CathPCI Registry®

V5 Data Dictionary Supplement
with Pending Data Element Updates

The mission of the NCDR® is to improve the quality of cardiovascular patient CathPCI by providing information, knowledge and tools; implementing quality initiatives; and supporting research that improves patient CathPCI and outcomes.

The NCDR® is an initiative of the American College of Cardiology Foundation, with partnering support from the Society for Cardiovascular Angiography and Interventions for the CathPCI Registry.

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Section G. Cath Lab Visit

Seq#7400 Indications for Cath Lab Visit

Name	Definition
ACS <= 24 hrs	The patient has Acute Coronary Syndrome (ACS) (unstable angina, NSTEMI or STEMI) **<= 24 hours** prior to cath lab presentation.
ACS > 24 hrs	The patient has Acute Coronary Syndrome (ACS) (unstable angina, NSTEMI or STEMI) **> 24 hours** prior to cath lab presentation. (STEMI/NSTEMI <= 7days from symptoms) *APPSUPPORT-7889 6/3/19*
New Onset Angina <= 2 months	The patient has **new onset angina** (typical or atypical angina), within two months of cath lab presentation.
Worsening Angina	The patient has a **history of angina** that has increased in severity or frequency within the last 2 months.
Resuscitated Cardiac Arrest	The patient presents status post cardiac arrest.
Stable Known CAD	The patient has **known** coronary artery disease >= 50% in at least one vessel.
Suspected CAD	The patient presents for **suspected** coronary artery disease, there is no prior documentation of CAD >= 50 % in a vessel.
Valvular Disease	The patient has disease of at least one heart valve.
Pericardial Disease	The patient has pericardial disease (an inflammation of the pericardial sac).

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Name	Definition
Cardiac Arrhythmia	The patient has a cardiac arrhythmia (also known as cardiac dysrhythmia or irregular heartbeat, a group of conditions in which the heartbeat is irregular, too fast, or too slow).
Cardiomyopathy	The patient has cardiomyopathy (disease of the heart muscle). Types of cardiomyopathy include; hypertrophic cardiomyopathy, dilated cardiomyopathy, restrictive cardiomyopathy, arrhythmogenic right ventricular dysplasia and Takotsubo cardiomyopathy.
LV Dysfunction	The patient has left ventricular (LV) dysfunction. In left-sided or left ventricular heart failure, the left side of the heart must work harder to pump the same amount of blood. The two types of LV dysfunction are systolic (reduced ejection fraction -HFrEF) and diastolic (preserved ejection fraction - HFpEF) heart failure.
Syncope	The patient has experienced syncope, a temporary loss of consciousness usually related to insufficient blood flow to the brain. It's also called fainting or "passing out".
Post Cardiac Transplant	The patient has received a cardiac transplant.
Pre-operative evaluation	The patient requires cardiac evaluation of the coronary arteries and/or LV function.
Evaluation for Exercise Clearance	The patient presents for clearance to participate in an exercise program or cardiac rehab.
Other	Not otherwise specified.

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Seq#7405 Chest Pain Symptom Assessment

Documentation of:	Supports coding:
▪ Typical angina ▪ Substernal chest discomfort with characteristic quality/duration that is provoked by exertion or emotional stress and relieved by rest or nitroglycerin ▪ CCS IV ▪ Angina *with* STEMI presentation ▪ Unstable angina	**Typical Angina** Symptoms meet all three of the characteristics of angina (also known as definite): 1. Substernal chest discomfort with a characteristic quality and duration that is 2. provoked by exertion or emotional stress and 3. relieved by rest or nitroglycerin.
▪ Atypical angina ▪ Two of the three characteristics of typical angina ▪ CCS I, II, III	**Atypical Angina** Symptoms meet two of the three characteristics of typical angina (also known as probable).
▪ Non-anginal chest pain ▪ One of the typical characteristics of angina ▪ Non-ischemic chest pain ▪ Costochondritis ▪ Chest wall pain	**Non-anginal Chest Pain** The patient meets one, or none of the typical characteristics of angina.
▪ No symptoms, no angina ▪ Asymptomatic ▪ No complaints of pain	**Asymptomatic** No typical or atypical symptoms or non-anginal chest pain.
Documentation of “anginal equivalent” symptoms are coded as ‘atypical angina’ unless provider documentation identifies they are representative of ‘typical angina’.	

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Section I. PCI Procedure

Seq#7825 Percutaneous Coronary Intervention Indication

Name	Definition
STEMI - Immediate PCI for Acute STEMI	Immediate PCI for STEMI (or STEMI equivalent) - PCI is performed emergently and without delay after diagnosis (<12 hrs).
STEMI - Stable (<= 12 hrs from Sx)	PCI for STEMI (or STEMI equivalent) occurs <= 12 hours from symptom. There are no symptoms of recurrent or persistent ischemia, symptoms of heart failure or electrical instability.
STEMI - Stable (> 12 hrs from Sx)	PCI for STEMI (or STEMI equivalent) occurs > 12 hours from symptom. There are no symptoms of recurrent or persistent ischemia, symptoms of heart failure or electrical instability.
STEMI - Unstable (> 12 hrs from Sx)	PCI for STEMI (or STEMI equivalent) > 12 hours from symptom with recurrent or persistent symptoms, symptoms of heart failure or ventricular arrhythmia.
STEMI (after successful lytics)	PCI for STEMI (or STEMI equivalent) after receiving full-dose thrombolysis. There are no symptoms of recurrent or persistent ischemia, symptoms of heart failure or electrical instability.
STEMI - Rescue (after unsuccessful lytics)	Rescue PCI for STEMI (or STEMI equivalent) after failed full-dose thrombolysis for symptoms of recurrent or persistent ischemia, symptoms of heart failure or electrical instability.
New Onset Angina <= 2 months	PCI is performed for the patient's new onset angina (typical or atypical angina) that developed **within the previous 2 months**

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Name	Definition
NSTE - ACS	PCI for NSTEMI (<= 7days from symptoms) or acute coronary syndrome. *APPSUPPORT-7889 6/3/19*
Stable Angina	Angina without a change in frequency or pattern for the six weeks prior to this cath lab presentation. Angina is controlled by rest and/or oral or transcutaneous medications.
CAD (without Ischemic Sx)	PCI is performed for known coronary artery disease there are no symptoms of ischemia (typical angina and/or ST segment elevation).
Other	PCI Indication not listed.

Review of Cath Lab Indications & Possible PCI Indications

Seq#7400 (Cath Lab Indications) All indications that apply to the case scenario are selected.
Seq#7825 (PCI Indication) The highest value PCI Indication that applies to the cath lab indication(s) is selected.
Whenever an ACS cath lab indication ***has been*** selected, choose the applicable ACS PCI Indication.
When an ACS cath lab indication has ***not been*** selected then the next highest cath lab indication will determine the PCI Indication selection (consider the presence/absence of chest pain symptoms).

	Immediate PCI for STEMI	STEMI Stable ≤12hrs / Sx	STEMI Stable > 12hrs / Sx	STEMI Unstable >12hrs / Sx	STEMI *after* successful lytics	STEMI Rescue *after* unsuccessful lytics	NSTE* or ACS	New Onset Angina ≤ 2months	Stable Angina	CAD *without* ischemic Sx	Other
ACS ≤24 hours											
ACS > 24 hours											
New Onset Angina ≤ 2 months											
Stable Known CAD											
Suspected CAD											
Worsening Angina											
Resuscitated Cardiac Arrest											
Valvular Disease											
Pericardial Disease											
Cardiac Arrhythmia											
Cardiomyopathy											
LV Dysfunction											
Syncope											
Post-Cardiac Transplant											
Pre-operative Evaluation											
Evaluation for Exercise Clearance											
Other											

**NSTEMI is only relevant when diagnosed ≤ 7 days from the PCI procedure*

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Section K. Intra and Post-Procedure Events

Seq#9001 Intra/Post Procedure Events

Name	Coding Instructions	Definition
Bleeding: Access Site	Indicate whether the patient experienced external bleeding at the access (percutaneous) site that was observed and documented in the medical record: To qualify there must be evidence of 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).	
Bleeding: Gastrointestinal	Indicate whether the patient experienced gastrointestinal bleeding that was observed and documented in the medical record: To qualify there must be evidence of 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).	

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Name	Coding Instructions	Definition
Bleeding: Genitourinary	Indicate whether the patient experienced genital or urinary bleeding that was observed and documented in the medical record: To qualify there must be evidence of 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).	
Bleeding: Hematoma at Access Site	Indicate whether the patient experienced a hematoma at the percutaneous entry site that was observed and documented in the medical record: To qualify there must be evidence of 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).	

Name	Coding Instructions	Definition
Bleeding: Retroperitoneal	Indicate whether the patient experienced retroperitoneal bleeding that was observed and documented in the medical record: To qualify there must be evidence of 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).	
Bleeding: Other	Indicate whether the patient experienced a bleeding event not available for selection within the registry that was observed and documented in the medical record: To qualify there must be evidence of 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).	

Name	Coding Instructions	Definition
Cardiac Arrest	Indicate whether the patient experienced cardiac arrest	Cardiac arrest is defined as ***acute cardiac event*** documented by one of the following: • Ventricular fibrillation • Rapid ventricular tachycardia or bradycardia rhythms with hemodynamic compromise causing loss of consciousness • Pulseless rhythms (PEA) • Asystole Requiring cardiopulmonary resuscitation (two or more chest compressions or open chest massage, emergency temporary pacing, pericardiocentesis, institution of ECMO, or defibrillation) and without these measures death would have almost certainly resulted. **Note**: If an event occurs that meets the above definition of cardiac arrest, code "yes" regardless of a resuscitation status of DNR/hospice/comfort care *APPSUPPORT-7606 5/3/19*
Cardiac Tamponade	Indicate whether the patient experienced fluid in the pericardial space compromising cardiac filling and requiring intervention	Tamponade must 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
Cardiogenic Shock	Indicate whether the patient experienced new onset or an acute recurrence of cardiogenic shock	Cardiogenic shock is defined as a sustained (>30 min) episode of systolic blood pressure <90 mm Hg and/or cardiac index <2.2 L/min per square meter determined to be secondary to cardiac dysfunction and/or the requirement for parenteral inotropic or vasopressor agents or mechanical support (eg, IABP, extracorporeal circulation, VADs) to maintain blood pressure and cardiac index above those specified levels. Note: Transient episodes of hypotension reversed with IV fluid or atropine do not constitute cardiogenic shock. The hemodynamic compromise (with or without extraordinary supportive therapy) must persist for at least 30 min.

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

Name	Coding Instructions	Definition
Myocardial Infarction	Indicate whether the patient experienced a **NEW** occurrence of biomarker positive myocardial infarction *(at least one determination of biomarkers obtained no sooner than 6 hours after the procedure, preferably within the interval of 6-24 hours post-procedure should be used)* **Notes:** Code 'Yes' when new Q waves are present with absent, incomplete or inconclusive biomarkers. Code 'Yes' when biomarkers are not obtained in the setting of post-PCI acute MI	See below

The term acute myocardial infarction (MI) should be used when there is evidence of myocardial necrosis in a clinical setting consistent with acute myocardial ischemia. Under these conditions, ***any one*** of the following criteria meets the diagnosis for MI:

- Detection of a rise and/or fall of cardiac biomarker values [preferably cardiac troponin (cTn)] with at least one value above the 99th percentile upper reference limit (URL) and with at least ***one*** of the following:
  - Symptoms of ischemia
  - New of presumed new significant ST-segment – T wave (ST-T) changes or new LBBB
  - Development of pathological Q waves in the ECG
  - Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality
  - Identification of an intracoronary thrombus by angiography or autopsy
- Cardiac death with symptoms suggestive of myocardial ischemia and presumed new ischemic ECG changes or new LBBB, but death occurred before cardiac biomarkers were obtained, or before cardiac biomarker values would be increased
- **PCI related MI** is arbitrarily defined by elevation of cTn values (>5 x 99th percentile URL) in patients with normal baseline values (≤99th percentile URL) or a rise of cTn values >20% if the baseline values are elevated and are stable or falling. In addition, either (i) symptoms suggestive of myocardial ischemia or (ii) new ischemia ECG changes or (iii) angiographic findings consistent with a procedural complication or (iv) imaging demonstration of loss of viable myocardium or new regional wall motion abnormality are required
- Stent thrombosis associated with MI when detected by coronary angiography or autopsy in the setting of myocardial ischemia and with a risk and/or fall of cardiac biomarker values with at least one value above the 99th percentile URL
- **CABG related MI** is arbitrarily defined by elevation of cardiac biomarker values (>10 x 99th percentile URL) in patients with normal baseline cTn values (≤99th percentile URL). In additional, either (i) new pathological Q waves or new LBB, or (ii) angiographic documented new graft or new native coronary artery occlusion, or (iii) imaging evidence of new loss of viable myocardium or new regional wall motion abnormality

Name	Coding Instructions	Definition
New Requirement for Dialysis	Indicate whether the patient experienced acute or worsening renal failure necessitating renal dialysis Note: Code 'Yes' if the patient is receiving continuous veno-venous hemofiltration (CVVH) as a result of renal failure (and not as treatment to remove fluid for heart failure)	
Other Vascular Complications Requiring Treatment	Indicate whether the patient experienced any other vascular complications (excluding external bleeding or hematomas) at the percutaneous entry site that required treatment or intervention. To qualify, this adverse outcome should be attributable to this procedure and not related to a previous or subsequent procedure.	Vascular complications can include, but are not limited to, access site occlusions, peripheral embolization's, 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.
Stroke: Hemorrhagic	Indicate whether the patient experienced 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. Hemorrhage may be a consequence of ischemic stroke. In this situation, the stroke is an ischemic stroke with hemorrhagic transformation and NOT a hemorrhagic stroke. **Note: Subdural hematomas are intracranial hemorrhagic events and not strokes.**

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Name	Coding Instructions	Definition
Stroke: Ischemic	Indicate whether the patient experienced an ischemic stroke	An ischemic stroke is an acute episode of focal or global neurological dysfunction caused by brain, spinal cord, or retinal vascular injury as a result of infarction of central nervous system tissue.
Stroke: Undetermined	Indicate whether the patient experienced a stroke of unknown origin	A stroke with insufficient information to allow categorization as either ischemic or hemorrhagic. A stroke is defined as an acute episode of focal or global neurological dysfunction caused by presumed brain, spinal cord, or retinal vascular injury.

Section M. Follow-Up

Seq#11011 Event(s)

Name	Coding Instructions	Definition
Bleeding Event	Indicate whether the patient experienced a bleeding event	A bleeding event must include evidence of 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).
CABG: Bypass of stented lesion	Indicate whether the patient had a stented lesion bypassed by a graft during coronary artery bypass graft surgery	Coronary artery bypass graft surgery of a stented lesion is when a previously stented native vessel of the heart is bypassed with another vessel (internal mammary artery, radial artery or saphenous vein) to restore normal blood flow to the obstructed coronary arteries.
CABG: Bypass of non-stented lesion	Indicated whether the patient had a non-stented lesion bypassed by a graft during coronary artery bypass graft surgery	Coronary artery bypass graft surgery of a NON-stented lesion is when a previously NON-stented native vessel of the heart is bypassed with another vessel (internal mammary artery, radial artery or saphenous vein) to restore normal blood flow to the obstructed coronary arteries.
Myocardial Infarction: NSTEMI	Indicate whether the patient experienced a Non-ST elevation myocardial infarction	A Non-ST-elevation myocardial infarction is defined as a development of heart muscle necrosis without the ECG change of ST-segment elevation.
Myocardial Infarction: Q Wave	Indicate whether the patient experienced a Q-wave myocardial infarction	A myocardial infarction characterized by Q waves that are abnormal either in character or number or both.

Name	Coding Instructions	Definition
Myocardial Infarction: STEMI	Indicate whether the patient experienced an ST elevation myocardial infarction	A type of heart attack that can be defined as development of full thickness cardiac muscle damage resulting from an acute interruption of blood supply to a part of the heart and is diagnosed by ECG change of ST-segment elevation.
Myocardial Infarction: Type Unknown	Indicate whether the patient experienced a myocardial infarction of unknown origin	A heart attack with insufficient information to allow categorization as STEMI, NSTEMI or Q-wave. Myocardial Infarction or heart attack is an acute interruption of blood supply to a part of the heart and can be demonstrated by an elevation of cardiac markers (CK-MB or troponin) in the blood.
PCI of non-stented lesion	Indicate whether the patient received mechanical revascularization to a NON-stented lesion during percutaneous coronary intervention	Percutaneous coronary intervention (PCI) of a NON-stented lesion is a non-surgical procedure used to treat narrowing of the coronary arteries of the heart found in coronary artery disease in a previously non-stented lesion. PCI is defined as any procedure that is performed to widen the lumen of an obstructed coronary artery and involves passing a catheter through the skin and into a blood vessel (as of the groin) to the site of obstruction so the blockage can be compressed (as by use of a balloon catheter often followed by placement of a stent) or removed (as by atherectomy).
PCI of stented lesion	Indicate whether the patient received mechanical revascularization to a stented lesion during percutaneous coronary intervention	Percutaneous coronary intervention (PCI) of a stented lesion is a non-surgical procedure used to treat narrowing (stenosis) of the coronary arteries of the heart found in coronary artery disease in a previously treated and stented lesion. PCI is defined as any procedure that is performed to widen the lumen of an obstructed coronary artery and involves passing a catheter through the skin and into a blood vessel (as of the groin) to the site of obstruction so the blockage can be compressed (as by use of a balloon catheter often followed by placement of a stent) or removed (as by atherectomy).

Name	Coding Instructions	Definition
Readmission: Non-PCI Related	Indicate whether the patient was readmitted to the hospital for a condition unrelated to the percutaneous coronary intervention	Readmission with a condition, unrelated to the percutaneous coronary intervention, and admission to a hospital ward, hospital room or intensive care unit. Visits to the emergency department or observation units do not qualify. A planned readmission for a staged PCI procedure does not qualify.
Stroke: Hemorrhagic	Indicate whether the patient experienced 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. Hemorrhage may be a consequence of ischemic stroke. In this situation, the stroke is an ischemic stroke with hemorrhagic transformation and NOT a hemorrhagic stroke. **Note: Subdural hematomas are intracranial hemorrhagic events and not strokes.**
Stroke: Ischemic	Indicate whether the patient experienced an ischemic stroke	An ischemic stroke is an acute episode of focal or global neurological dysfunction caused by brain, spinal cord, or retinal vascular injury as a result of infarction of central nervous system tissue.
Stroke: Undetermined	Indicated whether the patient experienced a stroke of unknown origin	A stroke with insufficient information to allow categorization as either ischemic or hemorrhagic. A stroke is defined as an acute episode of focal or global neurological dysfunction caused by presumed brain, spinal cord, or retinal vascular injury.
Thrombosis in non-stented lesion	Indicated whether the patient experienced a thrombosis in a NON-stented lesion	The formation of a blood clot inside a non-stented coronary artery lesion.
Thrombosis in stented lesion	Indicated whether the patient experienced a thrombosis in a stented lesion	The formation of a blood clot inside a previously treated and stented lesion.

Pending Data Dictionary Updates

Dear Participants:

Please note the data elements identified below that require edits (identified in red) and apply these amendments to your data abstraction process. The edits identified here have been logged internally and will be amended at the earliest opportunity.

This document will be updated as needed and participants will be alerted via the announcement page of the website. Please continue to monitor the website to ensure you have the most current information to support your data abstraction.

The CathPCI Registry Team

Section C. History and Risk Factors

Seq#4631 (Cardiac Arrest Witnessed)
Coding Instruction: Indicate if the out-of-hospital cardiac arrest was witnessed by another person.
Note(s): If multiple instances of 'cardiac arrest' occurred prior to arrival at a healthcare facility, please complete this data element based on the FIRST cardiac arrest event.
Target Value: The value on arrival at this facility
CVU-56 10/16/19

Seq#4632 (Cardiac Arrest After Arrival of Emergency Medical Services)
Coding Instruction: Indicate if the out-of-hospital cardiac arrest occurred after arrival of Emergency Medical Services (EMS).
Note(s): If multiple instances of 'cardiac arrest' occurred prior to arrival at a healthcare facility, please complete this data element based on the FIRST cardiac arrest event.
Target Value: The value on arrival at this facility
CVU-57 10/16/18

Section D. Pre-Procedure Information (Complete for each Cath Lab Visit)

Seq#5037 (Electrocardiac Assessment Method)
Coding Instruction: Indicate the method used for electrocardiac assessment.
Target Value: Last value (abnormal, uninterpretable or normal) between 30 days prior to 1st procedure (or previous procedure) and current procedure
CVU-45 10/16/18

Seq#5032 (Results)

Coding Instruction: Indicate the results of the electrocardiac assessment.

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

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

CVU-45 10/16/18

Section F. Labs

Seq#6030 (Hemoglobin Value)

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

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

CVU-11 12/22/17

Section G. Cath Lab Visit (Complete for each Cath Lab Visit)

Seq#7410 Cardiovascular Instability

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

Note(s): Code 'Yes' when the patient's signs and symptoms (that meet the definition) are present *or* actively being managed with pharmacological or mechanical support on arrival to the cath lab.

Code 'No' when signs/symptoms of cardiac instability are *not* present *or* actively being managed with pharmacological or mechanical support on arrival to the cath lab.

Target Value: The value on current procedure

APPSUPPORT-11156 3/24/20

Seq#7415 Cardiovascular Instability Type

Coding Instruction: Indicate the cardiovascular instability type.

Note(s): Indicate all instability types present or actively being managed

Only select 'hemodynamic instability (not cardiogenic shock)' when the definition is met and neither cardiogenic shock definition is applicable. This selection is all encompassing of hemodynamic instability and shock scenarios NOT including cardiogenic shock. When cardiogenic shock is present it is understood hemodynamic instability is present.

Target Value: ~~The value~~ Any occurrence on current procedure

APPSUPPORT-11156 3/24/20

Section H. Coronary Anatomy

Seq#7511 Native Vessel Adjunctive Measurements Obtained

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

Note(s): 'Yes' may also be coded when:

- A CT-FFR result (obtained **prior** to this cath lab visit) is the rationale for the current procedure
- An adjunctive measurement (FFR, iFR, IVUS, OCT) was obtained in this episode of care during a 'diagnostic only' procedure and is the rationale for PCI

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

SQOC – 4/2/20

Seq#7513 Native Vessel Instantaneous Wave-Free Ratio

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

Note(s): A CT-FFR result or a resting non-hyperemic flow reserve ratio may also be coded in this field

- Code '0' to indicate ischemia ***was*** identified (an abnormal result)
  Ischemia is defined as any ONE of the following:
  - CT-FFR value of ≤0.80
  - Abbott RFR value of <0.86
  - Boston Science DFR ≤0.89
  - Boston Science dPR ≤0.89
  - Boston Science Pd/Pa ≤ 0.89
  - OpSense dPR ≤ 0.89
  - Physician documentation that the study results demonstrate ischemia
- Code '1' to indicate ischemia ***was not*** identified
- Continue to enter the actual iFR value documented if iFR was used.

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

SQOC – 4/2/20

Seq#7527 (Segment Number)

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

Note(s): 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).

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

CVU-47 6/18/18

Seq#7531 Graft Vessel Adjunctive Measurements Obtained

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

Note(s): 'Yes' may also be coded when:

- A CT-FFR result (obtained **prior** to this cath lab visit) is the rationale for the current procedure
- An adjunctive measurement (FFR, iFR, IVUS, OCT) was obtained in this episode of care during a 'diagnostic only' procedure and is the rationale for PCI

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

SQOC – 4/2/20

Seq#7533 Graft Vessel Instantaneous Wave-Free Ratio

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

Note(s): A CT-FFR result or a resting non-hyperemic flow reserve ratio may also be coded in this field

- Code '0' to indicate ischemia ***was*** identified (an abnormal result)
  Ischemia is defined as any ONE of the following:
  - CT-FFR value of ≤0.80
  - Abbott RFR value of <0.86
  - Boston Science DFR ≤0.89
  - Boston Science dPR ≤0.89
  - Boston Science Pd/Pa ≤ 0.89
  - OpSense dPR ≤0.89
  - Physician documentation that the study results demonstrate ischemia
- Code '1' to indicate ischemia ***was not*** identified
- Continue to enter the actual iFR value documented if iFR was used.

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

SQOC – 4/2/20

Section I. PCI Procedure (Complete for each Cath Lab Visit in which a PCI was attempted/performed)

Seq#7815: Decision for PCI with Surgical Consult

Coding Instructions: Indicate if a cardiac surgical consult and recommendation were obtained prior to engaging in this PCI procedure

Note(s): Code 'No' if a CV consult/recommendation was obtained after the start of PCI (defined as guidewire insertion)

Target Value: The value on current procedure

CVU-62 12/6/18

Seq#7816 (Cardiovascular Treatment Decision)
Coding Instruction: Indicate the cardiovascular surgery recommendation and/or patient/family decision.
Target Value: The value on current procedure
Coding selection: Surgery Recommended, Patient/Family Accepted ~~(Hybrid Procedure)~~
CVU-7892 6/3/19

Seq#7850 (Patient Centered Reason for Delay in PCI)
Coding Instruction: Indicate if there was a patient-centered reason for delay in performing the percutaneous coronary intervention (PCI).
Target Value: ~~The value on current procedure~~ The first value between arrival at this facility and current procedure
CVU-4587 8/10/18

Seq#7851 (Patient Centered Reason for Delay in PCI Reason)
Coding Instruction: Indicate the patient-centered reason for delay in performing the percutaneous coronary intervention (PCI).
Target Value: ~~The value on current procedure~~ The first value between arrival at this facility and current procedure
CVU-4587 8/10/18

Section K. Intra and Post-Procedure Events (Complete for each Cath Lab Visit)

Element: 9001 Intra/Post-Procedure Events
Coding Instruction: Indicate the event that occurred between the procedure and the next procedure or discharge.
Note(s):
Multiple instances of the same event may be identified if the event occurred more than once during the target timeframe.
If the procedure was a diagnostic 'only' it is acceptable to limit coding events to 30-days when the post-procedure length of stay is >30days
If the procedure was PCI ***and*** the facility is not engaged in collecting follow-up data, it is acceptable to limit coding events to 30-days when the post-procedure length of stay is >30days
Target Value: Any occurrence between start of procedure and until next procedure or discharge
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Seq#9003 (Intra/Post Procedure Event Date/Time)
Coding Instruction: Indicate the date and time the event occurred.
Note(s): If an event occurred more than once on the same date, record the event multiple times with the same date.
If an event occurred more than once in the target timeframe but on different dates, record the event multiple times but with unique dates.
Target Value: Any occurrence between start of procedure and until next procedure or discharge
APPSUPPORT-8172 6/25/19