Hospital Inpatient Quality Reporting (IQR) Program

Inpatient Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Support Contractor

Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) v5.13 Review & Updates Question and Answer Summary Document

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The following document provides actual questions from audience participants. Webinar attendees submitted the following questions and subject-matter experts provided the responses during the live webinar. The questions and answers have been edited for grammar.

Transfer From Another Hospital or Ambulatory Surgery Center (ASC)

Question 1: **Would an outpatient chemotherapy unit transfer to the emergency department (ED) qualify as a transfer?**

Yes, you would select "Yes" for the *Transfer From Another Hospital or ASC* data element if the patient was received as a transfer from the outpatient department of an outside hospital.

Question 2: **Would a same day surgery or catheter lab at your hospital count as a transfer?**

No. If the patient was already at your hospital, you would select "No" for the *Transfer From Another Hospital or ASC* data element because the patient was not received as a transfer from an outside facility.

Severe Sepsis Present

Question 3: **Slide 10. What do "superscripted" and "footnoted" mean?**

These terms indicate that there is a symbol or notation next to the documentation or at the end of the line that refers the reader to another piece or additional information elsewhere in the medical record. Some electronic health records (EHRs) use superscripts that lead to a reference section. That section may have the time of documentation, the name of the person who made the note, or some additional explanations.

Question 4: **If using Epic as our EHR, are the dates/times displayed by the "HOVER" function considered superscripts or footnotes?**

In some EHRs, a window pops up when you hover the mouse over a piece of documentation. The pop-up window may display the date/time the documentation was entered. If the window displays the specified time for the particular piece of documentation, you could use it. Different EHRs have different functionality; CMS may allow your EHR's use of a hover time, a superscripted time, or a footnoted date and time as the specified time for a particular piece of documentation if they meet the

criteria identified in the respective data element for an abstracted date and time.

Abstraction of dates and times must meet two criteria: determining if the time stamp is specific to the documentation and meets the abstraction guidance and whether the time stamp will be available in an export of the medical record for a third-party reviewer if the case is selected for validation.

Question 5: **Slide 12. Does the order have to contain the condition that is being treated with an antibiotic to meet the requirement of suspected infection?**

For an inflammatory condition or sign or symptom of an infection to meet criteria A (infection), there must be associated documentation confirming it is an infection. This can be an antibiotic order in which the inflammatory condition or sign or symptom of an infection is documented as the reason for the antibiotic order, as referenced on slide 12, or narrative documentation that states the antibiotic was ordered for the inflammatory condition or sign of symptom. The inflammatory condition, or sign or symptom of infection does not have to be in the antibiotic order, but the documentation must indicate the antibiotic was ordered for the inflammatory condition or sign or symptom of infection.

Question 6: **Is the case excluded from the measure if the patient has been on intravenous (IV) antibiotics for 24 hours or more before the severe sepsis presentation?**

If the patient received an IV or intraosseous antibiotic within the 24 hours before severe sepsis presentation (up to and including 24 hours), they will meet the antibiotic administration requirement. If they also received that same antibiotic in the 48 hours prior to the 24-hour period before the *Severe Sepsis Presentation Time*, then the case would be excluded from the sepsis (SEP)-1 algorithm. Abstraction guidance limits the time frame for abstraction of antibiotics prior to the time of severe sepsis presentation to 72 hours.

Question 7: **Can you accept pneumonia listed on a chest x-ray (CXR) as an infection source without the order of an antibiotic?**

Yes, as long as it is physician/advance practice nurse (APN)/physician assistant (PA) or nursing documentation of pneumonia, the documentation of pneumonia on a CXR report would be acceptable.

Documentation of infections, such as pneumonia, does not require an antibiotic order to meet the infection clinical criterion. The documentation of the infection alone is acceptable for meeting criteria A.

Question 8: **Are pregnant patients in active delivery or with an epidural excluded?**

No. Pregnant patients in active delivery or receiving an epidural are not excluded from the measure. The *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element is used to help abstractors identify which systemic inflammatory response syndrome (SIRS) and sign of organ dysfunction criteria to use for abstraction of the *Severe Sepsis Present* data element. If you abstracted Value "1" for the *Pregnant 20 Weeks Through Day 3 Post-deliver* data element, you should use the pregnant 20 weeks through day 3 post-delivery clinical criteria for SIRS and sign of organ dysfunction; if you abstracted Value "2" you should use the non-pregnant clinical criteria to establish the presence of severe sepsis by clinical criteria.

Question 9: **Slide 22. Is the diagnosis of atrial fibrillation (A-fib) with rapid ventricular response (RVR) enough to exclude the elevated heart rate (HR), or is the actual rate required to be in the documentation?**

You would disregard the abnormal heart rate based on the physician/APN/PA documentation of A-fib with RVR as long as A-fib is documented as a chronic condition for the patient, as in the example on slide 22. The *Severe Sepsis Present* data element includes a table of terms that are defined by specific SIRS and organ dysfunction physiologic parameters. RVR is defined as a heart rate greater than 90. Because A-fib is documented with RVR, and RVR is defined as a heart rate greater than 90, documentation of the actual abnormal heart rate value is not required along with the A-fib diagnosis.

Question 10: **Slide 22. If a single physician documents chronic A-fib, likely worsened by infection, can the heart rate be used?**

Yes, you would use the heart rate because the documentation "chronic A-fib, likely worsened by infection" does not attribute the abnormal heart rates to the chronic condition (A-fib). Rather, it attributes the worsening of A-fib to an infection. Therefore, you would not disregard the abnormal heart rate based on that documentation.

Question 11: **Do patients who use continuous positive airway pressure (CPAP) at home, since it indicates chronic use, fall into the severe sepsis category?**

If there is documentation in the medical record indicating that the patient uses a CPAP machine at home, you would not use the start time of the CPAP in the hospital to meet criteria C (organ dysfunction) because it is not a new need for noninvasive mechanical ventilation. You would only use a new need for mechanical ventilation to establish criteria C. If the patient was on CPAP at home and there is documentation that they were started on bilevel positive airway pressure (BiPAP) or that they were placed on a ventilator at the hospital, then you can use the initiation of the BiPAP or the ventilator for the new need to establish organ dysfunction.

Question 12: **Is documentation of "sepsis exam completed," with no documentation of infection in the provider note, enough documentation of infection?**

No. Do not use documentation of "sepsis exam completed" for establishing criteria A (infection) for the *Severe Sepsis Present* data element. The updated guidance referenced in slide 35 ("Do not use physician/APN/PA documentation of a severe sepsis or septic shock exam or assessment being performed.") is in and specific to the *Severe Sepsis Present* and *Septic Shock Present* data elements. It refers to not using this type of documentation for establishing the presence of severe sepsis or septic shock, which includes the clinical criteria for establishing the presence of severe sepsis or septic shock.

Documentation of a sepsis, severe sepsis, or septic shock exam, assessment, or reassessment being performed indicates only that an exam, assessment, or reassessment was performed. It does not establish the presence or suspicion of an infection, sepsis, severe sepsis, or septic shock.

There were several other questions about the guidance in slide 35 that we would also like to address for clarification. Physician/APN/PA documentation that a sepsis, severe sepsis or septic shock exam, assessment or reassessment was completed is consistent with guidance in and acceptable for the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element. This type of documentation is sufficient to select Value "1" for that data element.

Question 13: **If a registered nurse (RN) documents a suspected infection in the sepsis screen prior to the physician documentation of infection, would you take the RN time over the physician time since it is earlier?**

Whether you use the nursing documentation or the physician documentation of an infection (criterion A) will depend on the timing of the other clinical criteria, SIRS (criterion B), and signs of organ dysfunction (criterion C). The nursing or physician/APN/PA documentation of an infection are both acceptable. Because the timing of all three criteria (A, B, and C) must be within six hours of each other, you would want to be sure the infection documentation time you end up using meets that timing requirement. The goal is to establish the earliest point that severe sepsis was identified as present. To do this, all three of the clinical criteria must be present, within six hours of each other, and you would use the time that the last clinical criterion of the three was met (criteria A, B, or C) to establish the earliest *Severe Sepsis Presentation Time*. This is because the time at which the last of the three criteria occurs is the point at which all three were present.

Question 14: **Does the documentation of "shock with sepsis" meet the criteria?**

Yes, with the new guidance added in Version (v)5.13 to the Inclusion Guidelines for Abstraction in the *Severe Sepsis Present* and *Septic Shock Present* data elements, documentation of "sepsis with shock" or "shock with sepsis" is acceptable for establishing the presence of severe sepsis and septic shock and selecting value "1" (Yes) for these data elements.

Repeat Lactate Level

Question 15: **Is the time frame for the repeat lactate level within six hours of *Severe Sepsis Presentation Time* or the *Initial Lactate Level Time*?**

The time frame for the *Repeat Lactate Level Collection* begins after the *Initial Lactate Level Collection Time* and ends six hours after the *Severe Sepsis Presentation Time*. Therefore, the repeat lactate must be collected within the six hours after *Severe Sepsis Presentation Time*.

Crystalloid Fluid Administration

Question 16: **The provider documented, "Will hold IV sepsis bolus because of anemia." Is this acceptable to abstract Value "1" for crystalloid fluids?**

No, this is not acceptable to abstract Value "1" for the *Crystalloid Fluid Administration* data element. The data element requires that a volume of fluid be ordered and administered. A volume of crystalloid fluids less than 30 mL/kg is acceptable, but there must be a lesser volume ordered, and the volume and the reason for a lesser volume must be included in the physician's documentation. Because the provider documentation example in the question does not include an order for any crystalloid fluids, and instead states "will hold" fluids, it is not acceptable for abstraction of Value "1" despite a documented reason (anemia).

Question 17: **Since the target volume cannot be zero, some providers have asked if a physician order of a 1 milliliter (mL) bolus will meet the criteria.**

There are several requirements that must be met for the *Crystalloid Fluid Administration* data element that make this question difficult to answer. Per the *Crystalloid Fluid Administration* data element, the fluid order must include the volume, type of fluid, and a rate of time over which to infuse the fluids. There must also be a documented infusion start time and either a rate at which the fluid was infused, an infusion duration, or an infusion end time. In addition, there must be documentation to confirm the fluid was infused at a rate greater than 125 mL/hour.

Septic Shock Present

Question 18: **Is "Sepsis with Shock" adequate documentation of septic shock?**

Yes. Physician/APN/PA documentation of "sepsis with shock" is abstracted the same as physician/APN/PA documentation of septic shock. With updates in v5.13 to the Inclusion Guidelines for Abstraction in the *Severe Sepsis Present* and *Septic Shock Present* data elements, documentation of "sepsis with shock" or "shock with sepsis" is acceptable for establishing the presence of severe sepsis and septic shock and selecting Value "1" (Yes) for these data elements.

Other Questions

Question 19: **When does v5.13 guidance go into effect?**

Specifications manual version 5.13 begins with discharges January 1, 2023, and goes through June 30, 2023.