Implantable Cardioverter Defibrillators Registry v1.08

Data Dictionary - Full Specifications

A. Participant Administration

Field Name: Participant ID
Seq No: 1000
Short Name: PartId
Core: Yes
Status: New
Harvested: Yes
Format: Integer
Data Source: Automatic
Parent Element:
Parent Value:
Missing Data: Illegal
Valid Range: 1-999999
Usual Range:
Description: Participant ID
Definition: Participant ID is a unique number assigned to each Participant by the ACC-NCDR. An ACC -NCDR Participant is defined as one entity that signs a Participation Agreement with the ACC, submits one data submission file to the harvest, and gets back one Outcomes Report on their data.

Each Participant's data if submitted to harvest must be in one data submission file. If one Participant keeps their data in more than one file (e.g. at two sites), then the data must be combined into a single data submission file for the harvest.

If two or more Participants share a single purchased software, and enter cases into one database, then the data must be exported into different data submisison files, one for each Participant ID.

Selections:

Field Name: Participant Name
Seq No: 1010
Short Name: PartName
Core: Yes
Status: New
Harvested: Yes
Format: Text (100)
Data Source: Automatic
Parent Element:
Parent Value:
Missing Data: Illegal
Valid Range:
Usual Range:
Description: Participant Name
Definition: The full official hospital name of the facility where the implant procedure was performed. Values should be full, official hospital names with no abbreviations or variations in spelling for a single hospital.
Selections:

Field Name: Medicare Provider Number
Seq No: 1015
Short Name: MPN
Core: Yes
Status: New
Harvested: Yes

Format: Text (6)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Medicare Provider Number
Definition: Indicate the medicare provider number of the facility at which the patient received the implant.
Selections:

Field Name: Participant NPI **Seq No:** 1016
Short Name: PartNPI **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (10)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Participant National Provider Identifier
Definition: Indicate the hospital's (N)ational (P)rovider (I)dentifier. NPIs, assigned by CMS, are used to uniquely identify hospitals for Medicare billing purposes.
Selections:

Field Name: Timeframe of Data Submission **Seq No:** 1020
Short Name: Timeframe **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (6)
Data Source: Automatic
Parent Element:
Parent Value:
Missing Data: Illegal
Valid Range:
Usual Range:
Description: Timeframe of Data Submission
Definition: Indicate the timeframe of data included in the data submission. Format: YYYYQQ. e.g. 2005Q4
Selections:

Field Name: Transmission Number **Seq No:** 1040
Short Name: XmsnId **Core:** Yes
Status: New **Harvested:** Yes

Format: Integer
Data Source: Automatic
Parent Element:
Parent Value:
Missing Data: Illegal
Valid Range: 1-999999999
Usual Range:
Description: Transmission Number
Definition: A unique number created and automatically inserted by the software. It identifies the number of times the software has created data submission files. The transmission number should be incremented by one every time the data submission files are exported. The transmission number should never be repeated.
Selections:

Field Name: Software Vendor Identifier **Seq No:** 1050
Short Name: VendorId **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (15)
Data Source: Automatic
Parent Element:
Parent Value:
Missing Data: Illegal
Valid Range:
Usual Range:
Description: Software Vendor Identifier
Definition: Software Vendor Identification (agreed upon by mutual selection between the vendor and the ACC) to identify software vendor. Vendors must use consistent name identification across sites. Changes to Vendor Name Identification must be approved by the ACC.
Selections:

Field Name: Vendor software version **Seq No:** 1060
Short Name: VendorVer **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (20)
Data Source: Automatic
Parent Element:
Parent Value:
Missing Data: Illegal
Valid Range:
Usual Range:
Description: Vendor software version
Definition: Vendor's software product name and version number identifying the software which created this record (assigned by vendor). Vendor controls the value in this field. Version passing certification/harvest testing will be noted at the ACC.
Selections:

Field Name: Registry Identifier
Seq No: 1070
Short Name: RegistryId
Core: Yes
Status: New
Harvested: Yes
Format: Text (20)
Data Source: Automatic
Parent Element:
Parent Value:
Missing Data: Illegal
Valid Range:
Usual Range:
Description: Registry Identifier
Definition: The ACC-NCDR Registry Identifier describes which ACC data registry these records apply. It is implemented in the software at the time the data is collected and the records are created. This is entered into the schema automatically by software.
Selections:

Field Name: Registry Version
Seq No: 1080
Short Name: RegistryVer
Core: Yes
Status: New
Harvested: Yes
Format: Text (10)
Data Source: Automatic
Parent Element:
Parent Value:
Missing Data: Illegal
Valid Range:
Usual Range:
Description: Registry Version
Definition: Registry Version describes the version number of the Data Specifications/Dictionary, to which each record conforms. It identifies which fields should have data, and what are the valid data for each field. It is the version implemented in the software at the time the data is collected and the records are created. This is entered into the schema automatically by software.
Selections:

Field Name: Patient Population
Seq No: 1090
Short Name: PatientPop
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Illegal
Valid Range:
Usual Range:
Description: Patient Population

Definition: Indicate the population of patients that should be included in the data export and submitted tothe registry.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	All Patients	All patients regardless of insurance payor and ICD Indication.
2	CMS Primary Prevention Patients	Patients with a Primary or Secondaryinsurance payor of"Medicare"andan ICD Indicationof"Primary Prevention".

Field Name: Data Submission File Password
Seq No: 1100
Short Name: Password
Core: Yes
Status: New
Harvested: No
Format: Text (20)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: No action
Valid Range:
Usual Range:
Description: Data Submission File Password
Definition: Indicates the ACC assigned password that should be applied to the data submission zip file.
Selections:

Field Name: Auxiliary 0
Seq No: 1110
Short Name: Aux0
Core: Yes
Status: New
Harvested: Yes
Format: Text (50)
Data Source: Automatic
Parent Element:
Parent Value:
Missing Data: No action
Valid Range:
Usual Range:
Description: Auxiliary 0
Definition: Not for participant use. A 50 character text field that may be used to collect additional administrative information about the data submission.
Selections:

B. Demographics

Field Name: Patient Last Name
Seq No: 2000
Short Name: Surname
Core: Yes
Status: New
Harvested: Yes
Format: Text (25)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Patient Last Name
Definition: Indicate the patient's last name.
Selections:

Field Name: Patient First Name
Seq No: 2010
Short Name: GivenName
Core: Yes
Status: New
Harvested: Yes
Format: Text (25)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Patient First Name
Definition: Indicate the patient's first name.
Selections:

Field Name: Patient Middle Name
Seq No: 2020
Short Name: MiddleName
Core: Yes
Status: New
Harvested: Yes
Format: Text (25)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Patient Middle Name
Definition: Indicate the patient's middle name or middle initial.
Selections:

Field Name: Patient SSN
Seq No: 2030
Short Name: SSN
Core: Yes
Status: New
Harvested: Yes
Format: Text (9)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Patient SSN
Definition: Indicate the nine digit patient's United States Social Security Number (SSN). If the patient does not have a US assigned SSN, then leave the SSN blank.
Selections:

Field Name: Unique Patient ID
Seq No: 2040
Short Name: PatientId
Core: Yes
Status: New
Harvested: Yes
Format: Integer
Data Source: Automatic
Parent Element:
Parent Value:
Missing Data: Illegal
Valid Range: 1-999999999
Usual Range:
Description: Unique Patient ID
Definition: This is an arbitrary number (not a recognizable ID like SSN or Medical Record Number) that uniquely identifies each patient. Once assigned to a patient at a health care facility, this will never be changed or reassigned to a different patient. If a patient returns to the same hospital, or for follow-up, they will receive this same unique patient identifier.
Selections:

Field Name: Other ID
Seq No: 2045
Short Name: OtherId
Core: Yes
Status: New
Harvested: Yes
Format: Text (50)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: No action
Valid Range:
Usual Range:
Description: Other ID
Definition: An additional 'optional' patient identifier, such as medical record number, that can be associated with the patient.

Selections:

Field Name: Patient DOB **Seq No:** 2050
Short Name: DOB **Core:** Yes
Status: New **Harvested:** Yes
Format: Date (mm/dd/yyyy)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range: Patient DOB > 01/01/1850 and Patient DOB < Previous ICD Date and Patient DOB < Previous CABG Date and Patient DOB < Admission Date
Usual Range:
Description: Patient date of birth
Definition: Indicate the patient's date of birth.
Selections:

Field Name: Gender **Seq No:** 2060
Short Name: Gender **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Gender
Definition: Indicate the patient's gender at birth.
Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Male	
2	Female	

Field Name: Race **Seq No:** 2070
Short Name: Race **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Race

Definition: Indicate the patient's race as determined by the patient/family.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	White	
2	Black/African American	
4	Asian	
5	American Indian/Alaska Native	
6	Native Hawaiian	
7	Other	

Field Name: Hispanic Ethnicity
Seq No: 2075
Short Name: HispEthnicity
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Hispanic Ethnicity
Definition: Indicate if the patient is of hispanic ethnicity.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Auxiliary 1
Seq No: 2080
Short Name: Aux1
Core: Yes
Status: New
Harvested: Yes
Format: Text (50)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: No action
Valid Range:
Usual Range:
Description: Auxiliary 2
Definition: For participant use only. A 50 character text field that may be used to collect additional information about the patient or admission.
Selections:

Field Name: Auxiliary 2
Seq No: 2090
Short Name: Aux2
Core: Yes
Status: New
Harvested: Yes

Format: Text (50)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: No action
Valid Range:
Usual Range:
Description: Auxiliary 2
Definition: For participant use only. A 50 character text field that may be used to collect additional information about the patient or admission.
Selections:

C. Admission

Field Name: Admission Date
Seq No: 3000
Short Name: AdmitDate
Core: Yes
Status: New
Harvested: Yes
Format: Date (mm/dd/yyyy)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Illegal
Valid Range: Admission Date > Previous ICD Date and Admission Date > PrevCABGDate and Admission Date <= Date of Implant
Usual Range:
Description: Admission Date
Definition: Indicate the date on which the patient was admitted to the hospital for the current stay.
Selections:

Field Name: Date of Implant
Seq No: 3010
Short Name: ImplantDate
Core: Yes
Status: New
Harvested: Yes
Format: Date (mm/dd/yyyy)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Illegal
Valid Range: Date of Implant >= Admission Date and Date of Implant <= Date of Discharge
Usual Range:
Description: ICD Implant Date
Definition: Indicate the date of the ICD implant.

Note: In the event that multiple ICDs were implanted/explanted during a single admission, this is the date of the first/initial ICD implant. For clarification, see Sequence Numbers 3507, 3508.

Selections:

Field Name: Insurance Payor-Primary
Seq No: 3020
Short Name: PayorPrim
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Illegal
Valid Range:

Usual Range:

Description: Insurance Payor-Primary

Definition: Indicate the patient's primary insurance payor.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Government	* RYHUQP HQWHUHV WR SDWLHQWV ZKR DUH FRYHUHG E\ JRYHUQP HQWHLP EXUVHG FDUH ,QWKH8 6 WKLV LQFOXGHV 0 HGLFDUH 0 HGLFDLG LQFOXGLQJ DOOWDWH IHGHUDO 0 HGLFDLG WWSH SURJUDP V 7UL&DUH WKH 9HWHUDQV $GP LQLWWDWLRQ+ HDOWK 3ODQ DQG) HGHUDO(P SOR\ HHV,QVXUDQFH
2	Commercial	Commercial refers to all indemnity (fee-for-service) carriers and Preferred Provider Organizations (PPOs) (e.g. Blue Cross/Blue Shield).
3	HMO	HMO refers to a Health Maintenance Organization (HMO) characterized by coverage that provides health services for members on a pre-paid basis.
4	Non-U.S. Insurance	Non-US Insurance refers to individuals who reside in and have health insurance in another country.
5	None/Self Pay	None/Self Pay refers to individuals with no or limited health insurance; thus, the individual is the payor regardless of ability to pay.

Field Name: Government Type-Primary
Seq No: 3025
Short Name: GovTypePrim
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element: Insurance Payor-Primary(3020)
Parent Value: Government
Missing Data: Illegal
Valid Range:
Usual Range:
Description: Government Insurance Type-Primary
Definition: Indicate the type of insurance if the patient's primary insurance payor is Government.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Medicare	
2	Medicaid	
3	TriCare	
4	Veteran's Administration Health Plan	
5	Federal Employee Insurance	

Field Name: Insurance Payor-Secondary
Seq No: 3027
Short Name: PayorSecond
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Illegal
Valid Range:
Usual Range:
Description: Insurance Payor-Secondary
Definition: Indicate the patient's secondary insurance payor.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Government	* RYHUQP HQWHUV WR SDWLHQWV ZKR DUH FRYHUHG E\ JRYHUQP HQWHLP EXUVHG FDUH ,QWKH8 6 WKLV LQFOXGHV 0 HGLFDUH 0 HGLFDLG LQFOXGLQJ DOOWDWH IHGHUDO 0 HGLFDLG WWSH SURJUDP V 7UL&DUH WKH 9HWHUDQV $GP LQLWWDWLRQ + HDOWK 3DQ DQG) HGHUDO(P SOR\ HHV,QVXUDQFH
2	Commercial	Commercial refers to all indemnity (fee-for-service) carriers and Preferred Provider Organizations (PPOs) (e.g. Blue Cross/Blue Shield).
3	HMO	HMO refers to a Health Maintenance Organization (HMO) characterized by coverage that provides health services for members on a pre-paid basis.
4	Non-U.S. Insurance	Non-US Insurance refers to individuals who reside in and have health insurance in another country.
5	None/Self Pay	None/Self Pay refers to individuals with no or limited health insurance; thus, the individual is the payor regardless of ability to pay.

Field Name: Government Type-Secondary
Seq No: 3029
Short Name: GovTypeSecond
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element: Insurance Payor-Secondary(3027)
Parent Value: Government
Missing Data: Illegal
Valid Range:
Usual Range:

Description: Government Insurance Type-Secondary

Definition: Indicate the type of insurance if the patient's secondary insurance payor is Government.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Medicare	
2	Medicaid	
3	TriCare	
4	Veteran's Administration Health Plan	
5	Federal Employee Insurance	

Field Name: Reason for Admission **Seq No:** 3030

Short Name: AdmissionReason **Core:** Yes

Status: New **Harvested:** Yes

Format: Text (Categorical)

Data Source: Client

Parent Element:

Parent Value:

Missing Data: Report

Valid Range:

Usual Range:

Description: Reason for Admission

Definition: Indicate the primary reason the patient was hospitalized for this admission.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Admitted for this Procedure	Admitted for ICD implantation.
2	Cardiac-CHF	Admitted for management of heart failure other than implantation of an ICD.
3	Cardiac-Other	Admitted for a cardiac reason other than heart failure or implantation of an ICD.
4	Non-Cardiac	Admitted for a non-cardiac reason other than implantation of an ICD.

Field Name: Auxiliary 3 **Seq No:** 3040

Short Name: Aux3 **Core:** Yes

Status: New **Harvested:** Yes

Format: Text (50)

Data Source: Client

Parent Element:

Parent Value:

Missing Data: No action

Valid Range:

Usual Range:

Description: Auxiliary 3

Definition: For participant use only. A 50 character text field that may be used to collect additional information about the patient or admission.

Selections:

Field Name: Auxiliary 4 **Seq No:** 3050
Short Name: Aux4 **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (50)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: No action
Valid Range:
Usual Range:
Description: Auxiliary 4
Definition: For participant use only. A 50 character text field that may be used to collect additional information about the patient or admission.
Selections:

D. History and Risk Factors

Field Name: Syncope
Seq No: 3060
Short Name: Syncope
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Syncope
Definition: Indicate if the patient had a sudden loss of consciousness, including loss of postural tone (not related to anesthesia) with spontaneous recovery as reported by the patient or an observer. Patient may experience syncope when supine.

Note: Patient history is defined as any time prior to the date of implant.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Family Hx Sudden Death
Seq No: 3070
Short Name: FHSudDeath
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Family History of Sudden Cardiac Death
Definition: Indicate if the patient has a known family history (parent or sibling) of sudden cardiac death.

Sudden cardiac death is defined as a natural death due to cardiac causes heralded by abrupt loss of consciousness, occurring before 75 years of age. The time and mode of death are unexpected even though preexisting heart disease may have been known to be present. Traumatic death subsequently proven to be due to sudden loss of control due to a cardiac problem is included. Coding Exception: If the patient is adopted, or the family history is unavailable, code "No".

Note: Patient history is defined as prior to the current admission.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: CHF
Seq No: 3080
Short Name: CHF
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Congestive Heart Failure
Definition: Indicate if the patient has a history of congestive heart failure (CHF), as documented in the medical record. Besides physician documentation of the CHF history, CHF can also be defined by one of the following:
1. Paroxysmal nocturnal dyspnea (PND);
2. Dyspnea on exertion (DOE) due to heart failure; or
3. Chest X-Ray (CXR) showing pulmonary congestion;
4. Pedal edema or dyspnea treated with medical therapy for heart failure.

Note: Patient history is defined as any time prior to the date of implant.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: CHF Duration
Seq No: 3090
Short Name: CHFDuration
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element: CHF(3080)
Parent Value: Yes
Missing Data: Report
Valid Range:
Usual Range:
Description: Congestive Heart Failure Duration
Definition: Indicate the time since the initial CHF diagnosis.

Note: This includes any time prior to date of implant.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Within the past 3 months	
2	3 to 9 months	
3	Greater than 9 months	

Field Name: Prior CHF Hospitalization **Seq No:** 3095
Short Name: PriorCHFHosp **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element: CHF(3080)
Parent Value: Yes
Missing Data: Report
Valid Range:
Usual Range:
Description: Prior Congestive Heart Failure Hospitalization
Definition: Indicate if the patient has ever been hospitalized for CHF prior to this admission. Indicate the timeframe associated with that hospitalization.

Note: This timeframe does NOT include this admission. The intent of this field is to capture hospitalizations for CHF excluding the current admission.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	Not Hospitalized	
1	Yes-Within 6 months	
2	Yes-Greater than 6 months	

Field Name: NYHA Class - Current Status **Seq No:** 3100
Short Name: NYHAclass **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: NYHA Class - Current Status (at time of implant)
Definition: Indicate the patient's New York Heart Association (NYHA) classification.

NOTE: For patients with no symptoms, code "Class 1".

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Class I	Patient has cardiac disease but without resulting limitations of ordinary physical activity. Ordinary physical activity (e.g., walking several blocks or climbing stairs) does not cause undue fatigue, palpitation, dyspnea, or anginal pain. Limiting symptoms may occur with marked exertion.
2	Class II	Patient has cardiac disease resulting in slight limitation of ordinary physical activity. Patient is comfortable at rest. Ordinary physical activity such as walking more than two blocks or climbing more than one flight of stairs results in limiting symptoms (e.g., fatigue, palpitation, dyspnea, or anginal pain).
3	Class III	Patient has cardiac disease resulting in marked limitation of physical activity. Patient is comfortable at rest. Less than ordinary physical activity (e.g., walking one to two level blocks or climbing one flight of stairs) causes fatigue, palpitation, dyspnea, or anginal pain.
4	Class IV	Patient has dyspnea at rest that increases with any physical activity. Patient has cardiac disease resulting in inability to perform any physical activity without discomfort. Symptoms may be present even at rest. If any physical activity is undertaken, discomfort is increased.

Field Name: Cardiac Arrest
Seq No: 3110
Short Name: Arrest
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Cardiac Arrest
Definition: Indicate if the patient experienced cardiac arrest due to arrhythmia.

Note: Patient history is defined as any time prior to the date of implant.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No Arrest	
1	Brady Arrest	
2	Tachy Arrest	

Field Name: Brady Arrest Reason
Seq No: 3111
Short Name: BradyArrest
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element: Cardiac Arrest(3110)
Parent Value: Brady Arrest
Missing Data: Report
Valid Range:
Usual Range:
Description: Brady Arrest Reason
Definition: Indicate the reason(s) for the Brady Arrest.

Selections:

Coding/Sort	Selection(Choose multiple)	Explanation
1	Acute MI	
2	Severe Electrolyte Disturbance	
3	Drug Induced Arrhythmia	
4	Sinus Node Dysfunction/AV Block	
5	Unknown Etiology	

Field Name: Tachy Arrest Reason
Seq No: 3112
Short Name: TachyArrest
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element: Cardiac Arrest(3110)
Parent Value: Tachy Arrest
Missing Data: Report
Valid Range:
Usual Range:
Description: Tachy Arrest Reason
Definition: Indicate the reason(s) for the Tachy Arrest.

Selections:

Coding/Sort	Selection(Choose multiple)	Explanation
1	Acute MI	
2	Severe Electrolyte Disturbance	
3	Drug Induced Arrhythmia	
4	Primary VT/VF	
5	Unknown Etiology	

Field Name: Atrial Fibrillation/Atrial Flu **Seq No:** 3120
Short Name: Flutter **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Atrial Fibrillation/Atrial Flutter
Definition: Indicate if the patient has a documented history of atrial fibrillation or flutter.

Note: Patient history is defined as any time prior to the date of implant.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Ventricular Tachycardia **Seq No:** 3130
Short Name: VT **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Ventricular Tachycardia
Definition: Indicate if the patient has a history of ventricular tachycardia (either spontaneous or induced) that led to the placement of the ICD. Ventricular tachycardia is defined as a cardiac arrhythmia of 3 or more consecutive complexes in duration emanating from the ventricles at a rate greater than 100 bpm (cycle length less than 600 msec).

Note: Patient history is defined as any time prior to the date of implant.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	No history of spontaneous ventricular tachycardia.
1	Yes-VT, Non-Sustained	Three or more consecutive beats of ventricular origin, terminating spontaneously in less than 30 seconds.
2	Yes-Monomorphic Sustained VT	VT greater than 30 seconds in duration and/or requiring termination due to hemodynamic compromise in less than 30 seconds.
3	Yes-Polymorphic Sustained VT	VT with a constantly changing morphology lasting greater than 30 seconds in duration and/or requiring termination due to hemodynamic compromise in less than 30 seconds.

Field Name: Sinus Node Function **Seq No:** 3140
Short Name: SinusNodeFn **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Sinus Node Function
Definition: Indicate if the patient's sinus node function was normal or abnormal.

Note: Timeframe includes any time prior to the date of implant.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Normal	
2	Abnormal	Abnormal - History of any pause longer than 3 seconds OR Tachy/Brady Syndrome.

Field Name: Cardiac Transplant **Seq No:** 3150
Short Name: XplantPrev **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:

Usual Range:

Description: Cardiac Transplant

Definition: Indicate if the patient had a history of cardiac transplant surgery.

Note: Patient history is defined as any time prior to the date of implant.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Non-Ischemic Dilated Cardiomyopathy **Seq No:** 3160
Short Name: NIDilatedCardMyo **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Non-Ischemic Dilated Cardiomyopathy
Definition: Indicate if the patient has a history of non-ischemic dilated cardiomyopathy documented by heart failure and reduced systolic function.

Note: Patient history is defined as any time prior to the date of implant.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes-Within the past 3 months	
2	Yes-3 to 9 months	
3	Yes-Greater than 9 months	

Field Name: Ischemic Heart Disease **Seq No:** 3180
Short Name: IschemicHD **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Ischemic Heart Disease

Definition: Indicate if the patient shows evidence of ischemic heart disease as documented by any of the following conditions:
-At least one major epicardial artery with more than 70% obstruction by coronary angiography.
-Other Diagnostic Tests: History of myocardial infarction associated with wall motion abnormality as shown by echocardiography or other cardiac imaging. Stress testing diagnostic of coronary artery disease with or without imaging; ECG with evidence of MI; history of chest pain associated with cardiac enzyme abnormality.

Note:
1. Patient history is defined as any time prior to the date of implant.
2. At least one major epicardial artery with more than 70% obstruction by coronary angiography takes precedence over other diagnostic tests if ischemic heart disease has been documented.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes-At Least 1 Epicardial artery greater than 70% Obstruction	At least one epicardial artery greater than 70% obstruction (Angiography).
2	Yes-Other Diagnostic Tests	History of myocardial infarction associated with wall motion abnormality as shown by echocardiography or other cardiac imaging. Stress testing diagnostic of coronary artery disease with or without imaging; ECG with evidence of MI; history of chest pain associated with cardiac enzyme abnormality.

Field Name: Previous MI
Seq No: 3190
Short Name: PrevMITime
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Previous Myocardial Infarction and timeframe

Definition: Indicate if the patient had a MI prior to the device implant.

The patient had at least one documented STEMI or NSTEMI. This can be coded based on physician documentation or history noted in the medical record.

Definitions: NON ST ELEVATION MYOCARDIAL INFARCTION (NSTEMI)

The patient was hospitalized for a myocardial infarction documented in the medical record.

AT LEAST ONE OF THE FOLLOWING BIOCHEMICAL INDICATORS for detecting myocardial necrosis must be present (see below for a definition of Reference Control Limits):

1) Troponin T or I:
a) Maximal concentration of troponin T or I > the MI decision limit on at least one occasion during the first 24 hours after the index clinical event.
2) CK-MB:
a) Maximal value of CK-MB > 2 x the upper limit of normal on one occasion during the first hours after the index clinical event. OR
b) Maximal value of CK-MB, preferable CK-MB mass, > upper limit of normal on two successive samples.
3) Total CK:
a) In the absence of availability of a troponin or CK-MB assay, total CK > 2 x the upper limit of normal, or the B fraction of CK may be employed, but these last two biomarkers are considerably less satisfactory than CK-MB.

AND ONE OF THE FOLLOWING:

1) Either ST segment depression or T wave abnormalities; or
2) Ischemic symptoms in the presence or absence of chest discomfort. Ischemic symptoms may include:
a) unexplained nausea and vomiting; or
b) persistent shortness of breath secondary to left ventricular failure; or
c) unexplained weakness, dizziness, lightheadedness, or syncope.

ST ELEVATION MYOCARDIAL INFARCTION (STEMI)

Indicate whether the patient was hospitalized for an ST Elevation Myocardial Infarction (STEMI) documented in the medical record.

AT LEAST ONE OF THE FOLLOWING BIOCHEMICAL INDICATORS for detecting myocardial necrosis must be present (see below for a definition of Reference Control Limits):

1) Troponin T or I:
a) Maximal concentration of troponin T or I > the MI decision limit on at least one occasion during the first 24 hours after the index clinical event.
2) CK-MB:
a) Maximal value of CK-MB > 2 x the upper limit of normal on one occasion during the first hours after the index clinical event; OR
b) Maximal value of CK-MB, preferable CK-MB mass, > upper limit of normal on two successive samples.
3) Total CK
a) In the absence of availability of a troponin or CK-MB assay, total CK > 2 x the upper limit of normal, or the B fraction of CK may be employed, but these last two biomarkers are considerably less satisfactory than CK-MB.

Definition: AND ONE OF THE FOLLOWING ECG CHANGES:

1) ST-segment elevation: New or presumed new ST segment elevation at the J point in two or more continguous leads with the cut-off points >=0.2 mV in leads V1, V2, or V3, or >=0.1 mV in other leads; OR
2) Development of any Q wave in leads V1 through V3, or the development of a Q-wave > or = to 30 ms (0.03s) in leads I, II, aVL, aVF, V4, V5, or V6. (Q wave changes must be present in any two continguous leads, and be > or = to 1mm in depth.)

Defining Reference Control Values (MI Diagnostic Limit and Upper Limit of Normal):

Reference values must be determined in each laboratory by studies using specific assays with appropriate quality control, as reported in peer-reviewed journals. Acceptable imprecision (coefficient of variation) at the 99th percentile for each assay should be defined as < or = to 10%. Each individual laboratory should confirm the range of reference values in their specific setting.

Note: If more than one MI occurred, code the most recent event.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes-Within 40 Days of ICD Implant	
2	Yes-Greater than 40 Days prior to ICD Implant	
3	Yes-Both Within 40 days/Greater than 40 days	

Field Name: Previous CABG **Seq No:** 3200
Short Name: PrevCABG **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Previous Coronary Artery Bypass Graft
Definition: Indicate if the patient had Coronary Bypass Graft Surgery by any approach.

Note: Patient history is defined as any time prior to the current admission. Timeframe does NOT include the current admission. CABGs performed during this admission should be coded within Sequence Number 3590: CABG During this Admission.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Previous CABG Date **Seq No:** 3210
Short Name: PrevCABGDate **Core:** Yes

Status: New **Harvested:** Yes
Format: Date (mm/dd/yyyy)
Data Source: Client
Parent Element: Previous CABG(3200)
Parent Value: Yes
Missing Data: Report
Valid Range: Previous CABG Date > Patient DOB and Previous CABG Date < Admission Date
Usual Range:
Description: Previous Coronary Artery Bypass Graft Date
Definition: Indicate the date of the most recent CABG. If month and/or day are not known enter 01.

Note: In the case of multiple CABGs prior to this admission, indicate the most recent.

Selections:

Field Name: Previous PCI **Seq No:** 3220
Short Name: PrevPCI **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Previous Percutaneous Coronary Intervention
Definition: Indicate if the patient had a previous percutaneous coronary intervention (PCI) (even if unsuccessful) of any type (balloon angioplasty, stent or other), performed prior to the current admission.

Note: Timeframe does NOT include the current admission. PCIs performed during this admission should be coded within Sequence Number 3610: PCI During this Admission.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes-Within the past 3 months	
2	Yes-Greater than 3 months	

Field Name: Previous Valvular Surgery **Seq No:** 3230
Short Name: PrevValveSurg **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report

Valid Range:
Usual Range:
Description: Previous Valve Surgery
Definition: Indicate if the patient had a previous surgical replacement and/or repair of a cardiac valve, by any approach.

Note: Patient history is defined as any time prior to the date of implant.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Permanent Pacemaker **Seq No:** 3240
Short Name: PermPacemaker **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Permanent Pacemaker
Definition: Indicate if the patient had a Pacemaker inserted prior to current ICD implant. If yes, indicate the type of pacemaker.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes-Atrial Chamber	
2	Yes-Ventricular Chamber	
3	Yes-Dual Chamber	Both atrial and ventricular chambers.
4	Yes-Biventricular	

Field Name: Previous ICD **Seq No:** 3250
Short Name: PrevICD **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Previous ICD

Definition: Indicate if the patient had an ICD Implant procedure prior to this admission.

Note: Timeframe does NOT include the current admission. This device is coded within Sequence Number 3570: ICD Explant Device ID.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes-Single Chamber	
2	Yes-Dual Chamber	
3	Yes-Biventricular	

Field Name: Previous ICD Date **Seq No:** 3260
Short Name: PrevICDDate **Core:** Yes
Status: New **Harvested:** Yes
Format: Date (mm/dd/yyyy)
Data Source: Client
Parent Element: Previous ICD(3250)
Parent Value: Yes-Single Chamber; Yes-Dual Chamber; Yes-Biventricular
Missing Data: Report
Valid Range: Previous ICD Date > Patient DOB and Previous ICD Date < Admission Date
Usual Range:
Description: Previous ICD Date
Definition: Indicate the date of the most recent previous ICD implant. If month and/or day are not known, enter 01.

Note: In the case of multiple implants prior to this admission, code the most recent.

Selections:

Field Name: Previous ICD Reason **Seq No:** 3280
Short Name: PrevICDReason **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element: Previous ICD(3250)
Parent Value: Yes-Single Chamber; Yes-Dual Chamber; Yes-Biventricular
Missing Data: Report
Valid Range:
Usual Range:
Description: Previous ICD Reason
Definition: Indicate the previous ICD indication (reason for ICD implant).

Selections:

Coding/Sort	Selection(Choose multiple)	Explanation
1	Primary Prevention	Primary Prevention was the original indication for patients who were at risk for sudden death but had not suffered from a spontaneous life-threatening ventricular arrhythmia, syncope, or sudden cardiac death.
2	Syncope with Inducible VT	Syncope: Sudden loss of consciousness with loss of postural tone, not related to anesthesia. Inducible VT refers to performance of electrophysiological testing with resulting induction of VT.
3	Spontaneous Monomorphic Sustained VT	VT with a constant morphology greater than 30 seconds in duration and/or requiring termination due to hemodynamic compromise in less than 30 seconds.
4	Spontaneous Polymorphic Sustained VT	VT with a constantly changing morphology lasting greater than 30 seconds in duration and/or requiring termination due to hemodynamic compromise in less than 30 seconds.
5	Ventricular Fibrillation	Rapid, usually more than 300 bpm (cycle length 180 msec or less), grossly irregular ventricular rhythm with marked variability in cycle length, lack of discernible discreet QRS complex.
6	Cardiac Arrest/Arrhythmia - Etiology Unknown	Sudden loss of consciousness requiring cardioversion or defibrillation to restore hemodynamic stability.
7	Syncope and High Risk Characteristics	Syncope: Sudden loss of consciousness with loss of postural tone, not related to anesthesia, and High Risk Characteristics specific for non-ischemic dilated cardiomyopathy, or ischemic heart disease with significant ventricular dysfunction, hypertrophic cardiomyopathy, Brugada Syndrome, Long QT Syndrome.

Selections:

8	AFib	A cardiac arrythmia arising from the atrium with an atrial rate greater than 300 bpm and an irregular ventricular response in the presence of conduction. AF can be further characterized as: First detected AF Paroxysmal AF: AF is self-terminating within 7 days of recognized onset. Persistent AF: AF is not self-terminating within 7 days, or is terminated electrically or pharmacologically. Chronic AF: AF lasting more than 6 months.

Field Name: Previous ICD Implant Site **Seq No:** 3290
Short Name: PrevICDsite **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element: Previous ICD(3250)
Parent Value: Yes-Single Chamber; Yes-Dual Chamber; Yes-Biventricular
Missing Data: Report
Valid Range:
Usual Range:
Description: Previous ICD Implant Site
Definition: Indicate the previous ICD implant site.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Pectoral	
2	Abdominal	

Field Name: Cerebrovascular Disease **Seq No:** 3310
Short Name: CVDisease **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Cerebrovascular Disease

Definition: Indicate if the patient had cerebrovascular disease (CVD) prior to device implant, defined as any one of the following:
- Cerebrovascular Accident (CVA): Patient has a history of stroke, i.e., loss of neurological function with residual symptoms at least 72 hours after onset.
- Reversible Ischemic Neurologic Deficit (RIND): Patient has a history of loss of neurological function with symptoms at least 24 hours after onset but with complete return of function within 72 hours.
- Transient Ischemic Attack (TIA): Patient has a history of loss of neurological function that was abrupt in onset but with complete return of function within 24 hours.
- Non-invasive/invasive carotid test with greater than 75% occlusion.
- Previous carotid artery surgery.This does not include neurological disease processes such as metabolic and/or anoxic ischemic encephalopathy.
Note: Patient history is defined as any time prior to the date of implant.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Chronic Lung Disease
Seq No: 3320
Short Name: LungDisease
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Chronic Lung Disease
Definition: Indicate if the patient has a documented history of chronic lung disease prior to this admission (i.e. chronic obstructive pulmonary disease, emphysema, asthma, chronic bronchitis), or has been or is currently being treated with pharmocologic therapy.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Diabetes
Seq No: 3330
Short Name: Diabetes
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:

Description: Diabetes

Definition: Indicate if the patient has a history of diabetes, regardless of duration of disease or need for antidiabetic agents. It does not include gestational diabetes.

Note: Patient history is defined as any time prior to the date of implant.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Hypertension **Seq No:** 3340
Short Name: Hypertension **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Hypertension

Definition: Indicate if the patient has a history of hypertension defined as any one of the following:
1. History of hypertension diagnosed and treated with medication, diet and/or exercise.
2. Blood pressure greater than 140 systolic or 90 diastolic on at least 2 occasions.
3. Currently on antihypertensive pharmacologic therapy.

Note: Patient history is defined as any time prior to the date of implant.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Renal Failure-Dialysis **Seq No:** 3350
Short Name: Dialysis **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Renal Failure - Dialysis

Definition: Indicate if the patient received or is receiving dialysis as a result of renal failure.

Note: Patient history is defined as any time prior to the date of implant.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

E. Diagnostic Studies

Field Name: Ejection Fraction Assessed
Seq No: 3360
Short Name: EFDone
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Ejection Fraction Assessed
Definition: Indicate if the patient's ejection fraction was assessed before or during the EP lab visit via invasive (i.e. LV gram) or non-invasive testing (i.e. Echo).

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: EF %
Seq No: 3370
Short Name: EFPercent
Core: Yes
Status: New
Harvested: Yes
Format: Integer
Data Source: Client
Parent Element: Ejection Fraction Assessed(3360)
Parent Value: Yes
Missing Data: Report
Valid Range: 1-99
Usual Range: 10-65
Description: Ejection Fraction %
Definition: Indicate the lowest Ejection Fraction percent that led to the decision to implant the ICD. The Ejection Fraction percent is the percentage of blood that has emptied from the ventricle at the end of the contraction.
Selections:

Field Name: EF Timeframe
Seq No: 3380
Short Name: EFTimeframe
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element: Ejection Fraction Assessed(3360)
Parent Value: Yes
Missing Data: Report

Valid Range:
Usual Range:
Description: Ejection Fraction Timeframe
Definition: Indicate the timeframe of the Ejection Fraction percent that led to the decision to implant the ICD.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	0 to 1 month	0 to 1 month (up to 30 days)
2	1 to 2 months	1 to 2 months (31-60 days)
3	2 to 3 months	2 to 3 months (61-90 days)
4	3 to 6 months	3 to 6 months (91-180 days)
5	6 to 12 months	6 to 12 months (181-365 days)
6	Greater than 12 months	Greater than 12 months (366 days and greater)

Field Name: Electrophysiology Study Done **Seq No:** 3390
Short Name: EPStudy **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Electrophysiology Study Done
Definition: Indicate if the patient had an EP Study prior to the ICD implant.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: EPS Timeframe **Seq No:** 3400
Short Name: EPSTimeframe **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element: Electrophysiology Study Done(3390)
Parent Value: Yes
Missing Data: Report
Valid Range:
Usual Range:
Description: Electrophysiology Study Timeframe
Definition: Indicate the timeframe of the most recent Electrophysiology study.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	0 to 1 month	0 to 1 month (up to 30 days)
2	1 to 2 months	1 to 2 months (31-60 days)
3	2 to 3 months	2 to 3 months (61-90 days)
4	3 to 6 months	3 to 6 months (91-180 days)
5	6 to 12 months	6 to 12 months (181-365 days)
6	Greater than 12 months	Greater than 12 months (366 days and greater)

Field Name: EPS Findings **Seq No:** 3410
Short Name: EPSFindings **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element: Electrophysiology Study Done(3390)
Parent Value: Yes
Missing Data: Report
Valid Range:
Usual Range:
Description: EPS Findings
Definition: Indicate the findings associated with the most recent Electrophysiology Study. If "No Arrythmias Induced" is selected, no other selections may be chosen.

Selections:

Coding/Sort	Selection(Choose multiple)	Explanation
0	No Arrythmias Induced	
1	VT Induced	
2	Non-sustained VT	
3	Sustained Monomorphic	
4	Sustained Polymorphic	
5	Ventricular Flutter Induced	
6	Ventricular Fibrillation Induced	
7	Results Unattainable	The results of the EP Study could not be obtained or located.

Field Name: QRS Duration **Seq No:** 3420
Short Name: QRSDuration **Core:** Yes
Status: New **Harvested:** Yes
Format: Integer
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range: 10-300

Usual Range: 20-250
Description: QRS Duration
Definition: Indicate the patient's QRS duration in milliseconds from simultaneous (preferably 3 or more) ECG leads, including I, II, and VI, from the onset to the termination of the QRS.

Note: Indicate the most recent EKG findings prior to the ICD implant.

Selections:

Field Name: PR Interval Attainable **Seq No:** 3429
Short Name: PRIntervalAtt **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: PR Interval Attainable
Definition: Indicate if the patient's PR Interval was attainable. No should be answered when a patient has Afib, a greater than 1st Degree Heart block or has a Ventricular Paced rhythm.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: PR Interval **Seq No:** 3430
Short Name: PRInterval **Core:** Yes
Status: New **Harvested:** Yes
Format: Integer
Data Source: Client
Parent Element: PR Interval Attainable(3429)
Parent Value: Yes
Missing Data: Report
Valid Range: 10-600
Usual Range: 40-350
Description: PR Interval
Definition: Indicate the patient's longest measured time in milliseconds from onset of P wave to onset of QRS complex in any given ECG lead.

Note: Indicate the most recent EKG findings prior to the ICD implant.

Selections:

Field Name: AV Conduction **Seq No:** 3440
Short Name: AVConduct **Core:** Yes
Status: New **Harvested:** Yes

Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: AV Conduction
Definition: Indicate the patient's Atrioventricular Conduction rhythm.

Note: Indicate the EKG findings leading to the decision to implant the ICD.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Normal	
2	Abnormal-1st Degree Heart Block Only	
3	Abnormal-Heart Block 2nd or 3rd Degree (not paced)	
4	Paced(any)	

Field Name: Intraventricular Conduction **Seq No:** 3450
Short Name: IVConduct **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Intraventricular Conduction
Definition: Indicate the patient's Intraventricular Conduction.

Note: Indicate the EKG findings leading to the decision to implant the ICD.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Normal	
2	Abnormal-Left Anterior Fascicular Block	
3	Abnormal-Left Posterior Fascicular Block	
4	Abnormal-LBBB	
5	Abnormal-RBBB	
6	Abnormal-Intraventricular Conduction Delay, Nonspecific	
7	Paced	
8	Abnormal-Bifascicular Block (RBBB Plus LAF)	
9	Abnormal-Bifascicular Block (RBBB Plus LPF)	

Field Name: Creatinine Level **Seq No:** 3460
Short Name: Creatinine **Core:** Yes
Status: New **Harvested:** Yes
Format: Decimal (2,1) eg. 99.9
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range: 0.1-30
Usual Range: 0.1-9
Description: Creatinine Level
Definition: Indicate the patient's most recent preoperative Creatinine level prior to the ICD implant. The creatinine level is measured in mg/dL.
Selections:

Field Name: BUN Level **Seq No:** 3470
Short Name: BUNLevel **Core:** Yes
Status: New **Harvested:** Yes
Format: Integer
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range: 1-150
Usual Range: 1-80
Description: Blood Urea Nitrogen Level
Definition: Indicate the patient's most recent preoperative BUN (Blood Urea Nitrogen) level prior to the ICD implant. The BUN level is measured in mg/dL.
Selections:

Field Name: Sodium Level
Seq No: 3480
Short Name: NaLevel
Core: Yes
Status: New
Harvested: Yes
Format: Integer
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range: 80-160
Usual Range: 110-150
Description: Sodium Level
Definition: Indicate the patient's most recent preoperative Sodium level prior to the ICD implant. The Sodium level is measured in mEq/L.
Selections:

Field Name: BNP Drawn
Seq No: 3485
Short Name: BNPDrawn
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: BNP Drawn
Definition: Indicate if the patient had a preoperative BNP (B-type Natriuretic Peptide) drawn prior to the ICD implant.
Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: BNP Level
Seq No: 3490
Short Name: BNPLevel
Core: Yes
Status: New
Harvested: Yes
Format: Integer
Data Source: Client
Parent Element: BNP Drawn(3485)
Parent Value: Yes
Missing Data: Report
Valid Range: 1-5000
Usual Range: 1-2000
Description: BNP Level

Definition: Indicate the patient's most recent preoperative BNP (B-type Natriuretic Peptide) prior to the ICD implant. The BNP is measured in pg/mL.

Selections:

Field Name: Systolic BP
Seq No: 3500
Short Name: SystolicBP
Core: Yes
Status: New
Harvested: Yes
Format: Integer
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range: 60-250
Usual Range: 70-200
Description: Systolic Blood Pressure
Definition: Indicate the patient's systolic blood pressure on day of implant prior to sedation. Measured in mm-Hg.
Selections:

F. ICD Procedure(s)

Field Name: ICD Indication
Seq No: 3505
Short Name: ICDIndication
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Illegal
Valid Range:
Usual Range:
Description: ICD Indication
Definition: Indicate the reason for the first ICD implantation in this patient's lifetime.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Primary Prevention	Primary prevention is an indication for patients who are at risk for sudden death but have not yet suffered from a spontaneous life-threatening ventricular arrhythmia, syncope, or sudden cardiac death. (This includes patients who have never experienced syncope or cardiac arrest but have inducible ventricular tachycardia during electrophysiologic testing for risk stratification.)
2	Secondary Prevention	Secondary prevention is an indication for patients who have already experienced a spontaneous life-threatening ventricular arrhythmia, a cardiac arrest, or unexplained syncope with workup suggesting a high probability that a ventricular tachyarrythmia was the cause of the syncope.

Field Name: Reason(s) for Re-implantation
Seq No: 3506
Short Name: ReImpReason
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element: Previous ICD(3250)
Parent Value: Yes-Single Chamber; Yes-Dual Chamber; Yes-Biventricular
Missing Data: Report
Valid Range:
Usual Range:
Description: Reason(s) for Re-implantation

Definition: Indicate the reason(s) why device was re-implanted.

Note: Applicable only if Sequence Number 3250: Previous ICD, is "Yes".

Selections:

Coding/Sort	Selection(Choose multiple)	Explanation
1	End of Battery Life	The manufacturer's designation that the pulse generator battery has reached the end of its service life.
2	Device Upgrage	Replacement of a pulse generator with a model with additional pacing capabilities such as an upgrade from a single to a dual chamber device, or the replacement of a non-CRT device with a CRT device.
3	Device Infection	Replacement of a device because of an infection involving a previously implanted device
4	Device Malfunction	' HYLFH SHUIRUP DQFH RXWLGH P DQXIDFWXUHUV GHVLJQDWHG VSHFLILFDWLRQ WKDW FDQQRW EH UHVROYHG ZLWK UHSURJUDP P LQJ QHFHVVLWDWLQJ LQ WKH UHSODFHP HQWRI WKH GHYLFH LQ WKH SK\VLFLDQ¶V RSLQLRQ
5	Device Under Manufacturer Advisory/Recalled	A device model recognized by the manufacturer as demonstrating a recurring performance failure resulting in an advisory letter to physicians. This may or may not reach the level of an FDA designated recall.

Field Name: Mult ICDs implanted during admit **Seq No:** 3507
Short Name: MultipleICDs **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Multiple ICDs implanted during this admission
Definition: Indicate if multiple ICD devices were implanted during the current admission.

Note: This field is meant to capture whether an ICD was implanted AND explanted during the current admission. Code "No" if the patient had only one implant during the current admission.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Reason for Device Repl during admit
Seq No: 3508
Short Name: DevRepReason
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element: Mult ICDs implanted during admit(3507)
Parent Value: Yes
Missing Data: Report
Valid Range:
Usual Range:
Description: Reason(s) for device replacement during this admission
Definition: Indicate the reason(s) for multiple implants during the current admission.

Note: Applicable only if Sequence Number 3507: Multiple ICDs implated during this admission, is "Yes".

Selections:

Coding/Sort	Selection(Choose multiple)	Explanation
1	Device Upgrade	Replacement of a pulse generator with a model with additional pacing capabilities such as an upgrade from a single to a dual chamber device, or the replacement of a non-CRT device with a CRT device.
2	Device Infection	Replacement of a device because of an infection involving a previously implanted device
3	Device Malfunction	' HYLFH SHUFRP DQFH RXWLGH P DQXIDFWXUHU¶V GHVLJQDWHG VSHFLILFDWLRQ WKDW FDQQRW EH UHVROYHG Z LWK UHSURJUDP P LQJ QHFHVVLWDWLQJ LQ WKH UHSODFHP HQW WKH GHYLFH LQ WKH SK\VLFLDQ¶V RSLQLRQ
4	Device Under Manufacturer Advisory/Recalled	A device model recognized by the manufacturer as demonstrating a recurring performance failure resulting in an advisory letter to physicians. This may or may not reach the level of an FDA designated recall.

Field Name: Implant Operator UPIN
Seq No: 3510
Short Name: DrUpin
Core: Yes
Status: New
Harvested: Yes
Format: Text (6)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:

Usual Range:

Description: Implant Operator's Unique Physician Identification Number

Definition: Indicate the implanting physician's (U)nique (P)hysician (I)dentification (N)umber. UPINs, assigned by CMS, are used to uniquely identify physicians for Medicare billing purposes and may contain any letter or number character combination. The UPIN should be specified for the physician implanting the device, not the physician placing the leads. Implanting physician is determined by the individual institution.

Selections:

Field Name: Implant Operator NPI **Seq No:** 3515
Short Name: DrNPI **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (10)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Implant Operator's National Provider Identifier
Definition: Indicate the physician's (N)ational (P)rovider (I)dentifier. NPIs, assigned by CMS, are used to uniquely identify physicians for Medicare billing purposes. The NPI should be specified for the physician implanting the device, not the physician placing the leads.
Selections:

Field Name: Implant Operator First Name **Seq No:** 3520
Short Name: DrGiven **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (50)
Data Source: Automatic
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Implant Operator's First Name
Definition: Indicate the implant operator's first name.
Selections:

Field Name: Implant Operator Middle Name **Seq No:** 3525
Short Name: DrMiddle **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (50)
Data Source: Automatic
Parent Element:
Parent Value:

Missing Data: Report
Valid Range:
Usual Range:
Description: Implant Operator's Middle Name
Definition: Indicate the implant operator's middle name or middle initial.
Selections:

Field Name: Implant Operator Last Name **Seq No:** 3530
Short Name: DrSurname **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (50)
Data Source: Automatic
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Implant Operator's Last Name
Definition: Indicate the implant operator's last name.
Selections:

Field Name: ICD Type **Seq No:** 3540
Short Name: ICDType **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: ICD Type
Definition: Indicate the type of ICD implanted.
Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Single Chamber	
2	Dual Chamber	
3	Biventricular	

Field Name: LV Lead Implantation Method **Seq No:** 3550
Short Name: LeadMethod **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client

Parent Element: ICD Type(3540)
Parent Value: Biventricular
Missing Data: Report
Valid Range:
Usual Range:
Description: LV Lead Implantation Method
Definition: Indicate the method for implanting the LV lead.
Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Coronary Sinus	
2	Epicardial Lead	
3	Other	

Field Name: ICD Manufacturer **Seq No:** 3560
Short Name: ICDManu **Core:** Yes
Status: New **Harvested:** No
Format: Text (100)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: No action
Valid Range:
Usual Range:
Description: ICD Manufacturer
Definition: Indicate the manufacturer of the implanted or explanted ICD.
Selections:

Field Name: ICD Model Name **Seq No:** 3561
Short Name: ICDName **Core:** Yes
Status: New **Harvested:** No
Format: Text (100)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: No action
Valid Range:
Usual Range:
Description: ICD Model Name
Definition: Indicate the model name of the implanted or explanted ICD.
Selections:

Field Name: ICD Model Number **Seq No:** 3562
Short Name: ICDNum **Core:** Yes
Status: New **Harvested:** No

Format: Text (100)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: No action
Valid Range:
Usual Range:
Description: ICD Model Number
Definition: Indicate the model number of the implanted or explanted ICD.
Selections:

Field Name: ICD Implant Device ID **Seq No:** 3565
Short Name: ICDImplID **Core:** Yes
Status: New **Harvested:** Yes
Format: Integer (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: ICD Implant Device ID
Definition: Indicate the unique ACC assigned identification number associated with the implanted device. The ACC will assign a unique identification number for each unique ICD device manufacturer, model and model number. The list of ICDs will be maintained by the ACC and added to the data entry tool as each new device receives FDA approval. Third party software vendors certified by the ACC will be required to download and import the ICD master list so that newly approved devices can be specified and submitted to the ACC. Only one ICD Implant Device can be specified.Note: In the event of multiple implantations, code the final/last device implanted during the current admission.
Selections:

Field Name: ICD Implant Serial Number **Seq No:** 3566
Short Name: ICDImplSerNo **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (100)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: ICD Implant Serial Number
Definition: Indicate the ICD Device Serial Number associated with the implanted device.
Selections:

Field Name: ICD Explant Device ID **Seq No:** 3570
Short Name: ICDExplID **Core:** Yes
Status: New **Harvested:** Yes
Format: Integer (Categorical)
Data Source: Client
Parent Element: Previous ICD(3250)
Parent Value: Yes-Single Chamber; Yes-Dual Chamber; Yes-Biventricular
Missing Data: Report
Valid Range:
Usual Range:
Description: ICD Explant Device ID
Definition: Indicate the unique ACC assigned identification number associated with the explanted device. The ACC will assign a unique identification number for each unique ICD device manufacturer, model and model number. The list of ICDs will be maintained by the ACC and added to the data entry tool as each new device receives FDA approval. Third party software vendors certified by the ACC will be required to download and import the ICD master list so that newly approved devices can be specified and submitted to the ACC. Only one ICD Explant Device can be specified.

Note(1): Applicable only if Sequence Number 3250: Previous ICD, is "Yes". The intent of this field is to record the device in the patient at the time of admission for the current hospital stay.
Note(2): This field is NOT to be used in the event of multiple implantations (Sequence Number 3507:Multiple ICDs implanted during this admission, is "Yes").
Selections:

Field Name: ICD Explant Serial Number **Seq No:** 3571
Short Name: ICDExplSerNo **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (100)
Data Source: Client
Parent Element: Previous ICD(3250)
Parent Value: Yes-Single Chamber; Yes-Dual Chamber; Yes-Biventricular
Missing Data: Report
Valid Range:
Usual Range:
Description: ICD Explant Serial Number
Definition: Indicate the ICD Device Serial Number associated with the explanted device.
Selections:

G. Adverse Events

Field Name: Available Adverse Events
Seq No: 3575
Short Name: AvailAdvEvent
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Automatic
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Available Events
Definition: Indicate the Adverse Events that were downloaded from the ACC website and imported into the ICD data collection tool. This element will be used to determine if the participant has the right adverse events in the ICD data collection tool for every admission.
Selections:

Field Name: Adverse Events Exist
Seq No: 3580
Short Name: AdvEventExists
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Illegal
Valid Range:
Usual Range:
Description: Adverse Events Exist
Definition: Indicate if the patient had any adverse events during or after the EP lab visit up until discharge. If "Yes" then complete the Adverse Events section.
Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Adverse Event
Seq No: 3581
Short Name: AdvEvent
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element: Adverse Events Exist(3580)
Parent Value: Yes
Missing Data: Report

Valid Range:
Usual Range:
Description: Adverse Event
Definition: Indicate the Adverse Event that occurred during or after the EP lab visit up until discharge. The same adverse event can be repeated with a different adverse event date.

Note: The initial set of Adverse Events that should be collected are documented in Appendix A of the data dictionary. These Adverse Events may be updated periodically by the ACC. When the Adverse Events have been updated, participants utilizing non-ACC software will be instructed to download and import the latest version of Adverse Event file into their data collection tool.

Selections:

Field Name: Adverse Event Date **Seq No:** 3583
Short Name: AdvEventDate **Core:** Yes
Status: New **Harvested:** Yes
Format: Date (mm/dd/yyyy)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range: Adverse Event Date >= Date of Implant and Adverse Event Date <= Date of Discharge
Usual Range:
Description: Adverse Event Date
Definition: Indicate the date that the Adverse Event occurred.
Selections:

H. Discharge

Field Name: CABG During This Admission
Seq No: 3590
Short Name: CABGProc
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: CABG During This Admission
Definition: Indicate if the patient had a CABG (Coronary Artery Bypass Graft Surgery) during the current admission.

Note: If multple CABGs are performed during this admission, code the date of the CABG performed closest to the date of implant.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: CABG Date
Seq No: 3600
Short Name: CABGDate
Core: Yes
Status: New
Harvested: Yes
Format: Date (mm/dd/yyyy)
Data Source: Client
Parent Element: CABG During This Admission(3590)
Parent Value: Yes
Missing Data: Report
Valid Range: CABG Date >= Admission Date and CABG Date <= Discharge Date
Usual Range:
Description: CABG During This Admission - Date
Definition: Indicate the date Coronary Artery Bypass Graft (CABG) Surgery was performed during the current admission.
Selections:

Field Name: PCI During This Admission
Seq No: 3610
Short Name: PCIProc
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:

Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: PCI During This Admission
Definition: Indicate if the patient had a PCI during this admission.

Note: If multiple PCIs are performed during this admission, code the date of the PCI performed closest to the date of implant.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: PCI Date **Seq No:** 3620
Short Name: PCIDate **Core:** Yes
Status: New **Harvested:** Yes
Format: Date (mm/dd/yyyy)
Data Source: Client
Parent Element: PCI During This Admission(3610)
Parent Value: Yes
Missing Data: Report
Valid Range: PCIDate >= Admission Date and PCIDate <= Discharge Date
Usual Range:
Description: PCI During This Admission - Date
Definition: Indicate the date PCI was performed during the current admission.
Selections:

Field Name: Vital Status **Seq No:** 3630
Short Name: VitalStatus **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Vital Status
Definition: Indicate if the patient expired during the hospital stay. If "Yes," indicate the cause of death.
Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Alive	
2	Deceased-Cardiac Death	
3	Deceased-Non-Cardiac Death	

Field Name: Date of Death This Admit **Seq No:** 3640
Short Name: DeathDate **Core:** Yes
Status: New **Harvested:** Yes
Format: Date (mm/dd/yyyy)
Data Source: Client
Parent Element: Vital Status(3630)
Parent Value: Deceased-Cardiac Death; Deceased-Non-Cardiac Death
Missing Data: Report
Valid Range: Date of Death This Admit >=Date of Implant and Date of Death This Admit <= Discharge Date
Usual Range:
Description: Date of Death This Admit
Definition: Indicate the date the patient expired during this hospitalization.
Selections:

Field Name: Death in Lab **Seq No:** 3645
Short Name: DeathInLab **Core:** Yes
Status: New **Harvested:** Yes
Format: Text (Categorical)
Data Source: Client
Parent Element: Vital Status(3630)
Parent Value: Deceased-Cardiac Death; Deceased-Non-Cardiac Death
Missing Data: Report
Valid Range:
Usual Range:
Description: Death In Lab
Definition: Indicate if the patient's death occurred in the lab where the device was implanted
Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Date of Discharge **Seq No:** 3650
Short Name: DischDate **Core:** Yes
Status: New **Harvested:** Yes
Format: Date (mm/dd/yyyy)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Illegal
Valid Range: Discharge Date >= Date of Implant and Discharge Date >= Admission Date
Usual Range:
Description: Date of Discharge
Definition: Indicate the patient's date of discharge.

Selections:

I. Discharge Medications

Field Name: Discharge Medication
Seq No: 3660
Short Name: Medication
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Automatic
Parent Element: Vital Status(3630)
Parent Value: Alive
Missing Data: Illegal
Valid Range:
Usual Range:
Description: Discharge Medication
Definition: Indicates the discharge medication.

Note: The initial set of discharge medications that should be collected are documented in Appendix B of the data dictionary. These medications may be updated periodically by the ACC. When the discharge medications have been updated, participants utilizing non-ACC software will be instructed to download and import the latest version of medication file into their data collection tool.

Selections:

Field Name: Discharge Medication Prescribed
Seq No: 3665
Short Name: MedPresc
Core: Yes
Status: New
Harvested: Yes
Format: Text (Categorical)
Data Source: Client
Parent Element:
Parent Value:
Missing Data: Report
Valid Range:
Usual Range:
Description: Discharge Medication Prescribed
Definition: Indicate if discharge medication was prescribed, not prescribed, contraindicated or blinded.

Note: "Blinded" should be specified if the patient was in a research study and the prescribing of this specific medication is unknown.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	
2	Contraindicated	
3	Blinded	

Appendix A - Adverse Events

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Implantable Cardioverter Defibrillators Registry v1.08

Adverse Events

Field Name: Cardiac Arrest **Adverse Event Seq No:** ae001

Adverse Event ID: 1

Effective Date: 01/01/2004 **Expiration Date:**

Definition: Indicate if the patient experienced a cardiac arrest as documented by sudden cessation of cardiac activity so that the patient became unresponsive, with no normal breathing and no signs of circulation.

Field Name: Drug Reaction **Adverse Event Seq No:** ae002

Adverse Event ID: 2

Effective Date: 01/01/2004 **Expiration Date:**

Definition: Indicate if the patient experienced a drug reaction as documented by anaphylaxis, rash, etc.

Field Name: Cardiac Perforation **Adverse Event Seq No:** ae003

Adverse Event ID: 3

Effective Date: 01/01/2004 **Expiration Date:**

Definition: Indicate if the patient experienced a cardiac perforation as documented by migration of pacing or defibrillator lead to epicardial surface, resulting in pain, pericardial effusion, failure to capture, capture of diaphragm, phrenic nerve, or intercostals muscle of sufficient magnitude to require repositioning.

Field Name: Cardiac Valve Injury **Adverse Event Seq No:** ae004

Adverse Event ID: 4

Effective Date: 01/01/2004 **Expiration Date:**

Definition: Indicate if the patient experienced a cardiac valve injury as documented by manipulation of pacing or defibrillating leads that may tear a valve leaflet or chordae rendinae (usually manifests as a new regurgitant mumur appearing after the procedure).

Field Name: Conduction Block **Adverse Event Seq No:** ae005

Adverse Event ID: 5

Effective Date: 01/01/2004 **Expiration Date:**

Definition: Indicate if the patient experienced a conduction block as documented by manipulation of pacing or defibrillating leads that may injure parts of the specialized cardiac conducting system. (Usually manifest as a new RBBB or new noset of complete heart block in a person with preexisting LBBB).

Field Name: Coronary Venous Dissection **Adverse Event Seq No:** ae006

Adverse Event ID: 6

Effective Date: 01/01/2004 **Expiration Date:**

Definition: Indicate if the patient experienced a coronary venous dissection as documented by manipulation of pacing or defibrillating leads in the coronary sinus (CS) may result in a tear of the CS endothelium, with dissection into the CS wall. This may occasionally result in perforation of the CS.

Field Name: Hematoma **Adverse Event Seq No:** ae007

Adverse Event ID: 7

Effective Date: 01/01/2004 **Expiration Date:**

Definition: Indicate if the patient experienced hematoma resulting in reoperation or transfusion.

Field Name: Lead Dislodgement **Adverse Event Seq No:** ae008

Adverse Event ID: 8

Effective Date: 01/01/2004 **Expiration Date:**

Definition: Indicate if the patient experienced a lead dislodgement as documented by movement of lead sufficient to require repositioning.

Field Name: Hemothorax **Adverse Event Seq No:** ae009

Adverse Event ID: 9

Effective Date: 01/01/2004 **Expiration Date:**

Definition: Indicate if the patient experienced a hemothorax as documented by accumulation of blood in thorax.

Field Name: Pneumothorax **Adverse Event Seq No:** ae010

Adverse Event ID: 10

Effective Date: 01/01/2004 **Expiration Date:**

Definition: Indicate if the patient experienced a pneumothorax as documented by air in thorax sufficient to require chest tube.

Field Name: Peripheral Nerve Injury **Adverse Event Seq No:** ae011

Adverse Event ID: 11

Effective Date: 01/01/2004 **Expiration Date:**

Definition: Indicate if the patient experienced peripheral nerve injury as documented by sensory or motor loss of peripheral nerve function. This may result from external nerve compression as a result of positioning during an implantationprocedure, internal compression (e.g. secondary to hematoma formation) or direct nerve.

Field Name: Peripheral Embolus **Adverse Event Seq No:** ae012

Adverse Event ID: 12

Effective Date: 01/01/2004 **Expiration Date:**

Definition: Indicate if the patient experienced a peripheral embolus as documented by acute occlusion of an artery resulting from embolization of a cardiac or proximal arterial thrombus.

Field Name: Phlebitis - Superficial **Adverse Event Seq No:** ae013

Adverse Event ID: 13

Effective Date: 01/01/2004 **Expiration Date:**

Definition: Indicate if the patient experienced superficial phlebitis as documented by signs of superficial venous inflammatio, such as local erythema, tenderness or swelling.

Field Name: Phlebitis - Deep **Adverse Event Seq No:** ae014

Adverse Event ID: 14

Effective Date: 01/01/2004 **Expiration Date:**

Definition: Indicate if the patient experienced deep phlebitis as documented by occlusion of deep vein resulting in extremity swelling, plus or minus signs of inflammation.

Field Name: TIA **Adverse Event Seq No:** ae015

Adverse Event ID: 15

Effective Date: 01/01/2004 **Expiration Date:**

Definition: Indicate if the patient experienced a TIA as documented by loss of neurological function that was abrupt in onset but with complete return of function within 24 hours.

Field Name: CVA/Stroke **Adverse Event Seq No:** ae016

Adverse Event ID: 16

Effective Date: 01/01/2004 **Expiration Date:**

Definition: Indicate if the patient experienced a cerebrovascular accident (CVA) as documented by a central neurological deficit persisting for > 72 hours.

Field Name: MI **Adverse Event Seq No:** ae017

Adverse Event ID: 17

Effective Date: 01/01/2004 **Expiration Date:**

Definition: Indicate if the patient experienced an MI during the EP lab visit or after lab visit until discharge (or before any subsequent lab visits) as documented by:
Definitions: NON ST ELEVATION MYOCARDIAL INFARCTION (NSTEMI)
The patient was hospitalized for a myocardial infarction documented in the medical record.
AT LEAST ONE OF THE FOLLOWING BIOCHEMICAL INDICATORS for detecting myocardial necrosis must be present (see below for a definition of Reference Control Limits):
1) Troponin T or I:
a) Maximal concentration of troponin T or I > the MI decision limit on at least one occasion during the first 24 hours after the index clinical event.
2) CK-MB:
a) Maximal value of CK-MB > 2 x the upper limit of normal on one occasion during the first hours after the index clinical event. OR
b) Maximal value of CK-MB, preferable CK-MB mass, > upper limit of normal on two successive samples.
3) Total CK:
a) In the absence of availability of a troponin or CK-MB assay, total CK > 2 x the upper limit of normal, or the B fraction of CK may be employed, but these last two biomarkers are considerably less satisfactory than CK-MB.

AND ONE OF THE FOLLOWING:
1) Either ST segment depression or T wave abnormalities; or
2) Ischemic symptoms in the presence or absence of chest discomfort. Ischemic symptoms may include:
a) unexplained nausea and vomiting; or
b) persistent shortness of breath secondary to left ventricular failure; or
c) unexplained weakness, dizziness, lightheadedness, or syncope.

ST ELEVATION MYOCARDIAL INFARCTION (STEMI)
Indicate whether the patient was hospitalized for an ST Elevation Myocardial Infarction (STEMI) documented in the medical record.
AT LEAST ONE OF THE FOLLOWING BIOCHEMICAL INDICATORS for detecting myocardial necrosis must be present (see below for a definition of Reference Control Limits):
1) Troponin T or I:
a) Maximal concentration of troponin T or I > the MI decision limit on at least one occasion during the first 24 hours after the index clinical event.
2) CK-MB:
a) Maximal value of CK-MB > 2 x the upper limit of normal on one occasion during the first hours after the index clinical event; OR
b) Maximal value of CK-MB, preferable CK-MB mass, > upper limit of normal on two successive samples.
3) Total CK
a) In the absence of availability of a troponin or CK-MB assay, total CK > 2 x the upper limit of normal, or the B fraction of CK may be employed, but these last two biomarkers are considerably less satisfactory than CK-MB.

AND ONE OF THE FOLLOWING ECG CHANGES:
1) ST-segment elevation: New or presumed new ST segment elevation at the J point in two or more continguous leads with the cut-off points >=0.2 mV in leads V1, V2, or V3, or >=0.1 mV in other leads; OR
2) Development of any Q wave in leads V1 through V3, or the development of a Q-wave > or = to 30 ms (0.03s) in leads I, II, aVL, aVF, V4, V5, or V6. (Q wave changes must be present in any two continguous leads, and be > or = to 1mm in depth.)

Defining Reference Control Values (MI Diagnostic Limit and Upper Limit of Normal):

Definition: Reference values must be determined in each laboratory by studies using specific assays with appropriate quality control, as reported in peer-reviewed journals. Acceptable imprecision (coefficient of variation) at the 99th percentile for each assay should be defined as < or = to 10%. Each individual laboratory should confirm the range of reference values in their specific setting.

Field Name: Pericardial Tamponade **Adverse Event Seq No:** ae018

Adverse Event ID: 18

Effective Date: 01/01/2004 **Expiration Date:**

Definition: Indicate if the patient experienced fluid in the pericardial space compromising cardiac filling, and requiring intervention as documented by either: 1) Echo showing pericardial fluid and signs of tamponade such as right heart compromise, or 2) Systemic hypotension due to pericardial fluid compromising cardiac function.

Field Name: AV Fistula **Adverse Event Seq No:** ae019

Adverse Event ID: 19

Effective Date: 01/01/2004 **Expiration Date:**

Definition: Indicate if the patient experienced an AV fistula as documented by a connection between the access artery and the accompanying vein that is demonstrated by arteriography or ultrasound and most often characterized by a continuous bruit.

Field Name: Infection Related to Device **Adverse Event Seq No:** ae020

Adverse Event ID: 20

Effective Date: 01/01/2004 **Expiration Date:**

Definition: Indicate if the patient experienced an infection related to the device.

Appendix B - Medications

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Implantable Cardioverter Defibrillators Registry v1.08

Medications

Field Name: ACE-Inhibitor (any) **Medication Seq No:** m001
Category: Ace Inhibitor **Medication ID:** 1
Effective Date: 01/01/2004 **Expiration Date:**

Field Name: Amiodarone **Medication Seq No:** m002
Category: Antiarrhythmic Agent **Medication ID:** 2
Effective Date: 01/01/2004 **Expiration Date:**

Field Name: Disopyramide **Medication Seq No:** m003
Category: Antiarrhythmic Agent **Medication ID:** 3
Effective Date: 01/01/2004 **Expiration Date:**

Field Name: Dofetilide **Medication Seq No:** m004
Category: Antiarrhythmic Agent **Medication ID:** 4
Effective Date: 01/01/2004 **Expiration Date:**

Field Name: Flecainide **Medication Seq No:** m005
Category: Antiarrhythmic Agent **Medication ID:** 5
Effective Date: 01/01/2004 **Expiration Date:**

Field Name: Mexiletine **Medication Seq No:** m006
Category: Antiarrhythmic Agent **Medication ID:** 6
Effective Date: 01/01/2004 **Expiration Date:**

Field Name: Procainamide **Medication Seq No:** m007
Category: Antiarrhythmic Agent **Medication ID:** 7
Effective Date: 01/01/2004 **Expiration Date:**

Field Name: Propafenone **Medication Seq No:** m008
Category: Antiarrhythmic Agent **Medication ID:** 8
Effective Date: 01/01/2004 **Expiration Date:**

Field Name: Quinidine **Medication Seq No:** m009
Category: Antiarrhythmic Agent **Medication ID:** 9
Effective Date: 01/01/2004 **Expiration Date:**

Field Name:	Sotalol	**Medication Seq No:**	m010
Category:	Antiarrhythmic Agent	**Medication ID:**	10
Effective Date:	01/01/2004	**Expiration Date:**	

Field Name:	Other Anti. Arrhy.	**Medication Seq No:**	m011
Category:	Antiarrhythmic Agent	**Medication ID:**	11
Effective Date:	01/01/2004	**Expiration Date:**	

Field Name:	Hydralazine	**Medication Seq No:**	m012
Category:	Antihypertensive	**Medication ID:**	12
Effective Date:	01/01/2004	**Expiration Date:**	

Field Name:	ARB (any)	**Medication Seq No:**	m013
Category:	ARB	**Medication ID:**	13
Effective Date:	01/01/2004	**Expiration Date:**	

Field Name:	ASA	**Medication Seq No:**	m014
Category:	ASA	**Medication ID:**	14
Effective Date:	01/01/2004	**Expiration Date:**	

Field Name:	Beta-Blocker (any)	**Medication Seq No:**	m015
Category:	Beta Blocker	**Medication ID:**	15
Effective Date:	01/01/2004	**Expiration Date:**	

Field Name:	Diltiazem	**Medication Seq No:**	m016
Category:	Calcium Channel Blocker	**Medication ID:**	16
Effective Date:	01/01/2004	**Expiration Date:**	

Field Name:	Verapamil	**Medication Seq No:**	m017
Category:	Calcium Channel Blocker	**Medication ID:**	17
Effective Date:	01/01/2004	**Expiration Date:**	

Field Name:	Other CCB	**Medication Seq No:**	m018
Category:	Calcium Channel Blocker	**Medication ID:**	18
Effective Date:	01/01/2004	**Expiration Date:**	

Field Name:	Coumadin	**Medication Seq No:**	m019
Category:	Coumadin	**Medication ID:**	19

Effective Date:	01/01/2004	**Expiration Date:**	
Field Name:	Digoxin	**Medication Seq No:**	m020
Category:	Digoxin	**Medication ID:**	20
Effective Date:	01/01/2004	**Expiration Date:**	
Field Name:	Diuretic (any)	**Medication Seq No:**	m021
Category:	Diuretic	**Medication ID:**	21
Effective Date:	01/01/2004	**Expiration Date:**	
Field Name:	Nitroglycerin SL, PRN	**Medication Seq No:**	m022
Category:	Nitrate	**Medication ID:**	22
Effective Date:	01/01/2004	**Expiration Date:**	
Field Name:	Nitroglycerin Long Acting	**Medication Seq No:**	m023
Category:	Nitrate	**Medication ID:**	23
Effective Date:	01/01/2004	**Expiration Date:**	
Field Name:	Clopidogrel	**Medication Seq No:**	m024
Category:	Platelet Aggregation Inhibitor	**Medication ID:**	24
Effective Date:	01/01/2004	**Expiration Date:**	
Field Name:	Ticlopidine	**Medication Seq No:**	m025
Category:	Platelet Aggregation Inhibitor	**Medication ID:**	25
Effective Date:	01/01/2004	**Expiration Date:**	
Field Name:	Statin (any)	**Medication Seq No:**	m026
Category:	Statin	**Medication ID:**	26
Effective Date:	01/01/2004	**Expiration Date:**	