STS General Thoracic Surgery Database
Version 2.2 Update May 2014

Fields with questions, clarifications, examples are in red:
620, 730, 760, 770, 790, 800, 820, 840, 930, 1140, 1250, 1300, 1320, 1420, 1480, 1500, 1610, 1710, 1810, 1830, 1860, 1910, 1970, 1990, 2020, 2040, 2090, 2150, 2230, 2240, 2340, 2300

GENERAL INFORMATION

July 2013 - The CPT codes provided on the DCF are for reference & information. The General Thoracic Surgery Database is a clinical database and for its purposes, the correct **clinical category** should be captured, not the CPT code. The CPT code a billing coder may use may not be correct for the purposes of a clinical database.

October 2013 – Non Analyzed Procedures (NAP) - Can isolated NAPs or those performed with another NAP be submitted for harvest? If yes, what happens to these procedures? *These cases would not be analyzed or reported by DCRI in your harvest report even if submitted with your file. Your DQR would give you the # of procedures that fall into this category.*

October 2013 - Some participants keep track of their NAP cases & use them for internal queries and to track cases. Some surgeons want to track all cases and some programs want to track volumes and resource utilization. The GTSD does not track any of this information.

December 2013 - Addendums may be added to the medical record within 30 days to be consistent with CMS.

April 2014 – INCLUSION: Would a thymectomy done during a CABG and MAZE be captured in the Thoracic database? It was an incidental finding when opening the sternum for the CABG. *No, it would be included in the ACSD as a "Other, non-cardiac-other." Sequence #5590.*

April 2014 – When trying to establish which codes to use, keep the following in mind: *If it's done using a scope, use the Thoracoscopy codes. If it's an open procedure, use the thoracotomy codes.*

Version 2.2 was designed to focus on major, risk adjusted procedures. A noteworthy and time-saving difference to the new data specifications is that procedures which are not analyzed will no longer be mandatory to collect. For example, isolated non-analyzed procedures which are not associated with major procedures during the same anesthesia, such as bronchoscopy, are now optional.

For STS purposes, such data won't be analyzed and data collection for these procedures will be at the surgeon's discretion. For those continuing to collect procedure data on all cases, a short Data Collection Form is available for the non-analyzed procedures to save time.

- A Major Procedure Data Collection Form (DCF) should be initiated every time the patient enters the Operating Room for Major Procedure(s). Major procedures are analyzed, may be risk adjusted and are included in Harvest Reports.
- Fields that appear underlined and in blue on the DCF are required for Major procedure record inclusion. If any of these fields are
  Missing data, the entire record will be excluded from the analysis.

- Procedures highlighted on the DCF, if performed as isolated procedures or with another highlighted procedure are not collected unless the Surgeon Participant chooses to track them. If collected, use the data set highlighted on the DCF or the Non-analyzed Procedure Data Set DCF. Sections and Fields that appear highlighted are suggested for these procedures.
- Highlighted procedures done in conjunction with major procedures should be included on the Major Procedure DCF.

Use the training manual to clarify field definitions and intent. Submit clinical questions to: FAQs. You will receive an email response and questions and answers will be posted below in red.

Training Manual Version 2.2 of the General Thoracic Surgery Database				
SeqNo	**ShortName**	**LongName**	**DataFieldIntent**	**FieldNameClarification**
10	RecordID	Operations Table Record Identifier		
20	RecordID	Procedures Table Record Identifier		
30	VendorID	Software Vendor's Identification		
40	SoftVrsn	Vendor's Software Version Number		
50	DataVrsn	Version Of STS Data Specification		
60	ParticID	Participant ID	Participant ID is a unique number assigned to each Database participant by the STS. A Database participant is defined as one entity that signs a Participation Agreement with the STS, submits one data file to the harvest, and gets back one report on their data. The participant ID must be entered into each record.	Each participant's data, if submitted to harvest, must be in one data file. If one participant keeps data in more than one file (e.g. at two sites), the participant must combine them back into one file for harvest submission. If two or more participants share single purchased software and enter cases into one database, the data must be extracted into two different files, one for each participant ID, with each record having the correct participant ID

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SeqNo	**ShortName**	**LongName**	**DataFieldIntent**	**FieldNameClarification**
				number.
70	PatID	Operations Table Patient Identifier	If a patient is admitted to the hospital more than once, each record for that patient will have the same value in this field. A record should be initiated for inpatient and outpatient thoracic procedures on every visit to the operating room (includes the Endoscopy Suite or Outpatient Surgical Center) whether planned or unplanned.	Once assigned to a patient, this number can never be changed or reused.
80	PatID	Demographics Table Patient Identifier	If a patient is admitted to the hospital more than once, each record for that patient will have the same value in this field. A record should be initiated for inpatient and outpatient thoracic procedures on every visit to the operating room (includes the Endoscopy Suite or Outpatient Surgical Center) whether planned or unplanned.	
90	DemogDataVrsn	Demographics Table Data Version		
100	MedRecN	Medical Record #	Indicate the patient's medical record number at the hospital where surgery occurred. This field should be collected in compliance with state/local privacy laws.	
110	PatFName	Patient's First Name	Indicate the patient's first name documented in the medical record.	
120	PatMInit	Patient's Middle Initial	Middle name or initial as documented in medical record	Leave “blank” if no middle initial.
130	PatLName	Patient's Last Name	Indicate the patient's last name documented in the medical record.	
140	SSN	Social Security Number	Unique patient identifier assigned by government	Although this is the Social Security Number in the USA, other countries may have a different National Patient Identifier Number. For example in Canada, this would be the Social Insurance Number. The Social Security Number is crucial to provide linkage for long term follow up and every attempt should be made to collect it.

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
150	STSTLink	STS Trial Link Number	The unique identification number assigned by the STS indicating the clinical trial in which this patient is participating. This field should be left blank if the patient is not participating in a clinical trial associated with the STS	
160	DOB	Date Of Birth	Indicate the patient's date of birth using 4-digit format for year.	
170	Age	Age At Time Of Surgery	This field is Required for Record Inclusion, because it is part of the risk models. If missing data, the entire record will be excluded from the analysis.	Calculated value based on DOB and surgery date
180	PostalCode	Zip Code	Indicate the ZIP Code, outside the USA, this data may be known by other names such as Postal Code (needing 6 characters). Software should allow sites to collect at least up to 10 characters to allow for Zip+4 values. This field should be collected in compliance with state/local privacy laws.	
190	Gender	Gender	Indicate the patient's gender at birth as either male or female. This field is Required for Record Inclusion and is used in Risk Models. If missing data, the entire record will be excluded from the analysis.	Patients who have undergone gender reassignment surgery maintain the risk associated with their chromosomal gender.
N\A	Race		The race fields are Required for Record Inclusion and included in Risk Models. If missing data, the entire record will be excluded from the analysis. The Census Bureau collects race data in accordance with guidelines provided by the U.S. Office of Management and Budget and these data are based on **self-identification.** The racial categories included in the census form generally reflect a social definition of race recognized in this country, and are not an attempt to define race biologically, anthropologically or genetically. In addition, it is recognized that the categories of the race item include racial and national origin or socio-cultural groups. People may choose to report more than one race to indicate their racial	Select all that apply. People who identify their origin (ETHNICITY) as Hispanic, Latino or Spanish may be of any race. Reference: www.whitehouse.gov/omb/fedreg/1997standards.html

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
			mixture, such as “American Indian and White.” In addition, it is recognized that the categories of the race item include both racial and national origin and socio-cultural groups. You may choose more than one race category.	
200	RaceCaucasian	Race - Caucasian	Indicate the patient's race, as reported by the patient or family, includes White.	
210	RaceBlack	Race - Black / African American	Indicate whether the patient's race, as determined by the patient or family, includes Black/African American.	This includes a person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American." Definition source: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity: The minimum categories for data on race and ethnicity for Federal statistics, program administrative reporting, and civil rights compliance reporting.
220	RaceAsian	Race - Asian	Indicate whether the patient's race, as determined by the patient or family, includes Asian.	This includes 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. Definition source: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity: The minimum categories for data on race and ethnicity for Federal statistics, program administrative reporting, and

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				civil rights compliance reporting.
230	RaceNativeAm	Race - American Indian / Alaskan Native	Indicate whether the patient's race, as determined by the patient or family, includes Native American.	Includes all in North American native peoples such as American Indian/Alaskan Native, Inuit.
240	RacNativePacific	Race - Native Hawaiian / Pacific Islander	Indicate whether the patient's race, as determined by the patient or family, includes Native Hawaiian/Pacific Islander.	This includes a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. Definition source: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity: The minimum categories for data on race and ethnicity for Federal statistics, program administrative reporting, and civil rights compliance reporting.
250	RaceOther	Race Other	Indicate whether the patient's race, as determined by the patient or family, includes any other race.	
260	RaceUnk	Race Unknown	Indicate if the patients race is unknown	Make every attempt to collect race since it is part of Risk Models.
270	Ethnicity	Hispanic Or Latino Ethnicity	Indicate if the patient is of Hispanic, Latino or Spanish ethnicity as reported by the patient/family.	Hispanic, Latino or Spanish ethnicity includes patient report of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, **regardless of race**. People who identify their origin as Hispanic, Latino or Spanish may be of any race.
280	AdmissionStat	Admission Status	Indicate whether the procedure was an Inpatient or Outpatient/Observation procedure. This field is Required for Record Inclusion. If missing data, the entire record will be excluded from the analysis.	Outpatient/Observation should be selected if the operation was performed as an ambulatory procedure or if it included a period of overnight observation.
290	AdmitDt	Admission Date	Indicate the date of admission. For those patients who originally enter the hospital in an outpatient capacity, the admit date is the date the patient’s status changes to	For purposes of this data definition, Outpatient and Observation status are the same. Enter INPATIENT admit

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
			inpatient.	date.
300	PayorGov	Payor - Government Health Insurance	Indicate whether government insurance was used by the patient to pay for part or all of this admission.	Government insurance refers to patients who are covered by government-reimbursed care. This includes Medicare, Medicaid, Military Health Care (e.g. TriCare), State-Specific Plan, and Indian Health Service. CHIP (Children's Health Insurance Plan), High Risk Pools Local Government Health Insurance Plan (LGHIP), state or federal prisoners Do not code yes if Medicare or Medicaid was applied for during the hospital stay but is not paying for current admission.
310	PayorGovMcare	Payor - Government Health Insurance - Medicare	All payor fields are "Select all that apply." If a patient has a Medicare HMO, code "Yes" to this field (PayorGovMcare) and PayorHMO re HMO.	

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
320	MedicareFFS	Medicare Fee For Service	Indicate whether the patient is a Medicare Fee For Service (FFS) patient, Medicare FFS=Medicare Part B There are four parts to Medicare: • Medicare Part A, Hospital Insurance; • Medicare Part B, Medical Insurance; • Medicare Part C (Medicare Advantage), which was formerly known as *Medicare + Choice;* and • Medicare Part D, prescription drug coverage You cannot assume if a patient has part A that they have Part B	The Social Security Website at www.socialsecurity.gov has a list explaining what the letters behind the Medicare claim # stand for. Those letters do not tell you whether they have Part B/Fee for service. It is the relationship of the cardholder to the Medicare/SSN #. For example, B stands for "Aged wife, 62 or older". The A would stand for "Primary claimant=the wage earner". D1 is for an "Aged widower, age 60 or over". This is used for PQRS Check with your hospital billing department if you are unsure whether the patient is considered Medicare Part B. Even if not using the registry for PQRS, CMS will be tracking outcomes for value based purchasing.
331	MHICNumber	Medicare Health Insurance Claim Number	Indicate the Medicare Health Insurance Claim (MHIC) number of the primary beneficiary. The	The MHIC # consists of the Social Security number and an alpha-numeric identifier (usually one digit but maybe two digits) It is the number found on a patient's Medicare card. This field should be collected in compliance with state/local privacy laws.
340	PayorGovMcaid	Payor - Government Health Insurance - Medicaid	Indicate whether the government insurance used by the patient to pay for part or all of this admission included Medicaid.	
350	PayorGovMil	Payor - Government Health Insurance - Military Health	Indicate whether the government insurance used by the patient to pay for part or all of this admission included	Examples include: TriCare, Champus, Department of Defense, and

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SeqNo	**ShortName**	**LongName**	**DataFieldIntent**	**FieldNameClarification**
		Care	Military Health Care.	Department of Veterans Affairs.
360	PayorGovState	Payor - Government Health Insurance - State-Specific Plan	Indicate whether the government insurance used by the patient to pay for part or all of this admission included State-Specific Plan.	
370	PayorGovIHS	Payor - Government Health Insurance - Indian Health Service	Indicate whether the government insurance used by the patient to pay for part or all of this admission included Indian Health Service.	
380	PayorCom	Payor - Commercial Health Insurance	Indicate whether commercial insurance was used by the patient to pay for part or all of this admission.	Commercial insurance refers to all indemnity (fee-for-service) carriers and Preferred Provider Organizations (PPOs), (e.g., Blue Cross and Blue Shield). Workman's compensation is considered commercial insurance.
390	PayorHMO	Payor - Health Maintenance Organization	Indicate whether Health Maintenance Organization (HMO) insurance was used by the patient to pay for part or all of this admission.	HMO refers to a Health Maintenance Organization characterized by coverage that provides health care services for members on a pre-paid basis.
400	PayorNonUS	Payor - Non-U.S. Insurance	Indicate whether any non-U.S. insurance was used by the patient to pay for part or all of	
410	PayorNS	Payor - None / Self	Indicate whether no insurance was used by the patient to pay for this admission.	None refers to individuals with no or limited health insurance; thus, the individual is the payor regardless of ability to pay. Only mark "None" when "self" or "none" is denoted as the first insurance in the medical record.
420	Surgeon	Surgeon's Name	Indicate the Surgeon's name. This field must have controlled data entry where a user selects the surgeon name from a user list. This will remove variation in spelling, abbreviations and punctuation within the field. Note: Surgeon name is encrypted in the analysis database. Punctuation, abbreviations and spacing differences cannot be corrected at the warehouse.	If two surgeons participate in the procedure and both surgeons are participating in the Database, the surgeon of record for the database is the physician under whom the patient is admitted or the physician responsible for the care of the patient. If this is not evident from the operative

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
				dictation, communication with the involved physicians is necessary.
430	SurgNPI	Surgeon's National Provider Identifier	Indicate the individual-level National Provider Identifier (NPI) of the surgeon performing the procedure. This field is Required for Record Inclusion. If missing data, the entire record will be excluded from the analysis	The NPI is a unique identification number for health care providers. Health care providers will use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number) Meaning that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. NPI look up link: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do
440	TIN	Taxpayer Identification Number	Indicate the TIN used by the physician office for billing purposes for this patient's procedure. There may be individual, hospital and medical group practice TINs, so be sure to enter the correct one.	If the physician is part of a medical group practice, use the name and taxpayer identification number of the medical group.
450	HospName	Hospital Name	Indicate the full name of the facility where the procedure was performed.	
460	HospZIP	Hospital Postal Code	Indicate the ZIP Code of the hospital. Outside the USA, these data may be known by other names such as Postal Code (needing 6 characters).	Software should allow sites to collect up to 10 characters to allow for Zip+4 values. This field should be collected in compliance with state/local privacy laws.
470	HospStat	Hospital State	Indicate the abbreviation of the state or province in which the hospital is located.	
480	HospNPI	Hospital National Provider Identifier	Indicate the hospital's National Provider Identifier (NPI).	This number, assigned by the Center for Medicare and Medicaid Services (CMS), is used to uniquely identify facilities for Medicare billing purposes.

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
				This is different from the surgeon NPI.
490	HeightCm	Height In Centimeters	Height and weight is extremely important for the accurate interpretation of PFTs, body surface area and risk calculations. Ft-in = cm 4’10’’ = 147 4’11’’ = 149 5’0’’ = 152 5’1’’ = 155 5’2’’ = 157 5’3’’ = 160 5’4’’ = 163 5’5’’ = 165 5’6’’ = 168 5’7’’ = 170 5’8’’ = 173 5’9’’ = 175 5’10’’ = 178 5’11’’ = 180 6’0’’ = 183 6’1’’ = 185 6’2’’ = 188 6’3’’ = 190 6’4’’ = 193 6’5’’ = 195 6’6’’ = 198 6’7’’ = 200	
500	WeightKg	Weight In Kilograms	Height and weight is extremely important for the accurate interpretation of PFTs, body surface area and risk calculations. To convert pounds to kilograms, divide # of lbs by 2.2.(1 kg = 2.2 lbs)	
510	WtLoss3Kg	Weight Loss In Past Three Months	This is a significant indicator of the patients overall health within the last few months. Unintentional weight loss may be an indicator of underlying pathology. If the	

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
			amount of weight loss is not documented or it is unclear how much has occurred in the 3 month window leave this field blank.	
520	Hypertn	Hypertension	The History & Physical form will list the patients past medical history and also will list the current medications. This definition comes from: ACCF/AHA Key Elements and Data Definitions for Measuring the Clinical Management and Outcomes of Patients with Acute Coronary Syndromes and Coronary Artery Disease A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Data Standards 2010 (Writing Committee to Develop Acute Coronary Syndromes and Coronary Artery Disease Clinical Data Standards)	Diagnosis of hypertension should not be based on a single elevated blood pressure reading, rather a diagnosis of hypertension, documented by one of the following: a) Documented history of hypertension diagnosed and treated with medication, diet and/or exercise b) 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. c) Currently on pharmacologic therapy to control hypertension.
530	Steroid	Steroids	Corticosteroids (or steroids) have been developed for their anti-inflammatory and immunomodulatory effects. Patients on steroids who present for surgery may be at increased risk of complications because of the adrenal suppression caused by steroid therapy. This often poses the greatest risk and deserves particular attention. Examples of oral and intravenous steroid medications include prednisone, hydrocortisone, dexamethasone, and methylprednisolone.	DO NOT include topical creams or inhalers that are steroidal in form. DO NOT include a one or two time dose of systemic treatment, or a pre-operative/pre-cath protocol.
540	CHF	Congestive Heart Failure	Congestive heart failure occurs when the heart is unable to pump blood effectively throughout the body. The term congestive is used because lung congestion causes some of the main symptoms of heart failure. ACCF/AHA Key Elements and Data Definitions for	Heart failure is defined as physician documentation or report of any of the following clinical symptoms of heart failure described as unusual dyspnea on light exertion, recurrent dyspnea occurring in the supine position, fluid

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
			Measuring the Clinical Management and Outcomes of Patients with Acute Coronary Syndromes and Coronary Artery Disease A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Data Standards 2010 (Writing Committee to Develop Acute Coronary Syndromes and Coronary Artery Disease Clinical Data Standards)	retention; or the description of rales, jugular venous distension, pulmonary edema on physical exam, or pulmonary edema on chest x-ray. A low ejection fraction without clinical evidence of heart failure does not qualify as heart failure.
550	CAD	Coronary Artery Disease	Coronary artery disease is a type of atherosclerosis in which plaque builds up inside the arteries that carry blood to the heart. As the artery walls thicken, the passageway for blood narrows. Sometimes platelets gather at the narrowing, forming a clot that decreases or prevents blood flow to the region of the heart supplied by the artery. May include documentation of angina, myocardial infarction (MI), CABG, PCI*, or sudden cardiac death with no known cause. *Percutaneous Coronary Intervention (PCI) includes angioplasty and coronary artery stenting.	Documented blockage ≥ 50% of one or more coronary arteries or documentation of CAD in H&P.
560	PVD	Peripheral Vascular Disease	This refers to diseases of blood vessels outside the heart and brain. It is often a narrowing of vessels that carry blood to the legs, arms, stomach or kidneys. Peripheral arterial disease excludes disease in the carotid or cerebral vascular arteries or thoracic aneurysms.	Peripheral arterial disease can include any of the following: • claudication either with exertion or rest; • amputation for arterial vascular insufficiency; • aorto-iliac occlusive disease reconstruction • vascular reconstruction, bypass surgery, or percutaneous intervention to the extremities (excluding dialysis fistulas and vein stripping) • peripheral angioplasty or stent

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
				documented • documented abdominal (below the diaphragm) aortic aneurysm with or without repair • positive non-invasive or invasive testing documented ankle brachial index ≤ 0.9, angiography, ultrasound, MRI or CT imaging of > 50% stenosis in any peripheral artery.
570	PriorCTS	Prior Cardiothoracic Surgery	Prior cardiothoracic surgery causes scar tissue to form and may increase difficulty and or risk in subsequent procedures.	Capture open and minimally invasive procedures
580	PreopChemoCur	Preoperative Chemo - Current Malignancy	Chemotherapy treatment for the current malignancy ONLY. Does not include chemo for prior thoracic or other malignancies.	Do not include methotrexate given for arthritis
590	PreopChemoCurWhen	Preoperative Chemo - Current Malignancy - When	Indicate whether chemotherapy was given within 6 months or greater than 6 months prior to procedure	
600	PreopXRT	Preoperative Thoracic Radiation Therapy	Radiation to the chest area for any disease process at any time prior to current surgery. If answered yes, answer the next field.	Radiation therapy causes changes to the tissues which may increase difficulty and or risk in subsequent surgeries.
610	PreopXRTDisWhen	Preoperative Thoracic Radiation Therapy - Disease And When Treated	If yes, select Same Disease, ≤6 months; Same Disease, > 6 months; Unrelated Disease, ≤ 6 months, or related Disease, > 6 months.	If patient did not receive preoperative radiation therapy as indicated by a "Yes" in PreopXRT, there should be no option to answer.
620	CerebroHx	Cerebrovascular History	Select No CVD history; Any reversible event; or Any irreversible event. If a history of previous cerebrovascular disease exists, it should be noted whether the patient's symptoms were or reversible (i.e. transient ischemic attack) or whether the deficit is permanent (i.e. stroke).	CVD may be documented by any one of the following: CVA (symptoms > 24 hrs after onset, presumed to be from vascular etiology) TIA (recovery within 24 hrs) Non-invasive carotid test with > 79% diameter occlusion Documented "severe" or "critical" carotid stenosis. Prior carotid surgery or stenting or prior cerebral aneurysm clipping or coil. Does not include

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
				neurological disease processes such as metabolic or ischemic encephalopathy.
What if a transient neuro event lasts more than 24 hours but resolves? Is this coded as reversible or irreversible?			Use the 24 hour timeframe- if symptoms resolve within 24 hours, code as reversible. If symptoms persist for more than 24 hours, code as irreversible. This will be reviewed for the next data version.	
630	PulmHypertn	Pulmonary Hypertension	High blood pressure in the arteries that supply the lungs is called pulmonary hypertension (PHT). The blood vessels that supply the lungs constrict and their walls thicken, so they cannot carry as much blood. This information may be found on a preoperative cardiac catheterization or echocardiogram. If the value is not known or documented, the data sheet should be marked accordingly.	
640	Diabetes	Diabetes	Diabetes is a condition whereby the body is not able to regulate levels of glucose (a sugar) in the blood, resulting in too much glucose being present in the blood. The American Diabetes Association criteria include documentation of the following: 1. A1c >6.5%; or 2. Fasting plasma glucose >126 mg/dl (7.0 mmol/l); or 3. Two-hour plasma glucose >200 mg/dl (11.1 mmol/l) during an oral glucose tolerance test; or 4. In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose >200 mg/dl (11.1 mmol/l)	Capture the presence and/or history of diabetes mellitus, regardless of duration of disease or need for anti-diabetic agents diagnosed prior to surgical intervention.
650	DiabCtrl	Diabetes Control		
660	Dialysis	Currently On Dialysis	This measure is related to hemodialysis , peritoneal dialysis or CRRT. Does not include ultrafiltration.	
670	CreatMeasured	Creatinine Level Measured	Creatinine, urea and urate all increase as the ability of the kidneys to filter fluid within the body declines. Creatinine is a marker for kidney function.	
680	CreatLst	Last Creatinine Level	The value used should be most recent one prior to entering the operating room.	
690	HemoglobinMeasured	Hemoglobin Level Measured	Hemoglobin is the protein molecule in red blood cells that carries oxygen from the lungs to the body's tissues	

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			and returns carbon dioxide from the tissues to the lungs. The iron contained in hemoglobin is responsible for the red color of blood.	
700	HemoglobinLst	Last Hemoglobin Level	The value used should be the most recent one prior to entering the operating room.	
710	COPD	COPD	Chronic Obstructive Pulmonary Disease (COPD) is a preventable and treatable lung disease with some significant extrapulmonary effects. It is characterized by airflow limitation that is not fully reversible, usually progressive and associated with an abnormal inflammatory response in lung tissue. Diagnosis is confirmed and severity is graded using pulmonary function testing (PFT). Bronchitis and emphysema are considered COPD, asthma is not.	
720	InterstitialFib	Interstitial Fibrosis	Interstitial lung disease, or ILD, is a common term that includes more than 200 chronic lung disorders Interstitial lung diseases are named after the tissue between the air sacs of the lungs called the interstitium. This tissue can be affected by fibrosis (scarring) and lead to respiratory insufficiency.	
730	CigSmoking	Cigarette Smoking	This field applies to cigarettes only. Select: Never Smoked; Past Smoker (stopped > 1 month prior to operation); or Current Smoker. “Current smoker” should be selected if the patient stopped smoking < than 1 month prior to surgical procedure. This field is Required for Record Inclusion. If missing data, the entire record will be excluded from the analysis.	
How do you code smoking status if there is conflicting documentation in the chart?			Code yes to smoking if any provider documents it in the record and capture the highest number of pack years documented.	
740	PackYearKnown	Pack Years Known or can be estimated		
750	PackYear	Pack-Years Of Cigarette Use	Multiply the average number of packs per day by the	

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
			number of years the patient smoked.	
760	PFT	Pulmonary Function Tests Performed	Note that per the definition, PFTs are part of the NQF measure set and are required before any major anatomic lung resection. This field is Required for Record Inclusion. If missing data, the entire record will be excluded from the analysis.	

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The following NQF measure specifications apply to 0458 PFTs before Major Anatomic Lung Resection (Pneumonectomy, Lobectomy, or Formal Segmentectomy).

S.6. Numerator Details

Number of patients undergoing major anatomic lung resection who undergo at least one pulmonary function test; PFT (STS General Thoracic Surgery Database, Version 2.2, sequence number 760) is marked as "Yes"

S.9. Denominator Details

1. Primary procedure is one of the following CPT codes:
   - Removal of lung, total pneumonectomy; (32440)
   - Removal of lung, sleeve (carinal) pneumonectomy (32442)
   - Removal of lung, total pneumonectomy; extrapleural (32445)
   - Removal of lung, single lobe (lobectomy) (32480)
   - Removal of lung, two lobes (bilobectomy) (32482)
   - Removal of lung, single segment (segmentectomy) (32484)
   - Removal of lung, sleeve lobectomy (32486)
   - Removal of lung, completion pneumonectomy (32488)
   - Resection of apical lung tumor (e.g., Pancoast tumor), including chest wall resection, without chest wall reconstruction(s) (32503)
   - Resection of apical lung tumor (e.g., Pancoast tumor), including chest wall resection, with chest wall reconstruction (32504)
   - Thoracoscopy, surgical; with lobectomy (32663)
   - Thoracoscopy with removal of a single lung segment (segmentectomy) (32669)
   - Thoracoscopy with removal of two lobes (bilobectomy) (32670)
   - Thoracoscopy with removal of lung, pneumonectomy (32671)
2. Non-missing data on whether or not PFT was done
3. Status of Operation (Status - STS General Thoracic Surgery Database, Version 2.2, sequence number 1420) is marked as “Elective”
4. Only analyze the first operation of the hospitalization meeting criteria 1-3

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
	S.11. Denominator Exclusion Details			
	Pulmonary function tests performed (PFT - STS General Thoracic Surgery Database, Version 2.2, sequence number 760) is marked as "No" and reason PFT not performed (PFT NotPerReas – STS GTSD, Version 2.2, sequence number 770) is marked "tracheostomy or ventilator," "patient unable to perform," or "urgent or emergent status."			
770	PFTNotPerReas	PFT Not Performed Reason	There are acceptable reasons not to perform PFTs. These will be included in the NQF exclusions: Not Major Lung Resection Never smoked, no lung disease Patient unable to perform Tracheostomy or ventilator dependent Urgent or emergent procedure	
April 2014		A wedge is not a major anatomic resection, even if therapeutic, but is a major (analyzed case) if it is therapeutic. The PFT field 770 should be answered "Not a major lung resection" for therapeutic (analyzed) wedges.		
780	FEV	Forced Expiratory Volume Test Performed	This field is Required for Record Inclusion. If missing data, the entire record will be excluded from the analysis.	
790	FEVPred	FEV1 Predicted	This field is Required for Record Inclusion. If missing data, the entire record will be excluded from the analysis.	
Should the FEV1 be pre or post bronchodilator? What timeframe is acceptable preop? *ADDENDUM October 2013*			The value should ideally be taken from a good quality spirometry exam prior to surgery. Choose the highest value reported for % predicted, whether pre or post bronchodilator. Do not use values obtained more than ~~6 months~~ prior to surgery. *Do not use values obtained more than **12 months** prior to surgery.*	
800	DLCO	DLCO Test Performed	The diffusing capacity (DLCO) is a test of the integrity of the alveolar-capillary surface area for gas transfer.	
Should DLCO be corrected for volume or hemoglobin? What timeframe is acceptable preop? *ADDENDUM October 2013*			Use the uncorrected/unadjusted DLCO. Do not use values obtained more than ~~6 months~~ prior to surgery. *Do not use values obtained more than **12 months** prior to surgery.*	
810	DLCOPred	DLCO Predicted	The diffusing capacity (DLCO) may be reduced, <80% predicted, in disorders such as emphysema, pulmonary fibrosis, obstructive lung disease, pulmonary embolism, pulmonary hypertension and anemia. DLCO>120% of predicted may be seen in normal lungs, asthma, pulmonary hemorrhage, polycythemia, and left to right intracardiac shunt.	

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
820	Zubrod	Zubrod Score	Select: Normal activity, no symptoms; Symptoms, fully ambulatory; Symptoms, in bed <= 50% of time; Symptoms, in bed > 50% but < 100% of time; Bedridden, or Moribund. Code the most severe Zubrod score within two weeks of surgery. For example: a patient enters hospital with Zubrod score of 1 but after 1 week in the hospital, the Zubrod score changes to 3, then the score entered on the data sheet should be "3". A new data collection form generated for a subsequent surgery may have a different Zubrod score than the previous data collection form (previous surgery). This field is Required for Record Inclusion. If missing data, the entire record will be excluded from the analysis.	This score is used in risk calculation therefore it is important not to "under code".
There is confusion about how and when to capture the Zubrod score. Since it is part of the risk model it is important to be consistent and accurate when coding this element.			**Clarification and Examples** Use the score that most accurately represents the patient's status at the time of surgery. If a patient is ambulatory at the time of admission but deteriorates in the hospital, becoming bedridden, capture the bedridden status. Conversely, if the patient comes in bedridden, but is stabilized and ambulatory just prior to surgery, capture ambulatory.	
830	LungCancer	Lung Cancer	If Lung Cancer documented, and resection performed, complete both Clinical Staging (ClinStageLungT, ClinStageLungN, and ClinStageLungM) AND Pathological Staging (PathStageLungT, PathStageLungN, and PathStageLungM). This field is Required for Record Inclusion. If missing data, the entire record will be excluded from the analysis.	
840	ClinStagDoneLung	Clinical Staging Performed For Lung Cancer	Clinical staging is based on evidence gathered before primary treatment. Diagnostic and/or radiologic tests are	

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SeqNo	**ShortName**	**LongName**	**DataFieldIntent**	**FieldNameClarification**
			performed to determine the type and extent of the cancer and used to guide treatment decisions.	
May 2014	Patient (RR) had a VATS wedge for lung cancer in October 2013. Now with recurrence and is having a completion lobectomy. Can I use the Clinical Staging Methods that were done prior to the first surgery, or must they be since the first surgery and up to the present procedure?		If it is a new primary, it has to be staged. If it's mets, then no need to stage.	
850	ClinStagLungBronc	Clinical Staging Method - Lung - Bronchoscopy	Bronchoscopy is a procedure in which a cylindrical fiberoptic scope is inserted into the airways. This scope contains allows the visual examination of the lower airways. During a bronchoscopy, a physician can visually examine the lower airways, including the larynx, trachea, bronchi, and bronchioles. The procedure is used to examine the mucosal surface of the airways for abnormalities that might be associated with a variety of lung diseases. Its use includes the visualization of airway obstructions such as a tumor, or the collection of specimens for the diagnosis of cancer originating in the bronchi of the lungs (bronchogenic cancer). It can also be used to collect specimens for culture to diagnose infectious diseases such as tuberculosis. The type of specimens collected can include sputum (composed of saliva and discharges from the respiratory passages), tissue samples from the bronchi or bronchioles, or cells collected from washing the lining of the bronchi or bronchioles. The instrument used in bronchoscopy, a bronchoscope, is a slender cylindrical instrument containing a light and an eyepiece. There are two types of bronchoscopes, a rigid tube that is sometimes referred to as an open-tube or ventilating bronchoscope, and a more flexible fiber optic tube. This tube contains four smaller passages—two for light to pass through, one for seeing through and one that can accommodate medical instruments that may be used for biopsy or suctioning, or that medication can be passed through.	
860	ClinStagLungEBUS	Clinical Staging Method - Lung	EBUS is an invasive procedure in which physicians use	

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
		- EBUS	ultrasound devices inside the airways and the lung for exploration of the structures of airway walls, the surrounding mediastinum, and the lungs.	
870	ClinStagLungEUS	Clinical Staging Method - Lung - EUS	A procedure that combines endoscopy and ultrasound to obtain images and information about the digestive tract and the surrounding tissue and organs. In EUS a small ultrasound transducer is installed on the tip of the endoscope allowing the transducer to get close to the organs inside the body so the resultant ultrasound images are often more accurate and detailed than ones obtained by traditional ultrasound.	
880	ClinStagLungMedia	Clinical Staging Method - Lung - Mediastinoscopy/Chamberlain	Mediastinoscopy is a procedure that enables visualization of the contents of the mediastinum, usually for the purpose of obtaining a biopsy. Mediastinoscopy is often used for staging of lymph nodes of lung cancer or for diagnosing other conditions affecting structures in the mediastinum such as sarcoidosis or lymphoma. Mediastinoscopy involves making an incision approximately 1 cm above the suprasternal notch of the sternum, or breast bone. Dissection is carried out down to the pretracheal space and down to the carina. A scope (mediastinoscope) is then advanced into the created tunnel which provides a view of the mediastinum. The scope may provide direct visualization or may be attached to a video monitor. The Chamberlain procedure is used to biopsy lymph nodes in the center of the chest, or to biopsy a mass in the center of the chest. The Chamberlain procedure differs from a cervical mediastinoscopy by the location of the incision, and the location of the lymph nodes or mass to be biopsied. The Chamberlain procedure is used to biopsy lymph nodes or masses in the aorto-pulmonary window on the left side of the chest, or nodes in the hilar areas of the lung. (In contrast, the cervical mediastinoscopy	

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
			procedure is used to biopsy nodes or masses to the front or side of the trachea, or windpipe.) The aorto-pulmonary window is the area in the center of the chest bound by the aorta superiorly, and the pulmonary artery inferiorly. This area contains lymph nodes that filter lymph coming from the left lung, especially the left upper lobe. If a lung cancer is present in the left lung, the Chamberlain procedure is useful for staging the cancer (determining the extent of spread.) The hilar areas of the lung (the hilum) are the areas of the lung where the pulmonary artery and vein (the blood supply) join the lung.	
890	ClinStagLungPET	Clinical Staging Method - Lung - PET or PET/CT	Positron emission tomography, also called PET imaging or a PET scan, is a type of nuclear medicine imaging. Nuclear medicine or radionuclide imaging procedures are noninvasive and, with the exception of intravenous injections, are usually painless medical tests that help diagnose medical conditions. These imaging scans use radioactive materials called radiopharmaceuticals or radiotracers.	
900	ClinStagLungCT	Clinical Staging Method - Lung - CT	Computed tomography (CT) scan, also called computerized axial tomography (CAT) scan, is used to create cross-sectional images of structures in the body. In this procedure, x-rays are taken from many different angles and processed through a computer to produce a three-dimensional (3-D) image called a tomogram.	
910	ClinStagLungVATS	Clinical Staging Method - Lung - VATS	Video-assisted thoracoscopic surgery (VATS) is a minimally invasive surgical technique used to diagnose and treat problems in the chest. During this surgery, a tiny camera (thoracoscope) and surgical instruments are inserted in the chest through small incisions. The thoracoscope transmits images of the inside of the chest onto a video monitor, guiding the surgeon performing the procedure. Video-assisted thoracoscopic surgery (VATS) can be used for many purposes, ranging from a	

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
			biopsy to removal of tumors or entire lobes from the lung.	
920	ClinStagLungLap	Clinical Staging Method - Lung - Laparoscopy	Laparoscopy is a minimally invasive procedure used as a diagnostic tool and surgical procedure that is performed to examine the abdominal and pelvic organs, or the thorax, head, or neck. Tissue samples can also be collected for biopsy using laparoscopy and malignancies treated when it is combined with other therapies. Laparoscopy can also be used for some cardiac and vascular procedures.	
921	ClinStagLungOth	Clinical Staging Method - Lung-Other	Indicate if any other method/technology was used for clinical staging.	
930	ClinStageLungT	Lung CA Tumor size - T	Choose from the list, if more than one tumor is present, choose the largest. American Joint Committee on Cancer 2010	
How are small nodules reported on lung CT addressed for staging?			If there is no biopsy, the PET CT is negative, nodules are < 5 mm and the surgeon/oncologist chooses not to address these, do not consider them when staging. 40% of people over the age of 50 have small lung nodules which are not cancerous.	
940	LCInvAdjStr	Lung Cancer- Invasion of Adjacent Structures	Based on preop testing, does tumor appear to invade adjacent structures? American Joint Committee on Cancer 2010	Choose all that apply
950	ClinStageLungTInvPl	Clinical Staging Lung Tumor Invasive Pleura	This refers to visceral pleura only. If the tumor invades the parietal pleura, code as invading the chest wall (next field)	
960	ClinStageLungTInvCW	Clinical Staging Lung Tumor Invasive Chest Wall	Code tumors that invade the parietal pleura as invading the chest wall.	
970	ClinStageLungTInvDia	Clinical Staging Lung Tumor Invasive Diaphragm		
980	ClinStageLungTInvPN	Clinical Staging Lung Tumor Invasive Phrenic Nerve		
990	ClinStageLungTInvPer	Clinical Staging Lung Tumor Invasive Pericardium		
1000	ClinStageLungTInvMB	Clinical Staging Lung Tumor Invasive Main Bronchus		
1010	ClinStageLungTInvOb	Clinical Staging Lung Tumor		

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
		Obstructive		
1020	ClinStageLungTInvNod	Clinical Staging Lung Tumor Invasive Nodule(s)		
1030	ClinStageLungTInvMed	Clinical Staging Lung Tumor Invasive Mediastinum		
1040	ClinStageLungTInvHt	Clinical Staging Lung Tumor Invasive Heart		
1050	ClinStageLungTInvGrVes	Clinical Staging Lung Tumor Invasion Great Vessels		
1060	ClinStageLungTInvTr	Clinical Staging Lung Tumor Invasion Trachea		
1070	ClinStageLungTInvRLN	Clinical Staging Lung Tumor Invasive Recurrent Laryngeal Nerve		
1080	ClinStageLungTInvEo	Clinical Staging Lung Tumor Invasive Esophagus		
1090	ClinStageLungTInvVB	Clinical Staging Lung Tumor Invasive Vertebral Body		
1100	ClinStageLungTInvC	Clinical Staging Lung Tumor Invasive Carina		
1110	ClinStageLungTInvNDL	Clinical Staging Lung Tumor Invasive Nodule(s) Diff Lobe		
1120	ClinStageLungN	Lung Cancer Nodes - N	Code nodal involvement if any. Ipsilateral = same side as tumor, contralateral= opposite side	
1130	ClinStageLungM	Lung Cancer Metastasis - M	Metastasis or metastatic disease (sometimes abbreviated mets), is the spread of cancer from one organ to another non-adjacent organ or part.	
1140	EsophCancer	Esophageal Cancer	If Esophageal Cancer documented, “Yes”, and resection performed, complete both Clinical Staging (ClinStageEsophT, ClinStageEsophN, ClinStageEsophM, ClinStageEsophH, and ClinStageEsophG) AND Pathological Staging (PathStageEsophT, PathStageEsophN, PathStageEsophM, PathStageEsophH, and PathStageEsophG).	

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SeqNo	**ShortName**	**LongName**	**DataFieldIntent**	**FieldNameClarification**
			This field is Required for Record Inclusion. If missing data, the entire record will be excluded from the analysis.	
Are there guidelines (measurements) for coding esophageal tumor location?			Use these measurements in cm from incisors: Upper third = 17-25 cm Middle third = 26-34 cm Lower third = 35-42 cm	
1150	ClinStagDoneEsoph	Clinical Staging Performed For Esophageal Cancer	Clinical staging is the Pre-Treatment estimate of cancer. Indicate whether clinical staging was performed and if so choose the method(s)	Choose all that apply
1160	ClinStagEsophBronc	Clinical Staging Method - Esophageal - Bronchoscopy	Bronchoscopy is a procedure in which a cylindrical fiberoptic scope is inserted into the airways. This scope contains allows the visual examination of the lower airways. During a bronchoscopy, a physician can visually examine the lower airways, including the larynx, trachea, bronchi, and bronchioles. The procedure is used to examine the mucosal surface of the airways for abnormalities that might be associated with a variety of lung diseases. Its use includes the visualization of airway obstructions such as a tumor, or the collection of specimens for the diagnosis of cancer originating in the bronchi of the lungs (bronchogenic cancer). It can also be used to collect specimens for culture to diagnose infectious diseases such as tuberculosis. The type of specimens collected can include sputum (composed of saliva and discharges from the respiratory passages), tissue samples from the bronchi or bronchioles, or cells collected from washing the lining of the bronchi or bronchioles. The instrument used in bronchoscopy, a bronchoscope, is a slender cylindrical instrument containing a light and an eyepiece. There are two types of bronchoscopes, a rigid tube that is sometimes referred to as an open-tube or ventilating bronchoscope, and a more flexible fiber optic tube. This tube contains four smaller passages—two for light to pass through, one for	

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
			seeing through and one that can accommodate medical instruments that may be used for biopsy or suctioning, or that medication can be passed through.	
1170	ClinStagEsophEBUS	Clinical Staging Method - Esophageal - EBUS	EBUS is an invasive procedure in which physicians use ultrasound devices inside the airways and the lung for exploration of the structures of airway walls, the surrounding mediastinum, and the lungs.	
1180	ClinStagEsophEUS	Clinical Staging Method - Esophageal - EUS	A procedure that combines endoscopy and ultrasound to obtain images and information about the digestive tract and the surrounding tissue and organs. In EUS a small ultrasound transducer is installed on the tip of the endoscope allowing the transducer to get close to the organs inside the body so the resultant ultrasound images are often more accurate and detailed than ones obtained by traditional ultrasound.	
1190	ClinStagEsophMedia	Clinical Staging Method - Esophageal - Mediastinoscopy/Chamberlain	Mediastinoscopy is a procedure that enables visualization of the contents of the mediastinum, usually for the purpose of obtaining a biopsy. Mediastinoscopy is often used for staging of lymph nodes or for diagnosing other conditions affecting structures in the mediastinum such as sarcoidosis or lymphoma. Mediastinoscopy involves making an incision approximately 1 cm above the suprasternal notch of the sternum, or breast bone. Dissection is carried out down to the pretracheal space and down to the carina. A scope (mediastinoscope) is then advanced into the created tunnel which provides a view of the mediastinum. The scope may provide direct visualization or may be attached to a video monitor. The Chamberlain procedure is used to biopsy lymph nodes in the center of the chest, or to biopsy a mass in the center of the chest. The Chamberlain procedure differs from a cervical mediastinoscopy by the location of the incision, and the location of the lymph nodes or	

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
			mass to be biopsied. The Chamberlain procedure is used to biopsy lymph nodes or masses in the aorto-pulmonary window on the left side of the chest, or nodes in the hilar areas of the lung. (In contrast, the cervical mediastinoscopy procedure is used to biopsy nodes or masses to the front or side of the trachea, or windpipe.) The aorto-pulmonary window is the area in the center of the chest bound by the aorta superiorly, and the pulmonary artery inferiorly.	
1200	ClinStagEsophPET	Clinical Staging Method - Esophageal - PET or PET/CT	Positron emission tomography, also called PET imaging or a PET scan, is a type of nuclear medicine imaging. Nuclear medicine or radionuclide imaging procedures are noninvasive and, with the exception of intravenous injections, are usually painless medical tests that help diagnose medical conditions. These imaging scans use radioactive materials called radiopharmaceuticals or radiotracers.	
1210	ClinStagEsophCT	Clinical Staging Method - Esophageal - CT	Computed tomography (CT) scan, also called computerized axial tomography (CAT) scan, is used to create cross-sectional images of structures in the body. In this procedure, x-rays are taken from many different angles and processed through a computer to produce a three-dimensional (3-D) image called a tomogram.	
1220	ClinStagEsophVATS	Clinical Staging Method - Esophageal - VATS	Video-assisted thoracoscopic surgery (VATS) is a minimally invasive surgical technique used to diagnose and treat problems in the chest. During this surgery, a tiny camera (thoracoscope) and surgical instruments are inserted in the chest through small incisions. The thoracoscope transmits images of the inside of the chest onto a video monitor, guiding the surgeon performing the procedure. Video-assisted thoracoscopic surgery (VATS) can be used for many purposes, ranging from a biopsy to removal of tumors.	
1230	ClinStagEsophEGD	Clinical Staging Method -	Esophagogastroduodenoscopy (EGD) is an examination	

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SeqNo	**ShortName**	**LongName**	**DataFieldIntent**	**FieldNameClarification**
		Esophageal - EGD	of the lining of the esophagus, stomach, and upper duodenum with a small camera (flexible endoscope) which is inserted down the throat.	
1240	ClinStagEsophLap	Clinical Staging Method - Esophageal - Laparoscopy	Laparoscopy is a minimally invasive procedure used as a diagnostic tool and surgical procedure that is performed to examine the abdominal and pelvic organs. Tissue samples can also be collected for biopsy using laparoscopy and malignancies treated when it is combined with other therapies.	
1241	ClinStagEsophOth	Clinical Staging Method - Esophageal - Other	Indicate if any other method/technology was used for clinical staging.	
1250	ClinStageEsophT	Esophageal Cancer Tumor - T	Record T based on EUS if done, if not done estimate T based on CT or PET/CT. No esophageal thickening= T1. Choose T2 if esophageal thickening is present.	
			If thickening noted on CT scan, code as T2. If stricture is noted on endoscopy or barium swallow or the patient is experiencing dysphagia, code as T3.	
1260	ClinStageEsophN	Esophageal Cancer Nodes - N	Indicate nodal status. Nodes > 1cm on CT or PET/CT or EUS are considered positive. All positive PET nodes are considered positive. Count biopsy positive nodes. Choose Nx if nodes cannot be assessed.	
1270	ClinStageEsophM	Esophageal Cancer Metastasis - M	Metastasis or metastatic disease (sometimes abbreviated mets), is the spread of cancer from one organ to another non-adjacent organ or part.	
1300	CategoryPrim	Category Of Disease - Primary	Choose the primary diagnosis or reason for the procedure. This field is Required for Record Inclusion. If missing data, the entire record will be excluded from the analysis.	May 2014- Input should be based upon the final pathology report. If you entered a Category of Disease before final path, then you need to change it based on the final pathology. Example, if you start with a diagnosis of "abnormal radiological finding", a wedge resection is done and cancer is found, the diagnosis should be changed to cancer based upon the pathology report.
1310	CategoryPrimOth	Category Of Disease - Primary	Capture unlisted primary diagnosis here after carefully	

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SeqNo	**ShortName**	**LongName**	**DataFieldIntent**	**FieldNameClarification**
		- Other Specify	reviewing choices above.	
1311	CategoryPrimOthICD	Category Of Disease - Primary - Other ICD	The intent is to track category of disease codes for possible inclusion in next version and /or for internal analysis.	
1320	CategorySecond	Category Of Disease - Secondary	Secondary diagnosis is captured here	June 2013- The Secondary diagnosis can be left blank. As long as a primary diagnosis is selected, the record will be accepted as complete without having a secondary indicated.
1330	CategorySecondOth	Category Of Disease - Secondary - Other Specify	Capture unlisted secondary diagnosis here after carefully reviewing choices above.	
1331	CategorySecondOthICD	Category Of Disease - Secondary - Other ICD	The intent is to track category of disease codes for possible inclusion in next version and /or for internal analysis.	
1340	SurgDt	Date Of Surgery	This field is Required for Record Inclusion. If missing data, the entire record will be excluded from the analysis.	
1350	OREntryT	OR Entry Time	This field is Required for Record Inclusion. If missing data, the entire record will be excluded from the analysis.	
1360	ORExitT	OR Exit Time	This field is Required for Record Inclusion. If missing data, the entire record will be excluded from the analysis.	Even if the thoracic surgeon was present for only part of the case, code the entire time.
1370	AnesthStartT	Anesthesia Start Time	This is the start of anesthetic management, placing lines, induction of anesthesia.	
1380	AnesthEndT	Anesthesia End Time	If the patient is extubated in the OR, indicate time of extubation otherwise use OR exit time as anesthesia end time.	
1390	ProcStartT	Procedure Start Time	This field is Required for Record Inclusion. If missing data, the entire record will be excluded from the analysis.	
1400	ProcEndT	Procedure End Time	This field is Required for Record Inclusion. If missing data, the entire record will be excluded from the analysis.	
1410	MultiDay	Multi-Day Operation	These are cases that continue through midnight.	

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SeqNo	**ShortName**	**LongName**	**DataFieldIntent**	**FieldNameClarification**
1420	Status	Status	This indicates the clinical status of the patient at the time of surgery. Emergent- procedure must be performed as soon as possible, within 24 hours. Urgent-not emergent or elective but necessary within the same hospital stay. Elective- The patient is stable in the days or weeks prior to surgery. Palliative- The procedure is being done to provide comfort or relief	
Can you give urgent vs. emergent clinical examples?			Emergent status is coded for cases that require immediate intervention to prevent life threatening deterioration or death such as (but not limited to) esophageal perforation, severe hemorrhage or massive hemoptysis. Urgent status is coded for cases in which the operation must be performed before the patient can be discharged. Examples of urgent cases would include bronchopleural fistula, pneumothorax or decortication for empyema. Cases that are performed during the same hospitalization for convenience would not be considered urgent. A medical patient with an incidental CXR finding who undergoes a diagnostic bronchoscopy or mediastinoscopy prior to discharge would have the procedure status coded as elective.	
1430	Reop	Reoperation	Did the patient have a previous operation in the same cavity or organ that affects this operative field?	
December 2013	If a patient is returned to the operating room from the post anesthesia care unit after the initial surgery, before they are sent to a patient disposition location (ICU, Regular Floor Bed, etc.), is the second surgery considered a new operation, thus requiring a separate STS data collection forms?		For this purpose, PACU would = intermediate care. Yes, fill out a 2nd form.	
1440	Robotic	Robotic Technology Assisted	Was robotic technology used for any part of the procedure?	
1450	IntraopPRBC	Intraoperative Packed Red Blood Cells		
1460	IntraopPRBCNum	Intraoperative Packed Red Blood Cells - Number		
1470	ASA	ASA Classification	ASA Classification is determined by the anesthesiologist of the procedure based on the patient's condition. This is a standard risk scale for patients	

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SeqNo	**ShortName**	**LongName**	**DataFieldIntent**	**FieldNameClarification**
			undergoing anesthesia. This field is Required for Record Inclusion. If missing data, the entire record will be excluded from the analysis.	
1480	Proc	Procedure	Check ALL the procedures that were performed. Complete Primary to indicate Primary procedure. The General Thoracic Surgery Database requires a separate data collection form for every OR or procedural area visit for major general thoracic procedure(s).	
June 2013	Procedure done was 1)Left Thoractomy with upper lobectomy 2)Medialstinal Lymph node dissection. The only procedue code that I can find is 38746 which is Thoracic Lymphadenectomy, regional, including mediastinal and peritracheal nodes. There were no Peritacheal nodes removed, but there were mediastinal. Is it appropriated to use this Code (38746) for this procedue?		No, don't use this code, not for just one. It's used for sampling.	
Oct. 2013	Is an Incisionless Transoral Fundoplication procedure listed in the Thoracic Database Version 2.2, along with a CPT Code? I cannot find it. How would I list that procedure?		Code "other" & write in the procedure.	
Oct. 2013	Pt has: 1. Redo Right Thoracotmy 2. Right chest partial decortication 3. Pleurodisis Code 32225 will be used for the Partial Decort. How do we code the Plurodisis? Code 32650 appears to be used only if done with thoracoscopy, not thoracotomy.		Code both. But, 2430 Decortication, pulmonary, partial (32225) will be the primary procedure.	
1490	ProcOth	Procedure Unlisted - Specify		
1491	ProcOthCPT	Procedure Unlisted - CPT		
1500	Primary	Primary Procedure		
Oct. 2013	What STS procedure code should I use for a VATS with closure of BP fistual? A Thoracoplasty was not done. Can I use 32815- open closure of major BP fistula even though the procedure was done thorascopically??		Yes, code 2860 Open closure of major bronchial fistula (32815)	
1510	LungResect	Lung Resection Performed		
1520	Laterality	Laterality		
1530	PatDisp	Patient Disposition	The intent is to capture the level of care following OR/PACU recovery period. Select ICU; Intermediate Care Unit; Regular Floor Bed;	

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
			Not Applicable (Expired in OR). This field is Required for Record Inclusion. If missing data, the entire record will be excluded from the analysis. ICU level of care counts as ICU day- ex. PACU used for ICU overflow Do not include PACU stay unless patient was kept beyond the recovery phase as described above.	
1532	ICUVisitInit	Initial Visit To ICU	All ICU days should be included on first procedure	
1533	ICUVisitInitDays	Initial ICU Visit Days		
1534	ICUVisitAdd	Additional Visit To ICU		
1535	ICUVisitAddDays	Additional Visit To ICU Days		
1540	PathStageLungT	Pathologic Staging - Lung Cancer - T	Use the final pathology report to code the lung tumor T descriptor.	If Lung Cancer documented, “Yes”, and lung resection performed, complete both Clinical Staging (ClinStageLungT, ClinStageLungN, and ClinStageLungM) AND Pathological Staging (PathStageLungT, PathStageLungN, and PathStageLungM). Reference: Goldstraw P, Crowley J et al. The IASLC Lung Cancer Staging Project: proposals for the revision of the TNM stage groupings in the forthcoming (seventh) edition of the TNM Classification of malignant tumours. J Thorac Oncol 2007; 2 (8): 706-714.
1550	PathStageLungN	Pathologic Staging - Lung Cancer - N	Use the final pathology report to code the lung tumor node(s)	
1560	PathStageLungM	Pathologic Staging - Lung Cancer - M	Use the final pathology report to code the lung tumor M descriptor.	
1570	LungCANodes	Lung Cancer - Number of Nodes	Enter the number of nodes sampled/harvested during this procedure.	
1580	LungCAPathMarg	Lung Cancer - Pathology	Use the final pathology report to code whether the	

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
		Margins	surgical margins were positive.	
1590	PathStageEsophT	Pathologic Staging - Esophageal Cancer - T	Use the final pathology report to code the appropriate T descriptor for the primary tumor.	If Esophageal Cancer documented, "Yes" and resection performed, complete both Clinical Staging AND Pathological Staging.
1600	PathStageEsophN	Pathologic Staging - Esophageal Cancer - N	Use the final pathology report to code assessment of the node(s)	
1610	PathStageEsophM	Pathologic Staging - Esophageal Cancer - M	Use the final pathology report to code metastatic status.	
June 2013	Our patient had an esophagectomy and her final path was 'small cell carcinoma'. On the Data Collection Form it only allows you to enter either Squamous or Adeno histology. Please advise how to enter this.		It should be listed in the pathology report (H1 if Squamous, H2 if Adeno) . You should reread it & it it's not there, leave blank. You may wish to notate in your files why it was left blank for your reference.	
1620	PathStageEsophH	Pathologic Staging - Esophageal Cancer - H	Use the final pathology report to code histologic type.	
1630	PathStageEsophG	Pathologic Staging - Esophageal Cancer - G	Use the final pathology report to code the grade of differentiation. If a range is reported choose the worst differentiation.	
1640	EsophCANodes	Esophageal Cancer - Number of Nodes	Enter the number of nodes sampled/harvested during this procedure.	
1650	EsophCAPathMarg	Esophageal Cancer - Pathology Margins	Use the final pathology report to code whether the surgical margins were positive.	
1710	POEvents	Postoperative Events Occurred	This field is meant to capture any instance of postoperative complications listed below that the patient developed due to the operation for which you are recording a Data Collection Sheet. These need to have occurred anytime during the patient's entire hospital stay or until 30 days post-op if they were discharged. This does not include events that occur during the operation or were present preoperatively, such as atrial fibrillation.	
May 2014	When does the postoperative period begin for recording PO events? Is it when the patient leaves the OR suite (OR Exit Time) or is it the Procedure End Time (patient is still in the OR)?		Post op begins when the patient leaves the OR.	
1720	ReturnOR	Unexpected Return To The OR	The intent of this field is to ask if the patient went back to the Operating Room for any type of unexpected	Do not include scheduled trips, such as surveillance bronchs or additional OR

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			surgery during their stay at the hospital.	trips to assess original surgery.
1730	ReturnORRsn	Reason for Unexpected Return to the OR	Choose the primary reason the patient was taken back to the OR.	
1750	AirLeak5	Air Leak Greater Than Five Days		
1760	Atelectasis	Atelectasis Requiring Bronchoscopy		
1770	CPlEff	Post-op-Pleural Effusion Requiring Drainage	Include only effusions requiring drainage with thoracentesis or chest tube. Do not code medically managed effusions.	
1780	Pneumonia	Pneumonia	Three of the five criteria must be met. (fever, leukocytosis, CXR with infiltrate, positive sputum culture, antibiotic treatment) Note: atelectasis and effusions do not necessarily indicate pneumonia, and neither does a single positive sputum culture without the other criteria/clinical findings documented.	
1790	ARDS	Adult Respiratory Distress Syndrome	Diagnosis of ARDS in medical record, or documentation of all criteria.	
1800	RespFail	Respiratory Failure	Inadequate gas exchange resulting in hypoxia and or hypercarbia.	
1810	Bronchopleural	Bronchopleural Fistula	Indicate if the patient experienced a complete or partial dehiscence of the bronchial stump documented by bronchoscopy or other operative intervention in the post-operative period.	
1820	PE	Pulmonary Embolus	Documented evidence in the chart by a high probability VQ scan, pulmonary angiogram or CT scan of the chest.	
1830	Pneumo	Pneumothorax	Only code a pneumothorax that required reinsertion of a chest tube. Do not code pneumothorax mentioned on CXR but not treated.	
Oct. 2013	Patient went home with Heimlich Valve due to “small apical pneumothorax.” The definition for Post-op events states: "pneumothorax requiring chest tube reinsertion." This patient never had his removed, they just left it in. Does this count as a post op event or not? Thank you.		Code as air leak > 5 days, not pneumothorax.	
1840	Vent	Initial Vent Support >48 Hours	The length of initial ventilatory support should be noted once the patient has the endotracheal tube removed after	

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
			the operative procedure. For patients that are re-intubated in the operating room at the conclusion of the operation, this should still be considered initial ventilator support and not re-intubation.	
1850	Reintube	Reintubate	Do not include reintubation for a planned postop bronchoscopy or other planned procedure. For patients that are re-intubated in the operating room at the conclusion of the operation, this should still be considered initial ventilator support and not re-intubation.	
1860	Trach	Tracheostomy	Do not include changing out a tracheostomy tube that was present preoperatively or tracheostomy done intraoperatively, during the initial operation.	New DCF optional
			Do not include prophylactic mini tracheostomy performed on the day of surgery	
1870	OtherPul	Other Pulmonary Event	Pulmonary events not listed that extend the length of stay or impact the patient's outcome.	Example: BiPap
1880	AtrialArryth	Atrial Arrhythmia Requiring Treatment	This field is intended to capture new onset of atrial arrhythmias that requires treatment. Treatment may include medications to slow the heart rate, increase the blood pressure, or any anti-coagulation administered for embolic prophylaxis. This does not include those patients with a preoperative history of atrial arrhythmias.	Patients with an episode of Afib that does not require treatment do not meet this definition.
1890	VentArryth	Ventricular Arrhythmia Requiring Treatment		
1900	MI	Myocardial Infarct		
1910	DVT	DVT Requiring Treatment		
May 2014	Patient JS was being followed for a DVT, confirmed by Doppler post op, but this was chronic and showed "no significant interval change" from pre-op. DC Summary states patient "did not require full anticoagulation," although she did receive 6 1/2 days worth of sq heparin q8 hrs. I am unsure whether or not to consider this DVT a Post Operative Event. I'm inclined to say not, since it was present pre-op.		Correct, it's pre-existing.	
1920	OtherCV	Other Cardiovascular Event	Cardiovascular events not listed that extend the length of stay or affected the patient's outcome.	Example: Pericardial effusion, pericarditis
1930	GastricOutlet	Gastric Outlet Obstruction		

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1940	Ileus	Ileus		
1950	AnastoMed	Anastomosis Requiring Medical Treatment Only	Placement of a drain under image guidance (CT scan or ultrasound) is considered medical treatment of an anastomotic leak.	
1970	DilationEsoph	Dilation Of The Esophagus		December 2013 - This includes the entire 30-day post-op period.
1980	OtherGI	Any Other GI Event	Gastrointestinal events not listed that extended the length of stay or affected the patient's outcome.	
1990	PostopPRBC	Postoperative Packed Red Blood Cells		
April 2014	Pt has a thoracic procedure(esophagoscopy with removal of foreign body). 10 days later the pt has a surgery(repair of right brachial artery pseudoaneurysm with fasciotomy) which is NOT a thoracic procedure. 4 days AFTER the non-thoracic surgery, the pt has blood products. Should those blood products be captured on the thoracic database for the initial procedure? Or should the blood products NOT be captured because they were given after a second procedure? There is nothing in the training manual/specs to clarify.		This is a non-analyzed procedure so no post-op events need to be answered.	
2000	PostopPRBCUnits	Postoperative Packed Red Blood Cells - Units		
2010	UTI	Urinary Tract Infection	Positive urine culture and treatment required. Do not code based on urinalysis results.	
2020	UrinRetent	Urinary Retention		
May 2014	Do straight cath's count here or only full foley recatherizations that are left in place?		Yes, straight cath is a catheterization.	
2030	DischFoley	Discharged With Foley Catheter		
2040	Empyema	Empyema Requiring Treatment	Empyema refers to an infected pleural space requiring additional antibiotic coverage or placement of additional chest tubes/drains.	Empyema may be confirmed by thoracentesis drainage of cloudy fluid or frank pus. Fluid analysis, if performed, would likely reveal leukocytosis, pH < 7.2, glucose < 60, elevated LDH, elevated protein and positive cultures.
2060	SurgSiteInfect	Surgical Site Infection	A surgical site infection, according to the CDC, is a	A superficial surgical site infection

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			documented infection of areas opened or manipulated during the procedure. It can involve tissue related to the primary or secondary surgical incision(s). It may be: Superficial- involving skin and subcutaneous tissue Deep- involving deep soft tissue layers such as fascia and muscle Organ space infection- involving body cavity, such as empyema or mediastinitis.	(SSI) must meet the following criteria: Infection occurs within 30 days after the operative procedure and involves only skin and subcutaneous tissue of the incision and patient has at least 1 of the following: a. purulent drainage from the superficial incision b. organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision c. at least 1 of the following signs or symptoms of infection: pain or tenderness, localized swelling, redness, or heat, and superficial incision is deliberately opened by surgeon and is culture positive or not cultured. A culture-negative finding does not meet this criterion. D. diagnosis of superficial incisional SSI by the surgeon or attending physician. Do not report a stitch abscess (minimal inflammation and discharge confined to the points of suture penetration) as an infection. If the incisional site infection involves or extends into the fascial and muscle layers, report as a deep incisional SSI. Classify infection that involves both superficial and deep incision sites as deep incisional SSI.

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
				A deep incisional SSI (DIP or DIS) must meet the following criterion: Infection occurs within 30 days after the operative procedure and involves deep soft tissues (e.g., fascial and muscle layers) of the incision and patient has at least 1 of the following: a. purulent drainage from the deep incision but not from the organ/space component of the surgical site b. a deep incision spontaneously dehisces or is deliberately opened by a surgeon and is culture-positive or not cultured when the patient has at least 1 of the following signs or symptoms: fever (>38°C), or localized pain or tenderness. A culture-negative finding does not meet this criterion. c. an abscess or other evidence of infection involving the deep incision is found on direct examination, during reoperation, or by histopathologic or radiologic examination d. diagnosis of a deep incisional SSI by a surgeon or attending physician. An “organ /space” surgical site infection would include empyema or mediastinitis. The diagnosis of organ space infection must meet the following criteria according to the CDC: Infection occurs within 30 days after the operative procedure

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
				and infection involves any part of the body, beyond the skin incision, fascia, or muscle layers, that is opened or manipulated during the operative procedure and patient has at least 1 of the following: a. purulent drainage from a drain that is placed through a stab wound into the organ/space b. organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space c. an abscess or other evidence of infection involving the organ/space that is found on direct examination, during reoperation, or by histopathologic or radiologic examination d. diagnosis of mediastinitis, an organ/space SSI by a surgeon or attending physician.
2070	Sepsis	Sepsis	Evidenced by positive blood cultures in the medical record.	
2080	OtherInfect	Other Infection Requiring IV Antibiotics		
2090	CentNeuroEvt	New Central Neurological Event		
April 2014	If a patient has history of a stroke pre-operatively and has a stroke in the post-operative period. Would I mark yes to New Central Neurological Event?		Yes, it's a new event.	
2100	RecLarynParesis	Recurrent Laryngeal Nerve Paresis		
2110	Delirium	Delirium		
2120	OtherNeuro	Other Neurological Event		Example: Seizure

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
2140	RenFailRIFLE	Renal Failure - RIFLE Criteria	Creatinine must rise to 3 times baseline or be ≥ 4.0 with an acute rise of at least 0.5 and/ or a new requirement for dialysis. Example: pre op creatinine = 3.8 and the post op = 4.1 with no dialysis initiated- Do Not Code as New Renal Failure.	The post operative creatinine will be used to evaluate renal function according to the RIFLE criteria. The Acute Dialysis Quality Initiative, a multidisciplinary collaboration, defined a range of acute renal dysfunction called the RIFLE classification system. It is used to define grades of severity based on objective measurements. **STS will use the underlined serum creatinine values to analyze post op renal function. GFR and urine output will not be included at this time.** **Renal Failure criteria are highlighted. Classifications of Loss and End-stage disease are beyond the current scope of follow-up.** **Risk (R)** - Increase in serum creatinine level X 1.5 or decrease in GFR by 25%, or UO <0.5 mL/kg/h for 6 hours **Injury (I)** - Increase in serum creatinine level X 2.0 or decrease in GFR by 50%, or UO <0.5 mL/kg/h for 12 hours **Failure (F)** - Increase in serum creatinine level X 3.0, or serum creatinine level ≥4 mg/dL , with an acute rise of at least 0.5 or decrease in GFR by 75%,; UO <0.3 mL/kg/h for 24 hours, or anuria for 12 hours **Loss (L)** - Persistent ARF, complete loss of kidney function >4 weeks **End-stage kidney disease (E)** - Loss of kidney function >3 months Reference:

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
				http://ccforum.com/content/8/4/R204
2150	ChyloMed	Chylothorax Requiring Drainage/Medical Treatment Only	This indicates the use of non-operative measures to address a postoperative chylothorax and refers to cessation of oral intake, initiation of total parenteral nutrition, etc.	Chylothorax is identified by the milky appearance of pleural fluid, which, if analyzed would have triglyceride levels> 110 mg/dl
2170	OtherSurg	Other events requiring OR with general anesthesia		
2180	UnexpectAdmitICU	Unexpected Admission To ICU	Did the patient have an unexpected admission or re-admission to the ICU in the post-operative period? If so, then the answer to this question would be "yes."	
2190	DischDt	Discharge Date	This field is Required for Record Inclusion. If missing data, the entire record will be excluded from the analysis.	
2200	MtDCStat	Discharge Status	This field is Required for Record Inclusion. If missing data, the entire record will be excluded from the analysis.	
2210	DisLoctn	Discharge Location	If Alive, select Home; Extended Care/Transitional Care Unit/Rehab; Other Hospital; Nursing Home; Hospice; or Other.	
2230	Readm30Dis	Readmission within 30 days of Discharge	Do not include ER or clinic visits.	This is 30 days after discharge, not to be confused with 30 days after surgery, collected in the mortality field.
Patients undergo outpatient mediastinoscopy or bronchoscopy for staging and are then admitted for planned surgery a few weeks later. Is this coded as a readmission?			Code the initial procedure, if your surgeon wishes to capture nonanalyzed procedures, on the short form, which has no field for readmission. Outpatient visits are not considered admissions so subsequent admission within 30 days would not be considered a readmission.	
Oct. 2013	My patient is from out of state with no PCP listed in her home state. Following her surgical procedure in my state, she returned home. I have no way of following up to know if she was readmitted within 30 days of discharge. The only responses are Yes/No. How should I answer this question?		Leave blank. You can try calling the patient to find out whether she has been readmitted elsewhere.	
2240	Mt30Stat	Status 30 Days After Surgery	A process must be in place to determine patient's status at 30 days after surgery ~~after discharge~~. There must be NO default to "Alive". Please see STS Database News articles on the STS Web site regarding how to collect this information.	**Correction! This should be 30 days after surgery, not after discharge.**

SeqNo	ShortName	LongName	DataFieldIntent	FieldNameClarification
			Documentation must be completed and/or have the ability to replicate obtaining status upon request of an auditor. Note: Data marked as "Unknown" will not show up as missing in the Data Quality Report, but will not be included in analyses. This field is Required for Record Inclusion. If missing data, the entire record will be excluded from the analysis.	
2250	MtDate	Date Of Death		
2270	CTubeDis	Discharged With Chest Tube	Do not capture long term drainage devices.	
2290	IVAntibioOrdered	IV Antibiotics Ordered Within One Hour	Indicate "Yes" if an order was documented, regardless if patient actually received any IV antibiotics. Applies to Inpatients only.	If vancomycin or a fluoroquinolone is given, the timeframe is extended to 2 hours since these must be infused at a slower rate.
2300	IVAntibioGiven	IV Antibiotics Given Within One Hour	If "Not indicated for procedure" selected, appropriate documentation must be in medical record. Applies to Inpatients only.	If vancomycin or a fluoroquinolone is given, the timeframe is extended to 2 hours since these must be infused at a slower rate.
June 2013	If the patient is in ICU and already on multiple antibiotics do I code this as yes even though one is not specifically ordered for the surgery? Should these patients' antibiotics be stopped and the patient be given the prophylactic one instead or in addition?		Code "no." That is a physician decision.	
2310	CephalAntiOrdered	Cephalosporin Antibiotic Ordered	Indicate "Yes" if an order was documented for a first or second-generation cephalosporin antibiotic, regardless if the patient actually received the antibiotic. If "Not indicated for procedure" or "Not indicated due to documented allergy; another appropriate antibiotic given" selected, appropriate documentation must be in medical record. Applies to Inpatients only.	
2320	AntibioticDiscOrdered	Prophylactic Antibiotics Discontinuation Ordered	Indicate "Yes" if an order to discontinue was documented as per the definition. If "Not, due to documented infection" selected, substantiating documentation must be in medical record.	

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			Applies to Inpatients only.	
2330	DVTProphylaxis	DVT Prophylaxis Measures	Applies to Inpatients only.	
2340	SmokCoun	Smoking Cessation Counseling	Choose yes, no, refused or patient is a nonsmoker.	July 2013: For the purpose of this sequence number, a “nonsmoker” can mean either someone who has never smoked or someone who is no longer smoking. If they are not a current smoker then they won’t need smoking cessation counseling.