STS ACSD FAQ's
August 2019

SEQ Number	Update August 2019
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.

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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"

	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