STS ACSD FAQ's
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Seq	Update
305	FAQ Sept 2020 - Patient came in for explantation of RV leads x2, explantation of AICD generator, implantation of RV lead, and implantation of new AICD generator. Patient was in "extended recovery" status the entire stay. Do I code surgery date as admit date even though the patient was never technically an inpatient? Answer - Yes code surgery date as admit date in this scenario
486	FAQ September 2020 - Patient has a history of liver disease and cirrhosis s/p liver transplant 2016. Are you still considered to have cirrhosis despite the transplant? Answer - In this scenario, since the patient has new liver, only code cirrhosis if the new liver has cirrhosis.
895	Update September 2020 - For elective patients, choose the CAD presentation that was the cause of consultation for CAB.
1141	Update September 2020 Repatha and other PCSK9 inhibitors are captured as a non-statin/other.
General Information Coronary Artery Stenosis	Update September 2020 – Coding of Native Vessel Stenosis in Patients who have had prior CAB Surgery. If all grafts are patent bypassing stenosis in the native vessels then capture RCA, LAD, CX, LM distribution 50% or > as NO. For example, patient had prior CAB x 3 most recent Cath shows 70% stenosis in native LM, 90% stenosis in native LAD, 80% stenosis in native CX, and 95% stenosis in native RCA. Bypass grafts to mid LAD, OM1, and right PDA are patent, code the LM, LAD, CX, and RCA distribution as NO to stenosis 50% or >.
General Information Coronary Artery Stenosis	Update September 2020 For NA choice – Use the NA choice in situations where the patient does not anatomically have the vessel such as no Ramus and also in situations where the vessel or any part of the vessel distribution has not been addressed in the medical record. For example, there is no mention of the RCA in the cath report or any of the other documentation in the medical record, code the RCA distribution 50% or > as NA.
General Concepts Valve Disease and Regurgitation	Update September 2020 - For pre-op valve regurgitation and stenosis Parent fields (Seq 1585,1600,1679,1690,1774,1776,1812,1822) the answers are Yes and No. If you have no documentation of any regurgitation or stenosis then code NO. Do not open up the child fields and code not documented.

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1601/ 1777 /1820	Update September 2020 Critical stenosis can be coded as severe.
1970	Update September 2020 - Prior thoracic endovascular aneurysm repair that needs another thoracic endovascular aneurysm repair should be coded as first reoperation.
2245 / 2270	Update September 2020 – If a patient is undergoing a catheter based or EP procedure that is not required to be entered into the STS Database and the patient has to convert to an open surgical procedure, for example, while undergoing a TAVR, surgery was converted to open SAVR, use the below directions for coding of OR entry and incision time: 1) For sites that have separate cath and OR logs. You will use the times on the OR log. 2) For sites that do not have separate Cath/OR logs and continue to use one log, the OR entry time and OR incision time will be coded as the same time. In this scenario, the incision time will be the time of sternotomy or open incision to perform the emergent STS qualifying procedure.
2361	All bicaval cannulation will be captured as as RA and SVC.
5433	FAQ September 2020 - If the intra-op EEG in a circ arrest case is documented as "isoelectric activity" is this coded as "yes" for documented EEG abnormality? Answer – Do not code as Yes for documented EEG abnormality in this scenario. An isoelectric EEG is abnormal, but it is "normal" for patients undergoing circulatory arrest.
5440	For section M2, 'device' refers to any implanted material within the Update July 2020 aortic valve for combined aorta and aortic valve procedures and the aorta; grafts or stent-grafts. This will include all synthetic prosthetics inserted. This may include Dacron, PTFE, homografts, autografts, stents, stent-grafts, and Update September 2020 patch grafts.
6610	Update September 2020 – Do not round ICU hours up. For example, if the ICU hours are 26.347, enter 26.34.
6595	Update September 2020 – Do not round additional ventilator hours up. For example, if the ventilator hours are 50.626, enter 50.62.

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7100	FAQ September 2020 - The training manual states we should take the last EF prior to discharge to determine if an ACE/ARB is required due to an EF < = 40%. A patient had a pre op EF of 46%. His post anesthesia, pre incision echo has EF of 35-40%. He has no other echo done prior to discharge. Would I use the intra op pre-incision echo results to determine the ACE/ARB at discharge? Answer - If an intraop-post surgery EF or a post-op EF had been done then the later of the 2 would be the last EF. In this scenario, the last EF prior to surgery would be the last EF to use. We would not recommend using the intra-op pre-incision EF results to determine if an ACE/ARB is needed at discharge.
7320	FAQ September 2020 – How should I code an Attending Anesthesiologist medically directing anesthesia PA? Answer - Code as Attending Anesthesiologist medically directing CRNA.
7335	FAQ September 2020- Do we capture heparin administered by anesthesia that is given during an off-pump case. Answer – Yes, capture any heparin given by anesthesia during surgery.

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Seq	Update
General Update UDI Number	STS does not want data managers to manually enter Device UDI numbers into the database. If your facility scans the UDI into the HIM record and your vendor allows automatic entry into their software, please use this method for entry. If the UDI is scanned into the chart and you can copy and paste this into our vendor software, please use this method. Update August 2020 - If you can't use either of these methods please leave blank.
485	FAQ August 2020 - Would ischemic hepatitis be coded as liver disease? Patient initially presented with septic shock and endocarditis with no documented prior liver history. Answer - No, ischemic hepatitis or shock liver is a result of the sepsis and is not liver disease as defined in SEQ 485.
545	Update August 2020 – Timeframe code the study closest and prior to OR Entry, done within 1 year of OR date.
810	Other Cardiac Intervention (not listed) – such as ethanol ablation, coronary artery brachytherapy or **Update July 2020** temporary mechanical assist devices that are placed open via implantation using an open surgical approach (transaxillary or transaortic) and **Update August 2020** Infrarenal abdominal aorta procedures.
810	Update August 2020 - If a patient has had multiples of the same type of intervention, coding once for each separate intervention is acceptable. For example, patient has had multiple previous cardioversions, code cardioversion one time in the grid
895	Update August 2020 - Time Frame: The highest value from arrival at transferring facility / arrival to your facility ~~admission~~ to OR Entry
1071	FAQ August 2020 - Patient receives aspirin at 1:15 PM the day before surgery with an AM OR time at 0808. Is that to be counted as "1" day of discontinuance (per the midnight instruction) or "0" as it is less than 24 hours. Answer – If it is clear in the documentation that the aspirin was given < 24 hours, then code "0". If documentation is unclear, then use the day discontinuation counting method as above.

General Information ECHO / Hemodynamics	Update August 2020 - If there are multiple values for the valve regurgitation within the same echo such as Under the Mitral Value is says moderate regurgitation and Under Impression is states mild regurgitation, use the value on the final impression / conclusion / summary from the reading physician.
1570	FAQ August 2020 - For PA Systolic pressure, the instructions specify not to take a value from in intra-op measurement after induction of anesthesia. However, the general statement for the hemodynamics section #3 states that you can obtain values that were not available anywhere else from any intra-op measurement prior to incision time. Which of these instructions are we to follow? Answer - For SEQ 1570, it is specific that if there are no PA pressures recorded or available pre-op from heart cath or echo, that you can only obtain pre-induction values. Do not use pre-incision values.
2631	Update August 2020 – Code the total number of distal anastomoses constructed using an artery to include IMA, radial, and other arterial conduits in this field.
3424	Update August 2020 - Leaflet commissural resuspension suture with replacement of the ascending aorta is not captured as a valve sparing root procedure in SEQ 4968. It is captured in SEQ 4958.
4956	Update August 2020 – For Composite Valve Conduit, capture SEQ 4956 as Other. Complete SEQ 4966 and SEQ 4967 to capture the type of composite valve conduit.
4958	Update August 2020 - Leaflet commissural resuspension suture with replacement of the ascending aorta is not captured as a valve sparing root procedure in SEQ 4968. It is captured in SEQ 4958.
5066	TEVAR are included as endovascular aorta cases if a CT surgeon on the participant agreement participated in the TEVAR. **Update August 2020** - TEVAR with any portion above the level of the diaphragm is to be entered into the database. EVARs are not included in the STS Database.
5220, 5270, 5320, 5360,	FAQ August 2020 - How do you code visceral vessel management for a TEVAR in the Descending Thoracic Aorta when the patient has a prior history of fenestrated stent-graft repair of juxtarenal aortic aneurysm? Should I code the

	presence of these prior stents and fenestrations to the celiac, mesenteric, renal and Iliac arteries even though they were not done during the current procedure? Answer - Code as "native flow" since the visceral vessels were not manipulated as part of the descending TEVAR procedure.
6749	Update August 2020 - If SEQ 6700 Post-Op-Deep Sternal Wound is coded "yes", then SEQ 6749 Deep Sternal Wound Infection Within 90 Day is automatically coded "yes" as well. For sites who do not normally follow infection for 90 days: If you code Yes to SEQ 6700 DSWI infection within 30 days, then also code SEQ 6749 as "Yes". For all other patients that do not have DSWI infection within 30 days, code unknown for SEQ 6749.
7016	FAQ August 2020 - Patient was screened for tobacco, alcohol and illicit drug use, but the patient was not positive for tobacco, alcohol or drug use. How do I code SEQ 7016? Answer - This is a 2 part question did you screen and did you provide counseling if necessary. In this scenario, code "Yes" you screened the patient for tobacco, alcohol and illicit drug use and no counseling was needed.
7165	FAQ August 2020 - If a patient is readmitted and a MRI with or without contrast is performed is this considered an "Other Procedure"? Answer - No, "Other" procedure for SEQ 7165 does not include diagnostic procedures and is defined as an invasive procedure with intent to treat. For example, patient is readmitted and an EGD with cauterization is performed for GI bleeding. This is to be captured as "other procedure' In SEQ 7165.
7225	FAQ August 2020 - Patient had documented positive COVID-19 PCR in month before surgery. COVID-19 negative x 2 in hospital before surgery. Post op course uneventful. Patient readmitted within 30 days post discharge and COVID-19 test positive again. What positive date should I code in SEQ 7225? Answer - Code the positive test date closest to surgery in this scenario.
7451	FAQ August 2020 - Our facility is using Isolyte which is not on the list of crystalloids in the DCF. How should this be captured for SEQ 7451? Answer - In this scenario, code SEQ 7448 as "Yes" and the amount given in SEQ 7450. Leave the type blank in SEQ 7451.
7579	Update August 2020 - The intent is to know if the arterial outflow temperature was measured by perfusion and if so, what was the highest arterial outflow temperature during rewarming.

7124 / 7125	A discharge to palliative care is an acknowledgement that the patient is not expected to survive. Therefore, a discharge to palliative care is equivalent to a discharge to hospice and should be regarded as a mortality **unless** the participant group provides proof otherwise.

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Seq	Update
150	FAQ July 2020 - Our electronic medical record allows a selection of 'two or more races' to capture patients of multiple race. When this is the only documentation available within our EMR for a patient, how do we code SEQ 150? Answer - Code SEQ 150 as NO in this scenario. It is important to work with your facility to accurately code Race since it is a component of the Risk Model
Lab General Statement	Update July 2020 – For lab values that are documented as more or less than a value (< or >), code as the next decimal point below or above the value. For example, if the total bilirubin closest to entry into the OR is documented as "<0.2". Code as 0.19
805	Implantable Loop Recorder, LifeVest, defibrillation or AED/ AICD shock for arrest or placement of IABP or Update July 2020 catheter based temporary mechanical assist device is not considered a previous CV intervention in Seq 805.
805	Update July 2020 Temporary mechanical assist devices that are placed open via implantation using an open surgical approach (transaxillary or transaortic), can be captured as Other Cardiac Intervention (not listed).
1855	Update July 2020 – the selection for "Endocarditis" is to be used for Endocarditis of the native valve. There is a separate selction for Endocarditis of a prosthetic valve.
2285 and 2290	Update July 2020 -The intent of the exclusion is to eliminate patients who are currently infectious and currently receiving antibiotics on a regular schedule within 24 hr of surgery
2566, 2571, 2576	FAQ July 2020 - Post repair AV Mean gradient was reported as 7-10 mmHg. How should I code this? Answer - Capture the highest value in this range. Code as 10 mmHg. This concept also applies to SEQ 2571 MV mean gradient and SEQ 2576 TV mean gradient.
4521	Note: Currently, the only applicable choice for root repair type is open – Update July 2020 the other choices in the selction set were added in the event endovascular root procedures started.
4966 and 5440	Update July 2020 Ross procedure with autograft capture in SEQ 4966 and for SEQ 5440 code as No to devices inserted.
5440	For section M2, 'device' refers to any implanted material within the Update July 2020 aortic valve for combined aorta and aortic valve procedures and the aorta; grafts or stent-grafts. This will include all synthetic prosthetics inserted. This may include Dacron, PTFE, homografts, autografts, stents, and stent-grafts. Do not capture the felt or Bioglue
6586	Update July 2020 Leave field blank if patient not intubated.
6870	FAQ July 2020 - Can you please explain what an "0.5 Rise" means? Does this mean that if a patient has a preop creatinine of 1.0 prior to

	surgery and a highest postop creatinine of 1.5 that this patient should be marked as "Renal Failure" in 6870 because he/she had a rise of 0.5? Answer - One of the indicators for renal failure is a serum creatinine level ≥4 mg/dL with at least a 0.5 mg/dL rise. For example, if your pre-op creatinine was 4.0 or greater and your highest post-op creatinine rises 0.5 or greater then that is coded as renal failure. For example, pre-op crt 4.1 and post-op 4.6 = renal failure.
7215	Temporary Field - Definition: The patient had a planned and consented Impella implantation using an open surgical approach (transaxillary or transaortic) during the index cardiac procedure. Please see Training Manual for complete details.
7225	FAQ July 2020 - It is documented that my patient had a positive COVID-19 test in April 2020. What date do I enter into the database when I only have the month and year of the positive COVID-19 test? Answer - If month and year are known code month/01/year. If only the year is known code 01/01/Year. Leave Blank if you have no information on the month, day, or year of the test.
7230	Update July 2020 - The nasal swab/OP swab, lower resp (RNA) test is the test that we are looking for. The IgG is the antibody test, this is not the test we are looking for. See image in Training Manual.