SEQ Number	Update June 2019
360	Patient has a hx of type 1 diabetes and has had a pancreatic transplant. Do you mark yes for history of Diabetes? Answer: Yes
365	How should diabetes control be coded for the patient who has had a pancreatic transplant? 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? 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? 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? Answer: No
525	If a patient has a brain/cerebral aneurysm, would I answer 'yes' to cerebrovascular disease? 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. Answer: Yes, if the valve was not visualized on the pre-op echo but was

	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"?. Answer: Code none
1145 Echo/Hemo Intro	Can I use this is for all valve insufficiency elements in version 2.9. +1 = trace/trivial, +2 = mild, +3 = moderate, and +4 = severe? 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? 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? 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? Answer: Code as Other Cardiac as this increases the patient risk during CABG since you are removing thrombus.

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? 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? 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? 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? 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. Answer: No complete both sections 3395 and 3462.
3775	Had a patient that was placed on VV ECCO2R. Is this coded as ECMO? Answer: Yes

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? 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? 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? Answer: No, code as a planned staged hybrid. Then capture the TEVAR accordingly in Seq. No. 5095. **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? 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? 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.

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? 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? 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.~~