name:** Intracoronary Device Counter**Coding Instructions:** 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**Selections:** (none)**Supporting Definitions:** (none)

H. Lesion and Devices

Seq. #: 7235 Name: Device Diameter**Coding Instructions:** Indicate the diameter of the intracoronary device in millimeters.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)

Seq. #: 7240 Name: Device Length**Coding Instructions:** Indicate the length of the device in millimeters.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)

Seq. #: 7255 Name: Auxiliary 5**Coding Instructions:** Reserved for future use.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)

Seq. #: 7260 Name: Auxiliary 6**Coding Instructions:** Reserved for future use.**Target Value:** N/A**Selections:** (none)**Supporting Definitions:** (none)

Z. Administration

Seq. #: 1000 Name: Participant ID

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

Target Value: N/A

Selections: (none)

Supporting Definitions: **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

Seq. #: 1010 Name: Participant Name

Coding Instructions: Indicate the full name of the facility.

Note(s):

Values should be full, official hospital names with no abbreviations or variations in spelling.

Target Value: N/A

Selections: (none)

Supporting Definitions: **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

Seq. #: 1016 Name: Participant NPI

Coding Instructions: Indicate the participant's National Provider Identifier (NPI).

Target Value: N/A

Selections: (none)

Supporting Definitions: **National Provider Identifier:**

This number, assigned by the Centers for Medicare and Medicaid Services (CMS), is used to uniquely identify facilities for Medicare billing purposes.

Source: NCDR

Seq. #: 1020 Name: Time Frame of Data Submission

Coding Instructions: Indicate the time frame of data included in the data submission. Format: YYYYQQ. e.g., 2006Q4

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Z. Administration

Seq. #: 1040 Name: Transmission Number

Coding Instructions: This is a unique number created, and automatically inserted by the software into extract file. It identifies the number of times the software has created data submission files. The transmission number should be incremented by one every time the data submission files are exported. The transmission number should never be repeated.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1050 Name: Vendor Identifier

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

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1060 Name: Vendor Software Version

Coding Instructions: Vendor's software product name and version number identifying the software which created this record (assigned by vendor). Vendor controls the value in this field. This is entered into the schema automatically by vendor software. Version passing certification/harvest testing will be noted at the NCDR.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1070 Name: Registry Identifier

Coding Instructions: The NCDR registry identifier describes the data registry to which these records apply. It is implemented in the software at the time the data is collected and records are created. This is entered into the schema automatically by software.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1080 Name: Registry Version

Coding Instructions: Registry version describes the version number of the Data Specifications/Dictionary, to which each record conforms. It identifies which fields should have data, and what are the valid data for each field. It is the version implemented in the software at the time the data is collected and the records are created. This is entered into the schema automatically by software.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1200 Name: Auxiliary 0

Coding Instructions: Reserved for future use

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

I. Labs

Seq. #: 7300 Name: CK-MB Pre-Procedure

Coding Instructions: Indicate the pre-procedure CK-MB baseline that was drawn at your facility. Exclude point-of-care (bedside) testing. (ng/mL)

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7301 Name: CK Pre-Procedure Not Applicable

Coding Instructions: Indicate if the pre-procedure CK baseline was not drawn, or not drawn at your facility, or drawn at your facility using point-of-care (bedside) testing.

Target Value: N/A

Selections:	Selection Text	Definition
	No	Code "no" when the pre-procedure CK baseline was drawn at the facility.
	Yes	Code "yes" when the pre-procedure CK was not drawn, not drawn at your facility, or drawn at your facility using point-of-care (bedside) testing.

Supporting Definitions: (none)

Seq. #: 7302 Name: CK Pre-Procedure Drawn and Normal

Coding Instructions: Indicate if the pre-procedure CK Level was drawn and was normal, thus the CK-MB was not measured at your facility.

Target Value: N/A

Selections:	Selection Text	Definition
	No	
	Yes	Code "yes" when pre-procedure CK level was drawn and normal.

Supporting Definitions: (none)

Seq. #: 7305 Name: Troponin I Pre-Procedure

Coding Instructions: Indicate the pre-procedure Troponin I baseline, in ng/mL, if drawn at your facility. Exclude point-of-care (bedside) testing.

Note(s):

Exclude values drawn at other facilities (they have different upper reference limits).

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7306 Name: Troponin I Pre-Procedure Not Drawn

Coding Instructions: Indicate if the pre-procedure Troponin I baseline was not drawn, not drawn at your facility, or drawn at your facility using point-of-care (bedside) testing.

Target Value: N/A

Selections:	Selection Text	Definition
	No	
	Yes	Code "yes" if the pre-procedure Troponin I baseline was not drawn or drawn at your facility using point-of-care (bedside) testing.

Supporting Definitions: (none)

I. Labs

Seq. #: 7310 Name: Troponin T Pre-Procedure

Coding Instructions: Indicate the pre-procedure Troponin T baseline, in ng/mL, if drawn at your facility. Exclude point-of-care (bedside) testing.

Note(s):

Exclude values drawn at other facilities (they have different upper reference limits).

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7311 Name: Troponin T Pre-Procedure Not Drawn

Coding Instructions: Indicate if the pre-procedure Troponin T baseline was not drawn, not drawn at your facility, or drawn at your facility using point-of-care (bedside) testing.

Target Value: N/A

Selections:	Selection Text	Definition
	No	
	Yes	Code "yes" when the pre-procedure Troponin T baseline was not drawn or drawn at your facility using point-of-care (bedside) testing.

Supporting Definitions: (none)

Seq. #: 7315 Name: Pre-Procedure Creatinine

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

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7316 Name: Pre-Procedure Creatinine Not Drawn

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

Target Value: N/A

Selections:	Selection Text	Definition
	No	
	Yes	Code "yes" when pre-procedure Creatine level was not collected.

Supporting Definitions: (none)

Seq. #: 7320 Name: Pre-Procedure Hemoglobin

Coding Instructions: Indicate the most recent hemoglobin level in g/dL.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7321 Name: Pre-Procedure Hemoglobin Not Drawn

Coding Instructions: Indicate if a pre-procedure hemoglobin level was not collected.

Target Value: N/A

Selections:	Selection Text	Definition
	No	
	Yes	Code "yes" when pre-procedure Hemoglobin is not drawn.

Supporting Definitions: (none)

I. Labs

Seq. #: 7325 Name: CK-MB Post-Procedure

Coding Instructions: Indicate the post-procedure CK-MB peak value within the interval of 6-24 hours post-PCI. If more than one value is available, code the peak value. (ng/mL)

Note(s):

If multiple biomarker samples are obtained in the 6-24 hour interval, then report the highest value obtained. Values obtained less than 6 hours following the conclusion of the PCI, and normal values obtained >24 hours after the conclusion of the PCI, should be coded as "CK-MB Post Procedure Not Drawn."

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7326 Name: CK Post-Procedure Not Applicable

Coding Instructions: Indicate if the post-procedure CK peak value was not drawn, or drawn using point-of-care (bedside) testing, or drawn outside of the 6-24 hour timeframe.

Note(s):

Values obtained less than 6 hours following the conclusion of the PCI, and normal values obtained >24 hours after the conclusion of the PCI, should be coded as "CK-MB Post Procedure Not Applicable - Yes."

Target Value: N/A

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	Code "no" when the post-procedure CK baseline was drawn at the facility.
	Yes	Code "yes" when the post-procedure CK was not drawn, not drawn at your facility, or drawn at your facility using point-of-care (bedside) testing.

Supporting Definitions: (none)

Seq. #: 7327 Name: CK Post-Procedure Drawn and Normal

Coding Instructions: Indicate if the post-procedure CK level was drawn and was normal, thus the CK-MB was not measured.

Target Value: N/A

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	Code "yes" when the post-procedure CK level was drawn and normal.

Supporting Definitions: (none)

Seq. #: 7330 Name: Troponin I Post-Procedure

Coding Instructions: Indicate the post-procedure Troponin I peak value, in ng/mL, within the interval of 6-24 hours post-PCI. If more than one value is available, code the peak value.

Note(s):

At least one determination of biomarkers obtained within the interval of 6-24 hours post-PCI is preferred. If multiple biomarker samples are obtained in the 6-24 hour interval, then report the highest value obtained. Values obtained less than 6 hours following the conclusion of the PCI, and normal values obtained >24 hours after the conclusion of the PCI, are not acceptable.

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

Selections: (none)

Supporting Definitions: (none)

I. Labs

Seq. #: 7331 Name: Troponin I Post-Procedure Not Drawn

Coding Instructions: Indicate if the post-procedure Troponin I peak value was not drawn or drawn using point-of-care (bedside) testing.

Target Value: N/A

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	Code "yes" when post-procedure Troponin I peak value was not drawn or drawn using point-of-care (bedside) testing.

Supporting Definitions: (none)

Seq. #: 7335 Name: Troponin T Post-Procedure

Coding Instructions: Indicate the post-procedure Troponin T value, in ng/mL. If more than one value is available, code the peak value.

Note(s):

At least one determination of biomarkers obtained within the interval of 6-24 hours post-PCI is preferred. If multiple biomarker samples are obtained in the 6-24 hour interval, then report the highest value obtained. Values obtained less than 6 hours following the conclusion of the PCI, and normal values obtained >24 hours after the conclusion of the PCI, are not acceptable.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7336 Name: Troponin T Post-Procedure Not Drawn

Coding Instructions: Indicate if the post-procedure Troponin T peak value was not drawn or drawn using point-of-care (bedside) testing.

Target Value: N/A

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	Code "yes" if the post-procedure Troponin Tpeak was not drawn or drawn at your facility using point-of-care (bedside) testing.

Supporting Definitions: (none)

Seq. #: 7340 Name: Post-Procedure Creatinine

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

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure creatinine to 30 days after the last procedure.

Target Value: The highest value between current procedure and until next procedure or discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7341 Name: Post-Procedure Creatinine Not Drawn

Coding Instructions: Indicate if a post-procedure creatinine level was not collected.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure creatinine to 30 days after the last procedure.

Target Value: N/A

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	Code "yes" when post-procedure Creatinine level was not collected.

Supporting Definitions: (none)

I. Labs

Seq. #: 7345 **Name:** Post-Procedure Hemoglobin**Coding Instructions:** Indicate the post-procedure hemoglobin level in g/dL.**Target Value:** The lowest value between current procedure and 72 hours after current procedure**Selections:** (none)**Supporting Definitions:** (none)

Seq. #: 7346 **Name:** Post-Procedure Hemoglobin Not Drawn**Coding Instructions:** Indicate if a post-procedure hemoglobin level was not collected.**Target Value:** N/A**Selections:** *Selection Text**Definition*

No

Yes

Code "yes" when post-procedure Hemoglobin is not drawn.

Supporting Definitions: (none)

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Seq. #: 8000 Name: Myocardial Infarction (Biomarker Positive)

Coding Instructions: Indicate the NEW occurrence of a biomarker positive myocardial infarction after PCI. At least one determination of biomarkers obtained no sooner than 6 hours after PCI, and preferably within the interval of 6-24 hours post-PCI, should be used to make this diagnosis.

Note(s):

Q waves with absent, incomplete or inconclusive biomarkers should be considered evidence of MI and should be coded as yes.

In rare situations, biomarkers may not be obtained in the setting of a post-PCI acute MI (e.g., sudden unexpected cardiac death without symptoms or ECG changes suggestive of ischemia, patient is transferred, or biomarkers were just not ordered). In these situations, the site may choose to report a clinically-diagnosed post-PCI myocardial infarction even in the absence of the usually required biomarker elevations.

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	

Supporting Definitions: Myocardial Infarction:

1. Myocardial infarction within 24 hours post-PCI:

a. Pts with normal baseline (pre-procedure) cardiac biomarker values:

Elevations of cardiac biomarkers above 3 times the upper limit of normal for your laboratory (i.e., above 3 times the 99th percentile upper reference limit for a "normal" population) are indicative of peri-procedural myocardial infarction. ECG changes or symptoms are not required to qualify.

Note: Some patients presenting with acute coronary syndrome will not have biomarker elevations prior to the PCI. Elevated biomarkers after PCI in these cases indicate the presence of a peri-procedural MI, but do not necessarily mean that the MI was caused by the PCI.

b. Pts with elevated baseline (pre-procedure) cardiac biomarkers have three possible scenarios:

i. Patients with monotonically rising and elevated biomarker levels prior to PCI are assumed to be in the midst of an acute myocardial infarction. In these patients, it is not possible to distinguish necrosis that resulted from the PCI vs. necrosis arising from the presenting acute MI, so code no for myocardial infarction after PCI.

ii. Patients with elevated biomarkers pre-procedure who do NOT have a characteristic rise and fall in biomarker levels are unlikely to be experiencing an acute myocardial infarction prior to the PCI (e.g., "flat" chronic elevations of troponin-T in patients with renal failure, chronic stable elevations of CK in patients with myositis or hypothyroidism). In this scenario, code no for myocardial infarction after PCI.

iii. Patients whose biomarkers exhibited a pre-procedure rise and fall most likely have completed their presenting infarct. In these patients, a post-procedural increase in biomarkers that is greater than three times the upper limit of normal for your laboratory is indicative of a post-PCI reinfarction and should be coded as yes for this event. "Greater than three times the upper limit of normal for your laboratory" means an additional rise in biomarkers that is three times the 99th percentile upper reference limit for a "normal" population. ECG changes or symptoms are not required to qualify.

2. MI > 24 hours post PCI but prior to discharge is evidenced by any of the following:

- a. A rise and fall in cardiac biomarkers (preferably troponin) with at least one of the values in the abnormal range for that laboratory, together with at least one of the developments listed below, is a manifestations of myocardial infarction. The abnormal range for your laboratory means levels above the 99th percentile of the upper reference limit (URL) for normal subjects.
 - i. Ischemic symptoms;
 - ii. ECG changes indicative of new ischemia (new ST-T changes, new left bundle branch block, or loss of R wave voltage);
 - iii. Development of pathological Q waves in 2 or more contiguous leads in the ECG (or equivalent findings for true posterior MI);
 - iv. Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality;
 - v. Documentation in the medical record of the diagnosis of acute myocardial infarction based on the cardiac biomarker pattern in the absence of any items enumerated in 1-4 due to conditions that may mask their appearance (e.g., peri-operative infarct when the patient cannot report ischemic symptoms; baseline left bundle branch block or ventricular pacing)

b. Imaging evidence of a region with new loss of viable myocardium at rest in the absence of a non-ischemic

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cause. This can be manifest as:

- i. Echocardiographic, CT, MR, ventriculographic or nuclear imaging evidence of left ventricular thinning or scarring and failure to contract appropriately (i.e., hypokinesis, akinesis, or dyskinesis)
- ii. Fixed (non-reversible) perfusion defects on nuclear radioisotope imaging (e.g., MIBI, thallium).

3. Peri-CABG MI (within the first 72 hours following CABG):

CABG-related myocardial infarction is defined by an increase of biomarkers greater than 5 times the upper limit of normal for your laboratory (i.e., above 5 times the 99th percentile upper reference limit for a 'normal' population) compared with the pre-CABG biomarker value closest to the time of surgery plus one of the following:

a) new pathological Q waves or new LBBB;

b) angiographically documented new occlusion or thrombosis of a graft or native coronary artery since the pre-operative angiogram;

c) imaging evidence of new loss of viable myocardium at rest in the absence of a non-ischemic cause.

Source: Joint ESC-ACC-AHA-WHF 2007 Task Force consensus statement "Universal Definition of Myocardial Infarction".

Seq. #: 8005 Name: Cardiogenic Shock

Coding Instructions: Indicate if the patient had a new onset or acute recurrence of cardiogenic shock.

Note(s):

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 minutes.

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

Selection Text	Definition
No	
Yes	

Supporting Definitions: Cardiogenic Shock:

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

Source: ACC Data Standards

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Seq. #: 8010 Name: Heart Failure

Coding Instructions: Indicate if the patient had new onset or acute recurrence of heart failure which necessitated new or increased pharmacologic therapy.

Note(s):

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Supporting Definitions: Heart Failure:

A previous hospital admission with a principal diagnosis of heart failure is considered evidence of heart failure history.

Heart failure is defined as physician documentation or report of any of the following clinical symptoms of heart failure: unusual dyspnea on light exertion; recurrent dyspnea occurring in the supine position; fluid retention; the description of rales, jugular venous distension, pulmonary edema on physical exam; or pulmonary edema on chest x-ray. A previous hospital admission with principal diagnosis of heart failure is considered evidence of heart failure history. A low ejection fraction without clinical evidence of heart failure does not qualify as heart failure.

Source: ACC Data Standards, The Society of Thoracic Surgeons

Seq. #: 8015 Name: CVA/Stroke

Coding Instructions: Indicate if the patient had a cerebrovascular accident (CVA).

Note(s):

A stroke or CVA is documented by a loss of neurological function caused by an ischemic or hemorrhagic event with residual symptoms lasting at least 24 hours after onset or leading to death.

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

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

Selections:

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Supporting Definitions: (none)

Seq. #: 8021 Name: Hemorrhagic Stroke

Coding Instructions: Indicate if the patient experienced a hemorrhagic stroke.

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

Selections:

<i>Selection Text</i>	<i>Definition</i>
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No

Yes

Supporting Definitions: Hemorrhagic Stroke:

A stroke with documentation on imaging (e.g., CT scan or MRI of hemorrhage in the cerebral parenchyma, or a subdural or subarachnoid hemorrhage). Evidence of hemorrhagic stroke obtained from lumbar puncture, neurosurgery, or autopsy can also conform the diagnosis.

Source: Acute Coronary Syndrome Data Standards (JACC 2001 38:2114-30)

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Seq. #: 8025 **Name:** Tamponade**Coding Instructions:** Indicate if the patient experienced fluid in the pericardial space compromising cardiac filling and requiring intervention.**Note(s):**

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure

Target Value: Any occurrence between start of procedure and until next procedure or discharge**Selections:***Selection Text**Definition*

No

Yes

Supporting Definitions: **Tamponade:**

Tamponade should be documented by either:

1. Echocardiogram showing pericardial fluid and signs of tamponade such as right heart compromise, or
2. Systemic Hypotension due to pericardial fluid compromising cardiac function.

Source: NCDR

Seq. #: 8030 **Name:** New Requirement for Dialysis**Coding Instructions:** Indicate if the patient experienced acute or worsening renal failure necessitating renal dialysis.**Note(s):**

If a patient is on receiving continuous veno-venous hemofiltration (CVVH) as a result of renal failure (and not as treatment to remove fluid for heart failure), code yes.

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

Target Value: Any occurrence between start of procedure and until next procedure or discharge**Selections:***Selection Text**Definition*

No

Yes

Supporting Definitions: (none)**Seq. #:** 8035 **Name:** Other Vascular Complications Requiring Treatment**Coding Instructions:** Indicate if the patient experienced any other vascular complications (excluding external bleeding or hematomas) at the percutaneous entry site that required treatment or intervention.**Note(s):**

Code 'yes' for patients treated with IV therapy for loss of distal pulse.

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

Target Value: Any occurrence between start of procedure and until next procedure or discharge**Selections:***Selection Text**Definition*

No

Yes

Supporting Definitions: **Vascular Complications Requiring Intervention:**

Vascular complications can include, but are not limited to, access site occlusions, peripheral embolizations, dissections, pseudoaneurysms and/or AV fistulas. Any noted vascular complication must have had an intervention such as a fibrin injection, angioplasty, or surgical repair to qualify. Prolonged pressure does not qualify as an intervention, but ultrasonic guided compression after making a diagnosis of pseudoaneurysm does qualify. A retroperitoneal bleed or hematoma requiring transfusion is not a vascular complication under this data element.

To qualify, this adverse outcome should be attributable to this procedure and not related to a previous or subsequent procedure.

Source: NCDR

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Seq. #: 8040 Name: RBC/Whole Blood Transfusion**Coding Instructions:** Indicate if there was a transfusion(s) of either whole blood or packed red blood cells.**Note(s):**

For patients with extended hospital stays, restrict coding of post-procedure events to 30 days after the last procedure.

Target Value: Any occurrence between start of procedure and until next procedure or discharge**Selections:***Selection Text**Definition*

No

Yes

Supporting Definitions: (none)**Seq. #: 8041 Name:** Hemoglobin Prior to Transfusion**Coding Instructions:** Indicate the patient's hemoglobin value, in g/dL, prior to transfusion.**Target Value:** The lowest value between start of procedure and until next procedure or discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 8050 Name:** Bleeding Event w/in 72 Hours**Coding Instructions:** Indicate if the patient experienced a suspected or confirmed bleeding event observed and documented in the medical record that was associated with any of the following:1. Hemoglobin drop of ≥ 3 g/dL;

2. Transfusion of whole blood or packed red blood cells;

3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding (such as surgical closures/exploration of the arteriotomy site, balloon angioplasty to seal an arterial tear, endoscopy with cautery of a GI bleed).

Note(s):

A patient who was actively bleeding with coffee ground emesis pre-procedure should not qualify as bleeding. However, a patient with peptic ulcer disease with no noted or active bleeding prior to procedure who starts bleeding after the procedure would qualify as a "yes".

Target Value: Any occurrence between start of procedure and 72 hours after current procedure**Selections:***Selection Text**Definition*

No

Yes

Supporting Definitions: (none)

J. Intra and Post Procedure Events

Seq. #: 8055 Name: Bleeding at Access Site

Coding Instructions: Indicate if the patient experienced significant external bleeding that occurred at the access or percutaneous entry site.

To qualify, it must be associated with any of the following:

1. Hemoglobin drop of ≥ 3 g/dL;
2. Transfusion of whole blood or packed red blood cells;
3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding (such as surgical closures/exploration of the arteriotomy site, balloon angioplasty to seal an arterial tear, endoscopy with cautery of a GI bleed).

Note(s):

Acute anemia with fall in Hgb >3 g/dL without other obvious source (e.g., GI, GU, operative, or hemolysis) that is attributable to intraprocedural blood loss (e.g., during equipment exchanges) should be considered bleeding at the access site, even if no hematoma is palpable or documented on imaging studies.

Prolonged pressure does not qualify as an intervention

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

Selections:	Selection Text	Definition
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No

Yes

Supporting Definitions: (none)

Seq. #: 8060 Name: Hematoma at Access Site

Coding Instructions: Indicate if the patient experienced a hematoma at the percutaneous entry site.

To qualify, it must be associated with any of the following:

1. Hemoglobin drop of ≥ 3 g/dL;
2. Transfusion of whole blood or packed red blood cells;
3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding (such as surgical closures/exploration of the arteriotomy site, balloon angioplasty to seal an arterial tear, endoscopy with cautery of a GI bleed).

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

Selections:	Selection Text	Definition
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No

Yes

Supporting Definitions: (none)

Seq. #: 8061 Name: Hematoma Size

Coding Instructions: Indicate the maximal dimension, in centimeters, of the hematoma (measured by palpation or imaging).

Target Value: The highest value between start of procedure and 72 hours after current procedure

Selections:	Selection Text	Definition
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<3 cm

3-5 cm

>5-10 cm

>10 cm

Supporting Definitions: (none)

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Seq. #: 8070 Name: Retroperitoneal Bleeding**Coding Instructions:** Indicate if the patient experienced retroperitoneal bleeding.

To qualify, it must be associated with any of the following:

1. Hemoglobin drop of ≥ 3 g/dL;
2. Transfusion of whole blood or packed red blood cells;
3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding (such as surgical closures/exploration of the arteriotomy site, balloon angioplasty to seal an arterial tear, endoscopy with cauterization of a GI bleed).

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

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: (none)**Seq. #: 8080 Name:** Gastrointestinal Bleeding**Coding Instructions:** Indicate whether the patient experienced gastrointestinal bleeding.

To qualify, it must be associated with any of the following:

1. Hemoglobin drop of ≥ 3 g/dL;
2. Transfusion of whole blood or packed red blood cells;
3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding (such as surgical closures/exploration of the arteriotomy site, balloon angioplasty to seal an arterial tear, endoscopy with cauterization of a GI bleed).

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

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: (none)**Seq. #: 8090 Name:** Genital-Urinary Bleeding**Coding Instructions:** Indicate whether genital or urinary bleeding occurred.

To qualify, it must be associated with any of the following:

1. Hemoglobin drop of ≥ 3 g/dL;
2. Transfusion of whole blood or packed red blood cells;
3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding (such as surgical closures/exploration of the arteriotomy site, balloon angioplasty to seal an arterial tear, endoscopy with cauterization of a GI bleed).

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

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: (none)

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Seq. #: 8100 **Name:** Other Bleeding**Coding Instructions:** Indicate if other bleeding occurred. Other bleeding includes bleeding from a site not specified, such as pulmonary bleeding.

To qualify, it must be associated with any of the following:

1. Hemoglobin drop of ≥ 3 g/dL;
2. Transfusion of whole blood or packed red blood cells;
3. Procedural intervention/surgery at the bleeding site to reverse/stop or correct the bleeding (such as surgical closures/exploration of the arteriotomy site, balloon angioplasty to seal an arterial tear, endoscopy with cauterization of a GI bleed).

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

Selection Text	Definition
No	
Yes	

Supporting Definitions: (none)

K. Discharge

Seq. #: 9000 Name: CABG

Coding Instructions: Indicate if the patient had coronary artery bypass graft (CABG) surgery.**Note(s):**

Code the appropriate selection for surgeries performed at your facility or transferred for planned CABG surgery at another facility.

Target Value: Any occurrence between arrival and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
No	
Yes	

Supporting Definitions: (none)

Seq. #: 9005 Name: CABG Status

Coding Instructions: Indicate the status of the coronary artery bypass graft (CABG) surgery.**Note(s):**

Code the appropriate selection for surgeries performed at your facility or transferred for planned CABG surgery at another facility.

Target Value: Any occurrence between arrival and discharge**Selections:**

<i>Selection Text</i>	<i>Definition</i>
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.
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
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 24 hours before surgery. 3. Pulmonary edema requiring intubation. b. Mechanical dysfunction (either of the following): 1. Shock with circulatory support 2. Shock without circulatory support.
Salvage	The patient is undergoing CPR in route to the operating room or prior to anesthesia induction.

Supporting Definitions: (none)

K. Discharge

Seq. #: 9010 Name: CABG Indication

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

Note(s):

Code the appropriate selection for surgeries performed at your facility or transferred for planned CABG surgery at another facility.

Target Value: Any occurrence between arrival and discharge

Selections:	<i>Selection Text</i>	<i>Definition</i>
	PCI complication	
	PCI failure without clinical deterioration	
	Treatment of CAD without PCI immediately preceding CABG	
	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.

Supporting Definitions: (none)

Seq. #: 9015 Name: CABG Location

Coding Instructions: Indicate the location where the coronary artery bypass graft (CABG) surgery is being performed.

Note(s):

Code the appropriate selection for surgeries performed at your facility or transferred for planned CABG surgery at another facility.

Target Value: Any occurrence between arrival and discharge

Selections:	<i>Selection Text</i>	<i>Definition</i>
	At your facility	
	Transferred to other facility	

Supporting Definitions: (none)

Seq. #: 9020 Name: CABG Date

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

Target Value: The first value between arrival and discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 9021 Name: CABG Time

Coding Instructions: Indicate the time of the coronary artery bypass graft (CABG) surgery.

Note(s):

The time of the procedure is the time to the nearest minute, that the skin incision, or its equivalent, was made in order to start the surgical procedure.

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

Target Value: The first value on CABG Date

Selections: (none)

Supporting Definitions: (none)

K. Discharge

Seq. #: 9025 Name: Other Major Surgery**Coding Instructions:** Indicate if the patient had other major surgery during this episode of care that may impact the patient's length of stay and/or clinical outcomes.**Note(s):**

Other major surgery may include other cardiac, vascular, thoracic, abdominal, peripheral or other surgical procedures.

Target Value: Any occurrence between arrival and discharge**Selections:***Selection Text**Definition*

No

Yes

Supporting Definitions: (none)**Seq. #: 9030 Name:** Left Ventricular Ejection Fraction**Coding Instructions:** Code the best estimate of the current left ventricular ejection fraction closest to discharge.**Note(s):**

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

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

If only a range is reported, report the center of the range (i.e. 50-55%, is reported as 53%).

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.

If LVEF was not performed at this facility, code "yes" for LVEF Not Assessed (9031).

Target Value: The last value between arrival and discharge**Selections:** (none)**Supporting Definitions:** LVEF:

The Left Ventricular Ejection Fraction is the percentage of the blood emptied from the left ventricle at the end of the contraction.

Source: NCDR, The Society of Thoracic Surgeons

Seq. #: 9031 Name: Left Ventricular Ejection Fraction Not Assessed**Coding Instructions:** Indicate whether the left ventricular ejection fraction was not assessed at this facility.**Target Value:** The last value between arrival and discharge**Selections:***Selection Text**Definition*

No

Yes

Supporting Definitions: (none)

K. Discharge**Seq. #: 9035 Name:** Discharge Date**Coding Instructions:** Indicate the date on which the patient was discharged from your facility.**Note(s):**

If the deceased is an organ donor, code the Discharge Date as the date of the final organ harvest.

Target Value: The value on discharge**Selections:** (none)**Supporting Definitions:** (none)**Seq. #: 9040 Name:** Discharge Status**Coding Instructions:** Indicate whether the patient was alive or deceased at discharge.**Target Value:** The value on discharge**Selections:**

Selection Text Definition

Alive

Deceased

Supporting Definitions: (none)**Seq. #: 9045 Name:** Discharge Location**Coding Instructions:** Indicate the location to which the patient was discharged.**Target Value:** The value on discharge**Selections:**

Selection Text Definition

Home

Extended

care/TCU/rehabilitation

Other acute care hospital

Nursing home

Hospice

Other

Left against medical advice

The patient was discharged or eloped against medical advice.

Supporting Definitions: (none)

K. Discharge

Seq. #: 9050 Name: Cardiac Rehabilitation Referral**Coding Instructions:** 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.**Note(s):**

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

Target Value: Any occurrence between arrival and discharge

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	
	Ineligible	Ineligible may be selected for patients considered ineligible based on patient-oriented barriers (patient refusal, for example), provider-oriented criteria (patient deemed to have a high-risk condition or contraindication to exercise such as dementia, homebound, long-term nursing home placement >60 days, for example), or health care system barriers (financial barriers or lack of cardiac rehab programs near a patient's home, for example)

Supporting Definitions: 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, et al. "AACVPR/ACC/AHA 2007 Performance Measures on Cardiac Rehabilitation for Referral to and Delivery of Cardiac Rehabilitation/Secondary Prevention Services." Journal of American College of Cardiology. 2007; 50(14), pp 1400-1433

Seq. #: 9055 Name: Death in Lab**Coding Instructions:** If the patient expired during this hospitalization, indicate if the patient expired while in the cath lab.**Target Value:** The value on discharge

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	

Supporting Definitions: (none)**Seq. #: 9060 Name:** Primary Cause of Death**Coding Instructions:** Select the PRIMARY cause of death, i.e. the first significant abnormal event which ultimately led to death.**Target Value:** Any occurrence on discharge

Selections:	<i>Selection Text</i>	<i>Definition</i>
	Cardiac	
	Neurologic	
	Renal	
	Vascular	
	Infection	
	Valvular	
	Pulmonary	
	Unknown	
	Other	

Supporting Definitions: (none)

K. Discharge

Seq. #: 9065 Name: Hospital Status

Coding Instructions: Indicate if the patient was considered an outpatient for the entire stay at your facility.**Note(s):**

The Center for Medicare and Medicaid Services defines an outpatient as a patient who receives professional services in a medical facility for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

Target Value: The value between arrival and discharge

Selections:	<i>Selection Text</i>	<i>Definition</i>
	Outpatient	The patient was an outpatient for this entire episode of care.
	Outpatient converted to inpatient	The patient was considered an outpatient on arrival to the facility, and was converted to an inpatient status during this episode of care.
	Inpatient	The patient was admitted as an inpatient upon arrival to the facility, for this episode of care.

Supporting Definitions: (none)

L. Medications

Seq. #: 9500 Name: Procedure Medications

Coding Instructions: Indicate which medications the patient received 24 hours prior to and during the current PCI procedure.

Note(s):

Complete for each PCI attempted or performed.

To code 'yes' for aspirin, the minimum dose should be at least 75mg.

Target Value: Any occurrence between 24 hours prior to current PCI procedure and during procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 9505 Name: Discharge Medications

Coding Instructions: Indicate which of the following medications the patient was prescribed upon discharge.

Note(s):

Complete only for patients who had a PCI procedure attempted or performed during this episode of care.

Discharge medications not required for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)".

To code 'yes' for aspirin, the minimum dose should be at least 75mg.

Target Value: Any occurrence on discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 9510 Name: Medication Administered

Coding Instructions: Indicates if the medication was administered, not administered, contraindicated or blinded.

Target Value: N/A

Selections:	Selection Text	Definition
	No	Medication was not administered or prescribed.
	Yes	Medication was administered or prescribed.
	Contraindicated	Medication was not administered because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record.
	Blinded	Patient was in a research study or clinical trial and the administration of this specific medication or class of medications is unknown.

Supporting Definitions: (none)

Seq. #: 9515 Name: Medication ID

Coding Instructions: Indicates the NCDR assigned ID for the medication in effect at the time of the patient's date of arrival to your facility.

The medications that should be collected in your application are controlled by the MedicationMaster 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 MedicationMaster 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

Selections: (none)

Supporting Definitions: (none)