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:

Selection Text	*Definition*
No	
Yes	

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 follow up, 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. Census Bureau

A. Demographics

Seq. #: 2071 **Name:** Race - Black/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:

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. Census Bureau

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:

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. Census Bureau

Seq. #: 2073 **Name:** Race - American Indian/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:

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. Census Bureau

A. Demographics

Seq. #: 2074 **Name:** Race - Native Hawaiian/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*
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. Census Bureau

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*
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

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. #: 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:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 3010 **Name:** Reason for Admission

Coding Instructions: Indicate the primary reason for admission to your facility.

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
Admitted for this procedure	The patient was admitted specifically to have the ICD or lead procedure.
Cardiac - Heart Failure	Heart failure is the primary reason the patient was admitted to this facility.
Cardiac - Other	A cardiac problem (excluding heart failure) is the primary reason the patient was admitted to this facility.
Non-Cardiac	A non-cardiac problem is the primary reason the patient was admitted to this facility.

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.

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. #: 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:

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

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:

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. #: 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:

Selection Text	*Definition*
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 (Non-Medicaid)

Coding Instructions: Indicate if the patient's insurance payor(s) included State-specific Plan (non Medicaid).

Target Value: The value on arrival at this facility

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **State Specific Plan:**

State-specific plan (non-Medicaid) - 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. #: 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 had 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 (HIC)

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

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

C. History and Risk Factors

Seq. #: 4000 **Name:** Heart Failure

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

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

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

Seq. #: 4005 **Name:** Duration of Symptoms Since Initial HF Onset

Coding Instructions: Indicate the duration of symptoms since initial diagnosis of heart failure.

Target Value: The first value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
< 3 months	
3 to 9 months	
> 9 months	

Supporting Definitions: (none)

Seq. #: 4010 **Name:** Prior Heart Failure Hospitalization

Coding Instructions: Indicate if the patient has been hospitalized for heart failure.

Target Value: The last value between birth and arrival

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4015 **Name:** Prior Heart Failure Hospitalization Timeframe

Coding Instructions: Indicate the timeframe of the most recent hospitalization for heart failure.

Target Value: The last value between birth and arrival

Selections:

Selection Text	*Definition*
<= 6 months	
> 6 months	

Supporting Definitions: (none)

C. History and Risk Factors

Seq. #: 4020 Name: NYHA Functional Classification

Coding Instructions: Indicate the patient's New York Heart Association (NYHA) Functional Classification at the time of decision to implant the generator.

Note(s):

If the patient has no symptoms, code "class 1".

Target Value: The highest value on the first generator procedure in this admission

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)

Seq. #: 4025 Name: Non-Ischemic Dilated Cardiomyopathy

Coding Instructions: Indicate if the patient has a history of non-ischemic dilated cardiomyopathy (NIDCM) documented by heart failure and reduced systolic function (ejection fraction <40%).

Note(s):

A patient with heart failure or a documented history of heart failure, with symptoms classified as New York Heart Association Class I, and an ejection fraction <40 would qualify as a yes if the operator feels the cardiomyopathy is non-ischemic in origin.

If the operator feels the cardiomyopathy is ischemic in origin, code 'No'.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4030 Name: Non-Ischemic Dilated Cardiomyopathy Timeframe

Coding Instructions: Indicate the timeframe since the initial diagnosis of non-ischemic dilated cardiomyopathy.

Target Value: The first value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
< 3 months	
3 to 9 months	
> 9 months	

Supporting Definitions: (none)

C. History and Risk Factors

Seq. #: 4035 **Name:** Prior Heart Transplant

Coding Instructions: Indicate if the patient has had previous heart transplant surgery.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4040 **Name:** On Heart Transplant Waiting List

Coding Instructions: Indicate if the patient is currently on a waiting list to receive a heart transplant.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4045 **Name:** Syncope

Coding Instructions: Indicate if the patient has a history of syncope.

Note(s):

If the patient reports pre-syncope/near syncope (as described by dizziness, lightheadedness, feeling faint, or graying out), code no.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Syncope:**

Syncope is defined as the sudden loss of consciousness with loss of postural tone, not related to anesthesia, with spontaneous recovery as reported by patient or observer. Patient may experience syncope when supine.

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

Seq. #: 4050 **Name:** Family History of Sudden Death

Coding Instructions: Indicate if the patient has a family history (parent or sibling) of sudden death.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Family History of Sudden Cardiac Death:**

Family History (parent or sibling) of sudden cardiac death, defined as natural death due to cardiac causes, heralded by abrupt loss of consciousness, occurring before 75 years of age. The time and mode of death are unexpected even though preexisting heart disease may have been known to be present. Traumatic death subsequently proven to be due to sudden loss of control due to a cardiac problem is included.

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

C. History and Risk Factors

Seq. #: 4055 **Name:** Atrial Fibrillation/Flutter

Coding Instructions: Indicate if the patient has a history of atrial fibrillation and/or atrial flutter documented in the medical record.

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

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. #: 4060 **Name:** Atrial Fibrillation/Flutter Classification

Coding Instructions: Indicate the classification of atrial fibrillation or flutter.

Note(s):

If a patient fits in more than one category choose their most recent and most frequent presentation. For example, first detected atrial fibrillation (AF) can be either paroxysmal or persistent. A patient may have several episodes of paroxysmal AF and occasional persistent AF (code as paroxysmal) or the reverse (code as persistent).

If a patient had permanent atrial fibrillation that was ablated, then it reoccurred and is now paroxysmal, code paroxysmal.

Termination with pharmacological therapy or direct-current cardioversion does not alter designation.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
Paroxysmal	The arrhythmia terminates spontaneously (without pharmacological therapy or electrical cardioversion).
Persistent (> 7 days)	The arrhythmia is sustained beyond seven days (and is not self terminating). This category also includes cases of long-standing atrial fibrillation (e.g. greater than one year), cases where atrial fibrillation terminates with pharmacological therapy or electrical cardioversion, or cases where cardioversion is not indicated, not attempted, or unsuccessful.
Permanent (> 1 year)	The arrhythmia has persisted for greater than one year, where pharmacological therapy and/or cardioversion has failed or has been foregone.
Secondary (reversible cause)	Secondary atrial fibrillation occurs when atrial fibrillation is transient and due to an unrelated, reversible cause. It is not the primary problem and treatment of the underlying disorder usually terminates the arrhythmia. It occurs in the setting of acute myocardial infarction, cardiac surgery, pericarditis, myocarditis, hyperthyroidism, or acute pulmonary disease. Conversely, when it is known that atrial fibrillation occurs in the course of a concurrent disorder like well-controlled hypothyroidism, it is not considered secondary.
Unknown	The patient has a history of atrial fibrillation but the classification is not known or not specified.

Supporting Definitions: (none)

C. History and Risk Factors

Seq. #: 4065 **Name:** Ventricular Tachycardia

Coding Instructions: Indicate if the patient had a history of ventricular tachycardia (VT). To qualify as history, VT should be spontaneous and not induced.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Ventricular Tachycardia:**

Ventricular Tachycardia is a cardiac arrhythmia of 3 or more consecutive complexes in duration emanating from the ventricles at a rate of >100 bpm (cycle length: <600 ms).

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

Seq. #: 4070 **Name:** Hemodynamic Instability

Coding Instructions: Indicate if the patient demonstrated hemodynamic instability while having episodes of sustained or non-sustained ventricular tachycardia. Hemodynamic instability can include periods of reduced, unstable, or abnormal blood pressure with near syncope, or episodes of syncope. It creates a state of hypoperfusion that does not support normal organ perfusion or function.

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

Selections:

Selection Text	*Definition*
No	
Yes	
Unknown	

Supporting Definitions: (none)

Seq. #: 4075 **Name:** Ventricular Tachycardia Type

Coding Instructions: Indicate the type of ventricular tachycardia.

Target Value: The highest value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
Non-sustained VT	Nonsustained or unsustained ventricular tachycardia (VT) is three or more beats in duration, terminating spontaneously in <30 seconds. Non-sustained VT can be monomorphic or polymorphic.
Sustained monomorphic VT	Sustained monomorphic ventricular tachycardia (VT) is VT >30 seconds in duration or requiring termination due to hemodynamic compromise in <30 seconds that has a stable, single QRS morphology.
Sustained polymorphic VT	Sustained polymorphic ventricular tachycardia (VT) is VT >30 seconds in duration or requiring termination due to hemodynamic compromise in <30 seconds that has a changing or multiform QRS morphology at cycle length >180 milliseconds.
Sustained monomorphic and polymorphic VT	The patient has a history of both sustained monomorphic and sustained polymorphic ventricular tachycardia.
Unknown	The patient has a history of ventricular tachycardia but the specific type is not known.

Supporting Definitions: (none)

C. History and Risk Factors

Seq. #: 4080 **Name:** Cardiac Arrest

Coding Instructions: Indicate if the patient experienced cardiac arrest due to arrhythmia.

Note(s):

If a patient experienced ventricular fibrillation caused by lead manipulation during the procedure, and it required defibrillation, code no.

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

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 death should not be used to describe events that are not fatal.

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

Seq. #: 4085 **Name:** Most Recent Cardiac Arrest Date

Coding Instructions: Indicate the date of the most recent cardiac arrest.

Target Value: The last value between birth and the first generator procedure in this admission

Selections: (none)

Supporting Definitions: (none)

Seq. #: 4090 **Name:** VTach/VFib Arrest

Coding Instructions: Indicate if the cardiac arrest was a result of ventricular tachycardia or ventricular fibrillation.

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.

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

Selections:

Selection Text	*Definition*
No	
Yes	
Unknown	

Supporting Definitions: (none)

Seq. #: 4095 **Name:** Bradycardia Arrest

Coding Instructions: Indicate if the cardiac arrest was a result of bradycardia.

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

Selections:

Selection Text	*Definition*
No	
Yes	
Unknown	

Supporting Definitions: (none)

C. History and Risk Factors

Seq. #: 4100 **Name:** Special Syndromes w/Risk of Sudden Death

Coding Instructions: Indicate if the patient has a special syndrome that puts him/her at risk for sudden death.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4105 **Name:** Special Syndrome Type

Coding Instructions: Specify the type of syndrome that puts the patient at risk for sudden death.

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

Selections:

Selection Text	*Definition*
Long QT syndrome	History of ECG findings of prolonged QT interval. Long QT Syndrome includes prolongation of the corrected QT interval beyond 440 ms for adult males, 460 ms for adult females and 50 ms in the presence of ventricular depolarization abnormalities (i.e., bundle branch blocks or IVCB more than 120 ms. Note: A normal QT interval in a resting ECG with a failure to shorten with an increase in heart rate qualifies as Long QT Syndrome.
Short QT syndrome	History of ECG findings of short QT interval. Short QT Syndrome is characterized by a QT interval of <=300 ms.
Brugada syndrome	Polymorphic ventricular tachycardia in the absence of structural heart disease, associated with a baseline ECG pattern during sinus rhythm showing right bundle branch block with ST segment elevation in leads V1 through V3. It can also be characterized by documentation of ECG patterns associated with Brugada Syndrome, some of which may be unmasked when provoked with drugs. The most common genetic mutations identified for Brugada syndrome are in a sodium channel gene (SCN5A). Sodium channel blocking drugs, therefore, may exacerbate the electrocardiographic features and clinical presentation. Brugada syndrome typically presents before the age of 50 years.
Catecholaminergic polymorphic VT	Ventricular Tachycardia associated with syncope and/or cardiac arrest triggered by emotion or exercise in patients whose baseline ECG is normal.
Idiopathic/primary VT/VF	Ventricular tachycardia or ventricular fibrillation whose cause is unknown.
Other	The patient has a special syndrome with risk of sudden death which is not specified above.

Supporting Definitions: (none)

Seq. #: 4110 **Name:** Previous ICD

Coding Instructions: Indicate if the patient had a previous implantable cardioverter defibrillator (ICD).

Target Value: Any occurrence between birth and arrival

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

C. History and Risk Factors

Seq. #: 4115 **Name:** Previous ICD Type

Coding Instructions: Indicate the type of implantable cardioverter defibrillator (ICD).

Target Value: The last value between birth and arrival

Selections:

Selection Text	*Definition*
Single chamber	A single-chamber ICD defibrillates the ventricle and paces the ventricle.
Dual chamber	A dual-chamber ICD defibrillates the ventricle and paces the atrium and ventricle.
CRT-D	A cardiac resynchronization therapy device and defibrillator (CRT-D) has dual capabilities. It is a biventricular pacemaker that sends electrical signals to both ventricles as well as a defibrillator. It may or may not have an atrial pacing wire.

Supporting Definitions: (none)

Seq. #: 4120 **Name:** Previous ICD Implant Site

Coding Instructions: Indicate the location in the body where the previous ICD was implanted.

Target Value: The last value between birth and arrival

Selections:

Selection Text	*Definition*
Pectoral	The ICD was implanted in the pectoral wall.
Abdominal	The ICD was implanted in the abdominal wall.

Supporting Definitions: (none)

Seq. #: 4125 **Name:** Previous ICD Date

Coding Instructions: Indicate the date the patient had a previous ICD.

Note(s):

If month or day is unknown, enter "01".

Target Value: The last value between birth and arrival

Selections: (none)

Supporting Definitions: (none)

C. History and Risk Factors

Seq. #: 4130 Name: Previous ICD Reason

Coding Instructions: Indicate the reason the previous ICD was implanted.

Note(s):

If the patient originally presented with an indication of primary prevention, then had an event that categorized them as secondary prevention, code the patient as secondary prevention.

Target Value: The last value between birth and the previous ICD date

Selections:

Selection Text	*Definition*
Primary prevention	Primary Prevention is an indication for an ICD to prevent sudden cardiac death. It refers to use of ICDs in individuals who are at risk for but have not yet had an episode of sustained ventricular tachycardia, ventricular fibrillation, or resuscitated cardiac arrest.
Secondary prevention	Secondary prevention refers to an indication for ICD exclusively for patients who have survived one or more cardiac arrests or sustained ventricular tachycardia. Patients with cardiac conditions associated with a high risk of sudden death who have unexplained syncope that is likely to be due to ventricular arrhythmias are considered to have a secondary indication.

Supporting Definitions:

Primary Prevention:

Primary Prevention is an indication for an ICD to prevent sudden cardiac death. It refers to use of ICDs in individuals who are at risk for but have not yet had an episode of sustained ventricular tachycardia, ventricular fibrillation, or resuscitated cardiac arrest.

Source: ACC/AHA//HRS 2008 Guidelines for Device-Based Therapy of Cardiac Rhythm Abnormalities

Secondary Prevention:

Secondary prevention refers to an indication for ICD exclusively for patients who have survived one or more cardiac arrests or sustained ventricular tachycardia. Patients with cardiac conditions associated with a high risk of sudden death who have unexplained syncope that is likely to be due to ventricular arrhythmias are considered to have a secondary indication.

Source: ACC/AHA//HRS 2008 Guidelines for Device-Based Therapy of Cardiac Rhythm Abnormalities

Seq. #: 4135 Name: Implant Decision LVEF

Coding Instructions: Indicate the left ventricular ejection fraction that led to the implant decision.

Target Value: Any occurrence between birth and the previous ICD date

Selections: (none)

Supporting Definitions: (none)

Seq. #: 4136 Name: Implant Decision LVEF Not Available

Coding Instructions: Indicate if the left ventricular ejection fraction that led to the implant decision is not available.

Target Value: Any occurrence between birth and the previous ICD date

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

C. History and Risk Factors

Seq. #: 4140 **Name:** Reason for Initial Implant - Cardiac Arrest/Arrhythmia-Etiology Unknown

Coding Instructions: Indicate if the reason the previous ICD was implanted for secondary prevention was that the patient had an episode of cardiac arrest or arrhythmia where the etiology was unknown. This includes a sudden loss of consciousness requiring cardioversion or defibrillation to restore hemodynamic stability.

Target Value: Any occurrence between birth and the previous ICD date

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4141 **Name:** Reason for Initial Implant - Spontaneous Sustained Ventricular Tachycardia

Coding Instructions: Indicate if the reason the previous ICD was implanted for secondary prevention was that the patient had an episode of ventricular tachycardia (VT) that started spontaneously. Spontaneous VT lasts >30 seconds in duration or requires termination due to hemodynamic compromise in <30 seconds.

Target Value: Any occurrence between birth and the previous ICD date

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4142 **Name:** Reason for Initial Implant - Syncope with High Risk Characteristics

Coding Instructions: Indicate if the reason the previous ICD was implanted for secondary prevention was that the patient had an episode of syncope (sudden loss of consciousness with loss of postural tone not related to anesthesia) with high risk characteristics. High risk characteristics include non-ischemic dilated cardiomyopathy, or ischemic heart disease with significant ventricular dysfunction, hypertrophic cardiomyopathy, Brugada Syndrome, or Long QT Syndrome.

Target Value: Any occurrence between birth and the previous ICD date

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4143 **Name:** Reason for Initial Implant - Syncope With Inducible Ventricular Tachycardia

Coding Instructions: Indicate if the reason the previous ICD was implanted for secondary prevention was that the patient had an episode of syncope (sudden loss of consciousness with loss of postural tone not related to anesthesia) while ventricular tachycardia (VT) was induced during an electrophysiological study that induced VT.

Target Value: Any occurrence between birth and the previous ICD date

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

C. History and Risk Factors

Seq. #: 4144 **Name:** Reason for Initial Implant - Ventricular Fibrillation

Coding Instructions: Indicate if the reason the previous ICD was implanted for secondary prevention was that the patient had an episode of ventricular fibrillation (VF). VF is a rapid, usually more than 300 beats per minute (cycle length 180 msec or less) grossly irregular ventricular rhythm with marked variability in cycle length, lack of discernible discreet QRS complex.

Target Value: Any occurrence between birth and the previous ICD date

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4145 **Name:** Reason for Initial Implant - Not Documented in the Medical Record

Coding Instructions: Indicate if the reason the previous ICD was implanted for secondary prevention was not documented in the medical record.

Target Value: Any occurrence between birth and the previous ICD date

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4150 **Name:** Permanent Pacemaker

Coding Instructions: Indicate if the patient currently has a permanent pacemaker or had a permanent pacemaker that was implanted at any time prior to this procedure. This includes patients that had a permanent pacemaker previously, but the device is no longer in place.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4155 **Name:** Pacemaker Type

Coding Instructions: Indicate the type of pacemaker.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
Atrial chamber	One wire or pacing lead is placed into the atrium of the heart.
Ventricular chamber	One wire or pacing lead is placed into the ventricle of the heart.
Dual chamber	Wires are placed in two chambers of the heart. One lead paces the atrium and one paces the ventricle. This type of pacemaker can coordinate function between the atria and ventricles.
CRT	Cardiac resynchronization therapy (CRT). A biventricular pacemaker that sends electrical signals to both ventricles that resynchronizes the heart chambers and helps it pump more effectively. It may or may not have an atrial pacing wire.

Supporting Definitions: (none)

C. History and Risk Factors

Seq. #: 4160 **Name:** Ischemic Heart Disease

Coding Instructions: Indicate if the patient has a history of ischemic heart disease that is documented in the medical record.

Target Value: The highest value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Ischemic Heart Disease:**

Ischemic heart disease is evidenced by any one of the following:

1. History of myocardial infarction (MI) manifested as
a) Wall motion abnormality felt consistent with MI on echocardiography, nuclear imaging, ventriculography, cardiac MR, or other imaging;
b) ECG evidence of prior MI or acute MI;
c) Cardiac biomarker elevation and clinical presentation (e.g., chest pain) consistent with MI;

2. History of Percutaneous Coronary Angioplasty;

3. History of Coronary Artery Bypass Graft Surgery;

4. Conventional coronary angiography demonstrates >=70% stenosis in at least one major coronary artery.

5. Stress testing (with or without imaging) diagnostic of coronary artery disease.

Source: NCDR

Seq. #: 4165 **Name:** One Epicardial Artery >=70% Confirmed by Angiography

Coding Instructions: Indicate if ischemic heart disease is confirmed with at least one epicardial artery with >= 70% obstruction by angiography (or the left main coronary artery >=50%).

Target Value: The highest value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

C. History and Risk Factors

Seq. #: 4170 **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 the first generator procedure in this admission

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., perioperative 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".

Seq. #: 4175 **Name:** Most Recent MI Timeframe

Coding Instructions: Indicate the timeframe of the most recent prior myocardial infarction.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
<= 40 days	
> 40 days	

Supporting Definitions: (none)

C. History and Risk Factors

Seq. #: 4180 Name: Prior PCI

Coding Instructions: Indicate if the patient had a percutaneous coronary intervention, prior to this admission.

Note(s):

Timeframe does NOT include PCIs performed after admission.

Target Value: Any occurrence between birth and arrival to 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

Seq. #: 4185 Name: Most Recent PCI Date

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

Note(s):

If month or day is unknown enter '01'.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 4190 Name: Prior CABG

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

Note(s):

Timeframe does NOT include CABG performed after admission.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4195 Name: Most Recent CABG Date

Coding Instructions: If the patient had a CABG prior to this admission, indicate the date of the most recent CABG.

Note(s):

If month or day is unknown enter '01'.

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

Selections: (none)

Supporting Definitions: (none)

C. History and Risk Factors

Seq. #: 4200 Name: Primary Valvular Heart Disease

Coding Instructions: Indicate if the patient has a history of primary valvular heart disease that is moderately severe or severe.

Note(s):

Valve disease that is felt to be significant but does not fulfill the definition for primary valvular heat disease is considered contributory valvular heart disease, and should be coded as 'No.'

An example of primary valvular heart disease is severe aortic stenosis that caused heart failure or cardiomyopathy. Aortic stenosis is the primary problem.

An example of secondary valvular heart disease is a patient who had a myocardial infarction that caused a valve defect, thus the valve disease is not primary.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Primary Valvular Disease:**

Primary valvular heart disease is defined by heart disease that is primarily due to a valvular defect or abnormality, and is classified as:
1. Moderately severe or severe, or 3+ or 4+ aortic insufficiency.
2. Moderately severe or severe, or 3+ or 4+ mitral insufficiency with echocardiographic evidence that mitral insufficiency is a primary abnormality and not secondary to ventricular dilation.
3. Moderately severe or severe aortic stenosis defined by estimated aortic valve area by catheterization or Doppler echocardiography of <=1.0 cm2.
4. Moderately severe or severe mitral stenosis defined by estimated mitral valve area by catheterization or Doppler echocardiography of <1.0 cm2.
5. Moderately severe or severe pulmonic or tricuspid valve disease that is known to be a primary abnormality.

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

Seq. #: 4205 Name: Other Structural Abnormalities

Coding Instructions: Indicate if the patient has any other structural abnormality of the heart, ventricles or great vessels (excluding primary valvular heart disease). These conditions are frequently found in imaging reports such as echo, MRI, CAT scan, MUGA or other imaging studies.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4210 Name: Structural Abnormality Type - Amyloidosis

Coding Instructions: Indicate if the patient has a history of amyloidosis. Amyloidosis is a rare and potentially fatal disease that occurs when substances called amyloid proteins build up in organs, including the heart.

Note(s):

Code yes if the patient has a documented history of amyloidosis. A biopsy of the heart to confirm involvement is not required to code yes.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

C. History and Risk Factors

Seq. #: 4211 **Name:** Structural Abnormality Type - Atrial Septal Defect

Coding Instructions: Indicate if the patient has a history of an atrial septal defect (ASD). An ASD is a hole in the wall between the two upper chambers of the heart.

Note(s):

Code no if the patient has an iatrogenic ASD (e.g. after trans-septal approach for a cath or EP study).

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4212 **Name:** Structural Abnormality Type - Chagas Disease

Coding Instructions: Indicate if the patient has a history of Chagas disease. Chagas disease is an inflammatory, infectious condition caused by a parasite called the reduvid bug and which is transmitted to humans. Also called American trypanosomiasis, may become chronic, and can result in serious heart and digestive problems.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4213 **Name:** Structural Abnormality Type - Common Ventricle

Coding Instructions: Indicate if the patient has a history of a common ventricle. Common ventricle is an umbrella term used to describe several very different complex congenital heart defects that share the same problem: the heart has only one functional ventricle (anatomically right or left or indeterminate) supplying the systemic circulation. These defects include tricuspid atresia, hypoplastic left or right heart syndrome, double outlet right ventricle, double inlet left ventricle, and other forms of single ventricle defects.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4214 **Name:** Structural Abnormality Type - Ebstein's Anomaly

Coding Instructions: Indicate if the patient has a history of Ebstein's anomaly. Ebstein's anomaly is a rare congenital heart defect that primarily involves the right ventricle and the tricuspid valve. Blood leaks back through the valve and into the right atrium which can lead to cardiomyopathy, and tachyarrhythmias.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

C. History and Risk Factors

Seq. #: 4215 **Name:** Structural Abnormality Type - Giant Cell Myocarditis

Coding Instructions: Indicate if the patient has a history of giant cell myocarditis. Giant cell myocarditis is a type of myocarditis (or inflammation of the myocardium) that is diagnosed by endocardial biopsy and thought to be mediated by T lymphocytes.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4216 **Name:** Structural Abnormality Type - Hypertrophic Cardiomyopathy

Coding Instructions: Indicate if the patient has a history of hypertrophic cardiomyopathy (HCM). HCM is a disease in which the heart muscle (myocardium) becomes abnormally thick or hypertrophied.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4217 **Name:** Structural Abnormality Type - Left Ventricular Aneurysm

Coding Instructions: Indicate if the patient has a history of a left ventricular aneurysm. A left ventricular aneurysm is a bulge or ballooning in the left ventricle of the heart.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4218 **Name:** Structural Abnormality Type - LV Non-compaction Syndrome

Coding Instructions: Indicate if the patient has a history of left ventricular non-compaction syndrome. This is an uncommon congenital abnormality where the left ventricular myocardium fails to compact during embryonic development, leading to cardiomyopathy with a variable degree of ventricular dysfunction. There is genetic heterogeneity and phenotypic variability. Characteristically, there are typically deep trabeculations in the noncompacted area, with varying proportions of the LV myocardium compacted. LV noncompaction is associated with rhythm abnormalities including Wolff-Parkinson-White syndrome, conduction defects, and ventricular tachyarrhythmias.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4219 **Name:** Structural Abnormality Type - Right Ventricular Dysplasia (ARVD)

Coding Instructions: Indicate if the patient has a history of right ventricular dysplasia (ARVD). ARVD is an inherited cardiomyopathy characterized by ventricular arrhythmia and right ventricular dysfunction.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

C. History and Risk Factors

Seq. #: 4220 **Name:** Structural Abnormality Type - Sarcoidosis

Coding Instructions: Indicate if the patient has a history of sarcoidosis. Sarcoidosis is a disease characterized by the development and growth of tiny clumps of inflammatory cells in different areas of the body, including the heart.

Note(s):

Code yes if the patient has a documented history of sarcoidosis. A biopsy of the heart to confirm involvement is not required to code yes.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4221 **Name:** Structural Abnormality Type - Transposition of Great Vessels

Coding Instructions: Indicate if the patient has a history of transposition of great vessels. Transposition of the great vessels is a congenital heart defect in which the two main arteries leaving the heart are reversed (transposed).

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4222 **Name:** Structural Abnormality Type - Tetralogy of Fallot

Coding Instructions: Indicate if the patient has a history of Tetralogy of Fallot. Tetralogy of Fallot is a congenital heart defect characterized by a large ventricular septal defect, pulmonary stenosis; right ventricular hypertrophy and an overriding aorta.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4223 **Name:** Structural Abnormality Type - Ventricular Septal Defect

Coding Instructions: Indicate if the patient has a history of a ventricular septal defect (VSD). A VSD is a hole in the wall between the two lower chambers of the heart.

Note(s):

The VSD can be congenital or acquired.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

C. History and Risk Factors

Seq. #: 4224 **Name:** Structural Abnormality Type - Other

Coding Instructions: Indicate if the patient has a history of a structural abnormality of the heart that is not otherwise specified.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4225 **Name:** Height

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

Target Value: The last value between arrival and the first generator procedure in this admission

Selections: (none)

Supporting Definitions: (none)

Seq. #: 4230 **Name:** Weight

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

Target Value: The last value between arrival and the first generator procedure in this admission

Selections: (none)

Supporting Definitions: (none)

Seq. #: 4235 **Name:** Cerebrovascular Disease

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

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

Selections:

Selection Text	*Definition*
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: ACC Clinical Data Standards (JACC 2001 38:2114-40), Society for Thoracic Surgeons Adult Cardiac Surgery Database (STS)

C. History and Risk Factors

Seq. #: 4240 **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 the first generator procedure in this admission

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. #: 4245 **Name:** Diabetes Mellitus

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

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

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: ACC Clinical Data Standards (JACC 2001 38:2114-40), Society for Thoracic Surgeons Adult Cardiac Surgery Database (STS)

Seq. #: 4250 **Name:** Sleep Apnea

Coding Instructions: Indicate if the patient has a history of sleep apnea that has been diagnosed by a sleep study.

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

Selections:

Selection Text	*Definition*
No	
Yes	
Not assessed	

Supporting Definitions: **Sleep apnea:**

Sleep apnea is defined as:
1. Obstructive sleep apnea: recurrent collapse of the pharynx during sleep.
2. Central sleep apnea: transient cessation of neural drive to respiratory muscles.
3. mixed sleep apnea

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

C. History and Risk Factors

Seq. #: 4255 **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: Any occurrence between arrival and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4260 **Name:** Hypertension

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

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

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: ACC Clinical Data Standards (JACC 2001 38:2114-40), Society for Thoracic Surgeons Adult Cardiac Surgery Database (STS)

Seq. #: 4270 **Name:** Patient Life Expectancy of >= 1 Year

Coding Instructions: Indicate if, by physician estimate, the patient is expected to live for one or more years.

Target Value: Any occurrence on the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	
Not Documented	

Supporting Definitions: (none)

D. Diagnostic Studies

Seq. #: 5000 Name: LVEF Assessed

Coding Instructions: Indicate if a left ejection fraction percentage has been assessed.

Note(s):

If the patient did not have an ejection fraction measured during this admission and their clinical status has not changed, it is acceptable to code the most recent recorded ejection fraction that was obtained within 12 months prior to the procedure.

Target Value: Any occurrence between 12 months prior to the first generator procedure and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5005 Name: Most Recent LVEF %

Coding Instructions: Indicate the most recent left ventricular ejection fraction. 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.

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

Target Value: The last value between 12 months prior to the first generator procedure and the first generator procedure in this admission

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, Society for Thoracic Surgeons Adult Cardiac Surgery Database (STS)

Seq. #: 5010 Name: Most Recent LVEF Timeframe

Coding Instructions: Indicate the timeframe the left ventricular ejection fraction was obtained.

Target Value: The last value between 12 months prior to the first generator procedure and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
<1 month	
>= 1 to <= 3 months	
>3 to <= 6 months	
>6 months	

Supporting Definitions: (none)

Seq. #: 5015 Name: Electrophysiology Study

Coding Instructions: Indicate if the patient had an electrophysiology study (EPS).

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Electrophysiology Study:**

One or more catheters capable of recording and pacing are placed in one or more of the cardiac chambers. The catheters may be used to measure conduction of the impulse from the sinus node to the ventricle; induce a tachycardia; and/or localize (map) the location where the tachycardia originates.

Source: NCDR

D. Diagnostic Studies

Seq. #: 5020 Name: EP Study Timeframe

Coding Instructions: Indicate the timeframe the electrophysiology study (EPS) was performed.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
<1 month	
>= 1 to <= 3 months	
>3 to <= 6 months	
>6 months	

Supporting Definitions: (none)

Seq. #: 5025 Name: Ventricular Arrhythmias Induced

Coding Instructions: Indicate if ventricular arrhythmias were induced during the electrophysiology study.

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

Selections:

Selection Text	*Definition*
No	Ventricular arrhythmias were not induced during the EP study.
Yes	Ventricular arrhythmias were induced during the EP study.
Results unattainable	The results of the electrophysiology study were unattainable.

Supporting Definitions: **Induced:**

Induced refers to arrhythmias that are induced through programmed ventricular stimulation, or delivery of external energy, such as radiofrequency current.

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

Seq. #: 5030 Name: VT Ablation Performed

Coding Instructions: Indicate if ventricular tachycardia ablation was performed.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Ablation:**

An application of an energy source delivered through a catheter to eliminate or modify a focus or re-entry circuit that causes an arrhythmia.

Source: NCDR

Seq. #: 5031 Name: EP Study Findings - Non-Sustained Ventricular Tachycardia

Coding Instructions: Indicate if non-sustained ventricular tachycardia was induced during the electrophysiology study.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Non-sustained Ventricular Tachycardia:**

Non-sustained or unsustained ventricular tachycardia refers to a cardiac arrhythmia that is 3 or more beats in duration, that terminates spontaneously in <30 seconds, emanating from the ventricles at a rate of >100 bpm (cycle length: <600 ms), that is induced during an EP study for diagnostic purposes.

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

D. Diagnostic Studies

Seq. #: 5032 **Name:** EP Study Findings - Sustained Monomorphic Ventricular Tachycardia

Coding Instructions: Indicate if sustained monomorphic ventricular tachycardia was induced during the electrophysiology study.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Sustained Monomorphic ventricular tachycardia:**

Sustained monomorphic ventricular tachycardia (VT) is VT >30 seconds in duration or requiring termination due to hemodynamic compromise in <30 seconds that has a stable, single QRS morphology, that is induced during an EP study for diagnostic purposes.

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

Seq. #: 5033 **Name:** EP Study Findings - Sustained Polymorphic Ventricular Tachycardia

Coding Instructions: Indicate if sustained polymorphic ventricular tachycardia was induced during the electrophysiology study.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Sustained polymorphic ventricular tachycardia:**

Sustained polymorphic ventricular tachycardia (VT) is VT >30 seconds in duration or requiring termination due to hemodynamic compromise in <30 seconds that has a changing or multiform QRS morphology at cycle length >180 milliseconds, that is induced during an EP study for diagnostic purposes.

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

Seq. #: 5034 **Name:** EP Study Findings - Ventricular Flutter

Coding Instructions: Indicate if ventricular flutter was induced during the electrophysiology study.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Ventricular Flutter:**

Ventricular flutter is demonstrated by a regular (cycle length variability 30 ms or less) ventricular arrhythmia approximately 300 bm (cycle length: 200 ms) with a monomorphic appearance; no isoelectric interval between successive QRS complexes.

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

D. Diagnostic Studies

Seq. #: 5035 **Name:** EP Study Findings - Ventricular Fibrillation

Coding Instructions: Indicate if ventricular fibrillation was induced during the electrophysiology study.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Ventricular Fibrillation:**

Ventricular Fibrillation is characterized by rapid, usually more than 300 bpm (cycle length: 180 ms or less), grossly irregular ventricular rhythm with marked variability in QRS cycle length, morphology, and amplitude.

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

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Seq. #: 5040 **Name:** 12 Lead ECG With Automated Measurements

Coding Instructions: Indicate if the patient had a 12 lead electrocardiogram (ECG) with automated measurements.

Note(s):

It is acceptable to code yes if the ECG was performed, but had not been interpreted by a qualified professional.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5045 **Name:** 12 Lead ECG With Automated Measurements Date

Coding Instructions: Indicate the date the 12 lead electrocardiogram (ECG) with automated measurements was performed.

Target Value: The last value between birth and the first generator procedure in this admission

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5055 **Name:** PR Interval

Coding Instructions: Indicate the PR interval, in milliseconds, on the electrocardiogram.

Note(s):

If the patient is in atrial fibrillation, atrial flutter, has a 2nd or 3rd degree heart block, or has a ventricular paced rhythm, leave blank and code 'Yes' for PR Interval Not Obtainable.

Target Value: The last value between birth and the first generator procedure in this admission

Selections: (none)

Supporting Definitions: (none)

D. Diagnostic Studies

Seq. #: 5056 **Name:** PR Interval Not Obtainable

Coding Instructions: Indicate if the PR interval on the electrocardiogram was not obtainable.

Note(s):

If the patient is in atrial fibrillation, atrial flutter, has a 2nd or 3rd degree heart block, or has a ventricular paced rhythm, code 'Yes'.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5060 **Name:** QRS Duration (Non-Ventricular Paced Complex)

Coding Instructions: Indicate the duration of the non-ventricular paced or intrinsic QRS complex, in milliseconds, that was derived from the surface electrocardiogram (ECG). Surface ECGs are obtained from the surface of the body and do not include intracardiac ECGs.

Note(s):

Do not code QRS measurements from an intracardiac ECG. Leave blank and code 'Yes' for Other Ventricular Paced QRS Complexes Present.

If more than one ECG is available, code the value on the ECG closest to the procedure.

Target Value: The last value between birth and the first generator procedure in this admission

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5061 **Name:** Only Ventricular Paced QRS Complexes Present

Coding Instructions: Indicate if there were only ventricular paced QRS complexes present.

Note(s):

If the patient has some intrinsic ventricular complexes present, code 'No'.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5065 **Name:** Cardiac Rhythm - AFib/Flutter

Coding Instructions: The cardiac rhythm is atrial fibrillation or atrial flutter.

Note(s):

Indicate the patient's cardiac rhythm. It is acceptable to code the patient's cardiac rhythm based on cardiac rhythm strips (as opposed to 12 lead ECGs) that are interpreted by a qualified professional. If more than one is available, code the rhythm based on the rhythm strip or ECG closest to the start of the procedure.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Diagnostic Studies

Seq. #: 5066 **Name:** Cardiac Rhythm - Atrial Tachycardia

Coding Instructions: The cardiac rhythm is greater than 100 beats per minute that originates from the atria or sinoatrial node.

Note(s):

Indicate the patient's cardiac rhythm. It is acceptable to code the patient's cardiac rhythm based on cardiac rhythm strips (as opposed to 12 lead ECGs) that are interpreted by a qualified professional. If more than one is available, code the rhythm based on the rhythm strip or ECG closest to the start of the procedure.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5067 **Name:** Cardiac Rhythm - Idioventricular

Coding Instructions: The cardiac rhythm originates in the ventricles. The heart rate is usually regular and ranging between 30-40 beats per minute (the intrinsic ventricular rate), but can be higher or lower. If atrial activity is present, there is usually no relationship between the atrial and ventricular complexes.

Note(s):

Indicate the patient's cardiac rhythm. It is acceptable to code the patient's cardiac rhythm based on cardiac rhythm strips (as opposed to 12 lead ECGs) that are interpreted by a qualified professional. If more than one is available, code the rhythm based on the rhythm strip or ECG closest to the start of the procedure.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5068 **Name:** Cardiac Rhythm - Junctional

Coding Instructions: The cardiac rhythm arises from the atrioventricular (AV) junction.

Note(s):

Indicate the patient's cardiac rhythm. It is acceptable to code the patient's cardiac rhythm based on cardiac rhythm strips (as opposed to 12 lead ECGs) that are interpreted by a qualified professional. If more than one is available, code the rhythm based on the rhythm strip or ECG closest to the start of the procedure.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Diagnostic Studies

Seq. #: 5069 **Name:** Cardiac Rhythm - Paced

Coding Instructions: The cardiac rhythm originates from a pacemaker.

Note(s):

Indicate the patient's cardiac rhythm. It is acceptable to code the patient's cardiac rhythm based on cardiac rhythm strips (as opposed to 12 lead ECGs) that are interpreted by a qualified professional. If more than one is available, code the rhythm based on the rhythm strip or ECG closest to the start of the procedure.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5070 **Name:** Cardiac Rhythm - Sinus Rhythm

Coding Instructions: The cardiac rhythm originates from the sinoatrial node. If the patient is in sinus rhythm with 1st degree heart block, code sinus rhythm.

Note(s):

Indicate the patient's cardiac rhythm. It is acceptable to code the patient's cardiac rhythm based on cardiac rhythm strips (as opposed to 12 lead ECGs) that are interpreted by a qualified professional. If more than one is available, code the rhythm based on the rhythm strip or ECG closest to the start of the procedure.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5071 **Name:** Cardiac Rhythm - Second Degree Heart Block

Coding Instructions: Characterized by one of the following:
Mobitz I: progressive PR prolongation and shortening of RR interval until P wave is blocked. Pause after blocked P wave is less than twice the PP interval. PR following block is shorter than PR immediately preceding block.
Mobitz II: regular sinus/atrial rhythm with intermittent nonconducted P waves. Constant PR interval in the conducted beats.

Note(s):

Indicate the patient's cardiac rhythm. It is acceptable to code the patient's cardiac rhythm based on cardiac rhythm strips (as opposed to 12 lead ECGs) that are interpreted by a qualified professional. If more than one is available, code the rhythm based on the rhythm strip or ECG closest to the start of the procedure.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Diagnostic Studies

Seq. #: 5072 **Name:** Cardiac Rhythm - Third Degree Heart Block

Coding Instructions: Characterized by independent atrial and ventricular complexes with the atrial rate usually exceeding ventricular rate. Also known as complete heart block.

Note(s):

Indicate the patient's cardiac rhythm. It is acceptable to code the patient's cardiac rhythm based on cardiac rhythm strips (as opposed to 12 lead ECGs) that are interpreted by a qualified professional. If more than one is available, code the rhythm based on the rhythm strip or ECG closest to the start of the procedure.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5075 **Name:** Underlying Atrial Rhythm

Coding Instructions: Indicate, for the paced rhythm, the underlying atrial rhythm.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
Sinus rhythm	The atrial rhythm originates from the sinoatrial node.
Atrial fibrillation/atrial flutter	There are no consistent P waves. With atrial flutter, in the place of P waves, there is uncoordinated atrial activity with rapid oscillations or fibrillation waves that vary in amplitude, shape, timing, and are associated with an irregular ventricular response (if atrioventricular conduction is intact). With atrial flutter, there is a sawtooth pattern of regular atrial activation.
Sinus arrest	The patient has no conduction through the sinoatrial node with a pause for a minimum of 3 seconds.
Unknown	

Supporting Definitions: (none)

Seq. #: 5080 **Name:** Pacing Type

Coding Instructions: Indicate the type of pacing noted in the cardiac rhythm.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
Atrial pacing	The patient's pacemaker is firing to create an atrial contraction or a "p wave".
Ventricular pacing	The patient's pacemaker is firing to create a ventricular contraction or a "QRS complex".
Both	The patient's pacemaker is firing to create both atrial and ventricular contractions.

Supporting Definitions: (none)

Seq. #: 5085 **Name:** Ventricular Paced QRS Duration

Coding Instructions: Indicate the duration of the ventricular paced QRS complex in milliseconds that was derived from the surface electrocardiogram (ECG). Surface ECGs are obtained from the surface of the body and do not include intracardiac ECGs.

Target Value: The last value between birth and the first generator procedure in this admission

Selections: (none)

Supporting Definitions: (none)

D. Diagnostic Studies

Seq. #: 5090 **Name:** Abnormal Intraventricular Conduction

Coding Instructions: Indicate if the patient has Abnormal intraventricular conduction, with fascicular blocks, bundle branch blocks, non-specific conduction delays or ventricular pacing.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5095 **Name:** Abnormal Intraventricular Conduction Type - Left Anterior Fascicular Block

Coding Instructions: Indicate if the patient has left anterior fascicular block.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Left anterior Fascicular Block:**

Left anterior fascicular block is characterized by all of the following: Left-axis deviation with frontal QRS axis between -45 degrees and -90 degrees; Q wave in lead aVL; rS in inferior leads ; QRS duration is <120 ms

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

Seq. #: 5096 **Name:** Abnormal Intraventricular Conduction Type - Left Posterior Fascicular Block

Coding Instructions: Indicate if the patient has left posterior fascicular block.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Left Posterior Fascicular Block:**

Left Posterior Fascicular Block is characterized by all of the following: Right-axis deviation with frontal QRS axis between +90 degrees and +180 degrees; rS in leads I and aVL and qR in inferior leads (Q waves 40 ms) QRS duration <120 ms; Exclude other causes of Right Axis deviation

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

Seq. #: 5097 **Name:** Abnormal Intraventricular Conduction Type - Left Bundle Branch Block

Coding Instructions: Indicate if the patient has left bundle branch block.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Left Bundle Branch:**

Left Bundle Branch is characterized by QRS duration 120 ms or longer, delayed onset of intrinsicoid deflection in 1, V5, and V6 >60 ms, Broad and notched or slurred R waves in I, aVL, V5, and V6, rS or QS complexes in right precordial leads, ST-segment and T waves in opposite polarity to the major QRS deflection

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

D. Diagnostic Studies

Seq. #: 5098 **Name:** Abnormal Intraventricular Conduction Type - Delay, Nonspecific

Coding Instructions: Indicate if the patient has an intraventricular conduction delay that was nonspecific.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Non-Specific Abnormal Intraventricular Conduction Delays:**

Non-Specific abnormal Intraventricular conduction delays are characterized by a QRS duration of 110 ms or more with morphology different from LBBB or RBBB

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

Seq. #: 5099 **Name:** Abnormal Intraventricular Conduction Type - Right Bundle Branch Block

Coding Instructions: Indicate if the patient has right bundle branch block.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **Right Bundle Branch Block:**

Right Bundle Branch Block is characterized by a QRS duration of 120 ms, rsR' or rSR' complexes in V1 and V2, Delayed onset of intrinsicoid, deflection in V1 and V2 >50 ms, Broad, slurred S wave in 1, V5, and V6 Secondary ST-T wave changes

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

Seq. #: 5100 **Name:** Abnormal Intraventricular Conduction Type - Ventricular Paced Rhythm

Coding Instructions: Indicate if the patient has a ventricular paced rhythm. If, on the ECG closest to the procedure, the patient is not paced 100% of the time, code no.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5105 **Name:** Systolic Blood Pressure

Coding Instructions: Indicate the systolic blood pressure in mmHg.

Target Value: The last value between birth and the first generator procedure in this admission

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5110 **Name:** Diastolic Blood Pressure

Coding Instructions: Indicate the diastolic blood pressure in mm Hg.

Target Value: The last value between birth and the first generator procedure in this admission

Selections: (none)

Supporting Definitions: (none)

D. Diagnostic Studies

Seq. #: 5115 **Name:** BUN

Coding Instructions: Indicate the blood urea nitrogen (BUN) value, in mg/dL.

Note(s):

If the BUN value was not drawn, leave blank and code 'Yes' for BUN Not Drawn.

Target Value: The last value between birth and the first generator procedure in this admission

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5116 **Name:** BUN Not Drawn

Coding Instructions: Indicate if a blood urea nitrogen (BUN) was not drawn.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5120 **Name:** Hemoglobin

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

Note(s):

If hemoglobin was not drawn, leave blank and code 'Yes' for Hemoglobin Not Drawn.

Target Value: The last value between birth and the first generator procedure in this admission

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5121 **Name:** Hemoglobin Not Drawn

Coding Instructions: Indicate if the hemoglobin value was not drawn.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5125 **Name:** Sodium

Coding Instructions: Indicate the sodium (Na) level, in mEq/L.

Note(s):

If sodium was not drawn, leave blank and code 'Yes' for Sodium Not Drawn.

Target Value: The last value between birth and the first generator procedure in this admission

Selections: (none)

Supporting Definitions: (none)

D. Diagnostic Studies

Seq. #: 5126 **Name:** Sodium Not Drawn

Coding Instructions: Indicate if the sodium level was not drawn.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5130 **Name:** Creatinine

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

Note(s):

If creatinine was not drawn, leave blank and code 'Yes' for Creatinine Not Drawn.

Target Value: The last value between birth and the first generator procedure in this admission

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5131 **Name:** Creatinine Not Drawn

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

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 5135 **Name:** Potassium

Coding Instructions: Indicate the Potassium (K) level, in mEq/L.

Note(s):

If the potassium level was not drawn, leave blank and code 'Yes' for Potassium Not Drawn.

Target Value: The last value between birth and the first generator procedure in this admission

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5136 **Name:** Potassium Not Drawn

Coding Instructions: Indicate if the potassium level was not drawn.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

D. Diagnostic Studies

Seq. #: 5140 **Name:** BNP

Coding Instructions: Indicate the patient's brain natriuretic peptide (BNP) level in pg/ml.

Note(s):

If BNP was not drawn, leave blank and code 'Yes' for BNP or NT-proBNP Not Drawn.

Target Value: The last value between birth and the first generator procedure in this admission

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5145 **Name:** NT-proBNP

Coding Instructions: Indicate the patient's NT-pro- brain natriuretic peptide (BNP) level in pg/ml.

Note(s):

If NT-proBNP was not drawn, leave blank and code 'Yes' for BNP or NT-proBNP Not Drawn.

Target Value: The last value between birth and the first generator procedure in this admission

Selections: (none)

Supporting Definitions: (none)

Seq. #: 5146 **Name:** BNP or NT-proBNP Not Drawn

Coding Instructions: Indicate if a BNP or NT-proBNP level was not drawn.

Target Value: The last value between birth and the first generator procedure in this admission

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

E. Procedure Information

Seq. #: 6000 **Name:** Procedure Date

Coding Instructions: Indicate the date of the procedure.

Target Value: Any occurrence on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6001 **Name:** Procedure Time

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

Note(s):

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

Target Value: Any occurrence on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6005 **Name:** Procedure Type

Coding Instructions: Indicate the procedure that was performed.

Note(s):

All new leads that were implanted and/or existing leads that were reused, extracted or abandoned should be identified in the lead assessment section. The only exception is a lead that is known to be abandoned during an evaluation prior to the procedure.

Include leads that are associated with ICD implants. Do not include leads that are used for other devices, such as permanent pacemakers.

Do not include leads that were attempted but could not be implanted successfully and were removed before the completion of the procedure.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
Initial generator implant	The patient is receiving an ICD generator for the first time. Complete all sections of the data collection form for all patients having an initial generator implant.
Generator change	The patient already has an ICD and is receiving a generator that is an upgrade or a change from one that was previously implanted. Complete all sections of the data collection form for all patients having a generator change/upgrade.
Lead only	A lead procedure is being performed without a generator change. Complete all sections of the data collection form, except section C (History and Risk), section D(Diagnostic Studies), and section F (ICD Implant) for all patients having a procedure where new leads were implanted and/or existing leads were reused, extracted or abandoned.

Supporting Definitions: (none)

E. Procedure Information

Seq. #: 6010 **Name:** Prophylactic Antibiotics w/in 1 Hour of Procedure Start Time

Coding Instructions: Indicate whether there is documentation of an order or administration of an antibiotic.

Note(s):

1. An order (written order, verbal order, or standing order/protocol) for prophylactic antibiotics to be given within one hour of procedure start time (two hours if receiving vancomycin or fluoroquinolone).

OR

2. Prophylactic antibiotic administered within one hour (if fluoroquinolone or vancomycin, two hours) prior to procedure start time.

In the event that the procedure is delayed, as long as the patient is redosed (if clinically appropriate) the appropriate selection should be applied.

Target Value: Any occurrence between 2 hours prior to procedure and start of current procedure

Selections:

Selection Text	*Definition*
No - not given, medical reason documented	
No - not given, reason unspecified	
Yes	

Supporting Definitions: (none)

Seq. #: 6015 **Name:** Routine Warfarin (Coumadin) Therapy

Coding Instructions: Indicate if the patient has been taking warfarin (Coumadin) on a routine basis, prior to the procedure.

Note(s):

If the patient has more than one EP lab visit in an episode of care/admission, and is still on warfarin therapy for the second procedure, code "yes." If warfarin has been suspended prior to the second (or subsequent) procedures, code "no" for those procedures.

Target Value: Any occurrence between 1 month prior to current procedure and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6020 **Name:** Warfarin (Coumadin) Held for Procedure

Coding Instructions: Indicate if warfarin was held or discontinued for the procedure.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6025 **Name:** INR Drawn

Coding Instructions: Indicate if an international normalized ratio (INR) was drawn.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

E. Procedure Information

Seq. #: 6030 **Name:** INR

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

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6035 **Name:** INR Drawn Date

Coding Instructions: Indicate the date the international normalized ratio (INR) sample was collected.

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

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6040 **Name:** Premarket Clinical Trial

Coding Instructions: Indicate if the ICD procedure (generator implant or lead procedure) is part of a clinical trial, excluding post-market surveillance trials.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6045 **Name:** Premarket Clinical Trial Name

Coding Instructions: Indicate the name of the premarket clinical trial.

Note(s):

Please use the most precise name possible.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6050 **Name:** Auxiliary 3

Coding Instructions: Reserved for future use

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6055 **Name:** Auxiliary 4

Coding Instructions: Reserved for future use

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

F. ICD Implant / Explant

Seq. #: 6100 **Name:** Generator Operator's Last Name

Coding Instructions: Indicate the last name of the operator who is implanting the device.

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. #: 6105 **Name:** Generator Operator's First Name

Coding Instructions: Indicate the first name of the operator who is implanting the device

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. #: 6110 **Name:** Generator Operator's Middle Name

Coding Instructions: Indicate the middle name of the operator who is implanting the device.

Note(s):

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

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

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6115 **Name:** Generator Operator's NPI

Coding Instructions: Indicate the National Provider Identifier (NPI) of the operator who is implanting the device. 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)

Seq. #: 6120 **Name:** Generator Group TIN

Coding Instructions: Indicate the group-level Taxpayer Identification Number for the Taxpayer holder of record for the Physician's National Provider Identifier (NPI) that implanted the device.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

F. ICD Implant / Explant

Seq. #: 6125 **Name:** ICD Indication

Coding Instructions: Indicate the ICD procedure indication

Note(s):

If the Previous ICD Reason is Primary Prevention and the patient subsequently had an event that categorized them as secondary prevention, code the current procedure as 'Secondary prevention.'

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
Primary prevention	Primary Prevention is an indication for an ICD to prevent sudden cardiac death. It refers to use of ICDs in individuals who are at risk for but have not yet had an episode of sustained ventricular tachycardia, ventricular fibrillation, or resuscitated cardiac arrest.
Secondary prevention	Secondary prevention refers to an indication for ICD exclusively for patients who have survived one or more cardiac arrests or sustained ventricular tachycardia. Patients with cardiac conditions associated with a high risk of sudden death who have unexplained syncope that is likely to be due to ventricular arrhythmias are considered to have a secondary indication.

Supporting Definitions:

Primary Prevention:

Primary Prevention is an indication for an ICD to prevent sudden cardiac death. It refers to use of ICDs in individuals who are at risk for but have not yet had an episode of sustained ventricular tachycardia, ventricular fibrillation, or resuscitated cardiac arrest.

Source: ACC/AHA//HRS 2008 Guidelines for Device-Based Therapy of Cardiac Rhythm Abnormalities

Secondary Prevention:

Secondary prevention refers to an indication for ICD exclusively for patients who have survived one or more cardiac arrests or sustained ventricular tachycardia. Patients with cardiac conditions associated with a high risk of sudden death who have unexplained syncope that is likely to be due to ventricular arrhythmias are considered to have a secondary indication.

Source: ACC/AHA//HRS 2008 Guidelines for Device-Based Therapy of Cardiac Rhythm Abnormalities

Seq. #: 6130 **Name:** Planned ICD Type

Coding Instructions: Indicate the type of ICD that was planned for implantation.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
Single chamber	A single-chamber ICD defibrillates the ventricle and paces the ventricle.
Dual chamber	A dual-chamber ICD defibrillates the ventricle and paces the atrium and ventricle.
CRT-D	A cardiac resynchronization therapy device and defibrillator (CRT-D) has dual capabilities. It is a biventricular pacemaker that sends electrical signals to both ventricles as well as a defibrillator. It may or may not have an atrial pacing wire.

Supporting Definitions: (none)

Seq. #: 6135 **Name:** Device Implanted

Coding Instructions: Indicate if an ICD device was implanted.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

F. ICD Implant / Explant

Seq. #: 6140 **Name:** Final Device Type

Coding Instructions: Indicate the ICD type that was implanted at the completion of the procedure.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
Single chamber	A single-chamber ICD defibrillates the ventricle and paces the ventricle.
Dual chamber	A dual-chamber ICD defibrillates the ventricle and paces the atrium and ventricle.
CRT-D	A cardiac resynchronization therapy device and defibrillator (CRT-D) has dual capabilities. It is a biventricular pacemaker that sends electrical signals to both ventricles as well as a defibrillator. It may or may not have an atrial pacing wire.

Supporting Definitions: (none)

Seq. #: 6145 **Name:** CS/LV Lead Successful

Coding Instructions: Indicate if the coronary sinus/left ventricular (CS/LV) lead was successfully implanted.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
Yes	
Not implanted	
Previously implanted	The lead was placed prior to this procedure (the patient had a previously implanted CRT-D, or had a lead placed during open heart surgery.

Supporting Definitions: (none)

Seq. #: 6150 **Name:** Reason CS/LV Lead Not Implanted

Coding Instructions: Indicate the reason a Coronary Sinus Access or Left Ventricular (CS/LV) lead was not implanted.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
Vascular access	
Coronary sinus access	
Tributary vein access	
Coronary sinus dissection	
Unacceptable threshold	
Diaphragmatic stimulation	

Supporting Definitions: (none)

Seq. #: 6155 **Name:** Implant Device ID

Coding Instructions: Indicate the unique ACC assigned identification number associated with the implanted device.

Target Value: Any occurrence on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6160 **Name:** Device Manufacturer

Coding Instructions: Indicate the name of the manufacturer of the device.

Target Value: Any occurrence on current procedure

Selections: (none)

Supporting Definitions: (none)

F. ICD Implant / Explant

Seq. #: 6165 **Name:** Device Model Name

Coding Instructions: Indicate the name of the model of the device.

Target Value: Any occurrence on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6170 **Name:** Device Model Number

Coding Instructions: Indicate the number of the model of the device.

Target Value: Any occurrence on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6175 **Name:** Implant Device Serial Number

Coding Instructions: Indicate the serial number of the device that was implanted.

Target Value: Any occurrence on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6180 **Name:** Lowest Energy Tested That Was Successful

Coding Instructions: Indicate the lowest energy tested (LET) or defibrillation threshold that demonstrated that the device performs successfully (in joules).

Target Value: The lowest value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6181 **Name:** LET Not Tested

Coding Instructions: Indicate if the lowest energy tested (LET) that was successful was not tested.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6185 **Name:** Upper Limit of Vulnerability (ULV)

Coding Instructions: Indicate the upper limit of vulnerability (ULV) in joules.

Target Value: The highest value on current procedure

Selections: (none)

Supporting Definitions: (none)

F. ICD Implant / Explant

Seq. #: 6186 **Name:** ULV Not Tested

Coding Instructions: Indicate if the upper limit of vulnerability (ULV) was not tested.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6190 **Name:** Reason(s) for Reimplant - End of Expected Battery Life

Coding Instructions: Indicate if a reason for reimplant is end of expected battery life of a previous ICD.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6191 **Name:** Reason(s) for Reimplant - Replaced At Time of Lead Revision

Coding Instructions: Indicate if a reason for reimplant is that the generator is being replaced at the time of lead revision.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6192 **Name:** Reason(s) for Reimplant - Upgrade

Coding Instructions: Indicate if a reason for reimplant is an upgrade of a previous device with additional pacing capabilities such as an upgrade from a single to a dual chamber device, or the replacement of a non-CRT with a CRT device.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6193 **Name:** Reason(s) for Reimplant - Infection

Coding Instructions: Indicate if a reason for reimplant is due to infection in the location of the previously implanted device.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

F. ICD Implant / Explant

Seq. #: 6194 **Name:** Reason(s) for Reimplant - Under Manufacturer Advisory/Recall

Coding Instructions: Indicate if a reason for reimplant is that the previous device has been recognized by the manufacturer as demonstrating a recurring performance failure resulting in an advisory letter to physicians. This may or may not reach the level of a food and drug administration (FDA) designated recall. This also may or may not have led to device malfunction.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6195 **Name:** Reason(s) for Reimplant - Faulty Connector/Header

Coding Instructions: Indicate if a reason for reimplant is that there was a faulty connector/header which required another implant.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6196 **Name:** Reason(s) for Reimplant - Device Relocation

Coding Instructions: Indicate if a reason for reimplant is that the device needed to be relocated because of a medical condition, or procedure near the original pocket. An example is if the patient was diagnosed with breast cancer and required treatment or surgery near the original implant.

Note(s):

If the device is being relocated because of an infection, code infection as the reason for reimplant (do NOT code device relocation).

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6197 **Name:** Reason(s) for Reimplant - Malfunction

Coding Instructions: Indicate if a reason for reimplant is that the previous generator has malfunctioned. The device performance is outside the manufacturer's designated specification and cannot be resolved with reprogramming, necessitating in the replacement of the device, in the opinion of the physician.

Note(s):

This does not include lead malfunctions.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

F. ICD Implant / Explant

Seq. #: 6200 **Name:** Reason for Malfunction

Coding Instructions: Indicate the reason for malfunction of the previous ICD.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
Atrial pacing	The malfunction affected atrial pacing.
Left ventricular (LV) pacing	The malfunction affected the left ventricular (LV) pacing.
Right ventricular (RV) pacing	The malfunction affected the right ventricular (RV) pacing.
Defibrillation	The malfunction affected the defibrillator.
Premature battery depletion	There was premature battery depletion.

Supporting Definitions: (none)

Seq. #: 6205 **Name:** ATP or Shock Therapy Delivered

Coding Instructions: Indicate if, at any point in time, the ICD being removed had delivered antitachycardia pacing (ATP) or shock therapy.

Target Value: Any occurrence between the previous ICD implant date and the current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6210 **Name:** ATP or Shock Therapy Appropriate

Coding Instructions: Indicate if, at any point in time, the ICD being removed had delivered appropriate antitachycardia pacing (ATP) or shock therapy for spontaneous ventricular tachycardia and/or ventricular fibrillation.

Note(s):

If the device had delivered appropriate therapies at any point in time, then the device had a malfunction (causing it to deliver inappropriate therapies), code yes. For example, a patient received at least one appropriate shock for VT, then a lead had a conductor fracture that resulted in inappropriate detection and shock due to oversensing, code yes.

Target Value: Any occurrence between the previous ICD implant date and the current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6215 **Name:** ATP Therapy Successful

Coding Instructions: Indicate if the antitachycardia pacing (ATP) therapy for ventricular tachycardia and/or ventricular fibrillation was successful.

Target Value: Any occurrence between the previous ICD implant date and the current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

F. ICD Implant / Explant

Seq. #: 6220 **Name:** Shock Therapy Successful

Coding Instructions: Indicate if the shock therapy for ventricular tachycardia and/or ventricular fibrillation was successful.

Target Value: Any occurrence between the previous ICD implant date and the current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6225 **Name:** Device Explanted

Coding Instructions: Indicate if the previous ICD was explanted.

Note(s):

Code "Yes" even if the Previous ICD (4110) was explanted prior to the current procedure.

Target Value: Any occurrence between previous ICD implant and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6230 **Name:** Explant Date

Coding Instructions: Indicate the date the device was explanted.

Target Value: The last value between previous ICD implant and current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6235 **Name:** Device Returned to Manufacturer

Coding Instructions: Indicate if the explanted generator device was returned to the manufacturer.

Target Value: Any occurrence between previous ICD implant and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6240 **Name:** Battery Voltage

Coding Instructions: Indicate the battery voltage (in volts) of the explanted device.

Target Value: The last value between previous ICD implant and current procedure

Selections: (none)

Supporting Definitions: (none)

F. ICD Implant / Explant

Seq. #: 6241 **Name:** Battery Voltage Not Available

Coding Instructions: Indicate if the battery voltage (in volts) of the explanted device was not available.

Target Value: Any occurrence between previous ICD implant and current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 6245 **Name:** Explant Device ID

Coding Instructions: Indicate the unique ACC assigned identification number associated with the explanted device.

Target Value: Any occurrence between previous ICD implant and current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6250 **Name:** Explant Device Serial Number

Coding Instructions: Indicate the serial number of the explanted device.

Target Value: Any occurrence between previous ICD implant and current procedure

Selections: (none)

Supporting Definitions: (none)

G. Lead Assessment

Seq. #: 7000 **Name:** Lead Operator's Last Name

Coding Instructions: Indicate the last name of the operator who is performing the lead procedure.

Note(s):

If the name exceeds 50 characters, enter the first 50 characters. If more than one physician performs the lead procedure, code the physician of record.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7005 **Name:** Lead Operator's First Name

Coding Instructions: Indicate the first name of the operator who is performing the lead procedure.

Note(s):

If the name exceeds 50 characters, enter the first 50 characters. If more than one physician performs the lead procedure, code the physician of record.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7010 **Name:** Lead Operator's Middle Initial

Coding Instructions: Indicate the middle name of the operator who is performing the lead procedure.

Note(s):

If the name exceeds 50 characters, enter the first 50 characters. If more than one physician performs the lead procedure, code the physician of record.

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

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7015 **Name:** Lead Operator's NPI

Coding Instructions: Indicate the National Provider Identifier (NPI) of the operator who is performing the lead procedure. 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)

Seq. #: 7020 **Name:** Lead Group TIN

Coding Instructions: Indicate the group-level Taxpayer Identification Number for the Taxpayer holder of record for the Physician's National Provider Identifier (NPI) that performed the lead procedure.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

G. Lead Assessment

Seq. #: 7025 **Name:** Lead Counter

Coding Instructions: The software-assigned lead counter should start at one and be incremented by one for each new or existing lead documented.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7030 **Name:** Lead Identification

Coding Instructions: Indicate if the lead is a new or existing lead. All new leads placed or existing leads extracted, abandoned, or reused should be identified in the leads section.

Note(s):

If a lead was attempted, but not actually implanted, do not include it. For example, if a lead turns out to be too short, or with inadequate coil spacing, or is too large/unstable for the coronary sinus branch vein, do not include it in the registry.

Target Value: The value on current procedure

Selections:

Selection Text	*Definition*
New lead	A lead that is implanted for the first time.
Existing lead	A lead that has been previously implanted.

Supporting Definitions: (none)

Seq. #: 7035 **Name:** Lead ID

Coding Instructions: Indicate the NCDR assigned ID for new or existing leads placed, identified, extracted or abandoned during the procedure.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7040 **Name:** Lead Manufacturer

Coding Instructions: Indicate the original manufacturer of the lead.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7045 **Name:** Lead Model Name

Coding Instructions: Indicate the manufacturer's model name of the lead.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

G. Lead Assessment

Seq. #: 7050 **Name:** Lead Model Number

Coding Instructions: Indicate the manufacturer's model number of the lead.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7055 **Name:** Lead Serial Number

Coding Instructions: Indicate the manufacturer's serial number of the lead.

Target Value: The value on current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7060 **Name:** Lead Location

Coding Instructions: Indicate the location of the lead.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
RA endocardial	A pacing lead placed transvenously into the right atrial endocardium.
LV epicardial	A pacing or defibrillation lead placed transthoracically onto the left ventricular epicardium.
RV endocardial	A pacing or defibrillation lead placed transvenously into the right ventricular endocardium.
SVC/subclavian	A defibrillating lead placed in the superior vena cava or subclavian vein.
LV via coronary venous system	A pacing or defibrillating lead placed transvenously onto the left ventricle through the coronary venous system.
Subcutaneous array	A defibrillation electrode that is placed subcutaneously.
Other	A lead placed in a location not specified above.

Supporting Definitions: (none)

Seq. #: 7065 **Name:** Existing Lead Implant Date

Coding Instructions: Indicate the date the existing lead was initially implanted.

Target Value: The last value between birth and current procedure

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7070 **Name:** Existing Lead Function

Coding Instructions: Indicate the function of the existing lead.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
Normal	The lead function was assessed and has been determined to be functioning normally with acceptable pacing, sensing and/or defibrillation parameters.
Abnormal	The lead function was assessed and has unacceptable pacing, sensing or defibrillation parameters.
Not assessed	The lead function was not assessed.

Supporting Definitions: (none)

G. Lead Assessment

Seq. #: 7075 **Name:** Manufacturer Advisory/Recall

Coding Instructions: Indicate if there is a recognized lead problem that has resulted in a formal advisory or recall from the manufacturer, or the Food and Drug Administration (FDA).

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7080 **Name:** Existing Lead Status

Coding Instructions: Indicate the status of the existing lead.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
Extracted	The existing lead was extracted in whole or part and removed.
Abandoned	The existing lead was left in situ, abandoned and not reused.
Reused	The existing lead was left in situ and reused.

Supporting Definitions: (none)

Seq. #: 7085 **Name:** Returned to Manufacturer

Coding Instructions: Indicate if the explanted lead was returned to the manufacturer.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7090 **Name:** Existing Lead Placement Issues

Coding Instructions: Indicate if the existing lead had placement issues (dislodgement, perforation or infection).

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7095 **Name:** Dislodgement

Coding Instructions: Indicate if there was movement (macroscopic or microscopic) of an existing lead within the heart or vascular tree away from the original implantation site.

Note(s):

If dislodgement occurred after the procedure is completed, code dislodgement as an adverse event, not as a lead function issue.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

G. Lead Assessment

Seq. #: 7100 **Name:** Perforation

Coding Instructions: Indicate if there was penetration of the existing lead through a systemic vein, coronary vein, or the myocardium.

Note(s):

If perforation occurred after the procedure is completed, code perforation as an adverse event, not as a lead function issue.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7105 **Name:** Erosion

Coding Instructions: Indicate if there was erosion of the existing lead.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7110 **Name:** Faulty Connector/Header

Coding Instructions: Indicate if there was a faulty connector/header in the existing lead.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7115 **Name:** Patient's Clinical Status

Coding Instructions: Indicate if a non-lead related medical or surgical procedure required the existing lead to be replaced.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7120 **Name:** Infection

Coding Instructions: Indicate if there was a suspected or documented infection of the existing lead.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

G. Lead Assessment

Seq. #: 7125 **Name:** Documented Infection

Coding Instructions: Indicate if there was a documented infection of the existing lead as evidenced by positive microbiological cultures/smears or other microbiological evidence indicating infection.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7130 **Name:** Pacing Issues

Coding Instructions: Indicate if there were pacing issues, such as oversensing, undersensing, failure to pace, failure to capture with acceptable safety margin, or extracardiac stimulation.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7135 **Name:** Oversensing

Coding Instructions: Indicate if the existing lead was functioning abnormally due to oversensing. Oversensing manifests as sensing of electrical signals not related to cardiac depolarization of the lead chamber that cannot be resolved acceptably by device reprogramming.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7140 **Name:** Undersensing

Coding Instructions: Indicate if the existing lead was functioning abnormally due to undersensing. Undersensing manifests as failure to sense appropriate cardiac depolarizations that cannot be resolved with reprogramming.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7145 **Name:** Failure To Pace

Coding Instructions: Indicate if the existing lead was functioning abnormally because there was failure to pace. Failure to pace manifests as absence of pacemaker stimulation artifacts on electrocardiographic recordings despite rates below pacemaker programmed rate.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

G. Lead Assessment

Seq. #: 7150 **Name:** Failure to Capture with Acceptable Safety Margin

Coding Instructions: Indicate if the existing lead was functioning abnormally because there was failure to capture with acceptable safety margins. This manifests as a high pacing threshold that results in either intermittent failure to capture at maximal programmed output or excessive battery drain leading to premature battery exhaustion.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7155 **Name:** Extracardiac Stimulation

Coding Instructions: Indicate if the existing lead was functioning abnormally because there was extracardiac stimulation. This manifests as stimulation by the lead of non-cardiac structures such as the diaphragm, chest wall, or pectoral muscle.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7160 **Name:** Defibrillation Issues

Coding Instructions: Indicate if the existing lead had defibrillation issues such as oversensing with or without shock/ATP, or failed shocks/inadequate DFT safety margins.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7165 **Name:** Oversensing with Shock or ATP

Coding Instructions: Indicate if the existing lead had defibrillation problems due to oversensing with shock/antitachycardia pacing (ATP). This manifests as sensing of non-cardiac depolarization signals that met arrhythmia detection criteria and elicited programmed tachyarrhythmia therapy.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7170 **Name:** Oversensing without Shock or ATP

Coding Instructions: Indicate if the existing lead had defibrillation issues due to oversensing without shock/antitachycardia pacing (ATP). This manifests as sensing of non-cardiac depolarization signals that did not meet arrhythmia detection criteria and do not elicit programmed tachyarrhythmia therapy.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

G. Lead Assessment

Seq. #: 7175 **Name:** Failed to Shock with Inadequate DFT Safety Margin

Coding Instructions: Indicate if the existing lead had defibrillation issues due to failed shocks or inadequate defibrillation threshold safety margins.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7180 **Name:** Lead Integrity Issues

Coding Instructions: Indicate if the existing lead had abnormal function due to lead integrity issues (insulation failure or conductor fracture).

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7185 **Name:** Insulation Failure

Coding Instructions: Indicate if the existing lead had abnormal function due to a lead integrity issue of insulation failure. Insulation failure manifests as low lead impedance either absolutely (below manufacturer's product specifications) or by a significant decrease from previously stable chronic values.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 7190 **Name:** Conductor Failure

Coding Instructions: Indicate if the existing lead had abnormal function due to a lead integrity issue of conductor failure. Conductor failure manifests by high lead impedance either absolutely (above manufacturer's product specifications) or by a significant increase from previously stable chronic values.

Target Value: Any occurrence on current procedure

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

H. Intra or Post Procedure Events

Seq. #: 8000 **Name:** Intra or Post Procedure Events

Coding Instructions: Indicate if there were any Intra or Post Procedure Events.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8005 **Name:** Cardiac Arrest

Coding Instructions: Indicate if the patient experienced cardiac arrest.

Target Value: Any occurrence between start of procedure and until next procedure or 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 death should not be used to describe events that are not fatal.

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

Seq. #: 8010 **Name:** Drug Reaction

Coding Instructions: Indicate if the patient experienced a drug reaction as documented by anaphylaxis, or rash.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8015 **Name:** Cardiac Perforation

Coding Instructions: Indicate if cardiac perforation occurred. Cardiac perforation may or may not be symptomatic and may or may not be self sealing. It can be documented by migration of pacing or defibrillator leads to the epicardial surface, resulting in pain and/or hypotension, pericardial effusion, cardiac tamponade, failure to capture, capture of the diaphragm, phrenic nerve or intercostals muscle of sufficient magnitude to require repositioning.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

H. Intra or Post Procedure Events

Seq. #: 8020 **Name:** Cardiac Valve Injury

Coding Instructions: Indicate if a new cardiac valve injury was documented in the medical record. Cardiac valve injury results when manipulation of the pacing or defibrillation leads results in a tear in a valve leaflet or chordae tendinae and manifests as a new regurgitant murmur after the 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. #: 8025 **Name:** Conduction Block

Coding Instructions: Indicate if a new atrial or ventricular conduction block was documented in the medical record. New conduction blocks occur when pacing or defibrillation leads are manipulated which causes an injury to the specialized cardiac conduction system. It can manifest as a new right bundle branch block, or a complete heart block in a patient with a pre-existing left bundle branch block.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8030 **Name:** Coronary Venous Dissection

Coding Instructions: Indicate if the patient had a coronary venous dissection as documented by manipulation of the pacing or defibrillating leads in the coronary sinus which can result in a tear of the coronary sinus endothelium with dissection into the coronary sinus wall sometimes at times referred to as "staining" following contrast injection. This can also result in perforation of the coronary sinus.

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:** Hematoma Requiring Re-op, Evacuation or Transfusion

Coding Instructions: Indicate if the patient experienced a hematoma as a result of the procedure, requiring a reoperation, evacuation or transfusion.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8040 **Name:** Hemothorax

Coding Instructions: Indicate if the patient experienced a hemothorax as documented by accumulation of blood in the thorax.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

H. Intra or Post Procedure Events

Seq. #: 8045 **Name:** Infection Requiring Antibiotics

Coding Instructions: Indicate if the patient experienced an infection related to the procedure which required antibiotics.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8050 **Name:** Lead Dislodgement

Coding Instructions: Indicate if the patient experienced a lead dislodgement as documented by movement of a lead that requires repositioning and reoperation.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

H. Intra or Post Procedure Events

Seq. #: 8055 **Name:** Myocardial Infarction

Coding Instructions: Indicate if the patient had a myocardial infarction.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions:

Myocardial Infarction:

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).

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

H. Intra or Post Procedure Events

Seq. #: 8060 **Name:** Pericardial Tamponade

Coding Instructions: Indicate if the patient experienced fluid in the pericardial space compromising cardiac filling and requiring intervention.

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. #: 8065 **Name:** Peripheral Embolus

Coding Instructions: Indicate if the patient experienced a peripheral embolus as documented by acute occlusion of an artery resulting from embolization of a cardiac or proximal arterial thrombus.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8070 **Name:** Peripheral Nerve Injury

Coding Instructions: Indicate if the patient experienced a peripheral nerve injury as documented by sensory or motor loss of peripheral nerve function. This may result from external nerve compression as a result of positioning during a procedure, internal compression (e.g. secondary to hematoma formation) or direct nerve damage.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8075 **Name:** Set Screw Problem

Coding Instructions: Indicate if the patient had a pacing and/or sensing problem associated with high impedance due to a poor connection between a lead and ICD caused by a loose set screw.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

H. Intra or Post Procedure Events

Seq. #: 8080 **Name:** Pneumothorax

Coding Instructions: Indicate if the patient experienced a pneumothorax as documented by air in the thorax sufficient to require insertion of a chest tube.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8085 **Name:** TIA or Stroke (CVA)

Coding Instructions: Indicate if the patient had a cerebrovascular accident (CVA or stroke), or a transischemic attack (TIA).

A TIA is documented by loss of neurological function that was abrupt in onset but with complete return of function within 24 hours.

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.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8090 **Name:** Urgent Cardiac Surgery

Coding Instructions: Indicate if the patient needed to have urgent, unplanned cardiac surgery.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 8095 **Name:** Venous Obstruction

Coding Instructions: Indicate if the patient experienced a venous obstruction distal to the vascular access site documented by swelling, pain and discoloration of an extremity and confirmed by some imaging technique demonstrating >50% diameter reduction in the affected vein.

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

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

I. Discharge

Seq. #: 9000 **Name:** CABG

Coding Instructions: Indicate if Coronary Artery Bypass Graft (CABG) Surgery was performed during this admission.

Target Value: Any occurrence between arrival and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 9005 **Name:** CABG Date

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

Note(s):

If the patient had more than one CABG during this episode of care, code the date of the first CABG.

Target Value: The first value between arrival and discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 9010 **Name:** PCI

Coding Instructions: Indicate if the patient had a percutaneous coronary intervention (PCI) during this admission.

Target Value: Any occurrence between arrival and discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: **PCI:**

A percutaneous coronary intervention (PCI) is the placement of an angioplasty guidewire, balloon, or other device (e.g. stent, atherectomy, brachytherapy, or thrombectomy catheter) into a native coronary artery or coronary artery bypass graft for the purposes of mechanical revascularization.

Source: NCDR

Seq. #: 9015 **Name:** PCI Date

Coding Instructions: Indicate the date of the percutaneous coronary intervention (PCI) procedure.

Target Value: The first value between arrival and discharge

Selections: (none)

Supporting Definitions: (none)

Seq. #: 9020 **Name:** Discharge Date

Coding Instructions: Indicate the date on which the patient was discharged from your facility.

Target Value: The value on discharge

Selections: (none)

Supporting Definitions: (none)

I. Discharge

Seq. #: 9025 **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. #: 9030 **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. #: 9035 **Name:** Death During The Procedure

Coding Instructions: Indicate if the patient expired during the procedure where the device or leads were being implanted.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 9040 **Name:** Discharged Against Medical Advice

Coding Instructions: Indicate if the patient was discharged or eloped against medical advice.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	
Yes	

Supporting Definitions: (none)

Seq. #: 9045 **Name:** ACE Inhibitor (Any)

Coding Instructions: Indicate if any ACE Inhibitor was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

I. Discharge

Seq. #: 9050 **Name:** Antiarrhythmic Agent (Amiodarone)

Coding Instructions: Indicate if Amiodarone was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

Seq. #: 9055 **Name:** Antiarrhythmic Agent (Disopyramide)

Coding Instructions: Indicate if Disopyramide was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

Seq. #: 9060 **Name:** Antiarrhythmic Agent (Dofetilide)

Coding Instructions: Indicate if Dofetilide was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

Seq. #: 9065 **Name:** Antiarrhythmic Agent (Flecainide)

Coding Instructions: Indicate if Flecainide was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

I. Discharge

Seq. #: 9070 **Name:** Antiarrhythmic Agent (Other)

Coding Instructions: Indicate if any antiarrhythmic agent was continued or prescribed at discharge that isn't otherwise specified.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

Seq. #: 9075 **Name:** Antiarrhythmic Agent (Procainamide)

Coding Instructions: Indicate if Procainamide was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

Seq. #: 9080 **Name:** Antiarrhythmic Agent (Propafenone)

Coding Instructions: Indicate if Propafenone was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

Seq. #: 9085 **Name:** Antiarrhythmic Agent (Mexiletine)

Coding Instructions: Indicate if Mexiletine was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

I. Discharge

Seq. #: 9090 **Name:** Antiarrhythmic Agent (Quinidine)

Coding Instructions: Indicate if Quinidine was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

Seq. #: 9095 **Name:** Antiarrhythmic Agent (Sotalol)

Coding Instructions: Indicate if Sotalol was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

Seq. #: 9100 **Name:** ARB (Any)

Coding Instructions: Indicate if any ARB was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

Seq. #: 9105 **Name:** ASA (Any)

Coding Instructions: Indicate if any ASA was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

I. Discharge

Seq. #: 9110 **Name:** Beta Blocker (Any)

Coding Instructions: Indicate if any Beta Blocker was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

Seq. #: 9115 **Name:** Calcium Channel Blocker (Diltiazem)

Coding Instructions: Indicate if Diltiazem was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

Seq. #: 9120 **Name:** Calcium Channel Blocker (Other)

Coding Instructions: Indicate if any calcium channel blocker was continued or prescribed at discharge that isn't otherwise specified.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

Seq. #: 9125 **Name:** Calcium Channel Blocker (Verapamil)

Coding Instructions: Indicate if Verapamil was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

I. Discharge

Seq. #: 9130 **Name:** Digoxin (Any)

Coding Instructions: Indicate if any Digoxin was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

Seq. #: 9135 **Name:** Diuretic (Any)

Coding Instructions: Indicate if any Diuretic was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

Seq. #: 9140 **Name:** Hydralazine (Any)

Coding Instructions: Indicate if any Hydralazine was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

Seq. #: 9145 **Name:** Lipid Lowering Agent (Statin)

Coding Instructions: Indicate if a Statin was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

I. Discharge

Seq. #: 9150 **Name:** Lipid Lowering Agent (Non-Statin)

Coding Instructions: Indicate if a Non-Statin was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

Seq. #: 9155 **Name:** Long Acting Nitroglycerin

Coding Instructions: Indicate if Long Acting Nitroglycerin was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

Seq. #: 9160 **Name:** Platelet Aggregation Inhibitor (Clopidogrel)

Coding Instructions: Indicate if Clopidogrel was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

Seq. #: 9165 **Name:** Platelet Aggregation Inhibitor (Prasugrel)

Coding Instructions: Indicate if Prasugrel was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

I. Discharge

Seq. #: 9170 **Name:** Platelet Aggregation Inhibitor (Ticlopidine)

Coding Instructions: Indicate if Ticlopidine was continued or prescribed at discharge.

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

Supporting Definitions: (none)

Seq. #: 9175 **Name:** Warfarin (Coumadin)

Coding Instructions: Indicate if Coumadin was prescribed at discharge.

Note(s):

Leave blank if the patient does not have an indication to have coumadin prescribed (typically heart failure and/or atrial fibrillation, among other diagnoses).

Target Value: Any occurrence on discharge

Selections:

Selection Text	*Definition*
No	Medication was not prescribed
Yes	Medication was prescribed
Contraindicated	Medication was not prescribed because of a contraindication. Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record
Blinded	Patient was in research study or clinical trial and administration of this specific medication is unknown

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.

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)

Z. Administration

Seq. #: 1090 **Name:** Patient Population

Coding Instructions: Indicate the population of patients and procedures that are included in the data submission.

Target Value: N/A

Selections:

Selection Text	*Definition*
All Patients	All patients, all procedures, regardless of insurance payor, ICD indication, or procedure performed.
Medicare Primary Prevention Patients	Patient procedures in which Insurance Payor is coded as 'Medicare', Procedure Performed is coded as 'Initial Implant' or 'Generator Change,' and ICD Indication is coded as 'Primary Prevention'.

Supporting Definitions: (none)

Seq. #: 1200 **Name:** Auxiliary 0

Coding Instructions: Reserved for future use

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)