**FREQUENTLY ASKED QUESTIONS**

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# HISTORY/COMORBIDITY

**Q1:**The history and physical only states “PVD”, can I capture this as yes for the PAD history.

**A1:**Please only capture as yes if there is other documentation of arterial disease such as prior invasive procedures to treat arterial disease or symptoms of arterial disease such as claudication etc.

**Q2:**What is the time frame for capturing history of CVA from BMC2? A patient was admitted with a CVA and NSTEMI. The dx of CVA was made prior to the PCI, after admission to the hospital.

**A2:**Consider the time frame as being pre PCI, not pre admission. In the case mentioned please indicate yes.

**Q3:**If a patient has had an ICD implanted in the past but it has been explanted since and prior to current PCI, would we still capture it?

**A3:**Yes, as the definition specifically states “placement at any time.”

# PROCEDURE/LESION INFO

**Q1**:  My doctor only writes "normal LVEDP", what should I enter?

**A1**:  You can only capture numerical values, please refer to the cath lab hemodynamics report.  If there is no value than you will not be able to capture this field.

**Q2**:  My patient has his diagnostic cath at the transferring in facility, should I enter the LVEDP obtained there?

A2:  Only capture the LVEDP obtained during the current PCI case.

**Q3**: When you were at our site we discussed that more than one lesion could be culprit, but when I add a lesion I can’t select anything for in the culprit field?

**A3:**The NCDR website will automatically gray out that field if that field was selected yes for lesion number one.  Please save the lesion subsequent lesion(s) and then you can go back up to the culprit field and make the appropriate selection.

**Q4:**A patient has a lesion length of 114. NCDR is giving me a system error. How do I get around this?

**A4:**You will have to split up the lesion as the website will not accept length over 99. Combine a couple of the segments and then code the other segments as lesion number 2. If that is the only vessel treated, you should make them both culprit as you would have no way to differentiate.

# LABS

**Q1:**  For the post hemoglobin and post creatinine should I be utilizing the results drawn in the lab?

**A1:**  Yes, in the case of Hgb and Cr, please use the labs drawn after the cath lab procedure has started.  You would not give these results any special consideration, just consider them as you would your other results.  You capture the highest Cr. until 5 days post procedure or another cath lab procedure.  Hgb you capture the nadir within 72 hours after procedure regardless of subsequent procedures and/or surgical procedures.

**Q2:** Do I capture ACT results if the patient has had no heparin?

**A2:** No, please do not include these values unless the patient has received heparin within 1 hour from the start of the procedure or during the procedure.

**Q3:**  What if I have a few ACT values?  Which one do I use?

**A3:**  You would capture the result that is the highest obtained during or just before the PCI.  Don't capture the ACT value obtained when the patient is exiting the room if the PCI procedure is no longer in process.

**Q4:**Pt. arrives from outlying facility to the cath lab at 17:37. Sheath (xylo) insertion 17:42. Has labs drawn with sheath insertion but they are labeled at 17:41. Should these be counted as
pre labs since the patient was already in the lab and technically the case
had started?

**A4:**Per NCDR, you could utilize these labs as pre if there was no anti-coagulation administered prior to obtaining the specimen.

**Q5:**If a patient has a PCI first for STEMI, and then a diagnostic procedure later in the same visit, are the post procedure labs only abstracted until the diagnostic procedure?

**A5:**The response depends on what lab value you are referring to:

Post Hgb: This value is lowest with 72 hours regardless of next procedure, OR etc.

Post Troponin: This value follows a timeframe of 6-24 hours post procedure.

Post Peak Creatinine: This value depends on the next procedure and if the next procedure includes PCI or diagnostic cath. So, for Creatinine, take the highest value from the end of your procedure to the next procedure or discharge.

# MEDICATIONS

**Q1:**If a patient went to emergent CABG after attempted PCI procedure, do we abstract the vasopressors given during and post CABG as IV vasopressors-post in BMC? Also, same question for heparin given just prior to the CABG; is it abstracted as IV heparin-post?

**A1:**Yes, please capture medications administered to the patient post PCI, even if they are post CABG.

**Q2:**If a post med is ordered post procedure and the patient doesn’t get a dose in the hospital but they are discharge on it, do we count it as given on the BMC2 form?

**A2:**No, we capture based on administration not order.

**Q3:**In collecting medications given post PCI prior to discharge, we found that a patient took his own medication. Do we capture this as “given” due to the fact that the nurse has the responsibility to give the med as ordered or clarify with the patient that they actually took it?

**A3:**Yes, please capture the medications administered, whether they be from the patient’s or the hospital’s stock.

Q4**:**Is patient refusal to take a prescribed medication a contraindication?

**A4:** Refusal of meds would not be captured as contraindication in BMC2 meds.

**Q5:**If there are no prior to arrival meds, do I just mark this as complete and check none of the boxes?

**A5: Please capture as "none".**

 **Q6:**Post meds are from cath to next procedure; does CABG count as next procedure? Are post meds on discharge ordered, or meds post cath given?

**A6:**“Next procedure” means cath lab procedure; please do not consider surgical procedures. Post meds for BMC2 are those medications actually administered to patient after they have left the cath lab.  Please continue to document discharge medications via NCDR.

# OUTCOMES

**Q1:**  My physician routinely uses a radial access for the diagnostic portion of the procedure, but moves to the femoral for the PCI portion of the procedure.  Is this additional procedural access, or failed access for the radial site?

**A1:**  The radial site would be considered a failed attempt r/t the inability of the radial site to support the PCI.

**Q2:**Do you consider a plaque shift into OM2 with TIMI 2 flow with ostium jailed by stent struts and vessel too small for intervention to be a side branch occlusion?

**A2:**If the side branch is occluded (no flow) then please capture yes.  If there is just a shift in plaque but the side branch still has flow, please select no.

**Q3:**Patient had PCI of mid LAD. When wire was crossing the lesion (mid LAD) the vessel closed and was opened with inflation. I abstracted this as no reflow since it was the targeted lesion. At the end of the procedure the distal (apical) LAD was occluded. They never could cross it with a wire to open that area. It is not a side branch occlusion, but it is not an acute closure of the treated area. How would that be abstracted?

**A3:**This would not meet criteria for side branch occlusion. There is nowhere to account for this

**Q4:**Would we capture a secondary access site only if they had established arterial access?

**A4:**Please enter those cases with noted attempts, whether or not they actually established access.

Example #1:

Radial access is achieved, physician moves to groin for PCI to utilize larger devices.  Radial would be secondary, groin would be primary.

Example #2:

Radial access is attempted, not achieved, physician moves to LFA to perform case.  LFA would be primary and radial would be secondary then failed access then radial.

**Q5:**A physician tried a right radial but ran into subclavian stenosis and had to go in from a left radial site. Would this be marked as yes to secondary access, with a rationale of failed access – radial?

**A5:**Yes. When you have a failed arterial access attempt, please capture under secondary, then failed, and then identify the site.

**Q6:**Patient presented as STEMI, PCI performed, attempted IABP insertion, access site perforation/laceration, patient sent to OR for surgical repair. IABP inserted in OR 2nd site. How do I capture this?

**A6:**In the lab the PCI site was converted to an attempted IABP site. Please code “surgical repair” under primary access site vasc comp. The IABP inserted in the OR would not be a secondary site as it was not inserted in the cath lab.

# MISCELLANEOUS

**Q1:**I have had a few patients that have both Medicare and Medicaid insurance. Since the website only allows for one choice, how is the second insurance captured?

**A1:**Please capture the primary insurance in these cases. Usually it is Medicare.

**Q2:**  What do we need to have documented in our EMR to capture "yes" for NCDR#10116 Cardiac Rehab?

**A2:  Per NCDR correspondence:** In order to code 'Yes' for Seq# 10116 (Cardiac Rehabilitation Referral) 3 distinct criteria MUST be met:

1. Written documentation of a referral by the primary cardiovascular provider for the patient to attend an outpatient phase II cardiac rehabilitation (CR) program is required.  A referral is defined as an official communication between the health care provider and the patient to carry out a referral order and is not just information as to the need or recommendation for cardiac rehab.  A referral MUST be provided PRIOR to discharge.

2. The patient is provided information that will allow them to enroll in an outpatient cardiac rehabilitation program.  (Note: this does not include inpatient Phase 1)

3. Lastly, there should be communication between the health care provider or health care system and the cardiac rehabilitation program that includes the patient’s referral information for the program. A hospital discharge summary or office note may potentially be formatted to include the necessary patient information to communicate with the CR program. This can be sent to the CR program with patient consent OR provided to the patient to present on their first visit to the CR program.