State of California
Office of Administrative Law

In re:
Office of Statewide Health Planning and Development

Regulatory Action:

Title 22, California Code of Regulations

Adopt sections:
Amend sections: 97170, 97174, 97177.25, 97177.35, 97177.55, 97177.60, 97177.65, 97177.67, 97177.70
Repeal sections:

NOTICE OF APPROVAL OF REGULATORY ACTION

Government Code Section 11349.3

OAL Matter Number: 2020-1021-01

OAL Matter Type: Regular (S)

The Office of Statewide Health Planning and Development updates regulations that establish data elements reported by hospitals in the California Coronary Artery Bypass Graft Outcomes Reporting Program.

OAL approves this regulatory action pursuant to section 11349.3 of the Government Code. This regulatory action becomes effective on 12/7/2020.

Date: December 7, 2020

Amy R. Gowan
Attorney

For: Kenneth J. Pogue
Director

Original: Robert David, Director
Copy: Denise Stanton

STATE OF CALIFORNIA--OFFICE OF ADMINISTRATIVE L

NOTICE PUBLICATION/REGULATIONS SUBMISSION

REGULAR

(See instructions on reverse)

STD. 400 (REV. 10/2019)

For use by Secretary of State only

ENDORSED - FILED
in the office of the Secretary of State
of the State of California
DEC 07 2020
1:32 P.M.

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z-2020-0813-02	2020-1021-01	S

For use by Office of Administrative Law (OAL) only

OFFICE OF ADMINISTRATIVE LAW

Electronic Submission

RECEIVED DATE	PUBLICATION DATE
08/13/2020	08/28/2020

2020 OCT 21 P 3:30

OFFICE OF ADMINISTRATIVE LAW

NOTICE REGULATIONS

AGENCY WITH RULEMAKING AUTHORITY
Office of Statewide Health Planning and Development

AGENCY FILE NUMBER (If any)

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE
CCORP Reporting Updates	Title 22	97170	9/4/2020

3. NOTICE TYPE	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
☒ Notice re Proposed Regulatory Action ☐ Other	Denise Stanton	(213) 215-2359	

OAL USE ONLY	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE
	☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/ Withdrawn	2020, 35-Z	8/28/20

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S)
CCORP Reporting Updates

1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S)

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) **(Including title 26, if toxics related)**

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)

TITLE(S): 22

ADOPT: per agency request a&a

AMEND: 97170, 97174, , 97177.25, 97177.35, 97177.55, 97177.60, 97177.65, 97177.67, 97177.70

REPEAL:

3. TYPE OF FILING

- ☒ Regular Rulemaking (Gov. Code §11346)
- ☐ Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- ☐ Emergency Readopt (Gov. Code, §11346.1(h))
- ☐ Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
- ☐ Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- ☐ File & Print
- ☐ Print Only
- ☐ Emergency (Gov. Code, §11346.1(b))
- ☐ Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- ☐ Other (Specify)

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)
per agency request a&a

5. EFFECTIVE DATE OF CHANGES (Gov. Code §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

- ☐ Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))
- ☒ Effective on filing with Secretary of State
- ☐ §100 Changes Without Regulatory Effect
- ☐ Effective other (Specify)

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

- ☒ Department of Finance (Form STD. 399) (SAM §6660)
- ☐ Fair Political Practices Commission
- ☐ State Fire Marshal
- ☐ Other (Specify)

7. CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional)
Denise Stanton	(213) 215-2359		denise.stanton@oshpd.ca.gov

8. I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.

SIGNATURE OF AGENCY HEAD OR DESIGNEE: Holly Hoegh — DATE: 10/21/2020

TYPED NAME AND TITLE OF SIGNATORY
Holly Hoegh, Ph.D., CDG manager, delegated by Marko Mijic, Acting Director

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED
DEC 07 2020
Office of Administrative Law

INSTRUCTIONS FOR PUBLICATION OF NOTICE AND SUBMISSION OF REGULATIONS

Use the form STD. 400 for submitting notices for publication and regulations for Office of Administrative Law (OAL) review.

ALL FILINGS

Enter the name of the agency with the rulemaking authority and agency's file number, if any.

NOTICES

Complete Part A when submitting a notice to OAL for publication in the California Regulatory Notice Register. Submit two (2) copies of the STD. 400 with four (4) copies of the notice and, if a notice of proposed regulatory action, one copy each of the complete text of the regulations and the statement of reasons. Upon receipt of the notice, OAL will place a number in the box marked "Notice File Number." If the notice is approved, OAL will return the STD. 400 with a copy of the notice and will check "Approved as Submitted" or "Approved as Modified." If the notice is disapproved or withdrawn, that will also be indicated in the space marked "Action on Proposed Notice." Please submit a new form STD. 400 when resubmitting the notice.

REGULATIONS

When submitting regulations to OAL for review, fill out STD. 400, Part B. Use the form that was previously submitted with the notice of proposed regulatory action which contains the "Notice File Number" assigned, or, if a new STD. 400 is used, please include the previously assigned number in the box marked "Notice File Number." In filling out Part B, be sure to complete the certification including the date signed, the title and typed name of the signatory. The following must be submitted when filing regulations: seven (7) copies of the regulations with a copy of the STD. 400 attached to the front of each (one copy must bear an original signature on the certification) and the complete rulemaking file with index and sworn statement. (See Gov. Code § 11347.3 for rulemaking file contents.)

RESUBMITTAL OF DISAPPROVED OR WITHDRAWN REGULATIONS

When resubmitting previously disapproved or withdrawn regulations to OAL for review, use a new STD. 400 and fill out Part B, including the signed certification. Enter the OAL file number(s) of all previously disapproved or withdrawn filings in the box marked "All Previous Related OAL Regulatory Action Number(s)" (box 1b. of Part B). Submit seven (7) copies of the regulation to OAL with a copy of the STD. 400 attached to the front of each (one copy must bear an original signature on the certification). Be sure to include an index, sworn statement, and (if returned to the agency) the complete rulemaking file. (See Gov. Code §§ 11349.4 and 11347.3 for more specific requirements.)

EMERGENCY REGULATIONS

Fill out only Part B, including the signed certification, and submit seven (7) copies of the regulations with a copy of the STD. 400 attached to the front of each (one copy must bear an original signature on the certification). (See Gov. Code §11346.1 for other requirements.)

NOTICE FOLLOWING EMERGENCY ACTION

When submitting a notice of proposed regulatory action after an emergency filing, use a new STD. 400 and complete Part A and insert the OAL file number(s) for the original emergency filing(s) in the box marked "All Previous Related OAL Regulatory Action Number(s)" (box 1b. of Part B). OAL will return the STD. 400 with the notice upon approval or disapproval. If the notice is disapproved, please fill out a new form when resubmitting for publication.

CERTIFICATE OF COMPLIANCE

When filing the certificate of compliance for emergency regulations, fill out Part B, including the signed certification, on the form that was previously submitted with the notice. If a new STD. 400 is used, fill in Part B including the signed certification, and enter the previously assigned notice file number in the box marked "Notice File Number" at the top of the form. The materials indicated in these instructions for "REGULATIONS" must also be submitted.

EMERGENCY REGULATIONS - READOPTION

When submitting previously approved emergency regulations for readoption, use a new STD. 400 and fill out Part B, including the signed certification, and insert the OAL file number(s) related to the original emergency filing in the box marked "All Previous Related OAL Regulatory Action Number (s)" (box 1b. of Part B).

CHANGES WITHOUT REGULATORY EFFECT

When submitting changes without regulatory effect pursuant to California Code of Regulations, Title 1, section 100, complete Part B, including marking the appropriate box in both B.3. and B.5.

ABBREVIATIONS

Cal. Code Regs. - California Code of Regulations
Gov. Code - Government Code
SAM - State Administrative Manual

For questions regarding this form or the procedure for filing notices or submitting regulations to OAL for review, please contact the Office of Administrative Law Reference Attorney at (916) 323-6815.

22 CCR § 97170

§ 97170. Definitions, as Used in this Article.

(a) California CABG Outcomes Reporting Program (CCORP). California CABG Outcomes Reporting Program means the Office's program charged with collecting coronary artery bypass graft (CABG) surgery data and publishing reports on the risk-adjusted outcomes for the procedure.
(b) Cardiac Online Reporting for California (CORC). CORC means the OSHPD Cardiac Online Reporting for California system that is the online transmission system through which reports are submitted using an Internet web browser either by file transfer or data entry. It is a secure means of electronic transmission of data in an automated environment.
(c) Computer system date. Computer system date means the date that exists on the computer system used for data automation at the time of data entry.
(d) Coronary artery bypass graft (CABG) surgery. CABG surgery means a procedure performed to bypass blockages or obstructions of the coronary arteries, and includes both isolated CABG surgeries and non-isolated CABG surgeries, as defined by ~~Subsection (a)(2) of~~ Section 97174.
(e) Days. Days are defined as calendar days unless otherwise specified.
(f) Designee. Designee means the person authorized by the Chief Executive Officer of the hospital to sign the CCORP Hospital Certification Form (OSH-CCORP 416 (New 10/02).
(g) Discharge. A discharge means a person who was formally admitted to a hospital as an inpatient for observation, diagnosis, or treatment, with the expectation of remaining overnight or longer, and who is released from the hospital under one of the following circumstances:
(1) is formally released from the care of the hospital and leaves the hospital,
(2) transfers within the hospital from one type of care to another type of care, as defined in Section 97212 of Title 22 of the California Code of Regulations, or
(3) has died.
(h) Facility identification number. Facility identification number means a unique six-digit number assigned to each hospital by CCORP.
(i) Licensee. Licensee means an entity that has been issued a license to operate a hospital, as defined in the Health and Safety Code Section 128700.
(j) Record. Record means the set of data elements required to be reported for each CABG surgery, as set forth in Section 97174.
(k) Report. Report means the collection of all required records filed by a hospital for a reporting period, pursuant to Section 97172.
(l) Responsible surgeon. Responsible surgeon means the principle surgeon who performs a coronary artery bypass procedure. If a trainee performs this procedure, then the responsible surgeon is the physician responsible for supervising this procedure performed by the trainee. In situations in which a responsible surgeon cannot otherwise be determined, the responsible surgeon is the surgeon who bills for the coronary artery bypass procedure.
(m) User Account Administrator. A hospital representative responsible for maintaining the hospital's CORC user accounts and user account contact information.

Note: Authority cited: Section 128810, Health and Safety Code. Reference: Section 128745, Health and Safety Code.

22 CCR § 97174

§ 97174. Required Data Elements.

(a) For patients discharged on or after July 1, 2020, a hospital shall submit the following data elements for each CABG surgery in compliance with the California CABG Outcomes Reporting Program (CCORP) Data Element Specifications Version 8.3, dated June 29, 2020, hereby incorporated by reference. This document is available for download from the OSHPD website. The office will make a hardcopy available on request. For all data elements categorized as postoperative events, with the exception of Deep Sternal, report only if the postoperative event occurred during the hospitalization for CABG surgery.

(1) Medical Record Number,
(2) Type of CABG,
(3) Date of Surgery,
(4) Date of Birth,
(5) Patient Age,
(6) Sex,
(7) Primary Payor,
(8) Secondary (Supplemental) Payor,
(9) Race Documented,
(10) Race – White,
(11) Race - Black/African American,
(12) Race – Asian,
(13) Race - American Indian/Alaskan Native,
(14) Race - Native Hawaiian/Pacific Islander,
(15) Race – Other,
(16) Hispanic or Latino or Spanish Ethnicity,
(17) Hospital Discharge Date,
(19) Patient Transfer to Another Acute Hospital,
(20) Patient Transferred to Acute Hospital – Date,
(21) Mortality Date,
(22) Mort – Status at 30 Days After Surgery (either discharged or in-hospital),
(23) Responsible Surgeon Name (3 separate fields),
(24) Responsible Surgeon CA License Number,
(25) Height (cm),
(26) Weight (kg),
(27) Diabetes,
(28) Diabetes Control,
(29) Dialysis,
(30) Hypertension,
(31) Endocarditis,
(32) Infectious Endocarditis Type,
(33) Chronic Lung Disease,
(34) Pneumonia,
(35) Liver Disease,
(36) Immunocompromised Present,
(37) COVID-19

(38) Cancer within 5 years,
(39) Peripheral Artery Disease,
(40) Cerebrovascular Disease,
(41) Prior CVA,
(42) Prior CVA When,
(43) CVD TIA,
(44) CVD – Carotid Stenosis,
(45) CVD Carotid Stenosis – Right,
(46) CVD Carotid Stenosis – Left,
(47) CVD Prior Carotid Surgery,
(48) Last Creatinine Level,
(49) Total Albumin,
(50) Total Bilirubin,
(51) INR,
(52) Sodium,
(53) Previous CABG,
(54) Previous Valve,
(55) Previous PCI,
(56) Previous PCI – Interval,
(57) Prior MI,
(58) MI – When,
(59) Heart Failure,
(60) Heart Failure Timing,
(61) Classification – NYHA,
(62) Cardiogenic Shock,
(63) Resuscitation,
(64) Cardiac Arrhythmia,
(65) Cardiac Arrhythmia - Vtach/Vfib,
(66) Cardiac Arrhythmia – Aflutter,
(67) Cardiac Arrhythmia - Third Degree Heart Block,
(68) Cardiac Arrhythmia - Atrial Fibrillation,
(69) Atrial Fibrillation-Type,
(70) Warfarin Use (within 5 days),
(71) Coronary Anatomy/Disease Known,
(72) Number Diseased Vessels,
(73) Left Main Stenosis >= 50% Known,
(74) Hemo Data EF Done,
(75) Hemo Data EF,
(76) PA Systolic Pressure Measured,
(77) PA Systolic Pressure,
(78) Mitral Valve Regurgitation,
(79) Mitral Regurgitation,
(80) Incidence,
(81) Status,
(82) Urgent / Emergent/Emergent Salvage Reason,
(83) Perfusion Strategy,

(84) CPB Utilization – Combination Plan,
(85) Internal Mammary Artery Used,
(86) Reason for No IMA,
(87) Valve,
(88) Aortic Valve,
(89) Aortic Valve Procedure Performed,
(90) Mitral Valve,
(91) Mitral Valve Procedure,
(92) Tricuspid Valve,
(93) Pulmonic Valve,
(94) Reoperation for Bleed/ Tampanade,
(95) Unplanned Coronary Artery Intervention,
(96) Unplanned Coronary Artery Intervention-Vessels,
(97) Deep Sternal,
(98) Neuro-Stroke Permanent,
(99) Pulm – Ventilation Prolonged,
(100) Renal - Renal Failure,
(101) Renal - Dialysis Requirement,
(102) Other - A Fib,
(103) Facility Identification Number

(b) If a value for a data element, other than data elements specified in Subsection (b)(1), is unknown or not applicable, a hospital may submit the record without a valid value for that data element.

(1) A valid value must be submitted for the following data elements: Medical Record Number, Type of CABG, Date of Surgery, Sex, Hospital Discharge Date, Status at Hospital Discharge, Responsible Surgeon Name, Responsible Surgeon CA License Number, Dialysis, Previous CABG, Previous PCI, Status, Reoperation for Bleed/ Tamponade, Unplanned Coronary Artery Intervention, Deep Sternal, Neuro - Stroke Permanent, Pulm - Ventilation Prolonged, Renal - Renal Failure, Renal - Dialysis Requirement, Other - A Fib, and Facility Identification Number.

(~~a~~c) For patients discharged on or after January 1, 2018 through June 30, 2020, a hospital shall submit the following data elements for each CABG surgery in compliance with the California CABG Outcomes Reporting Program (CCORP) Data Element Specifications Version 7.1, dated May 5, 2019, hereby incorporated by reference. This document is available for download from the OSHPD website. The office will make a hardcopy available on request. For all data elements categorized as postoperative events, with the exception of Deep Sternal Infection/Mediastinitis, report only if the postoperative event occurred during the hospitalization for CABG surgery.
(1) Medical Record Number,
(2) Type of Coronary Artery Bypass Graft (CABG),
(3) Date of Surgery,
(4) Date of Birth,
(5) Patient Age,
(6) Sex,

(7) Race Documented,
(8) Race - White,
(9) Race - Black/African American,
(10) Race - Asian,
(11) Race - American Indian/Alaskan Native,
(12) Race - Native Hawaiian/Pacific Islander,
(13) Race - Other,
(14) Hispanic or Latino or Spanish Ethnicity,
(15) Date of Discharge,
(16) Discharge/Mortality Status,
(17) Mortality Date,
(18) Responsible Surgeon Name (3 separate fields),
(19) Responsible Surgeon CA License Number,
(20) Height (cm),
(21) Weight (kg),
(22) Diabetes,
(23) Diabetes Control,
(24) Dialysis,
(25) Hypertension,
(26) Endocarditis,
(27) Infectious Endocarditis Type,
(28) Chronic Lung Disease,
(29) Liver Disease,
(30) Immunocompromise,
(31) Peripheral Arterial Disease,
(32) Cerebrovascular Disease,
(33) Prior CVA,
(34) Prior CVA - When,
(35) CVD TIA,
(36) CVD Carotid Stenosis,
(37) CVD Carotid Stenosis - Right,
(38) CVD Carotid Stenosis - Left,
(39) CVD Prior Carotid Surgery,
(40) Last Creatinine Level,
(41) Total Albumin,
(42) Total Bilirubin,
(43) INR,
(44) Previous CABG,
(45) Previous Valve,
(46) Previous PCI,
(47) Previous PCI - Interval,
(48) Prior MI,
(49) MI - When,
(50) Heart Failure,
(51) Heart Failure Timing,
(52) Classification - NYHA,

(53) Cardiogenic Shock,
(54) Resuscitation,
(55) Cardiac Arrhythmia,
(56) Cardiac Arrhythmia - VTach/VFib,
(57) Cardiac Arrhythmia - Aflutter,
(58) Cardiac Arrhythmia - Third Degree Heart Block,
(59) Cardiac Arrhythmia - Atrial fibrillation,
(60) Cardiac Arrhythmia - Atrial fibrillation Type,
(61) Warfarin Use (within 5 days),
(62) Coronary Anatomy/Disease Known,
(63) Number of Diseased Vessels,
(64) Percent Native Artery Stenosis Known,
(65) Percent Stenosis - Left Main,
(66) Ejection Fraction Done,
(67) Ejection Fraction (%),
(68) PA Systolic Pressure Measured,
(69) PA Systolic Pressure,
(70) Insufficiency - Mitral,
(71) Incidence,
(72) Status,
(73) Urgent Or Emergent Reason,
(74) CPB Utilization,
(75) CPB Utilization - Combination Plan,
(76) IMA Artery Used,
(77) Reason for No IMA,
(78) Valve,
(79) Aortic Valve,
(80) Aortic Valve Procedure,
(81) Mitral Valve,
(82) Mitral Valve Procedure,
(83) Tricuspid Valve,
(84) Pulmonic Valve,
(85) Reoperation for Bleed,
(86) Reintervention - Myocardial Ischemia,
(87) Reintervention - Myocardial Ischemia Vessel,
(88) Deep Sternal Infection/Mediastinitis,
(89) Neuro - Stroke Permanent,
(90) Pulm - Ventilation Prolonged,
(91) Renal - Renal Failure,
(92) Renal - Dialysis Requirement,
(93) Other - A Fib,
(94) Facility Identification Number,

(~~b~~d) If a value for a data element, other than data elements specified in Subsection (~~b~~d)(1), is unknown or not applicable, a hospital may submit the record without a valid value for that data element.

(1) A valid value must be submitted for the following data elements: Medical Record Number, Type of CABG, Date of Surgery, Sex, Date of Discharge, Discharge Status, Responsible Surgeon Name, Responsible Surgeon CA License Number, Dialysis, Previous PCI, Status, Reoperation for Bleed, Reintervention - Myocardial Ischemia, Reintervention - Myocardial Ischemia Vessel, Deep Sternal Infection/Mediastinitis, Neuro - Stroke Permanent, Pulm - Ventilation Prolonged, Renal - Renal Failure, Renal - Dialysis Requirement, Other - A Fib, and Facility Identification Number.

Note: Authority cited: Section 128810, Health and Safety Code. Reference: Section 128745, Health and Safety Code.

22 CCR § 97177.25

§ 97177.25. Report Format.

(a) For discharges beginning July 1, 2020:
1. A hospital shall submit a report to the Office for discharges occurring on or after July 1, 2020 in compliance with the Office's Format and File Specifications for California Coronary Artery Bypass Graft (CABG) Outcomes Reporting Program (CCORP) Version 8.3 dated May 11, 2020 and hereby incorporated by reference.
2. The Office's Format and File Specifications are available for download from the OSHPD website. The Office will make a hardcopy available to a hospital on request.

(~~a~~b) For discharges beginning January 1, 2018 through June 30, 2020:
1. A hospital shall submit a report to the Office for discharges occurring on or after July 1, 2018 through June 30, 2020 in compliance with the Office's Format and File Specifications for California Coronary Artery Bypass Graft (CABG) Outcomes Reporting Program (CCORP) Version 7.0 dated May 31, 2017 and hereby incorporated by reference.
2. The Office's Format and File Specifications are available for download from the OSHPD website. The Office will make a hardcopy available to a hospital on request.

~~(b) For discharges beginning January 1, 2009:~~
~~1. A hospital shall submit a report to the Office for discharges occurring on or after January 1, 2009 in compliance with the Office's Format and File Specifications for California Coronary Artery Bypass Graft (CABG) Outcomes Reporting Program (CCORP) Version 4.0, dated July 20, 2009 and hereby incorporated by reference.~~
~~2. The Office's Format and File Specifications are available for download from the OSHPD website. The Office will make a hardcopy available to a hospital on request.~~

Note: Authority cited: Section 128810, Health and Safety Code. Reference: Section 128745, Health and Safety Code

22 CCR § 97177.35

§ 97177.35. Report Acceptance Criteria.

~~For discharges beginning January 1, 2009:~~

The following requirements must be met for the Office to accept a report:

(a) Complete transmittal information must be submitted with each report, as required by Section 97177.30.

(b) The facility identification number in each of the records in the report must be consistent with the facility identification number stated in the transmittal information.

(c) The patient discharge date in each of the records in the report is consistent with the report period.

(d) The number of records stated in the transmittal information must be consistent with the number of records contained in the report.

(e) All records required to be reported pursuant to 97172 must be reported.

(f) The data must be reported in compliance with the format and file specifications in Section 97177.25.

(g) All records must include valid values for the data elements specified in either 97174(b)(1) or 97174(d)(1) as applicable.

Note: Authority cited: Section 128810, Health and Safety Code. Reference: Section 128745, Health and Safety Code.

22 CCR § 97177.55

§ 97177.55. Report Supplemental Documents.

~~For discharges beginning January 1, 2009:~~

Hospitals shall provide documentation to support data element values as required by the office. Documentation shall be faxed to the Office or uploaded through the Cardiac Online Reporting for California (CORC) system.

Note: Authority cited: Section 128810, Health and Safety Code. Reference: Section 128745, Health and Safety Code.

22 CCR § 97177.60

§ 97177.60. Correction of Data.

~~For discharges beginning January 1, 2009:~~

(a) After OSHPD completes the initial processing of reports for each report period, hospitals will be allowed a 21 day period to make report revisions. Hospitals will be notified by email of the beginning and end dates of this period.

(b) Hospitals shall use the CORC system for transmitting corrected reports. Each corrected report shall meet the acceptance criteria specified in section 97177.35.

(c) If a hospital fails to provide a valid value, or provides no value, for a data element for which, pursuant to either Section 97174(b)(1) or (d)(1) as applicable, a valid value is required, by the end of the 21-day period, the Office shall assign the data element in the record the lowest risk value as observed in the most current risk adjustment model. Hospitals shall provide documentation to support data element values as required by the office. Documentation shall be submitted ~~faxed~~ to the Office via fax or upload through the Cardiac Online Reporting for California (CORC) system.

Note: Authority cited: Section 128810, Health and Safety Code. Reference: Section 128745, Health and Safety Code.

22 CCR § 97177.65

§ 97177.65. Final Correction.

~~For discharges beginning January 1, 2009:~~

(a) After the 21 day data correction period and before the Office determines which hospitals are selected for audit, hospitals will be allowed a 30-day period to make final corrections. Hospitals will be notified by email of the beginning and end dates of this period.

(b) Hospitals shall use the CORC system for transmitting corrected reports.

(1) Each corrected report shall meet the acceptance criteria specified in section 97177.35.

(2) If a hospital fails to provide a valid value or provides no value, for a data element for which, pursuant to either Section 97174(b)(1) or (d)(1) as applicable, a valid value is required, by the end of the 30-day period, the Office shall assign the data element in the record the lowest risk value as observed in the most current risk adjustment model. Hospitals shall provide documentation to support data element values as required by the office. Documentation shall be submitted ~~faxed~~ to the Office via fax or upload through the Cardiac Online Reporting for California (CORC) system.

Note: Authority cited: Section 128810, Health and Safety Code. Reference: Section 128745, Health and Safety Code.

22 CCR § 97177.67

§ 97177.67. Final Report and Surgeon Certification.

~~For discharges beginning January 1, 2009:~~

(a) Within the 30-day period specified in section 97177.65, each hospital shall complete correction of its report and notify CORC that its last accepted report is its final report. Once a report has been designated as final, no further changes may be made by the hospital.

(b) Each surgeon identified as a responsible surgeon in a final hospital report shall attest to the accuracy of the data for his or her CABG surgeries in that report by completing a Surgeon Certification Form. Use ~~(~~OSH-CCORP 415 (Revised ~~06/17 03/02/20)~~) for reports of discharges beginning July 1, 2020 and for reports of discharges January 1, 2018-June 30, 2020 use OSH-CCORP 415 (Revised 06/17) ~~-~~and hereby incorporated by reference.

(1) A hospital shall file with the Office, via fax, email, or upload through the Cardiac Online Reporting for California (CORC) system, all completed and signed Surgeon Certification Forms. These shall also be filed within the 30-day period.

(2) The Surgeon Certification Form shall include the following information: the surgeon's name, the surgeon's California physician license number, the hospital name, the facility identification number, as defined in Section 97170, the reporting period's beginning and ending dates, the number of surgeon specific records in the report presented to them by the hospital. The statement portion of the certification is to be signed and dated by the surgeon prior to filing with the Office.

(3) The surgeon's name and physician license number specified on the Surgeon Certification Form shall be consistent with the surgeon's name and physician license number as provided in the submitted hospital records, and match the California Medical Board licensing information.

(4) If a surgeon does not sign a Surgeon Certification Form, the hospitals shall submit an unsigned surgeon certification form that includes the information identified in subsection (2). The hospital shall include the reason the form was unsigned.

(5) A hospital may obtain copies of the Surgeon Certification Form from the CORC system or on the OSHPD website.

(c) If a hospital does not designate a final report by the end of the 30-day period, the last accepted report for that hospital shall be considered the final report.

Note: Authority cited: Section 128810, Health and Safety Code. Reference: Section 128745, Health and Safety Code.

§ 97177.70. Hospital Data Contact Person, User Account Administrator.

~~For discharges beginning January 1, 2009:~~

(a) Each hospital at which CABG surgeries are performed shall designate a primary CCORP data contact person. A hospital shall notify CCORP of the designation in writing, by electronic mail or through the Cardiac Online Reporting for California (CORC) system within 30 days of the effective date of this regulation or within 30 days of beginning or resuming operation. A notification shall include the designated person's name, title, telephone number(s), mailing address, and electronic mail address.

(b) A hospital shall notify CCORP in writing, by electronic mail or through the CORC system within 30 days after any change in the person designated as the primary CCORP data contact person, or in the title, telephone number(s), mailing address, or electronic mail address, of the individual.

(c) Each hospital shall designate up to three User Account Administrators pursuant to Subsection (l) of Section 97170. For each User Account Administrator there must be ~~an original~~ a signed CORC User Account Administrator Agreement Form (OSH-CCORP 757 (Rev. 06/17)) and hereby incorporated by reference, submitted to the Office via fax, email, or upload through the Cardiac Online Reporting for California (CORC) system. Each hospital shall notify CCORP in writing, by electronic mail or through the CORC system within 30 days after any change in a designated User Account Administrator's name, title, telephone number(s), mailing address, or electronic mail address.

(d) Each hospital is responsible for submitting its own online data report to CCORP. The hospital shall be responsible for ensuring compliance with regulations and reporting requirements when a third party vendor assists a hospital with CCORP data.

Note: Authority cited: Section 128810, Health and Safety Code. Reference: Section 128745, Health and Safety Code.

OSHPD

Office of Statewide Health Planning and Development

FORMAT and FILE SPECIFICATIONS

California Coronary Artery Bypass Graft (CABG)
Outcomes Reporting Program
(CCORP)

Version 8.3

Released on June 29, 2020

Effective for DISCHARGES occurring
on or after July 1, 2020

CORC Cardiac Online Reporting for California

MINIMUM PC CONFIGURATION

1. Access to a personal computer (with the following minimum configuration)
    - High speed Internet connection (preferred)
    - Microsoft Internet Explorer version 11 (or higher), Microsoft Edge, Firefox, or Chrome
    - Adobe Acrobat Reader version 7.0 (or higher)
    - Virus Checking Software

2. E-mail

STANDARD RECORD FORMAT

Deviation from the format will not be accepted

- One reporting facility and time period per file
- Standard ASCII character coding
- Record length 239 characters

ADDITIONAL REQUIREMENTS

- The data file ***must*** be a text file with the extension of ".txt"
- No packed or binary data

Standard Record Format

Data Element	Start	End	Type & Size
Medical Record Number	1	12	A/N (12)
Type of CABG	13	13	N (1)
Date of Surgery	14	21	N (8)
Date of Birth	22	29	N (8)
Patient Age	30	32	N (3)
Sex	33	33	N (1)
Primary Payor	34	35	N (2)
Secondary (Supplemental) Payor	36	37	N (2)
Race Documented	38	38	N (1)
Race - White	39	39	N (1)
Race - Black/African American	40	40	N (1)
Race - Asian	41	41	N (1)
Race - American Indian/Alaskan Native	42	42	N (1)
Race - Native Hawaiian/Pacific Islander	43	43	N (1)
Race - Other	44	44	N (1)
Hispanic or Latino or Spanish Ethnicity	45	45	N (1)
Hospital Discharge Date	46	53	N (8)
Status at Hospital Discharge	54	54	N (1)
Patient Transfer to Another Acute Care Hospital	55	55	N (1)
Patient Transfer to Acute Care Hospital Date	56	63	N (8)
Mortality Date	64	71	N (8)
Mort-Status at 30 Days After Surgery (either discharged or in-hospital)	72	72	N (1)
Responsible Surgeon Name:			
Last Name	73	97	A (25)
First Name	98	117	A (20)
Middle Initial	118	118	A (1)
Responsible Surgeon CA License Number	119	127	A/N (9)
Height (cm)	128	131	N (4)
Weight (kg)	132	135	N (4)
Diabetes	136	136	N (1)
Diabetes Control	137	137	N (1)
Dialysis	138	138	N (1)
Hypertension	139	139	N (1)
Endocarditis	140	140	N (1)
Infectious EndocarditisType	141	141	N (1)
Chronic Lung Disease	142	142	N (1)
Pneumonia	143	143	N (1)
Liver Disease	144	144	N (1)
Immunocompromised Present	145	145	N (1)
COVID-19	146	147	N (2)
Cancer within 5 years	148	148	N (1)
Peripheral Artery Disease	149	149	N (1)
Cerebrovascular Disease	150	150	N (1)
Prior CVA	151	151	N (1)
Prior CVA - When	152	152	N (1)
CVD TIA	153	153	N (1)
CVD Carotid Stenosis	154	154	N (1)

Data Element (cont'd)	Start	End	Type & Size
CVD Carotid Stenosis – Right	155	155	N (1)
CVD Carotid Stenosis – Left	156	156	N (1)
CVD Prior Carotid Surgery	157	157	N (1)
Last Creatinine Level	158	161	N (4)
Total Albumin	162	165	N (4)
Total Bilirubin	166	169	N (4)
INR	170	173	N (4)
Sodium	174	177	N (4)
Previous CABG	178	178	N (1)
Previous Valve	179	179	N (1)
Previous PCI	180	180	N (1)
Previous PCI - Interval	181	181	N (1)
Prior MI	182	182	N (1)
MI – When	183	183	N (1)
Heart Failure	184	184	N (1)
Heart Failure Timing	185	185	N (1)
Classification - NYHA	186	186	N (1)
Cardiogenic Shock	187	187	N (1)
Resuscitation	188	188	N (1)
Cardiac Arrhythmia	189	189	N (1)
Cardiac Arrhythmia – VTach/VFib	190	190	N (1)
CardiacArrhythmia – AFlutter	191	191	N (1)
Cardiac Arrhythmia – Third Degree Heart Block	192	192	N (1)
Cardiac Arrhythmia – Atrial Fibrillation	193	193	N (1)
Atrial Fibrillation- Type	194	194	N (1)
Warfarin Use (within 5 days)	195	195	N (1)
Coronary Anatomy/Disease Known	196	196	N (1)
Number Diseased Vessels	197	197	N (1)
Left Main Stenosis>= 50% Known	198	198	N (1)
Hemo Data EF Done	199	199	N (1)
Hemo Data EF	200	202	N (3)
PA Systolic Pressure Measured	203	203	N (1)
PA Systolic Pressure	204	207	N (4)
Mitral Valve Regurgitation	208	208	N (1)
Mitral Regurgitation	209	209	N (1)
Incidence	210	210	N (1)
Status	211	211	N (1)
Urgent /Emergent /Emergent Salvage Reason	212	213	N (2)
Perfusion Strategy	214	214	N (1)
CPB Utilization Combination Plan	215	215	N (1)
Internal Mammary Artery Used	216	216	N (1)
Reason for No IMA	217	217	N (1)
Valve	218	218	N (1)
Aortic Valve	219	219	N (1)
Aortic Valve Procedure	220	220	N (1)
Mitral Valve	221	221	N (1)
Mitral Valve Procedure	222	222	N (1)
Tricuspid Valve	223	223	N (1)
Pulmonic Valve	224	224	N (1)
Reoperation for Bleed/Tamponade	225	225	N (1)

Data Element (cont'd)	Start	End	Type & Size
Unplanned Coronary Artery Intervention	226	226	N (1)
Unplanned Coronary Artery Intervention-Vessel	227	227	N (1)
Deep Sternal	228	228	N (1)
Neuro- Stroke Permanent	229	229	N (1)
Pulm – Ventilation Prolonged	230	230	N (1)
Renal – Renal Failure	231	231	N (1)
Renal – Dialysis Requirement	232	232	N (1)
Other – A Fib	233	233	N (1)
Facility Identification Number	234	239	N (6)

FOOTNOTES

1. Type & Size indicate data type and length (in parentheses). Data type is defined as:
   A = Alpha
   N = Numeric
   A/N = Alphanumeric

Data Fields

MEDICAL RECORD NUMBER

Record Position:	1 through 12
Data Length:	12
Data Type:	Alphanumeric
Harvest Codes:	N/A
Special Instructions:	This field *must not* be blank
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***85***
Coding Classification:	Demographics

TYPE OF CABG

Record Position:	13
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Isolated; 3 = CABG + Valve; 4 = Other Non-Isolated CABG
Special Instructions:	This field *must not* be blank
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	N/A; ***CCORP-specific variable***
Coding Classification:	Operative

DATE OF SURGERY

Record Position:	14 through 21
Data Length:	8
Data Type:	Numeric
Harvest Codes:	09 09 9999 Month Day Year
Special Instructions:	1. This field *must not* be blank 2. Single-digit months and days *must* include a preceding zero
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***310***
Coding Classification:	Hospitalization

DATE OF BIRTH

Record Position:	22 through 29
Data Length:	8
Data Type:	Numeric
Harvest Codes:	09 09 9999 Month Day Year
Special Instructions:	Single-digit months and days *must* include a preceding zero
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***65***
Coding Classification:	Demographics

PATIENT AGE

Record Position:	30 through 32
Data Length:	3
Data Type:	Numeric
Harvest Codes:	N/A
Special Instructions:	**Do not submit CABG for patients <18 yrs old**
Range:	18 – 100; low = 18, high = 110
Parent/Child Relationship:	N/A
STS Sequence Number:	***70***
Coding Classification:	Demographics

SEX

Record Position:	33
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Male; 2 = Female
Special Instructions:	This field *must not* be blank
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***75***
Coding Classification:	Demographics

PRIMARY PAYOR

Record Position:	34 through 35
Data Length:	2
Data Type:	Numeric
Harvest Codes:	1 = Non/Self; 2 = Medicare; 3 = Medicaid; 4 = Military Health 9 = Commercial Health Insurance; 10 = Health Maintenance Organization; 11 = Non-U.S. Plan; 13 = Other
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***291***
Coding Classification:	Hospitalization

SECONDARY (SUPPLEMENTAL) PAYOR

Record Position:	36 through 37
Data Length:	2
Data Type:	Numeric
Harvest Codes:	1 = Non/Self; 2 = Medicare; 3 = Medicaid; 4 = Military Health 9 = Commercial Health Insurance; 10 = Health Maintenance Organization; 11 = Non-U.S. Plan; 13 = Other
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***298***
Coding Classification:	Hospitalization

RACE DOCUMENTED

Record Position:	38
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No; 3 = Patient Declined to Disclose
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***150***
Coding Classification:	Demographics

RACE – WHITE

Record Position:	39
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Race Documented" = 1 (Yes); sequence #150
STS Sequence Number:	***151***
Coding Classification:	Demographics

RACE – BLACK/AFRICAN AMERICAN

Record Position:	40
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Race Documented" = 1 (Yes); sequence #150
STS Sequence Number:	***151***
Coding Classification:	Demographics

RACE – ASIAN

Record Position:	41
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Race Documented" = 1 (Yes); sequence #150
STS Sequence Number:	***151***
Coding Classification:	Demographics

RACE – AMERICAN INDIAN/ALASKAN NATIVE

Record Position:	42
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Race Documented" = 1 (Yes); sequence #150
STS Sequence Number:	***151***
Coding Classification:	Demographics

RACE – NATIVE HAWAIIAN/PACIFIC ISLANDER

Record Position:	43
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Race Documented" = 1 (Yes); sequence #150
STS Sequence Number:	***151***
Coding Classification:	Demographics

RACE – OTHER

Record Position:	44
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Race Documented" = 1 (Yes); sequence #150
STS Sequence Number:	***151***
Coding Classification:	Demographics

HISPANIC OR LATINO OR SPANISH ETHNICITY

Record Position:	45
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No; 3 = Not Documented
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***185***
Coding Classification:	Demographics

HOSPITAL DISCHARGE DATE

Record Position:	46 through 53
Data Length:	8
Data Type:	Numeric
Harvest Codes:	99 99 9999 Month Day Year
Special Instructions:	1. This field ***must not*** be blank 2. Single-digit months and days ***must*** include a preceding zero
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***7006***
Coding Classification:	Discharge / Mortality

STATUS AT HOSPITAL DISCHARGE

Record Position:	54
Data Length:	1
Data Type:	Numeric
Harvest Codes:	2 = Died in Hosp; 3 = Discharged Alive, Last Known Status Alive (Other than Hospice) ; 4 = Discharged Alive, died after discharge ; 5 = Discharged to Hospice
Special Instructions:	This field *must not* be blank
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***7007***
Coding Classification:	Discharge / Mortality

PATIENT TRANSFER TO ANOTHER ACUTE CARE HOSPITAL

Record Position:	55
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1= Yes; 2 = No
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***7003***
Coding Classification:	Discharge / Mortality

PATIENT TRANSFER TO ACUTE CARE HOSPITAL- DATE

Record Position:	56 through 63
Data Length:	8
Data Type:	Numeric
Harvest Codes:	99 99 9999 Month Day Year
Special Instructions:	Single-digit months and days *must* include a preceding zero
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***7004***
Coding Classification:	Discharge / Mortality

MORTALITY DATE

Record Position:	64 through 71
Data Length:	8
Data Type:	Numeric
Harvest Codes:	99 99 9999 Month Day Year
Special Instructions:	Single-digit months and days *must* include a preceding zero
Range:	N/A
Parent/Child Relationship:	"Status at Hospital Discharge" = 2 (Expired in Hospital); sequence 7007
STS Sequence Number:	***7121***
Coding Classification:	Discharge / Mortality

MORT - STATUS AT 30 DAYS AFTER SURGERY (EITHER DISCHARGED OR IN - HOSPITAL)

Record Position:	72
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Alive; 2 = Dead 3 = Unknown
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***7001***
Coding Classification:	Discharge / Mortality

RESPONSIBLE SURGEON NAME – LAST

Record Position:	73 through 97
Data Length:	25
Data Type:	Alpha
Harvest Codes:	N/A
Special Instructions:	1. This field *must not* be blank 2. Do not code titles such as "Junior", "Jr.", or "II" 3. Do not use special characters except hyphen (-)
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	N/A; ***CCORP-specific variable***
Coding Classification:	Operative

RESPONSIBLE SURGEON NAME – FIRST

Record Position:	98 through 117
Data Length:	20
Data Type:	Alpha
Harvest Codes:	N/A
Special Instructions:	This field *must not* be blank
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	N/A; ***CCORP-specific variable***
Coding Classification:	Operative

RESPONSIBLE SURGEON NAME – MIDDLE INITIAL

Record Position:	118
Data Length:	1
Data Type:	Alpha
Harvest Codes:	N/A
Special Instructions:	1. *Must be provided* if middle name is noted on license issued from California Medical Board 2. No special characters ex: (.) 3. *To verify a middle initial go to:* Physicians ***www.mbc.ca.gov/Breeze/License_Lookup.aspx*** and Osteopaths directly from Dept of Consumer Affairs https://search.dca.ca.gov/
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	N/A; ***CCORP-specific variable***
Coding Classification:	Operative

RESPONSIBLE SURGEON CA LICENSE NUMBER

Record Position:	119 through 127
Data Length:	9
Data Type:	Alphanumeric
Harvest Codes:	N/A
Special Instructions:	1. This field *must not* be blank 2. *To verify a license go to:* ***www.mbc.ca.gov/Breeze/License_Lookup.aspx*** and Osteopaths directly from Dept of Consumer Affairs https://search.dca.ca.gov/
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	N/A; ***CCORP-specific variable***
Coding Classification:	Operative

HEIGHT (cm)

Record Position:	128 through 131
Data Length:	4
Data Type:	Numeric
Harvest Codes:	N/A
Special Instructions:	1. Measured in centimeters 2. Do not code decimal (implied)
Range:	122.0 – 213.0; low = 20.0, high = 251.0
Parent/Child Relationship:	N/A
STS Sequence Number:	***330***
Coding Classification:	Risk Factors

WEIGHT (kg)

Record Position:	132 through 135
Data Length:	4
Data Type:	Numeric
Harvest Codes:	N/A
Special Instructions:	1. Measured in kilograms 2. Do not code decimal (implied)
Range:	30.0 – 181.8; low = 10.0, high = 250.0
Parent/Child Relationship:	N/A
STS Sequence Number:	***335***
Coding Classification:	Risk Factors

DIABETES

Record Position:	136
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No; 3 = Unknown
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***360***
Coding Classification:	Risk Factors

DIABETES CONTROL

Record Position:	137
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = None; 2 = Diet only; 3 = Oral; 4 = Insulin; 5 = Other; 6 = Other subcutaneous medication; 7 = Unknown
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Diabetes" = 1 (Yes); sequence #360
STS Sequence Number:	***365***
Coding Classification:	Risk Factors

DIALYSIS

Record Position:	138
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No; 3 = Unknown
Special Instructions:	1. This field *must not* be blank 2. If 'Yes', Postop Renal– Dialysis Requirement field must be coded 2 (No)
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***375***
Coding Classification:	Risk Factors

HYPERTENSION

Record Position:	139
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No; 3 = Unknown
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***380***
Coding Classification:	Risk Factors

ENDOCARDITIS

Record Position:	140
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***385***
Coding Classification:	Risk Factors

INFECTIOUS ENDOCARDITIS TYPE

Record Position:	141
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Treated; 2 = Active
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	“Endocarditis” = 1 (Yes); sequence #385
STS Sequence Number:	***390***
Coding Classification:	Risk Factors

CHRONIC LUNG DISEASE

Record Position:	142
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = No; 2 = Mild; 3 = Moderate; 4 = Severe; 5 = Lung disease documented, severity unknown; 6 = Unknown
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***405***
Coding Classification:	Risk Factors

PNEUMONIA

Record Position:	143
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = No 2 = Recent 3 = Remote 4 = Unknown
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***465***
Coding Classification:	Risk Factors

LIVER DISEASE

Record Position:	144
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No; 3 = Unknown
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***485***
Coding Classification:	Risk Factors

IMMUNOCOMPROMISED PRESENT

Record Position:	145
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No; 3 = Unknown
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***492***
Coding Classification:	Risk Factors

COVID-19

Record Position:	146 through 147
Data Length:	2
Data Type:	Numeric
Harvest Codes:	10 = No ; 11 = Yes, prior to hospitalization for this surgery; 12 = Yes, in hospital prior to surgery; 13 = Yes, in hospital after surgery
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***TempCode 7230***
Coding Classification:	

CANCER WITHIN 5 YEARS

Record Position:	148
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No; 3 = Unknown
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***500***
Coding Classification:	Risk Factors

PERIPHERAL ARTERY DISEASE

Record Position:	149
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No; 3 = Unknown
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***505***
Coding Classification:	Risk Factors

CEREBROVASCULAR DISEASE

Record Position:	150
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No; 3 = Unknown
Special Instructions:	1. If "2" then ALL CHILD fields *must* be blank. 2. If "1" then **at least one** of the CVD CHILD fields should be coded as 1=Yes: Prior CVA, CVD TIA, CVD Prior Carotid Surgery, or CVD Carotid Stenosis = 2,3,or 4.
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***525***
Coding Classification:	Risk Factors

PRIOR CVA

Record Position:	151
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No; 3 = Unknown
Special Instructions:	If "1" then Prior CVA – When *must* be specified
Range:	N/A
Parent/Child Relationship:	"Cerebrovascular Disease" = 1 (Yes); sequence #525
STS Sequence Number:	***530***
Coding Classification:	Risk Factors

PRIOR CVA – WHEN

Record Position:	152
Data Length:	1
Data Type:	Numeric
Harvest Codes:	3 = Recent (<= 30 days); 4 = Remote (> 30 days)
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Prior CVA" = 1 (Yes); sequence #530
STS Sequence Number:	***535***
Coding Classification:	Risk Factors

CVD TIA

Record Position:	153
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No; 3 = Unknown
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Cerebrovascular Disease" = 1 (Yes); sequence #525
STS Sequence Number:	***540***
Coding Classification:	Risk Factors

CVD CAROTID STENOSIS

Record Position:	154
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = None; 2 = Right; 3 = Left; 4 = Both; 5 = Not Documented
Special Instructions:	If "2, 3 or 4", CVD Carotid Stenosis Right and/or Left fields *must* be specified
Range:	N/A
Parent/Child Relationship:	"Cerebrovascular Disease" = 1 (Yes); sequence #525
STS Sequence Number:	***545***
Coding Classification:	Risk Factors

CVD CAROTID STENOSIS – RIGHT

Record Position:	155
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = 80-99% 2 = 100% 3 = 50-79% 4 = Not Documented
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"CVD Carotid Stenosis" = 2 (Right) or 4 (Both); sequence #545
STS Sequence Number:	***550***
Coding Classification:	Risk Factors

CVD CAROTID STENOSIS – LEFT

Record Position:	156
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = 80-99% 2 = 100% 3 = 50-79% 4 = Not Documented
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"CVD Carotid Stenosis" = 3 (Left) or 4 (Both); sequence #545
STS Sequence Number:	***555***
Coding Classification:	Risk Factors

CVD PRIOR CAROTID SURGERY

Record Position:	157
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Cerebrovascular Disease" = 1 (Yes); sequence #525
STS Sequence Number:	***560***
Coding Classification:	Risk Factors

LAST CREATININE LEVEL

Record Position:	158 through 161
Data Length:	4
Data Type:	Numeric
Harvest Codes:	N/A
Special Instructions:	Do not code decimal.
Range:	0.10 – 12.00; low = 0.10, high = 30.00
Parent/Child Relationship:	N/A
STS Sequence Number:	***605***
Coding Classification:	Risk Factors

TOTAL ALBUMIN

Record Position:	162 through 165
Data Length:	4
Data Type:	Numeric
Harvest Codes:	N/A
Special Instructions:	Do not code decimal (implied)
Range:	3.50 – 5.00; low = 1.00, high = 10.00
Parent/Child Relationship:	N/A
STS Sequence Number:	***585***
Coding Classification:	Risk Factors

TOTAL BILIRUBIN

Record Position:	166 through 169
Data Length:	4
Data Type:	Numeric
Harvest Codes:	N/A
Special Instructions:	Do not code decimal (implied).
Range:	0.20 – 1.30; low = 0.10, high = 50.00
Parent/Child Relationship:	N/A
STS Sequence Number:	***610***
Coding Classification:	Risk Factors

INR

Record Position:	170 through 173
Data Length:	4
Data Type:	Numeric
Harvest Codes:	N/A
Special Instructions:	Do not code decimal (implied)
Range:	0.90 – 1.30; low = 0.50, high = 30.00
Parent/Child Relationship:	N/A
STS Sequence Number:	***615***
Coding Classification:	Risk Factors

SODIUM

Record Position:	174 through 177
Data Length:	4
Data Type:	Numeric
Harvest Codes:	N/A
Special Instructions:	Do not code decimal (implied)
Range:	130.0-145.0; low = 30.0, high = 200.0
Parent/Child Relationship:	N/A
STS Sequence Number:	***600***
Coding Classification:	Risk Factors

PREVIOUS CABG

Record Position:	178
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	Nulls must be filled with “2” (No)
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***670***
Coding Classification:	Previous Cardiac Interventions

PREVIOUS VALVE

Record Position:	179
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***675***
Coding Classification:	Previous Cardiac Interventions

PREVIOUS PCI

Record Position:	180
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	1. This field *must not* be blank 2. Nulls must be filled with "2" (No) 3. If "1" Previous PCI Interval *must* be specified
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***775***
Coding Classification:	Previous Cardiac Interventions

PREVIOUS PCI – INTERVAL

Record Position:	181
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = <= 6 Hours; 2 = > 6 Hours
Special Instructions:	If Previous PCI is "2" then this field *must* be blank
Range:	N/A
Parent/Child Relationship:	"Previous PCI" = 1 (Yes); sequence #775
STS Sequence Number:	***800***
Coding Classification:	Previous Cardiac Interventions

PRIOR MI

Record Position:	182
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No; 3 = Unknown
Special Instructions:	If "1" MI When field ***must not*** be blank
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***885***
Coding Classification:	Preoperative Cardiac Status

MI – WHEN

Record Position:	183
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = <=6 Hrs 2 = >6 Hrs but <24 Hrs 3 = 1 to 7 Days 4 = 8 to 21 Days 5 = >21 Days
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Prior MI" = 1; sequence #885
STS Sequence Number:	***890***
Coding Classification:	Preoperative Cardiac Status

HEART FAILURE

Record Position:	184
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No; 3 = Unknown
Special Instructions:	If "1" Classification – NYHA field must be specified
Range	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***911***
Coding Classification:	Preoperative Cardiac Status

HEART FAILURE TIMING

Record Position:	185
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Acute; 2 = Chronic; 3 = Both
Special Instructions:	N/A
Range	N/A
Parent/Child Relationship:	"Heart Failure" = 1; sequence #911
STS Sequence Number:	***912***
Coding Classification:	Preoperative Cardiac Status

CLASSIFICATION – NYHA

Record Position:	186
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Class I 2 = Class II 3 = Class III 4 = Class IV 5 = Not Documented
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Heart Failure" = 1 (Yes); sequence #911
STS Sequence Number:	***915***
Coding Classification:	Preoperative Cardiac Status

CARDIOGENIC SHOCK

Record Position:	187
Data Length:	1
Data Type:	Numeric
Harvest Codes:	2 = No 3 = Yes, at the time of procedure 4 = Yes, not at the time of procedure, but within prior 24 hours
Special Instructions:	All cases coded Cardiogenic shock = 3 or 4 will require substantiating documentation be faxed or uploaded in CORC.
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***930***
Coding Classification:	Preoperative Cardiac Status

RESUSCITATION

Record Position:	188
Data Length:	1
Data Type:	Numeric
Harvest Codes:	2 = No 3 = Yes, within 1 hour of the start of the procedure 4 = Yes, more than 1 hour, but less than 24 hours of the start of the procedure
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***935***
Coding Classification:	Preoperative Cardiac Status

CARDIAC ARRHYTHMIA

Record Position:	189
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***945***
Coding Classification:	Preoperative Cardiac Status

CARDIAC ARRHYTHMIA – VTACH/VFIB

Record Position:	190
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = None; 2 = Remote (> 30 days); 3 = Recent (<=30 days)
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Cardiac Arrhythmia" = 1 (Yes); sequence #945
STS Sequence Number:	***950***
Coding Classification:	Preoperative Cardiac Status

CARDIAC ARRHYTHMIA – AFLUTTER

Record Position:	191
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = None; 2 = Remote (> 30 days); 3 = Recent (<=30 days)
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Cardiac Arrhythmia" = 1 (Yes); sequence #945
STS Sequence Number:	***960***
Coding Classification:	Preoperative Cardiac Status

CARDIAC ARRHYTHMIA – THIRD DEGREE HEART BLOCK

Record Position:	192
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = None; 2 = Remote (> 30 days); 3 = Recent (<=30 days)
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Cardiac Arrhythmia" = 1 (Yes); sequence #945
STS Sequence Number:	***970***
Coding Classification:	Preoperative Cardiac Status

CARDIAC ARRHYTHMIA – ATRIAL FIBRILLATION

Record Position:	193
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = None; 2 = Remote (> 30 days); 3 = Recent (<=30 days)
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Cardiac Arrhythmia" = 1 (Yes); sequence #945
STS Sequence Number:	***961***
Coding Classification:	Preoperative Cardiac Status

ATRIAL FIBRILLATION- TYPE

Record Position:	194
Data Length:	1
Data Type:	Numeric
Harvest Codes:	2 = Paroxysmal; 4 = Persistent
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Cardiac Arrhythmia – Atrial Fibrillation" = 2 or 3; sequence #961
STS Sequence Number:	***971***
Coding Classification:	Preoperative Cardiac Status

WARFARIN USE (within 5 days)

Record Position:	195
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No; 3 = Unknown
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***1091***
Coding Classification:	Preoperative Medications

CORONARY ANATOMY/ DISEASE KNOWN

Record Position:	196
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***1155***
Coding Classification:	Hemodynamics / Cath / Echo

NUMBER DISEASED VESSELS

Record Position:	197
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = None 2 = One 3 = Two 4 = Three
Special Instructions:	Left main disease (>=50%) is counted as Two vessels (LAD and Circumflex)
Range:	N/A
Parent/Child Relationship:	"Coronary Anatomy/Disease Known" =1 (Yes); sequence 1155
STS Sequence Number:	***1170***
Coding Classification:	Hemodynamics / Cath / Echo

LEFT MAIN STENOSIS >= 50% KNOWN

Record Position:	198
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No; 3 = N/A
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***1174***
Coding Classification:	Hemodynamics / Cath / Echo

HEMO DATA EF DONE

Record Position:	199
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***1540***
Coding Classification:	Hemodynamics / Cath / Echo

HEMO DATA EF

Record Position:	200 through 202
Data Length:	3
Data Type:	Numeric
Harvest Codes:	N/A
Special Instructions:	Do not code decimal (implied)
Range:	5.0 – 90.0; low = 1.0, high = 99.0
Parent/Child Relationship:	"Ejection Fraction Done" = 1 (Yes); sequence #1540
STS Sequence Number:	***1545***
Coding Classification:	Hemodynamics / Cath / Echo

PA SYSTOLIC PRESSURE MEASURED

Record Position:	203
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***1570***
Coding Classification:	Hemodynamics / Cath / Echo

PA SYSTOLIC PRESSURE

Record Position:	204 through 207
Data Length:	4
Data Type:	Numeric
Harvest Codes:	N/A
Special Instructions:	Do not code decimal (implied)
Range:	15.0 – 40.0; low = 10.0, high = 150.0
Parent/Child Relationship:	"PA Systolic Pressure Measured" = 1 (Yes); sequence #1570
STS Sequence Number:	***1575***
Coding Classification:	Hemodynamics / Cath / Echo

MITRAL VALVE REGURGITATION

Record Position:	208
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***1679***
Coding Classification:	Hemodynamics / Cath / Echo

MITRAL REGURGITATION

Record Position:	209
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Trivial/Trace; 2 = Mild; 3 = Moderate; 4 = Severe; 5 = Not documented
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***1680***
Coding Classification:	Hemodynamics / Cath / Echo

INCIDENCE

Record Position:	210
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = First cardiovascular surgery 2 = First re-op cardiovascular surgery 3 = Second re-op cardiovascular surgery 4 = Third re-op cardiovascular surgery 5 = Fourth or more re-op cardiovascular surgery
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***1970***
Coding Classification:	Operative

STATUS

Record Position:	211
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Elective 2 = Urgent 3 = Emergent 4 = Emergent Salvage
Special Instructions:	This field *must not* be blank All Cases coded Status = 4 must fax or upload in CORC substantiating documentation.
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***1975***
Coding Classification:	Operative

URGENT / EMERGENT / EMERGENT SALVAGE REASON

Record Position:	212 through 213
Data Length:	2
Data Type:	Numeric
Harvest Codes:	1 = AMI 2 = Anatomy 3 = Aortic Aneurysm 4 = Aortic Dissection 5 = CHF 6 = Device Failure 7 = Diagnostic/Interventional Procedure Complication 8 = Endocarditis 10 = IABP 11 = Infected Device 12 = Intracardiac mass or thrombus 13 = Ongoing Ischemia 14 = PCI Incomplete without Clinical Deterioration 15 = PCI or attempted PCI with Clinical Deterioration 16 = Pulmonary Edema 17 = Pulmonary Embolus 18 = Rest Angina 19 = Shock Circulatory Support 20 = Shock No Circulatory Support 21 = Syncope 22 = Transplant 23 = Trauma 24 = USA 25 = Valve Dysfunction 26 = Worsening CP

27 = Other
28 = Failed Transcatheter Valve Therapy- Acute Annular Disruption
29 = Failed Transcatheter Valve Therapy- Acute Device Malposition
30 = Failed Transcatheter Valve Therapy – Subacute Device Dysfunction

Special Instructions: If Status is "2" (Urgent), "3" (Emergent), OR "4" (Emergent salvage) this field *must* be specified
Range: N/A
Parent/Child Relationship: "Status" = 2 (Urgent), 3 (Emergent); or 4 (Emergent Salvage) sequence #1975
STS Sequence Number: ***1990***
Coding Classification: Operative

PERFUSION STRATEGY

Record Position: 214
Data Length: 1
Data Type: Numeric
Harvest Codes: 1 = None
2 = Combination
3 = Full
4 = Left Heart Bypass
Special Instructions: If "2" Perfusion Strategy Plan *must not* be blank
Range: N/A
Parent/Child Relationship: N/A
STS Sequence Number: ***2325***
Coding Classification: Operative

CPB UTILIZATION - COMBINATION PLAN

Record Position: 215
Data Length: 1
Data Type: Numeric
Harvest Codes: 1 = Planned
2 = Unplanned
Special Instructions: N/A
Range: N/A
Parent/Child Relationship: "Perfusion Strategy" = 2 (Combination); sequence #2325
STS Sequence Number: ***2330***
Coding Classification: Operative

INTERNAL MAMMARY ARTERY USED

Record Position:	216
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes 2 = No
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***2626***
Coding Classification:	Coronary Bypass

REASON FOR NO IMA

Record Position:	217
Data Length:	1
Data Type:	Numeric
Harvest Codes:	2 = Subclavian stenosis; 3 = Previous cardiac or thoracic surgery; 4 = Previous mediastinal radiation; 5 = Emergent or salvage procedure; 6 = No (bypassable) LAD disease; 7 = Other Not Acceptable STS Provided Exclusion 8 = Other-Acceptable STS Provided Exclusion
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Internal Mammary Artery Used" = 2 (No IMA); sequence #2626
STS Sequence Number:	***2627***
Coding Classification:	Coronary Bypass

VALVE

Record Position:	218
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Type of CABG" = 3 (CABG + Valve)
STS Sequence Number:	***2129***
Coding Classification:	Operative

AORTIC VALVE

Record Position:	219
Data Length:	1
Data Type:	Numeric
Harvest Codes:	2 = No 3 = Yes, planned 4 = Yes, unplanned due to surgical complication 5 = Yes, unplanned due to unsuspected disease or anatomy
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Valve" = 1 (Yes); sequence #2129
STS Sequence Number:	***2131***
Coding Classification:	Operative

AORTIC VALVE PROCEDURE

Record Position:	220
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Replacement 2 = Repair/Reconstruction 3 = Surgical Prosthetic Valve Intervention (not explant of valve)
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Aortic Valve" = 3 (Yes, planned), 4 (Yes, unplanned due to surgical complication), or 5 (Yes, unplanned due to unsuspected disease or anatomy); sequence #3390
STS Sequence Number:	***3395***
Coding Classification:	Valve Surgery

MITRAL VALVE

Record Position:	221
Data Length:	1
Data Type:	Numeric
Harvest Codes:	2 = No 3 = Yes, planned 4 = Yes, unplanned due to surgical complication 5 = Yes, unplanned due to unsuspected disease or anatomy
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Valve" = 1 (Yes); sequence #2129
STS Sequence Number:	***2133***
Coding Classification:	Operative

MITRAL VALVE PROCEDURE

Record Position:	222
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Repair 2 = Replacement 3 = Surgical Prosthetic Valve Intervention (Not explant of valve)
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Mitral Valve" = 3 (Yes, planned), 4 (Yes, unplanned due to surgical complication), or 5 (Yes, unplanned due to unsuspected disease or anatomy); sequence #3495
STS Sequence Number:	***3500***
Coding Classification:	Valve Surgery

TRICUSPID VALVE

Record Position:	223
Data Length:	1
Data Type:	Numeric
Harvest Codes:	2 = No 3 = Yes, planned 4 = Yes, unplanned due to surgical complication 5 = Yes, unplanned due to unsuspected disease or anatomy
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Valve" = 1 (Yes); sequence #2129
STS Sequence Number:	***2134***
Coding Classification:	Operative

PULMONIC VALVE

Record Position:	224
Data Length:	1
Data Type:	Numeric
Harvest Codes:	2 = No 3 = Yes, planned 4 = Yes, unplanned due to surgical complication 5 = Yes, unplanned due to unsuspected disease or anatomy
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Valve" = 1 (Yes); sequence #2129
STS Sequence Number:	***2135***
Coding Classification:	Operative

REOPERATION FOR BLEED/ TAMPONADE

Record Position:	225
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	1. This field *must not* be blank 2. Nulls must be filled with "2" (No)
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***6755***
Coding Classification:	Postoperative Events

UNPLANNED CORONARY ARTERY INTERVENTION

Record Position:	226
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	1. This field *must not* be blank 2. Nulls must be filled with "2" (No)
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***6771***
Coding Classification:	Postoperative Events

UNPLANNED CORONARY ARTERY INTERVENTION - VESSELS

Record Position:	227
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Native Coronary; 2 = Graft; 3 = Both
Special Instructions:	N/A
Range:	N/A
Parent/Child Relationship:	"Unplanned Coronary Artery Intervention" = 1 (Yes); sequence #6771
STS Sequence Number:	***6772***
Coding Classification:	Postoperative Events

DEEP STERNAL

Record Position:	228
Data Length:	1
Data Type:	Numeric
Harvest Codes:	2 = No; 3= Yes, within 30 days of procedure; 4=Yes> 30 after procedure, but during hospitalization for surgery
Special Instructions:	1. This field ***must not*** be blank 2. Nulls must be filled with "2" (No)
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***6700***
Coding Classification:	Postoperative Events

NEURO – STROKE PERMANENT

Record Position:	229
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	1. This field ***must not*** be blank 2. Nulls must be filled with "2" (No)
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***6810***
Coding Classification:	Postoperative Events

PULM – VENTILATION PROLONGED

Record Position:	230
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	1. This field ***must not*** be blank 2. Nulls must be filled with "2" (No)
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***6835***
Coding Classification:	Postoperative Events

RENAL – RENAL FAILURE

Record Position:	231
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	1. This field *must not* be blank 2. Nulls must be filled with "2" (No)
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***6870***
Coding Classification:	Postoperative Events

RENAL – DIALYSIS REQUIREMENT

Record Position:	232
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	1. This field *must not* be blank 2. Nulls must be filled with "2" (No) 3. If DIALYSIS is "1" then this field *must* be "2" (No)
Range:	N/A
Parent/Child Relationship:	"Renal – Renal Failure" = 1 (Yes); sequence #6870
STS Sequence Number:	***6875***
Coding Classification:	Postoperative Events

OTHER – A FIB

Record Position:	233
Data Length:	1
Data Type:	Numeric
Harvest Codes:	1 = Yes; 2 = No
Special Instructions:	1. This field *must not* be blank 2. Nulls must be filled with "2" (No)
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	***6945***
Coding Classification:	Postoperative Events

FACILITY IDENTIFICATION NUMBER

Record Position:	234 through 239
Data Length:	6
Data Type:	Numeric
Harvest Codes:	N/A
Special Instructions:	1. This field ***must not*** be blank 2. ***Must*** use OSHPD-issued six-digit number
Range:	N/A
Parent/Child Relationship:	N/A
STS Sequence Number:	N/A; ***CCORP-specific variable***
Coding Classification:	Hospitalization

Questions about the content of this document can be directed to:

CCORP Staff
916-326-3865
CCORP@oshpd.ca.gov

OSHPD

Office of Statewide Health Planning and Development

California CABG Outcomes Reporting Program (CCORP)

Data Element Specifications

Version 8.3

Cardiac Online Reporting for California

June 29, 2020

1. Medical Record Number:

   Format: Alphanumeric, length 12

   Valid Values: Free text

   Category: Demographics

   Definition/Description: Indicate the patient's medical record number at the hospital where surgery occurred.

2. Type of Coronary Artery Bypass Graft (CABG):

   Format: Numeric, length 1

   Valid Values: 1 = Isolated CABG; 3 = CABG + Valve; 4= Other non-isolated CABG

   Category: Operative

   Definition/Description: Indicate the type of CABG.

   Type of CABG should be coded Isolated CABG if none of the procedures listed in this subsection was performed concurrently with the coronary artery bypass surgery.

   - Valve repairs or replacements
   - Operations on structures adjacent to heart valves (papillary muscle, chordae tendineae, traebeculae carneae cordis, annuloplasty, infundibulectomy)
   - Ventriculectomy when diagnosed preoperatively as a rupture, aneurysm or remodeling procedure. Excludes 1) sites intra-operatively diagnosed, 2) patch applications for site oozing discovered during surgery and 3) prophylactic patch applications to reduce chances of future rupture
   - Repair of atrial and ventricular septa, excluding closure of patent foramen ovale
   - Excision of aneurysm of heart
   - Head and neck, intracranial endarterectomy
   - Other open heart surgeries, such as aortic arch repair, pulmonary endarterectomy
   - Endarterectomy of aorta
   - Thoracic endarterectomy (endarterectomy on an artery outside the heart)
   - Carotid endarterectomy
   - Heart transplantation
   - Repair of certain congenital cardiac anomalies, excluding closure of patent foramen ovale (e.g., tetralology of fallot, atrial septal defect (ASD), ventricular septal defect (VSD), valvular abnormality)
   - Any aortic aneurysm repair (abdominal or thoracic)
   - Aorta-subclavian-carotid bypass
   - Aorta-renal bypass
   - Aorta-iliac-femoral bypass
   - Caval-pulmonary artery anastomosis
   - Extracranial-intracranial (EC-IC) vascular bypass
   - Coronary artery fistula

- Resection of a lobe or segment of the lung (e.g., lobectomy or segmental resection of lung). Does not include simple biopsy of lung nodule in which surrounding lung is not resected, biopsy of a thoracic lymph node, or excision or stapling of an emphysematous bleb.
- Pleural decortication
- Mastectomy for breast cancer (not simple breast biopsy)
- Amputation of any part of an extremity (e.g., foot or toe)
- Resection of LV aneurysm
- Planned Ventricular Assist Device (VAD) for long term treatment.
- Septal myectomy with hypertrophic obstructive cardiomyopathy
- Full open MAZE
- Repair of aortic dissection

Type of CABG should be coded CABG + Valve if none of the procedures listed in this subsection were performed concurrently with a CABG that included aortic valve replacement (AVR), mitral valve replacement (MVR), mitral valve repair (MV repair), or AVR+MVR/MV repair.

- Pulmonic Valve Procedure
- Tricuspid Valve Procedure
- Ventriculectomy when diagnosed preoperatively as a rupture, aneurysm or remodeling procedure. Excludes 1) sites intra-operatively diagnose, 2) patch application for site oozing discovered during surgery, and 3) prophylactic patch applications to reduce chances of future rupture
- Repair of atrial and ventricular septa, excluding closure of patent foramen ovale
- Excision of aneurysm of heart
- Head and neck intracranial endarterectomy
- Other open heart surgeries such as aortic arch repair, pulmonary endarterectomy
- Endarterectomy of aorta
- Thoracic endarterectomy (endarterectomy on an artery outside the heart)
- Carotid endarterectomy
- Resection of LV aneurysm
- Heart transplantation
- Repair of congenital cardiac anomalies such as tetraology of fallot, atrial septal defect (ASD), ventricular septal defect (VSD), or other complex anomaly
- Any aortic aneurysm repair (abdominal or thoracic)
- Repair of aortic dissection
- Aorta-subclavian-carotid-bypass
- Aorta-renal bypass
- Aorta-iliac-femoral bypass
- Caval-pulmonary artery anastomosis

- Extracranial-intracranial (EC-IC) vascular bypass
- Coronary artery fistula
- Resection of a lobe or segment of the lung (e.g., lobectomy or segmental resection of lung). Does not include simple biopsy of lung nodule in which surrounding lung is not resected, biopsy of a thoracic lymph node or excision or stapling of an emphysematous bleb
- Pleural Decortication
- Mastectomy for breast cancer (not simple breast biopsy)
- Amputation of any extremity (e.g., foot or toe)
- Resection of LV aneurysm
- Planned Ventricular Assist Device (VAD) for long term treatment.
- Infundibulectomy
- Septal myectomy with hypertrophic obstructive cardiomyopathy
- Full Open MAZE for Aortic Valve cases only (epicardial MAZE procedures are not excluded and Full Open procedures are not excluded for Mitral Valve)

Type of CABG should be coded Other Non-isolated CABG if case is not included in Isolated CABG or CABG + Valve

3. Date of Surgery:

Format: Numeric, length 8

Valid Values: mmddyyyy

Category: Hospitalization

Definition/Description: Indicate the date of coronary artery bypass graft procedure.

4. Date of Birth:

Format: Numeric, length 8

Valid Values: mmddyyyy

Category: Demographics

Definition/Description: Indicate the patient's date of birth using 4-digit format for year.

5. Patient Age:

Format: Numeric, length 3

Valid Values: 18 - 110

Category: Demographics

Definition/Description: Indicate the patient's age in years, at time of surgery. This should be calculated from the date of birth and the date of surgery, according to the convention used in the USA (the number of birthdate anniversaries reached by the date of surgery).

6. Sex:

Format: Numeric, length 1

Valid Values: 1 = Male; 2 = Female

Category: Demographics

Definition/Description: Indicate the patient's sex at birth as either male or female.

7. Primary Payor

Format: Numeric, length 2

Valid Values: 1 = Non/Self; 2 = Medicare; 3 = Medicaid; 4 = Military Health; 9 = Commercial Health Insurance; 10 = Health Maintenance Organization; 11 = Non-U.S. Plan; 13 = Other

Category: Hospitalization

Definition/Description: Indicate the primary insurance payor for this admission. When there is more than one payor, the primary payor pays first.

8. Secondary (Supplemental) Payor

Format: Numeric, length 2

Valid Values: 1 = Non/Self; 2 = Medicare; 3 = Medicaid; 4 = Military Health; 9 = Commercial Health Insurance; 10 = Health Maintenance Organization; 11 = Non-U.S. Plan; 13 = Other

Category: Hospitalization

Definition/Description: Indicate which if any secondary insurance payor was used for this admission. When there is more than one payor, the secondary payor pays after the primary payor.

9. Race Documented

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No; 3 = Patient Declined to Disclose

Category: Demographics
Definition/Description: Indicate whether race is documented.

10. Race - White:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Demographics

Definition/Description: Indicate whether the patient's race, as determined by the patient or family, includes White. "White" refers to a person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicated their race(s) as "White" or reported entries such as Irish, German, Italian, Lebanese, Arab, Moroccan, or Caucasian.

11. Race - Black/African American:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Demographics

Definition/Description: Indicate whether the patient's race, as determined by the patient or

family, includes Black / African American. "Black or African American" refers to a person having origins in any of the Black racial groups of Africa. It includes people who indicated their race(s) as "Black, African Am., or Negro" or reported entries such as African American, Kenyan, Nigerian, or Haitian.

12. Race - Asian:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Demographics

Definition/Description: Indicate whether the patient's race, as determined by the patient or family, includes Asian. "Asian" refers to a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. It includes people who indicated their race(s) as "Asian" or reported entries such as "Asian Indian", "Chinese", "Filipino", "Korean" Japanese", "Vietnamese", and "Other Asian" or provided other detailed Asian responses.

13. Race - American Indian/Alaskan Native:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Demographics

Definition/Description: Indicate whether the patient's race, as determined by the patient or family, includes American Indian / Alaskan Native. "American Indian or Alaska Native" refers to a person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment. This category includes people who indicated their race(s) as "American Indian or Alaska Native" or reported their enrolled or principal tribe, such as Navajo, Blackfeet, Inupiat, Yup'ik, or Central American Indian groups or South American Indian groups.

14. Race - Native Hawaiian/Pacific Islander:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Demographics

Definition/Description: Indicate whether the patient's race, as determined by the patient or family, includes Native Hawaiian / Pacific Islander. "Native Hawaiian or Other Pacific Islander" refers to a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. It includes people who indicated their race(s) as "Pacific Islander" or reported entries such as "Native Hawaiian", "Guamanian or Chamorro", "Samoan", and "Other Pacific Islander" or provided other detailed Pacific Islander responses.

15. Race - Other:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Demographics

Definition/Description: Indicate whether the patient's race, as determined by the patient or family, includes any other race. "Some Other Race" includes all other responses not included in the White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander race categories described above.

16. Hispanic or Latino or Spanish Ethnicity:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No; 3 = Not Documented

Category: Demographics

Definition/Description: Indicate if the patient is of Hispanic, Latino or Spanish ethnicity as reported by the patient / family. "Hispanic, Latino or Spanish" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

17. Hospital Discharge Date:

Format: Numeric, length 8

Valid Values: mmddyyyy

Category: Discharge/ Mortality

Definition/Description: Indicate the date the patient was discharged from the hospital (acute care) even if the patient is going to a rehab or hospice or similar extended care unit within the same physical facility. If the patient died in the hospital, the discharge date is the date of death.

18. Status at Hospital Discharge:

Format: Numeric, length 1

Valid Values: 2 = Died in Hosp; 3 = Discharged Alive, Last Known status Alive (Other than Hospice) ; 4 = Discharged Alive, died after discharge ; 5 = Discharged to Hospice

Category: Discharge/ Mortality

Definition/Description: Indicate the discharge and current vital status of patient.

19. Patient Transfer to Another Acute Care Hospital

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Discharge/ Mortality

Definition/Description: Indicate if the patient was transferred to another acute care hospital.

20. Patient Transferred to Another Acute Hospital – Date

Format: Numeric, length 8

Valid Values: mmddyyyy

Category: Discharge/ Mortality

Definition/Description: Indicate the date the patient was transferred.

21. Mortality Date

Format: Numeric, length 8

Valid Values: mmddyyyy

Category: Mortality

Definition/Description: Indicate the date the patient was declared dead.

22. Mort – Status at 30 Days After Surgery (either discharged or in-hospital)

Format: Numeric, length 1

Valid Values: 1 = Alive; 2 = Dead; 3 = Unknown

Category: Discharge/ Mortality

Definition/Description: Indicate whether the patient was alive or dead at 30 days post-surgery (whether in hospital or not).

23. Responsible Surgeon Name (3 separate fields):

Format: Surgeon Last Name text length 25 (alpha) Surgeon First Name text length 20 (alpha) Surgeon Middle Initial text length 1(alpha)

Valid Values: Free Text

Category: Operative

Definition/Description: The responsible surgeon is the surgeon as defined in Section 97170.

24. Responsible Surgeon CA License Number:

Format: Alphanumeric, length 9

Valid Values: Free text

Category: Operative

Definition/Description: California physician license number of responsible surgeon, assigned by the Medical Board of California of the Department of Consumer Affairs. If the responsible surgeon is an osteopath, then the license number assigned by the Osteopathic Medical Board of California.

25. Height (cm):

Format: Numeric, length 4

Valid Values: 20.0-251.0 cm

Category: Risk Factors

Definition/Description: Indicate the height of the patient in centimeters closest to time of OR entry.

26. Weight (kg):

Format: Numeric, length 4

Valid Values: 10.0 - 250.0 kg

Category: Risk Factors

Definition/Description: Indicate weight closest to the date of surgery in kilograms.

27. Diabetes:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No; 3=Unknown

Category: Risk Factors

Definition/Description: History of diabetes diagnosed and/or treated by a healthcare provider. The American Diabetes Association criteria include documentation of the following:

A1c >=6.5%;

Fasting plasma glucose >=126 mg/dl (7.0 mmol/l);

Two-hour plasma glucose >=200 mg/dl (11.1 mmol/l) during an oral glucose tolerance test;

In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose >=200 mg/dl (11.1 mmol/l)

This does not include gestational diabetes.

28. Diabetes Control:

Format: Numeric, length 1

Valid Values: 1 = None; 2 = Diet only; 3 = Oral; 4 = Insulin; 5 = Other; 6= Other subcutaneous medication; 7 = Unknown

Category: Risk Factors

Definition/Descriptions: Indicate the patient's control method as presented on admission. Patients placed on a pre-procedure diabetic pathway of insulin drip at admission but whose diabetes was controlled by diet or oral method are not coded as being treated with insulin. Choose the most aggressive therapy from the order below:

Insulin: insulin treatment (includes any combination with insulin);

Other subcutaneous medications (e.g., GLP-1 agonist);

Oral: treatment with oral agent (includes oral agent with or without diet treatment);

Diet only: treatment with diet only;

None: no treatment for diabetes;

Other: other adjunctive treatment, non-oral/insulin/diet;

Unknown

29. Dialysis:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No; 3 = Unknown

Category: Risk Factors

Definition/Description: Indicate whether the patient is currently (prior to surgery) undergoing dialysis. Refers to whether the patient is currently on dialysis, not distant past history.

30. Hypertension:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No; 3 = Unknown

Category: Risk Factors

Definition/Description: Indicate if the patient has a current diagnosis of hypertension defined by any one of the following:

History of hypertension diagnosed and treated with medication, diet and/or exercise;

Prior documentation of blood pressure >140 mmHg systolic or 90 mmHg diastolic for patients without diabetes or chronic kidney disease, or prior documentation of blood pressure >130 mmHg systolic or 80 mmHg diastolic on at least 2 occasions for patients with diabetes or chronic kidney disease;

Currently undergoing pharmacologic therapy for treatment of hypertension.

31. Endocarditis:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Risk Factors

Definition/Description: Endocarditis must meet the current CDC definition. Choose "Yes" for patients with pre-operative endocarditis who begin antibiotics post-op. Code "Yes" for patients who are diagnosed intraoperatively:

Patient has organisms cultured from valve or vegetation;

Patient has 2 or more of the following signs or symptoms: fever (>38°C), new or changing murmur, embolic phenomena, skin manifestations (i.e., petechiae, splinter hemorrhages, painful subcutaneous nodules), congestive heart failure, or cardiac conduction abnormality with no other recognized cause and at least 1 of the following:

- Organisms cultured from 2 or more blood cultures
- Organisms seen on Gram's stain of valve when culture is negative or not done
- Valvular vegetation seen during an invasive procedure or autopsy
- Positive laboratory test on blood or urine (e.g., antigen tests for H influenzae, S pneumoniae, N meningitis, or Group B Streptococcus)
- Evidence of new vegetation seen on echocardiogram and if diagnosis is made antemortem, physician institutes appropriate antimicrobial therapy

32. Infectious Endocarditis Type:

Format: Numeric, Length 1

Valid Values: 1 = Treated; 2 = Active

Category: Risk Factors

Definition/Description: Indicate the type of endocarditis the patient has. If the patient is currently being treated for endocarditis, the disease is considered active. If no antibiotic medication (other than prophylactic medication) is being given at the time of surgery and the cultures are negative, then the infection is considered treated.

33. Chronic Lung Disease:

Format: Numeric, length 1

Valid Values: 1 = No; 2 = Mild; 3 = Moderate; 4 = Severe; 5= Lung disease documented, severity unknown; 6 = Unknown

Category: Risk Factors

Definition/Description: Indicate whether the patient has chronic lung disease, and the severity level according to the following classification:

No;

Mild: FEV1 60% to 75% of predicted, and/or on chronic inhaled or oral bronchodilator therapy;

Moderate: FEV1 50% to 59% of predicted, and/or on chronic oral/systemic steroid therapy aimed at lung disease;

Severe: FEV1 <50% and/or Room Air pO <60 or pCO2 > 50;

Chronic Lung Disease present, severity not documented;

Unknown.

34. Pneumonia

Format: Numeric, length 1
Valid Values: 1 = No; 2 = Recent; 3 = Remote; 4 = Unknown

Category: Risk Factors

Definition/Description: Indicate whether the patient had pneumonia at the time of procedure.

35. Liver Disease:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No; 3 = Unknown

Category: Risk Factors
Definition/Description: Indicate whether the patient has a history of hepatitis B, hepatitis C, drug induced hepatitis, autoimmune hepatitis, cirrhosis, portal hypertension, esophageal varices, liver transplant, or congestive hepatopathy. Exclude NASH in the absence of cirrhosis.

36. Immunocompromised Present:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No; 3 = Unknown

Category: Risk Factors
Definition/Description: Indicate whether immunocompromise is present due to immunosuppressive medication therapy within 30 days preceding the operative procedure or existing medical condition.

37. COVID-19

Format: Numeric, length 2

Valid Values: 10 = No; 11 = Yes, prior to hospitalization for this surgery; 12 = Yes, in hospital prior to surgery; 13 = Yes, in hospital after surgery
Category: TempCode

Definition/Description: Did the patient have a laboratory confirmed diagnosis of COVID-19?

38. Cancer Within 5 Years

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No; 3 = Unknown

Category: Risk Factors

Definition/Description: Indicate whether the patient has a history of cancer diagnosed within 5 years of procedure. Do not capture low grade skin cancers such as basal cell or squamous cell carcinoma.

39. Peripheral Artery Disease:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No; 3 = Unknown

Category: Risk Factors

Definition/Description: Indicate whether the patient has a documented history of peripheral arterial disease (includes upper and lower extremity, renal, mesenteric, and abdominal aortic systems). This can include:

1. Claudication, either with exertion or at rest,
2. Amputation for arterial vascular insufficiency,
3. Vascular reconstruction, bypass surgery, or percutaneous intervention to the extremities (excluding dialysis fistulas and vein stripping),
4. Documented abdominal aortic aneurysm with or without repair.
5. Documented subclavian artery stenosis.

Peripheral arterial disease excludes disease in the carotid, cerebrovascular arteries or thoracic aorta. PVD does not include DVT, pulmonary artery aneurysm, Raynaud's Disease or AVM.

40. Cerebrovascular Disease:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No; 3 = Unknown

Category: Risk Factors

Definition/Description: Indicate whether the patient has a current or previous history of any of the following:

A. Stroke: Stroke is an acute episode of focal or global neurological dysfunction caused by brain, spinal cord, or retinal vascular injury as a result of hemorrhage or infarction, where the neurological dysfunction lasts for greater than 24 hours.

B. TIA: is defined as a transient episode of focal neurological dysfunction caused by brain, spinal cord, or retinal ischemia, without acute infarction, where the neurological dysfunction resolves within 24 hours. C. Noninvasive or invasive arterial imaging test demonstrating >=50% stenosis of any of the major extracranial or intracranial vessels to the brain

D. Vertebral artery and internal carotid and intercranial consistent with atherosclerotic disease with document presence as CVD. External carotid disease is excluded.

E. Previous cervical or cerebral artery revascularization surgery or percutaneous intervention

F. Brain/cerebral aneurysm.

G. Occlusion of vertebral artery, internal carotid artery, and intercranial due to dissection.

This does not include chronic (nonvascular) neurological diseases or other acute neurological insults such as metabolic and anoxic ischemic encephalopathy. Subdural hematoma or AVM is not cerebral vascular disease.

41. Prior CVA:

Format: Numeric, length 1

Valid Values:1 = Yes; 2 = No; 3 = Unknown

Category: Risk Factors

Definition/Description: Indicate whether the patient has a history of stroke. Stroke is an acute episode of focal or global neurological dysfunction caused by brain, spinal cord, or retinal vascular injury as a result of hemorrhage or infarction, where the neurological dysfunction lasts for greater than 24 hours.

42. Prior CVA - When:

Format: Numeric, length 1

Valid Values: 3 = Recent <=30 days; 4=Remote >30 days

Category: Risk Factors

Definition/Description: Indicate when the CVA events occurred. Those events occurring within 30 days of the surgical procedure are considered recent, while all others are considered remote.

43. CVD TIA:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No; 3 = Unknown

Category: Risk Factors

Definition/Description: Indicate whether the patient has a history of a Transient Ischemic Attack (TIA): Transient ischemic attack (TIA) is defined as a transient episode of focal neurological dysfunction caused by brain, spinal cord, or retinal ischemia, without acute infarction, where the neurological dysfunction resolves within 24 hours.

44. CVD Carotid Stenosis:

Format: Numeric, length 1

Valid Values: 1 = None; 2 = Right; 3 = Left; 4 = Both; 5 = Not Documented

Category: Risk Factors
Definition/Description: Indicate which carotid artery was determined from any diagnostic test to be >=50% stenotic.

45. CVD Carotid Stenosis - Right:
Format: Numeric, length 1
Valid Values: 3 = 50% to 79%; 1 = 80% to 99%; 2 = 100%; 4 = Not documented
Category: Risk Factors
Definition/Description: Indicate the severity of stenosis reported on the right carotid artery.

46. CVD Carotid Stenosis – Left:
Format: Numeric, length 1
Valid Values: 3 = 50% to 79%; 1 = 80% to 99%; 2 = 100%; 4 = Not documented
Category: Risk Factors
Definition/Description: Indicate the severity of stenosis reported on the left carotid artery.

47. CVD Prior Carotid Surgery:
Format: Numeric, length 1
Valid Values: 1 = Yes; 2 = No
Category: Risk Factors
Definition/Description: Indicate whether the patient has a history of previous carotid artery surgery and/or stenting.

48. Last Creatinine Level:
Format: Numeric, length 4
Valid Values: 0.10 - 30.00
Category: Risk Factors
Definition/Description: Indicate the creatinine level closest to the date and time prior surgery but prior to anesthetic management (induction area or operating room).

49. Total Albumin
Format: Numeric, length 4
Valid Values: 1.00 - 10.00
Category: Risk Factors
Definition/Description: Indicate the total albumin closest to the date and time prior to surgery but prior to anesthetic management (induction area or operating room).

50. Total Bilirubin:
Format: Numeric, length 4
Valid Values: 0.10 - 50.00

Category: Risk Factors

Definition/Description: Indicate the total Bilirubin closest to the date and time prior to surgery but prior to anesthetic management (induction area or operating room).

51. INR:

Format: Numeric, length 4

Valid Values: 0.50 - 30.00

Category: Risk Factors

Definition/Description: Indicate the International Normalized Ratio (INR) at the date and time closest to surgery but prior to anesthetic management (induction area or operating room).

52. Sodium

Format: Numeric, length 4

Valid Values: 30.0 – 200.0

Category: Risk Factors

Definition/Description: Indicate the sodium closest to the date and time to surgery but prior to anesthetic management (induction area or operating room).

53. Previous CABG:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Previous Cardiac Interventions

Definition/Description: Indicate whether the patient had a previous Coronary Bypass Graft prior to the current admission.

54. Previous Valve:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Previous Cardiac Interventions

Definition/Description: Indicate whether the patient had a previous surgical replacement and/or surgical repair of a cardiac valve. This may also include percutaneous valve procedures or transcatheter valve procedures.

55. Previous PCI:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Previous Cardiac Interventions

Definition/Description: Indicate whether a previous Percutaneous Cardiac Intervention (PCI) was performed any time prior to this surgical procedure. Percutaneous Cardiac Intervention (PCI) is the placement of an angioplasty guide wire, balloon, or other devise (e.g. stent, atherectomy, brachytherapy, or thrombectomy catheter) into a native coronary artery or

coronary artery bypass graft for the purpose of mechanical coronary revascularization.

56. Previous PCI - Interval:

Format: Numeric, length 1

Valid Values: 1 = <=6 Hours; 2 = > 6 Hours

Category: Previous Cardiac Interventions

Definition/Description: Indicate the interval of time between the previous PCI and the current surgical procedure.

57. Prior MI:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No; 3 = Unknown

Category: Preoperative Cardiac Status

Definition/Description: Indicate if the patient has had at least one documented previous myocardial infarction at any time prior to this surgery.

58. MI - When:

Format: Numeric, length 1

Valid Values: 1 = <=6 Hrs.; 2 = >6 Hrs but <24 Hrs; 3 = 1 to 7 Days; 4 = 8 to 21 Days; 5 = >21 Days.

Category: Preoperative Cardiac Status

Definition/Description: Indicate the time period between the last documented myocardial infarction and surgery.

59. Heart Failure:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No; 3 = Unknown

Category: Preoperative Cardiac Status

Definition/Description: Indicate if there is physician documentation or report that the patient has been in a state of heart failure.

60. Heart Failure Timing:

Format: Numeric, length 1

Valid Values: 1 = Acute; 2 = Chronic; 3 = Both

Category: Preoperative Cardiac Status

Definition/Description: Indicate whether heart failure is acute, chronic or both (acute or chronic).

- Acute: New onset or worsening heart failure within 2 weeks prior to this procedure.
- Chronic: More than 2 weeks prior to this procedure.
- Both: Worsening heart failure with 2 weeks prior to this procedure.

61. Classification - NYHA:

Format: Numeric, length 1

Valid Values: 1 = Class I; 2 = Class II; 3 = Class III; 4 = Class IV

Category: Preoperative Cardiac Status
Definition/Description: Indicate the patient's worst dyspnea or functional class, coded as the New York Heart Association (NYHA) classification documented by a MD/Provider within the past 2 weeks.

Select the highest level of heart failure within the two weeks leading up to episode of hospitalization or at the time of the procedure. The intent is to capture the highest level of failure. Physician documentation should be in the medical record.

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, or dyspnea.

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, or dyspnea).

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, or dyspnea).

Class IV: Patient has cardiac disease resulting in inability to perform any physical activity without discomfort. Symptoms may be present. Patient has cardiac disease resulting in inability to perform any physical activity without discomfort. Symptoms may be present = Not Documented

62. Cardiogenic Shock:

Format: Numeric, length 1

Valid Values: 3 = Yes, at the time of the procedure; 4 = Yes, not at the time of the procedure, but within prior 24 hours; 2 = No

Category: Preoperative Cardiac Status
Definition/Description: Indicate if the patient developed cardiogenic shock. Cardiogenic shock is defined as a sustained

(>30 min) episode of hypoperfusion evidenced by systolic blood pressure <90 mm Hg and/or, if

available, cardiac index <2.2 L/min per square meter determined to be secondary to cardiac

dysfunction and/or the requirement for parenteral inotropic or vasopressor agents or mechanical support (e.g., IABP, extracorporeal circulation, VADs) to maintain blood pressure and cardiac index above those specified levels.

63. Resuscitation:

Format: Numeric, length 1

Valid Values: 3 = Yes, within 1 hour of the start of the procedure; 4 = Yes, more than 1 hour but less than 24 hours of the start of the procedure; 2 = No

Category: Preoperative Cardiac Status

Definition/Description: Indicate whether the patient required cardiopulmonary resuscitation before induction of anesthesia. Capture resuscitation timeframe: within 1 hour or 1-24 hours pre-op.

64. Cardiac Arrhythmia:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Preoperative Cardiac Status

Definition/Description Indicate whether the patient has a history of a cardiac rhythm disturbance prior to the induction of anesthesia.

65. Cardiac Arrhythmia - VTach/VFib:

Format: Numeric, length 1

Valid Values: 1= None; 2= Remote (>30 days); 3= Recent (<30days)

Category: Preoperative Cardiac Status

Definition/Description: Indicate whether arrhythmia was VTach or VFib.

66. Cardiac Arrhythmia - Aflutter:

Format: Numeric, length 1

Valid Values: 1= None; 2= Remote (>30 days); 3= Recent (<30days)

Category: Preoperative Cardiac Status

Definition/Description: Indicate whether arrhythmia was atrial flutter.

67. Cardiac Arrhythmia – Third Degree Heart Block:

Format: Numeric, length 1

Valid Values: 1= None; 2= Remote (>30 days); 3= Recent (<30days)

Category: Preoperative Cardiac Status

Definition/Description: Indicate whether arrhythmia was third degree heart block.

68. Cardiac Arrhythmia – Atrial fibrillation:

Format: Numeric, length 1

Valid Values: 1= None; 2= Remote (>30 days); 3= Recent (<30days)

Category: Preoperative Cardiac Status

Definition/Description: Indicate whether arrhythmia was atrial fibrillation.

69. Atrial fibrillation Type:

Format: Numeric, length 1

Valid Values: 2 = Paroxysmal; 4 = Persistent

Category: Preoperative Cardiac Status

Definition/Description: Indicate whether arrhythmia was atrial fibrillation and if so, which type.

70. Warfarin Use (within 5 days):

Format: Numeric, Length 1

Valid Values: 1 = Yes; 2 = No; 3 = Unknown

Category: Preoperative Medications

Definition/Description: Indicate whether the patient received warfarin (Coumadin) within 5 days preceding surgery.

71. Coronary Anatomy/Disease Known:

Format: Numeric, Length 1

Valid Values: 1 = Yes; 2 = No

Category: Hemodynamics / Cath / Echo

Definition/Description: Indicate whether coronary artery anatomy and/or disease is documented and available prior to surgery.

72. Number Diseased Vessels:

Format: Numeric, length 1

Valid Values: 1 = None; 2 = One; 3 = Two; 4 = Three

Category: Hemodynamics / Cath / Echo

Definition/Description: Indicate the number of diseased major native coronary vessel systems. A vessel that has ever been considered diseased, should always be considered diseased

73. Left Main Stenosis >= 50% Known:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No; 3 = N/A

Category: Hemodynamics / Cath / Echo

Definition/Description: Indicate if main stenosis greater or equal to 50% is known.

74. Hemo Data Ejection Fraction Done:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Hemodynamics / Cath / Echo

Definition/Description: Indicate whether the Ejection Fraction was measured prior to the induction of anesthesia.

75. Hem Data EF

Format: Numeric, length 3

Valid Values: 1.0 - 99.0

Category: Hemodynamics / Cath / Echo

Definition/Description: Indicate the Ejection Fraction (percentage of the blood emptied from the left ventricle at the end of the contraction). See TM for time frame and source document priority. Enter a percentage in the range of 1 - 99. If a percentage range is reported, report a whole number using the "mean" (i.e., 50-55% is reported as 53%).

- Hyperdynamic: >70%
- Normal: 50%–70% (midpoint 60%)
- Mild dysfunction: 40%–49% (midpoint 45%)
- Moderate dysfunction: 30%–39% (midpoint 35%)
- Severe dysfunction: <30%

Note: If no diagnostic report is in the medical record, a value documented in the medical record is acceptable. ACCF/AHA 2013

76. PA Systolic Pressure Measured:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Hemodynamics / Cath / Echo

Definition/Description: Indicate whether the PA systolic pressure was measured.

77. PA Systolic Pressure:

Format: Numeric, length 4

Valid Values: 10.0 - 150.0

Category: Hemodynamics / Cath / Echo

Definition/Description: Capture PA systolic pressure recorded

78. Mitral Valve Regurgitation:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Hemodynamics / Cath / Echo

Definition/Description: Indicate whether there is evidence of Mitral valve insufficiency/regurgitation.

79. Mitral Regurgitation

Format: Numeric, length 1

Valid Values: 1 = Trivial/Trace; 2 = Mild; 3 = Moderate; 4 = Severe; 5 = Not documented

Category: Hemodynamics / Cath / Echo

Definition/Description: Indicate whether there is evidence of Mitral valve insufficiency/regurgitation.

80. Incidence:

Format: Numeric, length 1

Valid Values:1 = First cardiovascular surgery; 2 = First re-op cardiovascular surgery; 3 = Second re-op cardiovascular surgery; 4 = Third re-op cardiovascular surgery; 5 = Fourth or more re-op cardiovascular surgery

Category: Operative

Definition/Description: Indicate if this is the patient's:

First surgery;

First re-op surgery;

Second re-op surgery;

Third re-op surgery;

Fourth or more re-op surgery

CV surgeries INCLUDE: CABG, valve replacement/repair, intracardiac repairs (ASD, VSD), ventricular aneurysmectomy, or surgery on the aortic arch. Use of CPB is not required.

-CV surgeries DO NOT INCLUDE: PCI's and non-cardiac vascular surgeries such as abdominal aortic aneurism repairs or fem-pop bypasses, percutaneous aortic stent grafts, percutaneous valves or pacemaker/ICD implantations.

The intent of this field is to capture the incidence of the procedure that the patient is about to go through during the current hospitalization, as compared to those procedures prior to this hospitalization. First operative means the patient has never had any procedure on the heart and/or great vessels...

81. Status:

Format: Numeric, length 1

Valid Values: 1 = Elective; 2 = Urgent; 3 = Emergent; 4 = Emergent Salvage

Category: Operative

Definition/Description: Indicate the clinical status of the patient prior to entering the operating room:

- Elective- The patient's cardiac function has been stable in the days or weeks prior to the operation. The procedure could be deferred without increased risk of compromised cardiac outcome.

- Urgent- Procedure required during same hospitalization in order to minimize chance of further clinical deterioration. Examples include but are not limited to: Worsening, sudden chest pain, CHF, acute myocardial infarction (AMI), anatomy, IABP, unstable angina (USA) with intravenous (IV) nitroglycerin (NTG) or rest angina.

- Emergent- Patients requiring emergency operations will have ongoing, refractory (difficult, complicated, and/or unmanageable) unrelenting cardiac compromise, with or without hemodynamic instability, and not responsive to any form of therapy except cardiac surgery. An emergency operation is one in which there should be no delay in providing operative intervention

- Emergent Savage- The patient is undergoing CPR en route to the OR or prior to anesthesia induction or has ongoing ECMO to maintain life.

82. Urgent / Emergent / Emergent Salvage Reason:

Format: Numeric, length 2

Valid Values: 1 = AMI; 2 = Anatomy; 3 = Aortic Aneurysm; 4 = Aortic Dissection; 5 = CHF; 6 = Device Failure; 7 = Diagnostic/Interventional Procedure Complication; 8 = Endocarditis; 10 = IABP; 11 = Infected Device; 12 = Intracardiac mass or thrombus; 13 = Ongoing Ischemia; 14 = PCI Incomplete without Clinical Deterioration; 15 = PCI or attempted PCI with Clinical Deterioration; 16 = Pulmonary Edema; 17 = Pulmonary Embolus; 18= Rest Angina; 19 = Shock Circulatory Support; 20 = Shock No Circulatory Support; 21 = Syncope; 22 = Transplant; 23 = Trauma; 24 = USA; 25 = Valve Dysfunction; 26 = Worsening CP; 27 = Other; 28 = Failed Transcatheter Valve Therapy – Acute, annular disruption; 29 = Failed Transcatheter Valve Therapy – Acute, device malposition; 30 = Failed Transcatheter Valve Therapy – Subacute, device dysfunction

Category: Operative

Definition/Description: Choose one reason from the list in (72)(B) above that best describes why this operation was considered urgent, emergent, or emergent salvage.

83. Perfusion Strategy:

Format: Numeric, length 1

Valid Values: 1 = None; 2 = Combination; 3 = Full; 4 = Left Heart Bypass

Category: Operative

Definition/Description: Indicate the perfusion strategy used during the procedure:

None: No CPB or coronary perfusion used during the procedure.

Combination: With or without CPB and/or with or without coronary perfusion at any time during the procedure (capture conversions from off-pump to on-pump only):

- At start of procedure: No CPB/No Coronary Perfusion -> conversion -> CPB
- At start of procedure: No CPB/No Coronary Perfusion -> Conversion to -> Coronary perfusion, or
- At start of procedure: No CPB/No Coronary Perfusion -> Conversion to -> Coronary perfusion -> conversion -> CPB

Full: CPB or coronary perfusion was used for the entire procedure.

84. CPB Utilization-Combination Plan:

Format: Numeric, length 1

Valid Values: 1 = Planned; 2 = Unplanned

Category: Operative

Definition/Description: Indicate whether the combination procedure from off-pump to on-pump was a planned or an unplanned conversion.

-Planned: The surgeon intended to treat with any of the combination options described in "CPB utilization".

-Unplanned: The surgeon did not intend to treat with any of the combination options described in "CPB utilization".

85. Internal Mammary Artery Used:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Coronary Bypass

Definition/Description: Indicate whether an internal mammary artery conduit was used.

86. Reason for No IMA:

Format: Numeric, length 1

Valid Values: 2 = Subclavian Stenosis; 3 = Previous cardiac or thoracic surgery; 4 = Previous mediastinal radiation; 5 = Emergent or salvage procedure; 6 = No (bypassable) LAD disease; 7 = Other Not Acceptable STS Provided Exclusion; 8 = Other-Acceptable STS Provided Exclusion

Category: Coronary Bypass

Definition/Description: Indicate the primary reason above that Internal Mammary Artery was not used as documented in the medical record.

87. Valve:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Operative

Definition/Description: Indicate whether a surgical procedure was done on the Aortic, Mitral, Tricuspid or Pulmonic valves.

88. Aortic Valve:

Format: Numeric, length 1

Valid Values: 3 = Yes, planned; 4 = Yes, unplanned due to surgical complication; 5 = Yes, unplanned due to unsuspected disease or anatomy; 2 = No

Category: Operative

Definition/Description: Indicate whether an aortic valve procedure was performed.

89. Aortic Valve Procedure:

Format: Numeric, length 1

Valid Values: 1 = Replacement; 2 = Repair/Reconstruction; 3 = Surgical Prosthetic Valve Intervention (not explant of valve)

Category: Valve Surgery

Definition/Description: Indicate procedure performed on aortic valve.

90. Mitral Valve:

Format: Numeric, length 1

Valid Values: 3 = Yes, planned; 4 = Yes, unplanned due to surgical complication; 5 = Yes, unplanned due to unsuspected disease or anatomy; 2 = No

Category: Operative

Definition/Description: Indicate whether a mitral valve procedure was performed.

91. Mitral Valve Procedure:

Format: Numeric, length 1

Valid Values: 1 = Repair; 2 = Replacement; 3 = Surgical Prosthetic Valve Intervention (Not explant of valve)

Category: Valve Surgery

Definition/Description: Indicate the type of procedure that was performed on the mitral valve.

92. Tricuspid Valve:

Format: Numeric, length 1

Valid Values: 3 = Yes, planned; 4 = Yes, unplanned due to surgical complication; 5 = Yes, unplanned due to unsuspected disease or anatomy; 2 = No

Category: Valve Surgery

Definition/Description: Indicate whether a tricuspid valve procedure was performed.

93. Pulmonic Valve:

Format: Numeric, length 1

Valid Values: 3 = Yes, planned; 4 = Yes, unplanned due to surgical complication; 5 = Yes, unplanned due to unsuspected disease or anatomy; 2 = No

Category: Valve Surgery

Definition/Description: Indicate whether a pulmonic valve procedure was performed.

94. Reoperation for Bleed/ Tampanade:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Postoperative Events

Definition/Description: Indicate whether the patient was reexplored for mediastinal bleeding with or without tamponade either in the ICU or returned to the operating room.

95. Unplanned Coronary Artery:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Postoperative Events

Definition/Description: Indicate if the patient had an unplanned coronary intervention (PCI) or

unplanned surgical intervention on a coronary artery.

96. Unplanned Coronary Artery Vessels:

Format: Numeric, length 1

Valid Values: 1 = Native Coronary; 2 = Graft; 3 = Both

Category: Postoperative Events

Definition/Description: Indicate the type of vessels that required post-operative reintervention.

97. Deep Sternal:

Format: Numeric, length 1

Valid Values: : 3 = Yes, within 30 days of procedure; 4 = Yes, >30 days after procedure but during hospitalization for surgery; 2 = No

Category: Postoperative Events

Definition/Description: Indicate whether a deep sternal wound infection or mediastinitis was diagnosed within 30 days of the OR date or at any time during the initial hospitalization.

98. Neuro – Stroke Permanent:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Postoperative Events

Definition/Description: Indicate whether the patient has a postoperative stroke (i.e., any confirmed neurological deficit of abrupt onset caused by a disturbance in blood supply to the brain) that was confirmed on imaging or did not resolve within 24 hours

99. Pulm - Ventilation Prolonged:

Format: Numeric, length 1

Valid Values:1 = Yes; 2 = No

Category: Postoperative Events

Definition/Description: Indicate whether the patient had prolonged post-operative pulmonary ventilation > 24.0 hours.

The hours of postoperative ventilation time include OR exit until extubation, plus any additional hours following reintubation.

100.Renal - Renal Failure:

Format: Numeric, length 1

Valid Values: 1 = Yes; 2 = No

Category: Postoperative Events

Definition/Description: Indicate whether the patient had acute renal failure or worsening renal function resulting in ONE OR BOTH of the following:

- Increase of serum creatinine level 3.0 X greater than baseline, or serum creatinine level >=4.0 mg/dl, Acute rise must be at least 0.5 mg/dl.

A new requirement for dialysis postoperatively.

101.Renal - Dialysis Requirement:

Format: Numeric, length 1

Valid Values:1 = Yes; 2 = No

Category: Postoperative Events

Definition/Description: Indicate whether the patient had a new requirement for dialysis postoperatively, which may include hemodialysis, peritoneal dialysis.

102.Other – A Fib:

Format: Numeric, length 1

Valid Values:1 = Yes; 2 = No

Category: Postoperative Events

Definition/Description: Indicate whether the patient experienced atrial fibrillation/flutter (AF) after OR Exit that a. last longer than one hour, or b. lasts less than one hour but requires medical or procedural intervention. Exclude patients who were in AFib at the start of surgery.

103.Facility Identification Number:

Format: Numeric, length 6

Valid Values: Free Text

Category: Hospitalization

Definition/Description: The six-digit facility identification number assigned by the Office, as defined in Section 97170.

CALIFORNIA CABG OUTCOMES REPORTING PROGRAM

Surgeon Certification Form

OSH-CCORP 415 (Revised 03/02/2020)

Surgeon's name: _____ _____ _____
(First) *(Middle Initial)l* *(Last)*

California Physician License Number: _____

Hospital name: _____

Facility Identification Number: _____

Report period: *From:* _____ *To:* _____
(Month) (Day) (Year) *(Month) (Day) (Year)*

Number of records included in this report: _____

Statement of Certification

I have reviewed the data for the cases assigned to me in the final hospital report accepted on _____ (date) at _____ (time). I affirm that the cases were correctly assigned to me and attest to the accuracy and completion of the data. I understand that these data, after any corrections or revisions required by the Office of Statewide Health Planning and Development, will be used to compute my risk-adjusted mortality rate for coronary artery bypass graft surgery. I understand that for data elements with invalid or missing values OSHPD will assign the lowest risk value as observed in the most current risk-adjustment model for predicting mortality.

Signature: _____

Isolated CABG cases: _____

[1]Isolated CABG in-hospital deaths: ___

CABG + Valve cases ____

[2]CABG + Valve in-hospital deaths: _____

Other Non-isolated cases: _____

Other Non-isolated in-hospital deaths _____

1: Used in hospital and surgeon public reporting **2: Used in hospital public reporting**

Hospital: Complete the section below only if the surgeon did not sign the form.

Surgeon unable to sign this form due to the following reason(s) (check any that apply):

No longer performs surgery at this hospital

□ Other *(explain):*

Fax Form to 916-445-7534
or
Email to CCORP@OSHPD.CA.GOV or
Upload in CORC

CALIFORNIA CABG OUTCOMES REPORTING PROGRAM

Surgeon Certification Form

OSH-CCORP 415 (Revised **03/02/2020**)

Surgeon's name: _____ _____ _____
(First) *(Middle Initial)l* *(Last)*

California Physician License Number: _____

Hospital name: _____

Facility Identification Number: _____

Report period: *From:* _____ *To:* _____
(Month) (Day) (Year) *(Month) (Day) (Year)*

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Signature: _____

Isolated **CABG** cases: _____

[1]**Isolated CABG in-hospital** deaths: _____

CABG + Valve cases _____

[2]**CABG + Valve in-hospital deaths:** _____

Other Non-isolated cases: _____

Other Non-isolated **in-hospital** deaths _____

1: Used in hospital and surgeon public reporting 2: Used in hospital public reporting

Hospital: Complete the section below only if the surgeon did not sign the form.

Surgeon unable to sign this form due to the following reason(s) (check any that apply):

☐ [redacted] No longer performs surgery at this hospital

☐ Other *(explain):* _____

Fax Form to 916-445-7534
or
Email to CCORP@OSHPD.CA.GOV or
Upload in CORC

Written Comments Received During 45-day Public Comment Period

No written comments were received.

Office of Statewide Health Planning and Development (OSHPD) California Coronary Artery Bypass Graft Outcomes Reporting Program

FINAL STATEMENT OF REASONS

Title 22, California Code of Regulations
Sections 97170, 97174, 97177.25, 97177.35, 97177.55,
97177.60, 97177.65, 97177.67, and 97177.70

LOCAL MANDATES

OSHPD has made the final determination that this regulation does not impose additional mandates on local agencies and school districts.

REASONABLE ALTERNATIVES

No alternative considered by OSHPD would be more effective in carrying out the purpose for which this regulation is proposed, would be as effective and less burdensome to affected private persons than the adopted regulation, or would be more cost effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

OSHPD has not identified any alternatives to the proposed regulation that would be less burdensome and equally effective in achieving the purposes of the regulation, and no alternatives have otherwise been identified and brought to the attention of OSHPD.

OSHPD has not identified any reasonable alternatives to the proposed regulatory action, including alternatives that would lessen any adverse impact on small business. The regulation as proposed would have no impact on small business.

DOCUMENTS INCORPORATED BY REFERENCE

Format and File Specifications for California Coronary Artery Bypass Graft (CABG) Outcomes Reporting Program Version 8.3 dated June 29, 2020

Data Element Specifications for California Coronary Artery Bypass Graft (CABG) Outcomes Reporting Program Version 8.3 dated June 29, 2020

Surgeon Certification Form OSH-CCORP 415 revised 3.2.2020

The documents met the criteria for incorporation by reference per Section 20 of Title 1 of the California Code of Regulations.

The documents listed above are incorporated by reference due to the cumbersome, unduly expensive, or otherwise impractical to publish the document in the California Code of Regulation. The combined length of the 3 documents is 70 pages.

The documents were made available upon request directly from OSHPD and were reasonably available to the affected public from a commonly known or specified source. The documents were available on OSHPD's website: www.oshpd.ca.gov. The documents were also available in the Cardiac Online Reporting for California (CORC) OSHPD's secure Coronary Artery Bypass Graft (CABG) data collection system. Hospital data contacts use the CORC system for direct upload of their data files. CCORP also discussed the documents with hospital data contacts in bi-monthly calls. In addition, CCORP emailed a copy of the Format and File Specifications to the hospitals' software vendors who create and update the hospitals data abstraction software.

The informative digest in the notice of proposed action clearly identifies the documents to be incorporated by title and date of publication or issuance.

The regulation text states that the documents are incorporated by reference and identifies the document by titles and date of publication or issuance.

The regulation text specifies which portions of the document are being incorporated by reference.

CHANGES TO SURGEON CERTIFICATION FORM

OSHPD proposes to make a few revisions to the Surgeon Certification Form OSH-CCORP 415. OSHPD is delineating the Isolated CABG cases and deaths from the CABG + Valve cases and deaths. The purpose of this revision is to provide the CABG + Valve information to hospitals and surgeons. Previously the surgeon certification form grouped CABG + Valve summary data with all other non-isolated CABGs, even though hospitals are rated on CABG + Valve mortalities. OSHPD received requests from hospitals and surgeons to separate CABG + Valve listings from all other non-isolated CABGs so they would have a better idea of what their ratings would be. OSHPD is also listing the email address and guidance that the form can be uploaded in CORC to provide flexibility to hospitals in how they return the form to OSHPD.