Section F: PREOPERATIVE CARDIAC STATUS

Section Intent: The intent is to document the condition of the patients cardiac status as close to the surgical procedure as possible. Data Elements within section F may be used as consistency checks with the reported surgical status (seq# 1240).

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
751	Previous MI	Has the patient had at least one documented previous myocardial infarction at any time prior to this surgery?	There is no time limit on when the myocardial infarction (MI) occurred. If the history and physical indicates there was a history of MI, yet no additional documentation is available to determine if definitional criteria are met, code as MI based on information provided. For an MI that has occurred during the same hospitalization as the surgery, definition criteria must be met. Note: The current data specifications do not recognize echo as a method of documenting MI. Do not code MI based on echo reports: look for further supportive documentation.	Consultations ECG/EKG History & Physical Laboratory report Nuclear imaging report
760	MI-When	Report the time interval of last documented MI to time of surgery.	Time of surgery is documented as the hour the patient entered the operating room suite. Select the time-interval category based on information available on when the MI occurred. MI occurrence is the time of diagnosis and/or when confirmation of the last MI is documented prior to surgery.	Admit or ED notes Anesthesia record Consultations History & Physical Physician progress notes

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770	Heart Failure	Has the physician documented that the patient is currently in heart failure within two weeks prior to the initial surgical procedure?	The intent is to capture current diagnosis of or exacerbation of an existing condition. DO NOT code stable or non-symptomatic compensated failure. A low ejection fraction (EF) without clinical presentation does not qualify for history of heart failure.	Admit or ED notes Chest X-Ray Consultations History & Physical Medication administration record Outpatient record Radiology reports
775	Classification-NYHA	Select the patient's highest New York Heart Classification (NYHA) within two weeks prior to surgery. NYHA classification represents the overall functional status of the patient in relationship to heart failure. **Note: The definition in the 2.61 Data Specifications describe NYHA as representing "functional status of the patient in relationship to both heart failure and angina." This in an error. Please use NYHA for heart failure only, to the fullest extent possible.**	Select the highest level of heart function **leading** up to episode of hospitalization or the time of the procedure. NYHA is for either congestive heart failure (CHF) with or without angina. *Example: Minimal exertion such as walking and gardening results in patient experiencing angina = Class III. One day, while gardening, patient experiences chest pain that results in a trip to the hospital. While in the ambulance the patient is experiencing pain at rest. This pain at rest however, does not represent the overall functional class that led to hospitalization. The minimal exertion such as walking and gardening, Class III, represents the overall and highest functional class that lead to hospitalization. The patient's activity initiated the angina at rest, angina was not initially occurring at rest.*	Admit or ED notes Consultations History & Physical Outpatient record

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791	Cardiac Presentation on Admission	Indicate the type of angina present prior to this surgical intervention.	1. No Symptoms or Angina. 2. Symptoms Unlikely to be Ischemia: Pain, pressure or discomfort in the chest, neck or arms not clearly exertional or not otherwise consistent with pain or discomfort of myocardial ischemic origin. This includes patients with non-cardiac pain (e.g. pulmonary embolism, musculoskeletal, or esophageal discomfort), or cardiac pain not caused by myocardial ischemia (e.g., acute pericarditis). 3. Stable Angina: Angina without a change in frequency or pattern for the six weeks prior to this surgical intervention. Angina is controlled by rest and/or oral or transcutaneous medications. 4. Unstable Angina - There are three principal presentations of unstable angina: 1) rest angina, 2) new -onset (less than 2 months) angina, and 3) increasing angina (in intensity, duration and/or frequency). 5. Non-ST Elevation MI (Non-STEMI) - The patient was hospitalized for a non-ST elevation myocardial infarction as documented in the medical record. Non-STEMIs are characterized by the presence of both criteria: A. Cardiac biomarkers (creatinine kinase-myocardial band, Troponin T or I, and/or myoglobin) exceed the upper limit of normal according to the individual hospital's laboratory parameters with a clinical presentation which is consistent or suggestive of ischemia. ECG changes and/or ischemic symptoms may or may not be present. B. Absence of ECG changes diagnostic of a STEMI (see STEMI).	Admit or ED notes Cardiac cath report Consultations ECG/EKG History & Physical Nursing assessment notes
791	Cardiac Presentation		6. ST Elevation MI (STEMI) - The patient	

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(continued)	on Admission		presented with a ST elevation myocardial infarction as documented in the medical record. STEMIs are characterized by the presence of both criteria: A. ECG evidence of STEMI: New or presumed new ST-segment elevation or new left bundle branch block not documented to be resolved within 20 minutes. ST-segment elevation is defined by new or presumed new sustained ST-segment elevation (0.1 mV in magnitude) in two or more contiguous electrocardiogram (ECG) leads. If no exact ST-elevation measurement is recorded in the medical chart, physician's written documentation of ST-elevation is acceptable. If only one ECG is performed, then the assumption that the ST elevation persisted at least the required 20 minutes is acceptable. Left bundle branch block (LBBB) refers to LBBB that was not known to be old on the initial ECG. For purposes of the Registry, ST elevation in the posterior chest leads (V7 through V9), or ST depression in V1 and V2 demonstrating posterior myocardial infarction is considered a STEMI equivalent and qualifies the patient for reperfusion therapy. B. Cardiac biomarkers (creatinine kinase-myocardial band, Troponin T or I, and/or myoglobin) exceed the upper limit of normal according to the individual hospital's laboratory parameters a clinical presentation which is consistent or suggestive of ischemia.	

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810	STS Cardiogenic Shock	At the time of the procedure, was the patient in cardiogenic shock.	Indicate whether the patient was, at the time of procedure, in a clinical state of hypoperfusion sustained for greater than 30 minutes, according to either of the following criteria: 1. Systolic BP < 80 and/or Cardiac Index < 1.8 despite maximal treatment; 2. IV inotropes and/or IABP necessary to maintain Systolic BP > 80 and/or CI > 1.8.	Cardiac cath report Consultations Critical care notes Medication administration record Nursing assessment notes Operative record Physician progress notes
830	Resuscitation	Was the patient receiving CPR within one hour before the start of the operative procedure?	CPR must have been either started, on going or concluded within one hour before the start of the operative procedure.	Cardiac arrest notes Cardiac cath report Critical care notes Operative record Physician progress notes
840 840	Arrhythmia Arrhythmia	Is there a history of preoperative arrhythmia (sustained ventricular tachycardia, ventricular fibrillation, atrial fibrillation, atrial flutter, third degree heart block) that has been treated with any of the following modalities: • Ablation therapy • Automatic implantable cardioverter/defibrillator (AICD) • Pacemaker • Pharmacological treatment • Electrocardioversion	There is no time line to the presentation of these arrhythmias. The arrhythmia must have been treated and/or clinically documented with one or more of the definitional list of therapies. These do not include arrhythmias such as 1st or 2nd degree heart block, occasional premature ventricular contractions (PVC's) or supraventricular tachycardia (SVT). If the patient had a history of an arrhythmia (i.e. a-fib or V-tach) and is currently on medication to control rate and rhythm, and presents in sinus rhythm, code the patient as having the arrhythmia. To define "treated for an arrhythmia": a patient is considered to be treated for arrhythmia if they are on a medication specifically to treat an arrhythmia. Today, most arrhythmias are treated with antiarrhythmics. Coumadin would not be considered a treatment for A-fib. Rather, patients may be on Coumadin to treat	Consultations ECG/EKG History and Physical Medication administration record

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(continued)			potential complications of the arrhythmia but not to treat the arrhythmia. Patients may or may not be on Digoxin to treat arrhythmias. In the past Digoxin was used to treat A-fib, but patients can also be on Digoxin to decrease the O2 demands on the heart, increase contractility etc. Therefore, do not assume that all patients that are on Digoxin are being treated for A-fib. Amniodarone and other antiarrhythmic medications are used to treat for A-fib and other arrhythmias. These antiarrhythmics should be recognized as such as compared to Digoxin and anticoagulants.	
851	Arrhythmia Type-Vtach/Vfib	Was sustained ventricular tachycardia or fibrillation present within two weeks of the surgical procedure?	V-tach rhythm must be sustained/persistent or paroxysmal sufficient as to require some type of intervention (pharmacological and/or electrical) to interrupt and cease the arrhythmia.	Consultations ECG/EKG History & Physical Medication administration record Nursing assessment notes Outpatient record Physician progress notes
852	Arrhythmia Type-3rd HB	Was third degree heart block present within two weeks of the surgical procedure?	Heart block is applicable only if the patient has or did have 3rd degree heart block (complete heart block) within two weeks of the surgical procedure.	Consultations ECG/EKG History & Physical Medication administration record Nursing assessment notes Outpatient record Physician progress notes
853	Arrhythmia Type-Afib/Aflutter	Was atrial fibrillation or flutter present within two weeks of the surgical procedure?	The pre-op arrhythmia is present within two weeks of the procedure, whether chronic, new onset, stable or unstable. The patient may be receiving prescribed medication.	Consultations ECG/EKG History & Physical Medication administration record Nursing assessment notes Outpatient record Physician progress notes