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) v5.11a Measure Updates

Question and Answer Summary Document

Speakers

Noel Albritton, MSN, RN,
Lead Solutions Specialist
Behavioral Development and Inpatient and Outpatient
Measure Maintenance Support Contractor

Jennifer Witt, RN,
Senior Health Informatics Solutions
Behavioral Development and Inpatient and Outpatient
Measure Maintenance Support Contractor

Moderator

Candace Jackson, AND
Project Lead, Hospital IQR Program
Inpatient VIQR Outreach and Education Support Contractor

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

Question 1: **For blood pressure (BP) readings, can we use an arterial line reading?**

Yes, a BP documented from an arterial line can be used. The abstraction guidance does not specify or restrict which type of BP can be used. A documented systolic BP or a mean arterial pressure (MAP) that meets the criteria is acceptable whether it is an invasive or non-invasive BP reading.

Question 2: **With the change to the crystalloid fluids, are the bundle compliance elements met if the prescribing practitioner documents the rationale for giving less than the required 30 milliliter (mL)/kilogram (kg) volume?**

Yes, you would select Value "1" (Yes) for the *Crystalloid Fluid Administration* data element if the required physician/Advanced Practice Nurse (APN)/Physician Assistant (PA) documentation includes the volume and a reason for ordering the lesser volume. The order for the volume and documentation that the fluids were administered are also required.

Question 3: **If the volume to be administered is taking the place of the 30 mL/kg, must an actual volume be documented or ordered or is zero (0) mL acceptable documentation?**

Documentation of a volume of "0" mL would not be acceptable for the *Crystalloid Fluid Administration* data element. The physician documentation requirement for administering a volume less than 30 mL/kg, for manual version 5.11a, requires a volume documented by the physician/APN/PA along with a reason for ordering the lesser volume. This can be documented in mL or as a weight-based volume, such as mL/kg.

Question 4: **What is the smallest volume allowed for a patient with a fluid concern (e.g., fluid overload or congestive heart failure)? Can fluids be omitted if there is a documented concern or reason?**

The *Crystalloid Fluid Administration* data element abstraction guidance does not provide a minimum required volume. However, there must be a volume ordered, and that volume must be administered at a rate greater than 125 mL/hour (hr) to meet the remaining requirements of the data element. If there is a reason documented and the physician ordered 0 ml, that would not be acceptable as there must be an actual volume documented, ordered and administered at a rate greater than 125 mL/hr.

Question 5: **Is the *Crystalloid Fluid Administration Time* the time in which the target fluid volume was initiated or the time in which the entire volume was completely infused?**

The *Crystalloid Fluid Administration Time* data element is the time the fluid volume was started, not when the fluids were completed. However, the abstracted *Crystalloid Fluid Administration Time* data element can vary slightly depending on whether there is a single fluid order or multiple fluid orders. If there is a single order for the fluids, then you would use the start time of the first infusion as the *Crystalloid Fluid Administration Time*. If there are multiple fluid orders, then the guidance states to use the start time of the infusion that completed the target ordered volume as the *Crystalloid Fluid Administration Time*.

Question 6: **To select Value "1" for *Crystalloid Fluid Administration*, will giving colloids only meet the requirements? Is administration of crystalloids and colloids needed to select Value "1"?**

The *Crystalloid Fluid Administration* data element abstraction guidance states that a portion of the crystalloid fluid volume administered as colloids is acceptable with the required physician/APN/PA documentation. Therefore, administering colloids only would not meet the guidance in the data element, and you would not select Value "1" (Yes). Only a portion of the target ordered volume could be colloids, the other portion must be a crystalloid or a balanced crystalloid solution.

Question 7: **Is there a time frame for the provider to document the reason for not providing the 30 mL/kg?**

No, the *Crystalloid Fluid Administration* guidance does not specify a time frame within which the physician/APN/PA must document a reason to use a volume less than 30 mL/kg as the target ordered volume.

Question 8: **Are advanced or end stage heart failure/renal failure the only acceptable reasons for ordering less than 30mL/kg of fluids?**

No, heart failure or renal disease are no longer the only acceptable reasons for ordering a volume less than 30 mL/kg. The updated guidance in manual v5.11a allows for physician documentation of a volume less than 30 mL/kg with a documented reason for ordering less than 30 mL/kg. Examples of reasons for ordering less than 30 mL/kg are included in the *Crystalloid Fluid Administration* data element.

Question 9: **Does the ordering physician need to be the one to document the reason for not administering the required fluids?**

Yes, the ordering physician/APN/PA must document in a single note the volume to be administered and the reason for ordering less than 30 mL/kg.

Question 10: **Can you use the operating room (OR) end time as the intravenous (IV) fluid end time since the stop time for the last IV bag running is not always documented?**

No, the exception for fluids administered in the OR provided in the *Crystalloid Fluid Administration* data element states there must be a documented end time or infusion rate to use the fluids administered in the OR toward the target ordered volume. The OR end time alone should not be used as the infusion end time.

Question 11: **Does the colloid administration require a rate of above 125 mL/hr to be used toward the fluid calculation?**

Yes, all infusions (crystalloid or colloid) used toward the target ordered volume must be administered at greater than 125 mL/hr.

Question 12: **Does the targeted fluid volume still allow for using ideal body weight (IBW) if the body mass index (BMI) is greater than 30?**

Yes, the guidance in the *Crystalloid Fluid Administration* data element continues to allow for the use of IBW to determine the target ordered volume when there is physician/APN/PA documentation of obesity or a BMI greater than 30.

Question 13: **Does a class or stage need to be documented for heart failure and end stage renal disease (ESRD)?**

No, the guidance in version 5.11a of the *Crystalloid Fluid Administration* data element no longer requires physician/APN/PA documentation of the class or stage of advanced or end-stage heart failure or renal disease.

Question 14: **For *Initial Hypotension*, do you use the second BP reading?**

Yes, the time of the second hypotensive reading is used to determine the *Initial Hypotension Time*.

Question 15: **How do we determine *Persistent Hypotension* when multiple fluid bolus orders are in the medication administration record (MAR)?**

To determine the hour to assess for *Persistent Hypotension*, you must first determine the completion time of the target ordered volume of crystalloid fluids. Per the notes for abstraction in the *Crystalloid Fluid Administration* data element, if there are multiple physician/APN/PA fluid orders, begin with abstracting the earliest crystalloid fluids ordered and started within the specified time frame. The *Persistent Hypotension* data element provides example calculations that may be helpful when determining the hour to assess for persistent hypotension.

Question 16: **What value is selected for *Persistent Hypotension* if two or more BPs were documented in the hour after fluids, including a normal BP followed by a hypotensive BP as the last two readings in the hour, and a vasopressor was administered?**

Select Value "1" (Yes) for the *Persistent Hypotension* data element because there is a normal BP followed by a hypotensive BP and a vasopressor was administered. *Persistent Hypotension* is unable to be determined when there is a normal BP followed by a hypotensive BP. However, the administration of a vasopressor supports the presence of persistent hypotension. Therefore, you would select Value "1" (Yes) for the *Persistent Hypotension* data element.

Question 17: **Does the completion time of the targeted volume determine the start time of the hour to assess for *Persistent Hypotension*?**

Yes, persistent hypotension is assessed in the one hour following the completion of the target ordered volume of crystalloid fluids.

Question 18: **Since you do not use Systemic Inflammatory Response Syndrome (SIRS) vitals and low BP as evidence of organ dysfunction if a patient is in the operating room (OR), would we use them if the patient was in the preoperative holding area (POHA) or the post anesthesia care unit (PACU)?**

Yes, SIRS criteria and evidence of organ dysfunction obtained in the POHA and PACU would not be disregarded. The *Severe Sepsis Present* guidance specifically refers only to disregarding criteria obtained in the OR. You would continue to use SIRS criteria and evidence of organ dysfunction obtained in the POHA or PACU unless there is further physician/APN/PA documentation attributing the abnormal values to medication, chronic condition, or other factors stated in the abstraction guidance.

Question 19: **If the patient has acute respiratory failure, as evidenced by a new need for invasive or non-invasive mechanical ventilation, is high flow nasal cannula (HFNC) considered mechanical ventilation when determining organ dysfunction?**

No, HFNC is not a form of mechanical ventilation and would not be used to establish organ dysfunction. Only the initiation of invasive mechanical ventilation or non-invasive mechanical ventilation, such as continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BiPAP), would meet criteria c (organ dysfunction).

Question 20: **Should we look at admit orders that state severe sepsis present as opposed to the clinical criteria for the presentation time, or is this only applicable to documentation that denotes severe sepsis was present on admission?**

You would abstract the earliest *Severe Sepsis Presentation Time* based on both physician/APN/PA documentation of severe sepsis and the clinical criteria. If the earliest presentation time of severe sepsis is based on the physician/APN/PA documentation of severe sepsis in an admit order, you would abstract the order time. However, if the clinical criteria for severe sepsis were met before the physician/APN/PA documentation of severe sepsis, you would use the earliest time all three clinical criteria were met.

Question 21: **If severe sepsis on admission is documented on day 27 of a 30-day stay, would you still use this documentation?**

Yes, you would abstract the earliest *Severe Sepsis Presentation Time* available. If the patient was hospitalized for 30 days and on day 27 there was physician/APN/PA documentation that the patient had severe sepsis on admission, you would abstract the corresponding admission time. If the patient stayed in the hospital 30 days and severe sepsis was identified on day 27, you would abstract the *Severe Sepsis Presentation Time* on day 27.

Question 22: **If the patient is already on a vasopressor at the time of septic shock, what should be used as the start time of the vasopressor, the septic shock time or the original start time of the vasopressor?**

If a vasopressor is infusing at the time of septic shock presentation, abstract the start time of the vasopressor that was infusing when septic shock was met.

Question 23: **If COVID-19 was suspected later in the stay and not within severe sepsis or septic shock, would we exclude the whole case? Does it have to be within time zero?**

The abstraction guidance related to selecting Value "2" based on documentation that COVID-19 is present or suspected does not contain a specific time frame within which that documentation must occur. Therefore, you would select Value "2" (No) for the *Severe Sepsis Present* data element if there is physician/APN/PA documentation within the medical record that states COVID-19 is present or suspected.

Question 24: **Does a COVID-19 test and/or the results of the test give ground to select Value "2" for *Severe Sepsis Present* or does the physician need to document the suspicion of COVID-19?**

Neither documentation that a COVID-19 test was performed nor the test result is sufficient to select Value "2" as the guidance requires physician/APN/PA documentation that coronavirus or COVID-19 is suspected or present. Physician/APN/PA documentation that the COVID-19 test result was positive is sufficient to select Value "2" (No).

Question 25: **If a stand-alone emergency department (ED) has the same CMS Certification Number (CCN) as the hospital receiving the patient, is this considered a "transfer" as far as the admission source?**

Yes, the guidance in the *Transfer From Another Hospital or ASC* data element indicates you would select "Yes" when the patient is received as a transfer from an outside ED even if the stand alone/satellite ED is a part of your hospital system or has the same CCN.

Question 26: **Is the time frame for the repeat lactate between the collection of the first lactate (not the result time) and the collection of the second lactate?**

The time frame within which the *Repeat Lactate Level Collection* must occur is from the *Initial Lactate Level Collection Date* and *Time* through six hours after the *Severe Sepsis Presentation Date* and *Time*.

Question 27: **Can the lab personnel document a patient's refusal?**

No, the *Administrative Contraindication to Care, Severe Sepsis* and *Administrative Contraindication to Care, Septic Shock* data elements specify that only physician/APN/PA or nursing documentation of a refusal is acceptable. Documentation by lab personnel, such as a phlebotomist, is not acceptable for these data elements.

Question 28: **Does the physician documentation of a "physical exam" in the time frame for *Repeat Volume Status and Tissue Perfusion Assessment Performed* suffice for the assessment being performed?**

Physician/APN/PA documentation that they completed or performed a "physical exam" is acceptable for the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element. However, if "physical exam" is the title or heading of a form, section, or field in the medical record, instead of physician/APN/PA documentation of performing a physical exam, it would not be acceptable.

Question 29: **Does the reassessment note need to specify that it is a "sepsis reassessment," or is the documentation of just "reassessment" acceptable?**

Physician/APN/PA documentation attesting to performing a "sepsis reassessment" or "reassessment" within the specified time frame is acceptable.

Question 30: **Are there new changes related to antibiotics? I can no longer find the antibiotic medication list for Monotherapy and the "A" and "B" choices.?**

Yes, the *Broad Spectrum or Other Antibiotic Administration Selection* data element was removed from the measure in manual v5.10a. As a result, the antibiotic tables that were used when abstracting that data element were removed. You are no longer required to determine which antibiotic(s) the patient received.

Question 31: **When do these changes begin?**

Abstraction using specifications manual version 5.11a applies to discharges starting January 1, 2022, through June 30, 2022.