# STS ACSD FAQ's
# January 2020

| Seq | Update |
|---|---|
| 430 | FAQ Dec 2019 - The PFT report lists DLCO_SB, DLCOcSB, DLCO/VA. Are we to look for the lowest % predicted among these three? Answer - The difference in the DCLO SB (simple DCLO) and the DCLOcSB is that the DCLOcSB is corrected for the hgb value. In this scenario, capture the lowest of these 3 numbers.<br><br>Update January 2020 use the lowest DLCO_SB or DLCO/VA value. Do not use the DLCOcSB since it is a corrected value. |
| 485 | Added Hepatitis E to the not included list. |
| 510 | FAQ Nov 2019 – Can Aortic ectasia can be coded as YES to thoracic aortic disease. Answer – Yes<br><br>Update January 2020 – Code Thoracic Aorta Disease only if annulo-aortic ectasia is documented. |
| 545 | FAQ January 2020 - When a carotid duplex reports stenosis as 0-59% but states "no evidence of hemodynamic significance," I want to confirm that since it is reported in a range we take the highest number which would put this in the 50-79% / moderate category.<br><br>Answer - Code No for CVD in this scenario given the range of 0-59% and documentation of no hemodynamic significance. |
| 2285 | FAQ January 2020 - Both Ancef & Vancomycin are given as pre-op antibiotics routinely per protocol at our facility. The Ancef dose is given > 1 hr before incision, but Vancomycin is given within two hours of incision. Can we code yes to Seq 2285?<br><br>Answer - Code No to Seq 2285 in this scenario. If hospitals choose to develop a pre-op antibiotic protocol where 2 antibiotics are given, then both must be administered within one hour of surgical incision or start of procedure if no incision required (two hours if receiving Vancomycin or fluoroquinolone) in order to code YES to Seq 2285. |
| 2710 | None (isolated in-situ mammary) – Update January 2020 none can also be selected for patients who are under circ arrest during proximal graft anastomosis. |
| 4120 | FAQ January 2020 – My patient has a VAD inserted and then later in the same episode of care has a heart transplant. Which procedure is considered the index procedure in this EOC? Answer - The transplant is the index procedure in this EOC. The mechanical assist device should be coded as previous CV interventions. |

# STS ACSD FAQ's
# January 2020

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| 6780 &6790 | FAQ January 2020 - Patient has a superficial sternal infection and is taken to OR for Sternal I&D. Do I need to code only Seq 6790 or do I need to code both Seq 6780 and Seq 6790? Answer – Code both Seq 6780 and Seq 6790 in this scenario. |
| 6893 | Update January 2020 – Capture events that require a procedural intervention or surgery at the site to treat cannula site issue. |
| 6930 | FAQ January 2020 - A patient is on amiodarone prophylactically and has an occurrence of a fib post op. The patient was not in a fib upon entry to the OR. Is this coded as Afib post-op? Answer - Since the patient was on a protocol to prevent Afib and he was not in Afib upon entry to OR, this should be coded "Yes" as a post op Afib. |
| 7009 | FAQ January 2020 - Which is the correct location for coding when a patient goes home with hospice? Is it "home" or should we code "hospice"? Answer - Code as Hospice |
| 7010 | Update January 2020 - This is a Joint Commission endpoint and is to be documented on every patient. NQF 0643 - Outpatient Cardiac Rehab (OPCR) is required for patients who had had Coronary Artery Bypass Graft, Percutaneous Coronary Intervention, Cardiac Valve surgery, Cardiac Transplant or Acute Myocardial Infarction. |

# STS ACSD FAQ's
# December 2019

| Seq | Update |
|---|---|
| General Information | Update Dec 2019 – When entering values into the DCF, if your values are outside of the allowable range for the field, then you should enter the highest / lowest allowable value for that field. For example, patient has preop BNP 75,744. The allowable value for BNP is between 5 and 70,000. In this situation code 70,000. Before using the highest or lowest allowable values, please verify the unit for the value is correct. |
| 430 | FAQ Dec 2019 - The PFT report lists DLCO_SB, DLCOcSB, DLCO/VA. Are we to look for the lowest % predicted among these three? Answer - The difference in the DCLO SB (simple DCLO) and the DCLOcSB is that the DCLOcSB is corrected for the hgb value. In this scenario, capture the lowest of these 3 numbers. |
| 505 | Update Dec 2019 - Data managers are not expected to interpret the diagnostic results, please review the chart for other documentation of PAD to confirm this diagnosis. |
| 911 | Update Dec 2019 - Time frame – capture any occurrence between birth and entry to OR for index procedure. |
| 945 | Update Dec 2019 – the intent is to capture the below arrthymias – permanently paced rhythm, Ventricular Tachycardia/ Ventricular Fibrillation, Sick Sinus Syndrome, Atrial Flutter, Atrial Fibrillation, Second Degree Heart Block, Third Degree Heart Block |
| 1030 | Yes - include those who received within 24 hours prior to or at the same time as (Update Dec 2019) of incision. |
| 1545 | FAQ Dec 2019 - If there are multiple values for the EF within the echo closest to surgery such as Under the Left Ventricle the EF is 35% and Under Impression LVEF 35-40% which value do I take? Answer - In this scenario, use the value on the final impression / conclusion from the reading physician. |
| 1545 | FAQ Nov 2019 - From the echocardiogram, should we take the dimensions from the 2D Mode or the M mode? Answer - Use the 2D measurements as priority source when you have values from both modes. **Update Dec 2019 - In addition, if you have a 3D mode, it will take precedence over the 2D or M mode.** |
| 1646 | FAQ Dec 2019 – What etiology is functional bicuspid valve disease captured as? Answer - Functional bicuspid disease should be captured as Degenerative - Calcified etiology. |

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| 2120 | FAQ Dec 2019 - Our facility received a patient from another facility secondary to need for higher level of care. The patient had an emergent aortic dissection repair and was unable to come off CPB requiring ECMO insertion at the other facility. The patient was transferred emergently to our facility requiring a direct admit to our hybrid suite for cardiac cath which revealed CAD. A CABG was then emergently performed. Is the CABG still part of the other facility's episode of care or do we start a new DCF for the CABG performed at our facility? Answer - The CABG is a return to OR on the first DCF for the first hospital. The second hospital captures the risk of the aorta surgery from the first hospital on a new DCF for the CABG. |
| 2120 | FAQ Dec 2019 – If a coronary bypass graft is performed for myocardial bridging with no evidence of any atherosclerotic disease is this captured as a Congenital procedure or a CABG? Answer - If a bypass graft is performed for myocardial bridge then code as a CABG. If another procedure is performed to relieve the bridge then code as a congenital procedure. If the other procedure is performed in conjunction with other atherosclerotic vessels, then it is an ISOCAB only. |
| 2285 | Update Dec 2019 - the antibiotic must be initiated / started within one hour prior to surgical incision (two hours if receiving Vancomycin or fluoroquinolone). If no incision is required then it must be started by the start of procedure. |
| 2340 | FAQ Dec 2019 - If the innominate is cannulated for cerebral perfusion during bypass, do we mark this cannulation? Answer – No. The intent is to only capture coronary perfusion cannulation sites. |
| 2582 | FAQ Dec 2019 - Some anesthesiologists are documenting visual EF, 2D or 3D EF measurement, and Simpson's EF measurement post CPB. Which EF are we supposed to capture? Answer - use the 2D or 3D mode measurement. If you have both a 2D and a 3D measurement, code the 3D measurement |
| 4090 | Update Dec 2019 - Subaortic stenosis (or subvalvular aortic stenosis) is a narrowing of the area below the aortic valve. This may vary from a thin layer of extra tissue to large bundles of heart muscle. This procedure is sometimes called septal myomectomy. |
| 5434 | Update Dec 2019 - The use of IVUS is during the actual aorta procedure not IVUS used only to obtain percutaneous access. |
| 6605 | **Intent/Clarification:** Indicate whether the patient received ICU level of care immediately following the initial surgery. Include ICU units and other similar critical care environments. Do not include PACU if only used for Phase I **recovery** **in patients who are sent to non-ICU beds after Phase 1 recovery (Update Dec 2019).** Do include PACU if used as a critical care unit when an ICU bed was not available. |

# STS ACSD FAQ's
# December 2019

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| 6610 | **Intent/Clarification:** ICU hours begin **from OR Exit Date and Time** ~~when the patient arrives in the ICU or your institutions equivalent to an ICU~~ **(Update Dec 2019)** and ends when they physically leave the ICU. |
| 6675 | FAQ Dec 2019 - Some hospital labs have begun reporting Troponin T in a new HS (highly sensitive) format and it is reported in ng/l. Is there a conversion formula available/recommended, or should HS Troponin T values be ignored, and Field #6675 be left blank? Answer – Yes, it is acceptable to convert. There are many acceptable conversion calculators online. http://unitslab.com/node/139 |
| 6755 | FAQ Dec 2019 - Pt returns to OR for exploration of bleed without tamponade. The surgeon documents hematoma evacuation and washout no active bleeding. Is this considered ReopBleed or Reop Non-cardiac? Answer - This is a reop bleed. The patient was re-explored for mediastinal bleeding and a hematoma was evacuated. |
| 6771 | **Intent/Clarification:** Only capture surgical or Cath lab interventions that occur during the hospitalization prior to discharge. **Update Dec 2019 - Capture an unplanned coronary intervention (PCI) or unplanned surgical intervention on a coronary artery in this field.** |
| 6780 | **This includes** procedures requiring a return to the operating room, such as a tracheostomy, hematoma evacuation **of a non-cardiac / non-primary operative space such as abdominal hematoma or retroperitoneal hematoma etc... (Update Dec 2019)** |
| 6680 | FAQ Dec 2019 - When looking at the last postop EKG performed, can the findings be coded if the EKG has not been officially read? Answer – No, use the last EKG that has been officially read for Seq 6680. |
| 6785 | **Intent/Clarification:** This allows capture of patients who have the chest left open with a planned delayed sternal closure. Update Dec 2019 - **The intent is to capture the delayed sternal closure of the chest following the index surgical procedure.** |
| 7008 | FAQ Dec 2019 - Pt presents for AVR but, upon opening the chest, MD discovers significant aortic calcification and feels that the surgery cannot be performed at our facility. Sternotomy is closed and the patient is transferred to another acute care facility and the AVR is performed there. Would I need to code the subsequent surgery at the transferring facility as a reop for the canceled surgery at my facility? Answer - In this scenario, capture as cancelled case at your facility and complete DCF based on the discharge date at your hospital. The facility that the patient was transferred to will start new DCF for the surgical procedure done there. |

# STS ACSD FAQ's
# December 2019

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| 7121 | FAQ Dec 2019 – If I find out that a discharged patient died after 30 days of surgery. Can I enter the mortality date in the database, or should I only enter the mortality date if it occurred within or on the 30th day after surgery? Answer - Yes, you can enter the mortality date for the discharged patient in the Database regardless of whether it has been greater than 30 days from the date of surgery. However, you are only required to follow patients discharged alive for 30 days after the date of surgery to capture whether the patient is alive or dead at the end of the 30th day after the day of index surgery |

# STS ACSD FAQ's
# November 2019

| SEQ Number | Update November 2019 |
|---|---|
| TM Introduction | Update Nov 2019 - Unless otherwise indicated, Data Managers are not required to go back in past records to update them based on new updated FAQ's and Updates to the Training Manual. Data Mangers should move forward with new updated FAQ's and Updates to the Training Manual as they abstract records. In the event of an audit, records will be audited based on the Training Manual at that time |
| 375 | Updated intent to say receiving routinely prior to surgery with intent to resume post-surgery. |
| 380 | Update Nov 2019 - ~~Prior documentation of blood pressure >140 mm Hg systolic and/or 90 mm Hg diastolic for patients without diabetes or chronic kidney disease, or prior documentation of blood pressure >130 mm Hg systolic or 80 mm Hg diastolic on at least 2 occasions for patients with diabetes or chronic kidney disease~~ |
| 380 | Update Nov 2019 - Capturing of HTN as a risk factor must be based on Provider diagnosis of HTN in the medical record. |
| 460 | Update Nov 2019 - Sleep Apnea cannot be diagnosed with a screening tool. It needs to be diagnosed with a formal diagnostic tool such as sleep study. |
| 505 | Update Nov 2019 - Do not code PAD for AVM. |
| 510 | FAQ Nov 2019 – Can Aortic ectasia can be coded as YES to thoracic aortic disease. Answer - Yes |
| 525 | Update Nov 2019 - Do not code CVD for AVM. |
| General Lab Information | Update Nov 2019 – Please do not round lab values up enter the value based on the limitations of the vendor tool for example if INR is 1.16 but vendor will only allow you to enter one place after the decimal point, then enter as 1.1. |
| 565 | Update Nov 2019 – The unit of measurement for WBC is x10^3/µl or $10^3$/µl (1000 µl) or $10^3$/$mm^3$ (1000/$mm^3$) or K/µl or K/mm3 |
| 570 | Update Nov 2019 – The unit of measurement for Hgb is g/dl or g/100 ml or g%. |
| 575 | Update Nov 2019 – The unit of measurement for Hct is %. |

# STS ACSD FAQ's
# November 2019

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| 580 | Update Nov 2019 – The unit of measurement for Platelets is x10^3/µl or $10^3$/µl (1000 µl) or $10^3$/$mm^3$ (1000/$mm^3$) or K/µl or K/mm3 |
| 585 | Update Nov 2019 – The unit of measurement for Creatinine is mg/dl or mg/100ml or mg% |
| 590 | Update Nov 2019 – The unit of measurement for Albumin is g/dl or g/100 ml or g%. |
| 595 | Update Nov 2019 – The unit of measurement for Bilirubin is mg/dl or mg/100 ml or mg%. |
| 600 | Update Nov 2019 – The unit of measurement for A1C is %. |
| 620 | Update Nov 2019 – The unit of measurement for BNP is pg/ml |
| 1135 | FAQ Nov 2019 - Patient is on Repatha (no other lipid lowering meds) with last dose 9 days prior to surgery. Should 1135 lipid lowering medication be answered as yes since they are taking it appropriately, once every 2 weeks? Answer - Code Yes to lipid lowering medication in this scenario since they are taking it appropriately, once every 2 weeks, and should be therapeutic. |
| 1170 | FAQ Nov 2019 - If there is ONLY ramus disease, would that count as 1V disease? Answer – Yes, the Ramus should count as a single vessel disease vessel on the left side. |
| 1175 | FAQ Nov 2019 - Patient has a cath 14 months before AVR that shows 1 vessel RCA CTO. No cath is repeated within 1 year. I know I have to code NO to Cath performed since > 1 year, but can I say YES to Seq 1155 CAD known and Yes to Seq 1170 Number of diseased vessels since I have cath report in chart and once diseased always diseased? Should I code Seq 1175 Native Stenosis known as NO since the cath is > 1 year old? Answer - In this scenario, code YES to Seq 1155 CAD known. Code 1 vessel to Seq 1170 and in Seq 1175 in the coronary Grid code 100% for RCA since it was a CTO. |
| 1175, 1215 | Update Nov 2019 - Ostial disease can be considered proximal disease in a coronary artery. |
| 1175 | Update Nov 2019 - The PLB artery can also be known as the PLA artery. |

# STS ACSD FAQ's
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| 1435 | Update Nov 2019- The right posterior atrioventricular segment (PAV or rPAV) and should be captured as the RCA in the Database. |
| 1545 | FAQ Nov 2019 - What is the correct value to code when the EF is listed as < 15%. Answer – Capture as 14%. |
| 1545 | FAQ Nov 2019 - What is the correct value to code when the EF is listed as > 55%? Answer - Capture as 56%. |
| 1545 | FAQ Nov 2019 - What value do we code when the conclusion for EF states "normal" and the left heart portion of the report says 60-70% by visual estimate. Do we code 60% for "normal" verbiage or 65% since we have a numerical range? Answer - Use the numerical values first in this scenario capture as 65%. Use descriptive terms when you have no numerical values. |
| 1560 | FAQ Nov 2019 - From the echocardiogram, should we take the dimensions from the 2D Mode or the M mode? Answer - Use the 2D measurements as priority source when you have values from both modes. |
| 1575 | FAQ Nov 2019 - If echo reports a RVSP of <35 what would I enter for sequence 1575? Answer - Capture as 34, in addition if it is documented as > 35, then enter 36 |
| 1970 | Update Nov 2019 - Incidence will be defined by the number of times of entry into the space for a specific procedure. A CABG/AVR/ MVR is in the pericardial space. A root/ascending/arch would be the pericardial space. An open distal arch/descending would be the pleural space. An open thoracoabdominal would involve the pleural and abdominal space. |
| 1970 | Previous descending with a current AVR/Root/CAB. This would be first incidence into the pericardial space. |
| 1970 | Previous AVR/Root/hemiarch with a current CAB. This would be first re-op into the pericardial space. |
| 1970 | Previous CAB/AVR with a current open descending. This would be first incidence for pleural space. |
| 1970 | Previous Ascending aorta repair in 2008. Previous Hemi arch in 2010. Previous TEVAR in 2015. Now presenting for open thoracoabdominal aneurysm repair. This would be first incidence for pleural and abdominal space. |
| 2128 | Aorta procedures for the purpose of the database refers to actual aorta procedures not stand-alone head or visceral vessels management without an additional aorta or planned staged aorta procedure performed. |

# STS ACSD FAQ's
# November 2019

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| 2140 | FAQ Nov 2019 - Pt has a planned PCI of the LAD and a bioprosthetic MVR in a hybrid OR. In v2.9, how would I capture this PCI done in the OR with the MVR? (since concurrent PCI was removed from this version). In this case the PCI was done prior to the MVR within the hybrid procedure. Wondering if I should capture the concurrent PCI as a planned Other Cardiac procedure in addition to the MVR or should it be captured as a prior PCI within same episode of care? Answer - Code PCI as other planned, other cardiac procedure in this scenario. |
| 2260 | FAQ Nov 2019 - The respiratory therapist always documents the extubation time. However, the ICU nurse also documents the extubation time on her flow sheet. I often get the following scenario, RT time extubated documented as 0700, RN documents on her flowsheet 0703. Which time do I take? Answer - Capture the time documented by the Respiratory Therapist as priority source documentation in this scenario. |
| 2310 | Update Nov 2019 – The unit of measurement for Hgb is g/dl or g/100 ml or g%. |
| 2315 | Update Nov 2019 – The unit of measurement for Hct is %. |
| 2320 | Update Nov 2019 – The unit of measurement for Glucose is mg/dl. |
| 2340 | Update Nov 2019 - The cannulation site refers to where the catheter is inserted. Two stage/triple stage cannulation = right atrium. Code all caval/ bicaval cannulation as venous site = right atrium. An option for SVC will be added in the upgrade |
| 2340 | FAQ Nov 2019 - How do I code femoral and IJ cannulation? Answer - Code as femoral and jugular. |
| 2390 | Update Nov 2019 - Code all caval/ bicaval cannulation as venous site = right atrium. An option for SVC will be added in the upgrade. |
| 2545 | Update Nov 2019 – Code YES for systemic clotting factors. This does not include topical clotting factors. |
| 3605 | Additional clarification Nov 2019 - STS realizes that native chords are ideal, however, given the current limitations in this version it is believed this is the best way to signify the presence of artificial chords. |
| 3605 | FAQ Nov 2019 - For an MVR, if the surgeon dictates that he removed the anterior leaflet, does that mean the chords came out with it? Answer - That is correct. If it is dictated that the anterior leaflet is removed and it is not specified specifically that the anterior chords were preserved, and the posterior leaflet is left intact then it should be recorded as posterior preservation only. This is the most common scenario. |

# STS ACSD FAQ's
# November 2019

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| 3775 | FAQ Nov 2019 - Currently if ECMO is placed via thoracic catheters (chest opened) at bedside it is considered a return to OR, other cardiac. If ECMO is inserted peripherally it is captured in the timing of ECMO and not captured as a return to OR. Please clarify how we are to capture ECMO? Answer - Capture institution of post-operative ECMO in Seq 3775 - 3785 and as Seq 6778 a return to OR for any ECMO regardless of where ECMO is performed. |
| 4040 | FAQ Nov 2019 - How can I determine primarily intracardiac vs primarily epicardial lesions? Is there a specific number of lesion sets that qualifies the ablation as intracardiac? Answer - If the procedure includes any intracardiac lesions then code this as intracardiac. Once the heart is open and an intracardiac lesion set is performed, then it is an intracardiac ablation no matter how many lesion sets are performed. |
| 4895 | Update October Timeframe - capture results closest and prior to OR Entry, within 1 year of OR date. |
| 6550 | Update Nov 2019 – The unit of measurement for Glucose is mg/dl. |
| 6555 | Update Nov 2019 – The unit of measurement for Creatinine is mg/dl or mg/100ml or mg% |
| 6556 | Update Nov 2019 – The unit of measurement for Hgb is g/dl or g/100 ml or g%. |
| 6557 | Update Nov 2019 – The unit of measurement for Hct is %. |
| 6595 | Update Nov 2019 - FAQ December 2018: Do not include the additional hours ventilated if the patient returns to the operating room **or procedure room (Update Nov 2019)** and requires reintubation for the procedure and is extubated before leaving the operating room **or procedure room (Update Nov 2019)**. |
| 6595 | FAQ Nov 2019 - The respiratory therapist always documents the extubation time. However, the ICU nurse also documents the extubation time on her flow sheet. I often get the following scenario, RT time extubated documented as 0700, RN documents on her flowsheet 0703. Which time do I take? Answer - Capture the time documented by the Respiratory Therapist as priority source documentation in this scenario. |
| 6625 | FAQ Nov 2019 - Patient has three postop echo's, one performed on 9/12, one on 9/17 and the last on 9/18. Echo from 9/18(limited) states 'pulmonic valve was not well visualized'. Echo dated 9/17 (full) states ' PV not well visualized, and echo from 9/12 states "there is mild pulmonic valve regurgitation". How would I answer postop pulmonic valve insufficiency? Answer - In this scenario, code as mild PV regurgitation since the one closest to discharge and prior to that did not visualize the PV. |

# STS ACSD FAQ's
# November 2019

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| 6665 | Update Nov 2019 – The unit of measurement for CKMB is u/l or IU/l or µmol/(min.L) |
| 6670 | Update Nov 2019 – The unit of measurement for Troponin is ng/ml or µg/l |
| 6675 | Update Nov 2019 – The unit of measurement for Troponin T is ng/ml or µg/l |
| 6774 | FAQ Nov 2019 - Patient had an aortic aneurysm repair Elephant Trunk I. On the same admission, he went back to the OR after 7 days for planned Elephant trunk II procedure. Do I capture the return to OR as 6774? Answer – No capture as one procedure, not return to OR. Use the date and times for OR from the first procedure |
| 6778 | FAQ Nov 2019 - Currently if ECMO is placed via thoracic catheters (chest opened) at bedside it is considered a return to OR, other cardiac. If ECMO is inserted peripherally it is captured in the timing of ECMO and not captured as a return to OR. Please clarify how we are to capture ECMO? Answer - Capture institution of post-operative ECMO in Seq 3775 - 3785 and Seq 6778 return to OR for any ECMO regardless of where ECMO is performed. |
| 6810 | Update Nov 2019 - A confirmed stroke on imaging supersedes the 24-hour time period. |
| 6815 | FAQ Nov 2019 - Patient had an MRI that was positive for a post-op stroke. In discussion with the cardiac team it was felt that this would not be captured as a post-op stroke because the symptoms resolved within 24 hours. How would this be captured since the symptoms resolved within 24 hours? Answer - code YES to post-op CVA in this scenario. A confirmed stroke on imaging supersedes the 24- hour time period |
| 6830 | Update Nov 2019 - Transient - is non-lasting and of short (< 24 hours) duration & Permanent - is enduring, lasting, or without change for more than 24 hours. |
| 6930 | FAQ Nov 2019 – In order to code this as a post-op event, I need to know if the patient was in Afib at the start of surgery. What is the best way to determine if the patient is in Afib at the start of surgery? Answer - Use the first rhythm documented on the anesthesia record to see if the patient is in afib upon entry to OR. |
| 7010 | Update Nov 2019 - Patients sent to rehab / transitional care/ SNF with plans to return home are not included in this category. |

# STS ACSD FAQ's
# October 2019

| SEQ Number | Update October 2019 |
|---|---|
| Introduction | Data Manager Quick-Links added |
| 330 | Update October 2019 - Time frame – capture height closest to time of OR for index procedure. Use the Anesthesia Record as priority source, followed by the Perfusion record. If height is not available from the above sources, use the height recorded in other documents closest to entry to OR for index procedure. |
| 335 | Update October 2019 - Time frame – capture weight closest to time of OR for index procedure. Use the Anesthesia Record as priority source, followed by the Perfusion record. If weight is not available from the above sources, use the weight recorded in other documents closest to entry to OR for index procedure. |
| 355 | FAQ October 2019 - Patient history has strong family history of CAD with multiple first-degree family members; however, no ages are given in medical record for any family member with history of CAD. Patient was able to give a complete history, so no issues there. Should this be coded as "No" or "Unknown". Answer - Code unknown in this scenario. |
| 490 | FAQ October 2019 - Is a patient with IgG4 related sclerosing disease considered immunosuppressed? The patient is not on any medications currently for this illness. Answer - No |
| 500 | FAQ October 2019 – My patient has a history of cancer; however, I do not know if the cancer occurred within 5 years. Can I code unknown in this case? Answer - Yes |
| 525 | FAQ October 2019 - Can we code CVD for occlusion of right Common Carotid Artery in an aortic Dissection? MRA mentions " A 1.1 cm long occlusion at the proximal right CCA, partial reconstitution of flow at the proximal cervical segment of the right CCA for a 3.0 cm segment. Distal to that, there is progressively decreased flow related enhancement in the cervical right CCA. Reconstitution of flow of the right ECA from collateral flow. A long intraluminal thrombus in the distal right CCA and extending to the precavernous segment of the right ICA. Answer - Code Yes to account for the risk of a dissection because the blood flow is null so a dissection acts like an occlusion. |
| General Information Pre-op Medications | Update October 2019 - Contraindications for pre-op medication requires documentation of a contraindication for the class of medications when applicable such as statin, beta blockers, ADP inhibitors etc. not just one medication in the medication class. For example, a documented contraindication for Toprol at pre-op would need to be documented as a contraindication for Beta Blockers, instead of one drug in the medication class. |

# STS ACSD FAQ's
# October 2019

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| Hemo/ Cath/ECHO | Effective October 2019 Source Document Priority for Coding: 1. Pre-op results captured from objective studies (cath, echo, nuclear study, etc..) closest and prior to OR Entry, within 6 months of OR date (while it is preferred that the cath be done within 6 months, they can be used for up to one year). 2. Use the OR pre-incision results if pre-incision results change the planned surgery. For example, if pre-op MV regurgitation was mild and pre-incision MV regurgitation is severe and the surgeon decides to do a MV Repair – code severe for MV regurgitation. 3. Use the OR pre-incision results if no other values are available or if the valves were not visualized on any of the pre- operative exams regardless if planned surgery was changed or not. 4. If no other results are available, then Surgeon documentation should be used. |
| 1185 | FAQ October 2019 - If there is documentation that the patient had a previous coronary stent; however, no documentation about which vessel has the stent how should we abstract this data? Answer - In the scenario you described, code Yes to history of previous PCI and stent in Seq 775 and 779 and in the Coronary GRID code Yes to stent present and leave all selections blank since you do not know what vessel was stented in the past. If you knew the vessel, you could code not documented to that stent in the grid. In this situation you will receive a consistency error, however, the error consistency error is sort of like an outlier report it is asking you to double check your data. If you have and the data entered into the database is correct then, ignore the consistency error. This will be addressed in the upgrade. |
| 2120 | FAQ October 2019 - Could you advise how unroofing of an anomalous coronary artery should be captured? Answer - If only anomalous vessel CABG, then this should be captured as a congenital procedure, not ISOCAB. If in conjunction with other atherosclerotic vessels, then it is an ISOCAB only. If bypass is performed for an anomalous, kinked or damaged vessel, this vessel is counted as one diseased or abnormal vessel in Seq 1170. |
| 2250 | FAQ October 2019 - A patient underwent CABG surgery, the Physician closed the chest, and while moving the patient off the OR table the patient had a VFIB arrest. She was placed back on the OR table, IABP Inserted, and her chest re-opened and an additional bypass graft performed. They re-closed the chest, took the patient off the table to another Hybrid OR room where a Cath Lab Physician placed an Impella. After the Impella was placed, the patient was transferred to the ICU. The hybrid room is across the hall from the previous OR Room. Same staff attended and care was not interrupted. How do I code OR exit date and time? Answer - Code as all one procedure. The patient never left the OR in this situation – use the final time of OR exit |
| 2626 | FAQ October 2019 - How do I code the use of an existing LIMA to the Mid LAD that was removed from the Mid LAD and attached to the 1st Diag branch? The proximal IMA was not brought down by pedicle or skeletonized, it already existed. A decision was made to transpose the LIMA over to the adjacent diagonal branch which was a much better target. The left internal thoracic artery was transposed and then sewn end-to-side to diagonal branch. Answer – Code Seq 2626 as Yes for |

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| | IMA used, Seq 2629 – leave blank unless you have the original operative note describing the technique, and capture Seq 2630 as direct vision. |
| 2627 | FAQ October 2019 - I have had multiple cases where the IMA in not used but the physician places an SVG to the LAD. The cardiac cath shows no LAD disease but does have LM disease. The surgeon documents "I elected not use use IMA since the patient does not have any specific LAD disease" Would this be coded as no LAD disease (since there is technically no LAD disease) or other ( just because they bypassed the LAD to assist the LM). Answer – No LAD disease is not an acceptable exclusion in this situation. Left main is functionally 2 VD LAD and CX disease. Code OTHER as reason for no IMA. |
| 2630 | FAQ October 2019 - When LIMA is harvested as a pedicle graft proximally pedicle and skeletonized distally, should we count it as Pedicle or Skeletonized? Answer - Code as skeletonized in this situation. |
| 3460 | FAQ October 2019 - For Aortic annular enlargement with a patch, do you code 3460 (Aortic annular enlargement with patch) and Seq 3469 (patch used)? Answer – Code Yes to Seq 3460 only. Do not code Seq 3469. |
| 3460 | FAQ October 2019 – Do I code Seq 3462 Aortic Root Procedure when the surgeon performs only an annular enlargement and no other aortic root procedure? Answer – Code Seq 3460 as YES and do not code Seq 3462 for Aortic Root Procedure unless the surgeon does something other than an annular enlargement on the root |
| 3605 | FAQ October 2019 - Due to endocarditis, the entire mitral valve and subleaflet apparatus was excised and a replacement performed. The surgeon also placed artificial chords from each papillary muscle to the annulus. How would this be coded? Answer – Code Yes to chords preserved in this scenario |
| 4070 | FAQ October 2019 - Could you advise how unroofing of an anomalous coronary artery should be captured? Answer - If only anomalous vessel CABG, then this should be captured as a congenital procedure, not ISOCAB. If in conjunction with other atherosclerotic vessels, then it is an ISOCAB only. If bypass is performed for an anomalous, kinked or damaged vessel, this vessel is counted as one diseased or abnormal vessel in Seq 1170. |
| 6600 | FAQ October 2019 - How do we count the total ventilation hours when the pt returns to the OR for surgery? The patient was not extubated prior to returning to the OR. Do we count the hours he was in the OR as part of his 24 hr post op ventilation time? Answer - You must include the hours during re-operation in this situation since the patient was not extubated before return to OR |

# STS ACSD FAQ's
# October 2019

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| 6605 | Update October 2019 - ICU hours are calculated with a decimal point so that minutes can be included. Divide the number of minutes by 60. See example in TM. |
| 6690<br>6725 | Updated with CDC link on SSI and DSWI<br>Update October 2019 - Capture all strategies employed to treat the infection that was diagnosed within 30 days of surgery. The interventions used may occur > 30 days. |
| 6855 | Update October 2019 – include upper and lower extremity events. |
| 6875 | Update to include iHD |
| 7011 | Update October 2019 -Time frame for smoking cessation counseling is at or prior to discharge. |
| General Discharge Medication | Update October 2019 - Contraindications for discharge medication requires documentation of a contraindication for the class of medications when applicable such as statin, beta blockers, ADP inhibitors etc. not just one medication in the medication class. For example, a documented contraindication for Toprol at discharge would need to be documented as a contraindication for Beta Blockers, instead of one drug in the medication class. |
| 7335 | FAQ October 2019 - When you ask for cell saver volume, I am correct in that you want total cell saver given back to the patient including cell saver given on CPB by the perfusionist plus amount given by anesthesia? Answer – Yes, code any amount of cellsaver given to the patient. |
| 7340 | FAQ October 2019 - For total heparin, the definition states you want the amount of heparin anesthesia gives before going on CPB. Do you not want the total heparin given on the case? Perfusion gives heparin as well, and sometimes it can be substantial. Sometimes perfusion gives extra loading dose heparin through the pump if crashing on bypass, which really could be recorded as part of pre-CPB dose? Answer – Capture only heparin given by anesthesia prior to initiation of CPB. |

# STS ACSD FAQ's
# September 2019

| SEQ Number | Update September 2019 |
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| 292 & 294 | FAQ Sept 2019 - Are Medicare Replacement Plans or Managed Care Plans that pay via PFFS (Private-Fee-for-Service) answered as YES in Seq 292 or is this field only for traditional Medicare plans that pay via FFS (Fee-for-service)? Answer: This field is for traditional Medicare plans that pay via FFS (Fee-for-service)? Medicare Replacement and Managed Care plans are no longer Medicare FFS. The intent is to discern the way the patient's care is managed. |
| 360 | Update Sept 2019 - Time frame – capture any occurrence between birth and entry to OR for index procedure. |
| 385 | Update Sept 2019 - Time frame – capture any occurrence between birth and entry to OR for index procedure. |
| 405 | Update - Mild: FEV1 60% to 75% of predicted, ~~and/~~or on chronic inhaled or oral bronchodilator therapy. Moderate: FEV1 50% to 59% of predicted,~~ and/~~or on chronic oral/systemic steroid therapy aimed at lung disease. Severe: FEV1 < 50% ~~and/~~or Room Air pO2 < 60 or pCO2 > 50. |
| 470 | FAQ Sept 2019 - Is it appropriate to answer "unknown" when drug use has not been assessed? Answer – Yes, code unknown if drug use has not been assessed. |
| 480 | FAQ Sept 2019 - Is it appropriate to answer "unknown" when alcohol use has not been assessed? Answer – Yes, code unknown if alcohol use has not been assessed |
| 485 | Update Sept 2019 - Time frame – capture any occurrence between birth and entry to OR for index procedure |
| 490 | FAQ Sept 2019 - If a patient had a partial splenectomy in the past would Seq#490 be a coded as "yes"? Answer: Code no in this scenario. A partial splenectomy may reduce both short and long-term mortality by preserving immune system functioning. |
| 495 | Update Sept 2019 - Time frame – capture any occurrence between birth and entry to OR for index procedure. |
| 505 | Update Sept 2019 - Time frame – capture any occurrence between birth and entry to OR for index procedure. |
| 510 | Update Sept 2019 - Time frame – capture any occurrence between birth and entry to OR for index procedure. |
| 530 | Update Sept 2019 - Time frame – capture any occurrence between birth and entry to OR for index procedure. |
| 530 | FAQ Sept 2019 - Do I code a history of subarachnoid hemorrhage as a prior CVA? Answer – No not all subarachnoid hemorrhages will create a stroke. There must be some form of deficit documented in the chart to code SAH as a CVA. |
| 540 | Update Sept 2019 - Time frame – capture any occurrence between birth and entry to OR for index procedure. |

# STS ACSD FAQ's
# September 2019

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| 545 | Update- Code what is found **on the study closest to entry into OR for index procedure** ~~at the time of surgery,~~ even if a prior stent is in place. |
| 560 | Update Sept 2019 - Time frame – capture any occurrence between birth and entry to OR for index procedure. |
| 810 | **Update - Permanent** Pacemaker |
| 895 | FAQ Sept 2019 - I have physician documentation that the patient is NHYA 3, and CCS 3. Can I equate CCS 3 as angina, since CCS is a grading system for angina? The physician does not explicitly state the word 'angina'. I see in the Training Manual there is a recent FAQ for HF seq. 915 that states I cannot code HF based on documentation of an NYHA class, so I am wondering if I can code an angina from CCS documentation. Answer - You can code YES to Seq 895 in this scenario. CCS Class is specific to patients having angina. The NYHA Class is often used to document functional class and may or may not be associated with a diagnosis of heart failure. You will have to clarify with the physician as to the type of angina if you cannot determine the type based on the documentation in the medical record. |
| 895 | **Update - Other** – Aortic dissections, sudden death, heart block, arrhythmia, syncope, heart failure or **other symptoms associated with non-coronary artery disease conditions such as Aortic or Mitral stenosis / insuffficiency without CAD**. |
| 911 | FAQ Sept 2019 -Is heart failure Seq 911 specific to left heart failure or do we capture right and left heart failure? Answer – Capture either right or left heart failure in Seq 911. |
| 930 | At the time of the procedure. **Update Sept 2019 - Do not code cardiogenic shock after induction** |
| 1035, 1040, 1045, 1055 | Update Sept 2019 - Anti-anginal medications: beta blockers, calcium channel blockers, long acting nitrates and other antianginal medication are to be captured if the patient is on them at home > 2 weeks prior to admission, even if they are stopped prior to surgery. Capturing these home meds demonstrates that the physician caring for these patients were appropriately attempting to manage the patient's CAD. |
| 1150 | FAQ Sept 2019 - If the only documentation indicates cardiac catheterization was performed on May 2019, with no exact day. How should I code the date? Answer - If month and year are known code 5/1/19. 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 cath. |
| 1646 & 4505 | FAQ Sept 2019 - A patient had a pre-operative diagnosis of Bicuspid aortic valve and Ascending Aortic Aneurysm. Once patient was in the OR the surgeon notes that the aortic valve was unicuspid. What do I choose for Seq 1646 Aoritc Etiology and Seq 4505 Patient's gentic history? Answer – Code bicuspid in both Seq 1646 and Seq 4505 as these are along the same pathophysiologic process and are variants of valve morphology. |

# STS ACSD FAQ's
# September 2019

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| 2245 & 3400 | FAQ Sept 2019 - I had a patient who had a planned CABG for 1 day and a planned TVAR the next day. Per the Training Manual, I am to capture this as one procedure in the Aortic Valve Section even though it was done on a different day. In this scenario, do I enter the OR times from the CABG or TAVR procedure? Answer - Use the OR times Seq 2245, 2250, 2253, 2265, 2270, and 2275 from the CABG in this scenario. |
| 2280 | FAQ Sept 2019 - Is Clindamycin an appropriate choice for PCN allergic patients? Answer - An alternative antibiotic can be given as the primary (prophylactic) antibiotic for patients with a PCN allergy as deemed appropriate by hospital infectious disease consultant. Standing orders are acceptable as long as an Infection Disease Consultant was involved in the development of the orders |
| 3390 & 3462 | FAQ Sept 2019 - If a patient has a root repair with a valve resuspension, should you code both aortic valve repair (3395), then repair type (3425) for leaflet commissural resuspension in addition to the root proc (3462) & valve sparing root operation (3466), and the resuspension of the AV? Answer - You do not need to code the AV repair Seq 3395 / 3425 since it is already captured in sequence 3467 (Resuspension AV with replacement of Ascending Aorta). |
| 3485 | FAQ Sept 2019 - Our hospital is using ON-X valves with sizes such as 27/29. Our software only allows 2 numbers, which one should I use, 27 or 29? Answer - Code this valve as a 27 |
| 3485 | FAQ Sept 2019 – The Perceval Sutureless Valve comes in 4 sizes, S, M, L, XL. How should I code the size of the valve? Answer – Code the size of the last digits in the model number. For example, PSV23 will be coded as 23 |
| 3610 | Updated Intent/Clarification to include an explanation about TMVR and entry into the STS Database. |
| 3630 | FAQ Sept 2019 - Our hospital is using ON-X valves with sizes such as 27/29. Our software only allows 2 numbers, which one should I use, 27 or 29? Answer - Code this valve as a 27 |
| 6500 | FAQ Sept 2019 - For congenital defect repair, if we are to exclude bicuspid valve, should we also exclude a quadricuspid/unicuspid valve, and leave it in the isolated valve category, instead of completing the congenital section? Answer – Yes, these are variants of valve morphology and should be left in the isolated valve category do not code as a congenital case. |
| 6690 | Update 2019 - Diagnosis of "cellulitis" (redness/warmth/swelling) by itself. Conversely, an incision that is draining or that has organisms identified by culture or non-culture based testing is not considered a cellulitis. |
| 6778 | Update Intent/Clarification to include return to OR suite or equivalent OR environment (i.e., ICU setting) as identified by your institution, that require surgical re-intervention to investigate/correct other non-bleed cardiac issues such as emergent open chest in the ICU for cardiac arrest. |

# STS ACSD FAQ's
# September 2019

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| 6810 | FAQ Sept 2019 - A patient developed a post-op ischemic stroke. Three days after this diagnosis, a repeat head CT showed "evidence of hemorrhagic transformation". Should the stroke be coded as "ischemic" or as "hemorrhagic"? Answer - Code as ischemic. |
| 7010 | Update Sept 2019 - Time frame for Cardiac rehab referral is at or prior to discharge |
| 7115 | FAQ Sept 2019 - If a physician documents 'no Lipitor due to elevated liver enzymes", is this sufficent to code contraindicated or does it need to specify the class of medications? Answer - Seq 7115 refers to statin's and the contraindication documentation should indicate that the patient is not discharged on a statin instead of one drug in the class. Based on your information, code No to discharge statin |
| 7730 | FAQ Sept 2019 - Should the time frame on this field begin at midnight on POD 3, or at 72 hours from OR exit? Answer - The timeframe is counted by days, not hours so POD 0 is the day of surgery, POD 1 is the day after surgery, etc… |
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# STS ACSD FAQ's
# August 2019

| SEQ Number | Update August 2019 |
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| General Information | FAQ August 2019 – A patient had a TEVAR performen on June 1st and was discharged on June 4th. The patient returned on June 15th with an endoleak and required another TEVAR to fix the endoleak. How do I account for this second procedure, we don't want to lose data from this case. Answer – On the first DCF from the June 1st TEVAR you will enter this as a readmission (readmit primary reason – Other – related readmission), and a readmit primary procedure of 'OR for Aorta Intervention.' A DCF will need to be filled out for the second case as well since it was a separate readmission and any complications following the second procedure will be captured on the second DCF. This is true for all primary procedures that are captured in the STS ACSD. If a patient has a CABG and then comes back within 30 days for a Valve, the valve would be captured on a separate DCF. If there are additional questions about when a second DCF should be filled out for a new admission requiring and ACSD procedure within 30 days of the first procedure then please send in a FAQ. |
| General Information | FAQ August 2019 - Data Manager's have shared they are using an internet link that provides UDI for valves. Does this sound correct? Answer – No, there is no internet link that will provide you with a UDI. The UDI's are device specific which means they are unique for each device impanted into each patient. No two devices will have the same UDI. See the below image for what an UDI number looks like. The current data specs allow for 50 charecters to be entered for the UDI. However, most UDI's are greater than 50 charecters, please advise? The UDI is made up of 5 different identifiers and each identifier is preceed by a number in paraentheses (e.g (GIN (01) #; Expiration Date (17); Manufacturing Date (11); Lot number (10) AND Serial number (21)). It is necessary to enter all of the charecters, including the paraentheses, into the database so the FDA can identify each unique device. If you are not able to enter the entire UDI, including the paraentheses, then please leave this field blank. The field length will be addressed in the 2020 version upgrade to allow for more charecters. |
| General Pre-Op Lab Information | Update Aug 2019 - Use results closest to surgery, prior to anesthesia provider initiating care. Lab values should be collected ~~STS recommends values~~ within 30 days, unless otherwise stated below. |
| 645 | FAQ August 2019 - What is the time frame on the 5M walk test? Answer – To cod 'YES' to 5M walk test performed it should be done within 3 months of surgery. |
| 911 | FAQ August 2019 – Can I code heart failure for a patient with a documented diagnosis of cardiomyopathy without a diagnosis of heart failure documented in the medical record? Answer - Do not code heart failure for this patient. A diagnosis of heart failure must be documented in the medical record to code heart failure. Cardiomyopathy may or may not be associated with a heart failure diagnosis. |

# STS ACSD FAQ's
# August 2019

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| 1135 | FAQ August 2019 - The patient was on red rice yeast prior to surgery, can this be abstracted as 'YES' for meds-lipid lowering within 24 hours? Answer - If the patient is prescribed red rice yeast as a lipid lowering agent, you may code this as a non-statin/other agent. Capture red rice yeast as a non-statin/other. |
| 1141 | FAQ August 2019 - The patient was on red rice yeast prior to surgery, can this be abstracted as yes for meds-lipid lowering within 24 hours? Answer - If the patient is prescribed red rice yeast as a lipid lowering agent, you may code this as a non-statin/other agent. Capture red rice yeast as a non-statin/other |
| Hemodynamics | FAQ August 2019 - If the pre-op echo reports 'structurally normal valve'. Is this valve considered normal with no disease? Answer - This documentation implies that the valve is normal without disease or regurgitation. |
| 1195 plus all other native artery stenosis fields | Update General Statement / FAQ September 2017: Do we enter vessel stenosis in a coronary artery in the data collection form if it is less than 50%? Answer: When coding the % stenosis in a native coronary artery, code all the known percentages even if they are less than 50%. For reports where there is 0% stenosis, enter 0%. If stenosis of the vessel is not reported, then leave blank. Understand that these fields will only need to be completed when the number of diseased vessels in NumDisV - seq 1170 is select as one or more. |
| 1970 | FAQ August 2019 – Update of FAQ Jan 2018 and Feb 2018 - Patient has a history of a CABG, then later a VAD, then a heart transplant. The patient is now having a CABG on his transplanted heart. What is the incidence for this surgery? Answer: Code incidence as third reoperation. The key distinction is surgical entry into the pericardial space |
| 2125 & 2140 | FAQ August 2019 - A patient was admitted for tricuspid valve endocarditis and had an AngioVac-assisted extirpation of matter from the tricuspid valve via percutaneous approach with cardiopulmonary bypass support. Is this case included in the Registry? Answer - Aortic thrombectomy using the AngioVac system is not collected, unless done in conjunction with an STS qualifying procedure, such as CAB or AVR etc.. |
| 2251 | FAQ August 2019 - Is general anesthesia to be checked "Yes" if used anytime during the procedure. This is related to cases that start with MAC and convert to general anesthesia? Answer - The intent of this field is to capture if general anesthesia was used at any time during the procedure, regardless if they started with procedural sedation. |
| 4250 | FAQ August 2019 - How should a unilateral pulmonary vein isolation be captured? Previously, in version 2.81, this same field was named "Pulmonary Vein Isolation." The word bilateral was added to the field in v2.9. Answer – Code both unilateral pulmonary vein isolation and bilateral pulmonary vein isolation in Seq 4520 |
| General Aorta Information | FAQ August 2019 - Use the following table only as a guide to the anatomical location of zones. Please verify with your surgeon the proximal and distal locations using zones, do not assume. For example, do not assume that the procedure was performed in Zone 2 if you surgeon states it was an "Arch" |

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| | procedure. You will to verify with your surgeon if it was Zone 1, 2, or 3. Please refer to the training manual for the table. |
| 6870 | Updated August 2019 FAQ February 2019: The right and left renal arteries were covered with endograft secondary to emergency rupture. A dialysis catheter was placed in surgery and dialysis was started post-op. Should renal failure be coded? Answer: Code yes to renal failure. |
| 6870 | FAQ August 2019 - Dialysis temporary catheters were placed. However, dialysis was not started as the patient's family decided to withdraw care. Post-op Creatinine does not meet the definition, but the intent was to start dialysis. Do I code post-op renal failure since dialysis was intended but not started? Answer – Do not code post-op renal failure in this scenario since dialysis was intended but not started and the post-op creatinine did not meet the data definition. |
| 7000 | FAQ August 2019 - Is the last follow-up limited to appointment with surgeon (post-op check) or can it be with PCM or care call (telephone follow-up)? Answer - Other methods can be used. It is basically the date that you have verified that the patient is alive so phone, clinic, etc.. If you see that the patient has visited the hospital, lab, x-ray, rehab or physician office any time after 30 days you can code that date. If the patient dies within the hospital stay, the date of death is the last follow-up. If the patient is lost to follow-up, the discharge date is the date |

# STS ACSD FAQ's
# July 2019

| SEQ Number | Update July 2019 |
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| 291 | **FAQ July 2019**; Since the Payors are now part of the Risk Model, which option is recommended to capture the Payor fields when the Hospital documents state "Medicaid Pending"? The 2.9 definition states "for this admission", suggesting that the patient is uninsured (None/Self) at the time of admission. Is this insurance at time of arrival or at time of discharge?<br>**Answer:** Please capture insurance at time of arrival. |
| 355 & 4500 | **FAQ July 2019**: How are half-siblings captured?<br>**Answer:** Half-siblings are considered second-degree relatives and will not be coded as family history of first degree / direct blood relatives |
| 405 | **FAQ July 2019**: Patient had PFT done, with FEV1 % Predicted of 48%. I have not seen any documented diagnosis of chronic lung disease in the chart. Do I still code as 'Severe', based on the PFT or does there also have to be a diagnosis of chronic lung disease?<br>**Answer:** This should be coded as severe COPD per FEV1 results and does not require physician documentation. |
| 490 | **FAQ July 2019:** Pt has systemic lupus taking Plaquenil QD. Is this considered immunocompromised?<br>**Answer:** Yes, Plaquenil suppress the immune system |
| 505 & 510 | **FAQ July 2019:** Is a pulmonary artery aneurysm captured in the risk factor section?<br>**Answer**: No, this is not captured. |
| 505 | **FAQ July 2019:** Is Raynaud's Disease coded as 'YES" to peripheral arterial disease?<br>**Answer:** Raynaud's is an idiopathic vasomotor response to cold or stress and not peripheral arterial disease |
| 790 & 795 | **FAQ July 2019:** When a patient has a prior history of stents, and then comes to the hospital on this admission and gets a balloon angioplasty before CABG, there is not a way to mark both of those. I mark yes on Previous PCI, but then I have to choose whether it was on this admission or not. If there was something done this admission (in this case, a balloon angioplasty), then I mark "Within this episode; Yes, at this facility" but then that takes away the possibility of me marking anything about the prior stents.<br>**Answer:** Code Yes to prior Stent - this field is a child of 775 (Prior PCI), not 780 (Previous PCI Time frame) - so history of prior stent and type of stent from any prior PCI will be captured in 790 and 795. |

# STS ACSD FAQ's
# July 2019

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| 911 | **FAQ July 2019**: How should heart failure be coded when there is not supportive documentation of the patient being in heart failure or history of heart failure, but the OP note states NYHA Class I. Should these cases be coded yes for heart failure and enter NHYA Class I or code NO for heart failure?<br>**Answer**: NYHA Class documentation alone can't be used for diagnosis for heart failure, you must have physician documentation that states heart failure. There needs to be documentation in the chart that the patient has been in or was in a state of heart failure. |
| 913 | **FAQ July 2019:** Does there need to be specific physician documentation of the type of heart failure in the chart or can the Data Manger determine if it is systolic or diastolic based on the patient's EF?<br>**Answer**: There must be physician documentation in the medical record indicating if the heart failure is systolic, diastolic, or combined dysfunction. |
| 915 | **FAQ July 2019:** Does the physician specifically have to document NYHA class or can the Data Manager select the class that matches the definitions listed above?<br>**Answer:** There must be physician documentation in the medical record indicating the NYHA class |
| 962 | **FAQ July 2019:** Patient had one episode of rapid Afib in Sept 2018 was treated with Amiodarone and has been on Amiodarone since with no recurrence. Do I code as persistent or paroxysmal afib?<br>**Answer:** If the AF required medication or procedure to convert in Sept 2018 code it as persistent. If it converted spontaneously in Sept 2018 and then the patient was placed on medication for prevention reoccurrence then this would be coded as paroxysmal. |
| 1065 & 1071 | **FAQ July 2019**: Patient receives last dose of Plavix on 4/27 at 1:15pm. Surgery is 4/29 at 730 am. Is Plavix discontinuation counted as 2 days before surgery or 1 day since it is less than 48 hours?<br>**Answer**: Code as 2 days counting each day starting at midnight. Day one is 4/28, Day two is 4/29. |
| 1170 | **Updated Intent/ Clarification:** If bypass is performed for an anomalous, kinked or damaged vessel, or **myocardial bridging** this vessel is counted as one diseased or abnormal vessel. |

# STS ACSD FAQ's
# July 2019

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| 1731 | **FAQ July 2019:** My patient's documented MV disease etiology was chronic ischemic, however, the patient has never had a MI. Can I choose the Ischemic- chronic (MI > 21 days) selection even though my patient has not had a MI?<br>**Answer**: Yes, this will be addressed in the upgrade |
| 1970 | **FAQ July 2019:** The patient had a TMVR Procedure at another facility one year ago. Now is admitted with severe Mitral insufficiency. The decision is to take the patient for Mitral valve Replacement Surgery. Is this first re-op or first surgery?<br>**Answer:** Prior TMVR case that needs a redo-MVR should be coded as first reoperation. Prior TMVR case that needs another cardiac procedure such as a CAB or AVR should be code as incidence as first CV surgery |
| 2125 | **FAQ July 2019** - While undergoing TAVR procedure, surgery was converted to open AVR. I know this 'conversion to open' will be captured in the TVT database, but do I still enter the case in STS since it is now an open procedure? My site does not normally enter TAVR cases into the STS.<br>**Answer**: Yes, this should be entered into the STS Database. If the site usually enters TAVRs into the STS database and the patient ends up converting to SAVR then the TAVR **should not be captured** as the index procedure, the SAVR should be entered as the index procedure with the preoperative risk of the failed TAVR captured. |
| 2310 | **FAQ July 2019:** The definition states do not use calculated values however, under intent it states if you do not have a value you can use a calculated value? So which is it you can use calculated or you can not?<br>**Answer:** Calculated values are acceptable to use if that is all that is documented. |
| 2435 | **FAQ July 2019:** How is cross clamp time documented when performing descending aorta surgery when the beating heart is perfusing the upper body and the bypass pump is perfusing the lower body? During these surgeries the cross clamp is moved as the vessels are reimplanted.<br>**Answer:** Capture the time from start to finish of the entire cross clamp time. This means any time the clamp is on the aorta regardless if the clamp is moved. |
| 2581 | **Updated Intent/Clarification:** Indicate if an ejection fraction was obtained intraoperatively **by an intra-op TEE** post-procedure |
| 2627 | **FAQ July 2019:** The patient has pectus carinatum and it is documented "We attempted to harvest the left internal mammary |

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| | artery however due to the patient's severe pectus, it was impossible to visualize the mammary artery? How do I code reason for no IMA.<br>**Answer:** Capture this as Subclavian Stenosis. This will be addressed in the upgrade. |
| 4052 | **Updated FAQ September 2017:** Is there supposed to be a drop-down list of atrial ligation devices in this field? Answer: No, there is no drop-down list. **Sites are to manually enter in the device model used. Sites should only type-in AtriClip, Lariat, or Other. DO NOT PUT OTHER INFORMATION IN THIS FIELD. This will be addressed in the upgrade.** |
| 4889 | **FAQ July 2019:** How does one answer the Patient IMA bypass graft when a patient did not have a previous CABG. To select 'No' implies they did have a CABG and it is not patent OR if "No' to CABG in Previous interventions is marked it will be analyzed correctly by DCRI?<br>**Answer:** Leave this blank since there is not IMA Graft. We will add N/A to the upgrade |
| 4995, 5010 & 5440 | **FAQ July 2019:** The surgeon performed an open elephant trunk and the graft material covered the Left Subclavian. Therefore, he fenestrated the graft and stented into the Left Subclavian to restore flow. How should this be captured?<br>**Answer:** This should be captured as Arch Reimplantation (seq 4995) 'yes', and Left Subclavian (seq 5010) 'yes.' Capture the graft material in the device section, but you do not need to capture the stent in the device section. |
| 5440 | **FAQ July 2019:** There was an FAQ that suggested we enter the same graft (30 hemashield) twice and choose both "below STJ" and "mid ascending to distal ascending" but that would be entering the same product being inserted twice.<br>**Answer:** In the device section you enter the zones the implant covers, both proximal and distal. Therefore, the information for model number, UDI, and if successful is being entered twice in the device section. The only part that is entered once is the locations/zones |
| 5440 | **FAQ September 2018/Updated July 2019:** A patient had previous Ross procedure with Pulmonary Autograft implanted in Aortic Position, with reconstruction of aortic annulus with |

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| | reduction annuolplasty and reconstruction of RVOT. He now has aneurysmal dilation of the ascending aorta and returns for AVR + Aortic Root Reconstruction and replacement of the ascending aorta. An OnyxAAP (free-style) valve was used, bard felt and a graft was placed, is this coded in the aortic devices?<br>**Answer:** ~~Code this as an aortic valve implant and code it in the aorta device section, include any additional conduits in the aorta section as well.~~ If a separate valve is used, code the valve in the valve section and the graft should go in the aorta section. Do not capture the felt. If an aortic conduit is used, capture, this device in the Aorta section. **Do not enter devices twice**. |
| 6720 | **Updated Intent/Clarification:** Capture infections of cannulation sites for the index procedure aorta / venous sites cannulated during surgery for CPB and the transcatheter cannulation site for transcatheter procedures such as TAVR. |
| 6778 | **FAQ July 2019:** A week after CABG, patient continues to be in cardiogenic shock. They are taken back to OR to have an Impella placed to bridge to LVAD and transplant work up. Does this qualify for ReOP for Other Cardiac Reasons? IABP was in right femoral. Surgeon and cardiologist did not feel the patient could tolerate removal of IABP then placement of femoral impella. She was taken to OR for right axillary impella via cut down.<br>**Answer:** Do not code as re-op code only under MAD |
| 6891 | **FAQ July 2019:** If a patient has a necrotic tip of L thumb and L great toe thought to be related to pressors (IABP was in the R), palpable pulses and Doppler studies of arterial all normal, is this "acute limb ischemia?"<br>**Answer:** do not code as acute ischemic event as this was a low flow perfusion situation and not an acute ischemic event that caused the necrosis |
| 6893 & 7160 | **FAQ March 2019/July 2019:** A patient was readmitted with an infection at the IABP cannulation site. This readmission infection is only related to the IABP should it only be captured as cannulation site infection in sequence number 6720 and MAD site infection in sequence number 6893?<br>**Answer:** No, do not capture as cannulation site infection in Seq 6720 since the IABP is not a cannulation sites used for the index procedure aorta / venous sites cannulated during surgery for CPB and/or the transcatheter cannulation site for transcatheter procedures such as TAVR.<br><br>Capture Readmit reason as Wound Other |

# STS ACSD FAQ's
# July 2019

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| 6900 | **FAQ July 2019:** We have TWO patients this month who went to OR with permanent pacers implanted a long time before their surgery. During the surgery the leads became dislodged. Postoperatively, they had to go back to the EP lab to get their wires replaced by cardiology. Does this count as "YES" to cardiac rhythm disturbance under the postoperative events, or an "other", or don't code it?<br>**Answer:** Do not code as re-op or as rhythm disturbance requiring permanent device |
| 6930 | **FAQ July 2019:** Is the start of surgery for this Seq 6930 when the incision occurs or when the patient enters the OR?<br>**Answer:** When the patient enters the OR |
| General Information: Discharge Medication | **FAQ July 2019**: The patient was discharged without an order for Beta-Blocker Therapy. The surgeon's office noticed on the first post-discharge visit and call in the prescription 6 days after discharge. The Surgeon addended his Discharge Summary to indicate that the patient was discharged on Beta Blocker Therapy. Is it ok to code this as Yes to Discharge Beta Blocker?<br>**Answer:** No, the medication has to be prescribed at the **time** of discharge. Addendums can be accepted for STS data, but only for events that actually occurred prior to discharge. For example, the patient was not sent home on a Beta Blocker because of a contraindication. The contraindication was not documented at the time of discharge. The data manager notified the Surgeon of the discrepancy in documentation and he addended his discharge summary according to hospital policy to indicate the contraindication. This would be an acceptable addendum. |
| 7070 | **FAQ July 2019:** If a physician documents 'no Plavix r/t low platelets', is this sufficient to code contraindicated or does it need to specify the class of medications?<br>**Answer:** Seq 7070 refers to ADP's and the contraindication documentation should indicate that the patient is not discharged on ADP inhibitors instead of one drug in the class. Based on your information, code No to discharge ADP Inhibitors. |
| 7630 | **Updated Intent/Clarification:** Time frame for TEE is the closest time before OR Exit time after final discontinuation of cardiopulmonary bypass time**. Indicate if an ejection fraction was obtained via TEE by the anesthesiologist post-procedure.** |

| SEQ Number | Update June 2019 |
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| 360 | Patient has a hx of type 1 diabetes and has had a pancreatic transplant. Do you mark yes for history of Diabetes?<br>Answer: Yes |
| 365 | How should diabetes control be coded for the patient who has had a pancreatic transplant?<br>Answer: If the patient has had a pancreatic transplant code "other", since the insulin from the new pancreas is not exogenous insulin. |
| 435 | Beginning June 2019 use the arterial blood gas value closest to surgery within 30 days of surgery. |
| 435 | Can I use an arterial blood gas that was drawn 2 months prior to surgery?<br>Answer: No use the arterial blood gas value closest to surgery within 30 days of surgery. |
| 485 | Indicate whether the patient has a history of hepatitis B, hepatitis C, cirrhosis, portal hypertension, esophageal varices, ~~**chronic alcohol abuse**~~ or congestive hepatopathy. Exclude NASH in the absence of cirrhosis. |
| 485 | Is ANY history of alcohol abuse to be coded liver disease, regardless of number of years in recovery? Example: If the patient has been in recovery for a significant amount of time, and liver work up is clean, do we still code YES for liver disease?<br>Answer: Do not code liver disease. Chronic ETOH is not considered liver disease without other liver disease criteria being met. |
| 490 | Is splenic sequestration considered an immunocompromised medical condition?<br>Answer: No |
| 525 | If a patient has a brain/cerebral aneurysm, would I answer 'yes' to cerebrovascular disease?<br>Answer: Yes |
| 1145 Echo/Hemo Intro | Pre-op results closes and prior to OR Entry, within 6 months of OR date, unless pre-incision results change the planned surgery. Use the OR pre-incision results if no other values are available **or if the valves were not visualized on any of the pre-operative echos** regardless if planned surgery was changed or not**.** |
| 1145 Echo/Hemo Intro | If the patient's valve is not visualized on a preoperative echo but visualized on the intraoperative pre-incision echo, may I code those values.<br>Answer: Yes, if the valve was not visualized on the pre-op echo but was |

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| | visualized on the intra-op preincision echo then you may use the intra-op preincision echo for the value of those valve only, not for all the valves if they were visualized on the pre-op echo. |
| 1145 Echo/Hemo Intro | If valve regurgitation is dictated from echocardiogram as "NO SIGNIFICANT REGURGITATION" do we code as "None" or "Trivial/Trace"?.<br>Answer: Code none |
| 1145 Echo/Hemo Intro | Can I use this is for all valve insufficiency elements in version 2.9.<br>+1 = trace/trivial, +2 = mild, +3 = moderate, and +4 = severe?<br><br>Answer: You cannot assume that +1 equals trace. Please work with your echo dept to develop a protocol that clearly defines what the scoring system equals in terms of descriptive terminology. Have this protocol available in the event of an audit. |
| 1145 | ~~Capture procedures done within 6 months prior to surgery~~. **While it is preferred that the cath be done within 6 months, they can be used for up to one year**. Do not include stand-alone right heart catheterization in this field; include coronary angiogram either done with or without right and/or left heart pressures. |
| 1775 | Patient underwent a tricuspid valvectomy in 2013 and the preop echo for TV Replacement states Severe TV insufficiency. Do I code severe insufficiency for the tricuspid valve since the valve isn't there?<br>Answer: Code as severe |
| 1970 | The patient had a Mitral Clip Procedure at another facility one year ago. Now is admitted with severe Mitral insufficiency. The decision is to take the patient for Mitral valve Replacement Surgery. Do I code this as first re-op surgery?<br>Answer: Mitral Valve replacement should be coded as the first operation. |
| 2140 | Patient underwent CABG and LV Thrombus Evacuation. A transverse low incision on the aorta was made and the LV cavity was inspected through the aortic valve. The aortic valve of the right coronary cusp was retracted gently, and the apex was visualized transaortic. The clot was removed in pieces. Should the LV Thrombus Evacuation be captured as Other Cardiac Procedure?<br>Answer: Code as Other Cardiac as this increases the patient risk during CABG since you are removing thrombus. |

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| 2320 | When the patient is placed on left heart bypass during an open descending thoraco-abdominal aneurysm repair, is the left heart bypass time captured under cardiopulmoanry bypass time?<br>Answer: Please code NO to Seq 2325 as this is not actual bypass as defined by the Training Manual. |
| 2606 | Indicate if the patient returned to the Cath Lab any time after OR EXIT Time and before discharge for a percutaneous coronary intervention (PCI) that was planned prior to **or during** coronary, valve, or aorta surgery. To be considered "planned" this would need to be indicated in the Medical Provider's preoperative / **operative** notes |
| 2606 | The patient goes to surgery for a CAB on 3/11/2019. During the operation the surgeon determines that the patient will need a post op PCI on a vessel that is too small to bypass. The patient is taken back to the cath lab on 3/14/2019 for a planned PCI of the vessel that was too small to bypass. There is no information in the chart after surgery suggesting the patient is having ischemia. Do we capture this as Reintervention Myocardial Ischemia?<br>Answer: At time of initial surgery if the surgeon determines that a vessel is not bypasasable and more suitable for PCI then Seq 2606 can be coded as YES. |
| 3395 | Is an aortic endarterectomy considered part of the AVR procedure or does this need to be coded elsewhere?<br>Answer: This can be part of an AVR and should not be coded elsewhere. |
| 3395 / 3500 | Patient had an AVR for endocarditis. The surgeon also performed unroofing of the mitral valve sub annular abscess. How do I code the mitral valve procedure?<br>Answer: Don't code---- part of the AVR for endocarditis. |
| 3395 / 3642 | My facility is working on a form for the physicians to complete following the valve sections. They have brought up a question due to repeated questions. If a patient only has a Bentall would you capture no to replacement (3395) and then only complete Yes starting at root procedure (3462) then continue to complete section M.<br>Answer: No complete both sections 3395 and 3462. |
| 3775 | Had a patient that was placed on VV ECCO2R. Is this coded as ECMO?<br>Answer: Yes |

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| 3500 / 4135 | Patient had MVR for endocarditis. There was erosion of the abscess into the left ventricle posteriorly causing atrioventricular disruption measuring about 2 x 3 cm. This area was repaired with a pericardial patch. Would this be coded under "other cardiac procedures", seq # 4135?<br>Answer: No, it is an inherent part of the procedure for an MVR for endocarditis. |
| 4135 | Patient has a CABG with pericardiectomy performed during the procedure. Do I code the pericardiectomy as other cardiac procesure?<br>Answer: Pericardiectomy is coded as other cardiac procedure only when the pericardium is removed from the left phrenic nerve to the right phrenic nerve. A partial resection is not included as other cardiac procedure. |
| 4970 | The patient was initially scheduled for TEVAR but after a series of CT scans and manifestations of signs and symptoms, the surgeon opted to repair the ascending aortic flap first and then, 3 days later, he took the patient back to the OR for the TEVAR. Should this be captured as post-operative event aortic reintervention?<br>Answer: No, code as a planned staged hybrid. Then capture the TEVAR accordingly in Seq. No. 5095.<br>**Capture the TEVAR with the index procedure on the same data collection form.** |
| 5066 / 5095 | Should TEVAR procedures alone be included in the STS Registry for Adult Cardiac Surgery Database?<br>Answer: TEVAR are included as endovascular aorta cases if done by a CT surgeon on the participant agreement. EVAR is not included. |
| 6821 | Updated encephlopathy choices to include Mixed and strikethrough Other |
| 6840 | Should there be diagnostic evidence the patient has pneumonia or is it sufficient for the patient to have cough and rales, for example?<br>Answer: To code pneumonia accurately, there should be a physician diagnosis documented in the medical record based on radiologic evidence as well as symptoms, i.e. fever, leukocytosis, sputum, etc. Do not code pneumonia based solely on cough and rales. Code pneumonia based on the CDC definition AND Physician Documentation. |

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| 6870 | **Failure (F)** – Increase in serum creatinine level X 3.0, or serum creatinine **≥ mg/dL 4.0** with at least a 0.5 mg/dL rise, or decrease in GFR by 75%; UO <0.3 mL/kg/h for 24 hours, or anuria for 12 hours. |
| 6914 | June 2019 Update: Patients with a positive HITA test followed by a negative SRA (Serotonin Release Assay) should not be coded as being HIT positive, even if the SRA results come back after the patient was discharged, since oftentimes these labs are sent out to be read and may take a while to get back. |
| 6920 | FAQ June 2019 - The definition for prolonged ileus does not give a time frame. How long should a documented ileus last before it is noted as a complication?<br>Answer: There is no real time frame, it really has to do with treatment and impact on LOS. Example: A patient experiences a postoperative paralytic ileus that does not increase the length of stay and does not require invasive therapy. Do not code a GI complication. |
| 6921 | FAQ June 2019: Should a patient with post-op shock liver be coded as YES to post-op liver dysfunction?<br>Answer: Yes |
| 6950 | **The following FAQ's below have been updated – please code this as a post-op Afib event.** |
| 6950 | ~~FAQ March 2018: I have a patient who went back to the cath lab with anesthesia for TEE with cardioversion (for afib). I am not certain if I should code this here or not. There was not an incision, however this is procedural. Afib is already coded. How do I reflect this intervention for STS? Answer: Code comps-other-other.~~ |
| 6950 | ~~FAQ March 2018: My patient had post-op AFlutter and AFib and was taken to the electrophysiology lab for comprehensive electrophysiology study (EPS) and successful radiofrequency ablation (RFA) of cavotricuspid isthmus (CTI. I have coded post-op AF, do I also need to code "re-op other cardiac reasons"? Answer: Code comps-other-other.~~ |