Sepsis WebEx 7/22/19
Q&A

Questions	Answers
Re: Blood Pressure Timeframe Q1: What is the timeframe between blood pressure readings for initial hypotension?	A1: For 'Initial Hypotension', timeframe is 2 separate blood pressure readings. - Based on DOH 5.1/CMS 5.4 (2018) dictionary, this is anytime within the window of abstraction, i.e. 6 hours prior to 6 hours after severe sepsis presentation; but before completion of target IV fluid (and do not need to be consecutive hypotensive blood pressures). - Based on DOH 6.3/CMS 5.6 (2019) dictionary, the hypotensive blood pressure readings do not need to be consecutive but need to be within 3 hours of each other and within the window of abstraction (i.e. 6 hours prior to 6 hours after severe sepsis presentation; but before completion of target IV fluid).
Q2: What is the timeframe for blood pressure readings for persistent hypotension?	A2: For 'Persistent Hypotension', time frame are 2 separate, consecutive blood pressure readings within one hour of conclusion of the target crystalloid fluid target volume. - Based on DOH/CMS (2018 & 2019)* dictionary, for 2 low blood pressures to be consecutive, there must not be a normal blood pressure recorded in-between these 2 blood pressures. **DOH 5.1/CMS 5.4 (2018) & DOH 6.3/CMS 5.6 (2019)*
Re: Multiple Blood Pressures (Choosing which 2 BPs) Q1: If more than two blood pressures are documented within 6 hours prior to 6 hours after severe sepsis presentation, which blood pressure do we refer to for 'Initial Hypotension'?	A1: According to DOH/CMS (2018 & 2019)* dictionary, Initial Hypotension** is the earliest datetime of the second hypotensive blood pressure documented within the time period of 6 hours prior to or within 6 hours following severe sepsis presentation - i.e. report the 2nd hypotensive blood pressure documented within the time period
Q2: If more than two blood pressures are documented within 1 hour of completion of target IV fluid administration, which blood pressure do we refer to for 'Persistent Hypotension'?	A2: According to DOH/CMS (2018 & 2019)* dictionary, for Persistent Hypotension**, refer to the last two consecutive blood pressure and determine: - If two normal blood pressures, select Value "2" - If normal blood pressure followed by a low blood pressure, select Value"3" - If low blood pressure followed by a normal blood pressure, select Value "2" - If low blood pressure followed by a low blood pressure, select Value "1"

	DOH 5.1/CMS 5.4 (2018) & DOH 6.3/CMS 5.6 (2019)* * For both initial/persistent hypotension, report the datetime of the 2nd blood pressure of the 2 low blood pressures.*
Re: Antibiotic Administration vs. Selection Q: For antibiotics given 24 hours prior to severe sepsis presentation, can this be any type of antibiotic (i.e. antibiotics not listed on the antibiotic selection guidelines, such as sulfamethazole-trimethoprim)? Is this the same for 2018 and 2019?	A: According to DOH/CMS (2018 & 2019)* dictionary, any intravenous/interosseous antibiotic can be used to validate the variable **Antibiotic Administration Datetime** if given within the window, 24hrs prior to 3 hours after severe sepsis presentation. - For variable **Antibiotic Administration Selection**, only antibiotics listed on the antibiotic selection guidelines (CMS SEP-1 Broad Spectrum or Other Antibiotic Administration Selection), given within 3 hours after severe sepsis presentation can be used. **DOH 5.1/CMS 5.4 (2018) & DOH 6.3/CMS 5.6 (2019)*
Re: Platelet Count (Thrombocytopenia) Q: What value is considered thrombocytopenia? Platelet count <150K or <100K?	A: According to DOH 5.1 (2018)/DOH 6.3 (2019)* dictionary, platelet count is used for two separate data elements*: - If used for "**Severity Adjustment Variable**", select "Yes" (1) if platelet count <150K - If used for organ dysfunction criteria for severe sepsis presentation, only use if platelet count <100K *For both data elements, the clinical criteria timeframe is within 6 hours before to 6 hours after the identification of severe sepsis and/or septic shock.
Re: Severe Sepsis Presentation Datetime Q: When using the time where an LIP (licensed independent practitioner) has documented Severe Sepsis, should we use the time the note was initiated, or the time at which the LIP closes the note?	A: According to DOH/CMS (2018 & 2019)* dictionary, if severe sepsis/septic shock is documented in a **Physician/APN/PA note** without a specific date or documented using the acronym POA (present on admission), the following apply: - If it is the only documentation of Severe Sepsis or Septic shock in the note, use the date the note was started or opened. - If Severe Sepsis or Septic Shock is documented multiple times within the same note, use the earliest specified date. **DOH 5.1/CMS 5.4 (2018) & DOH 6.3/CMS 5.6 (2019)*
Re: Provider seen patient vs. Note created Q1: Can ED timeline documentation of the time that a	A1: According to both DOH/CMS (2018 & 2019)* dictionary,

provider saw the patient be used even if the note documenting severe sepsis/septic shock had a later datetime? Q2: If the note was started at 10am by a resident noting severe sepsis, and the attending physician adds his/her note and documents severe sepsis with a time (i.e. 10:30am). Do we take the time note was opened or the time the attending documents severe sepsis?	use the datetime of Physician/APN/PA note that documents severe sepsis/septic shock. If the datetime of when the provider saw the patient is documented on the same note where severe sepsis/septic shock is documented, this datetime can be used as the datetime the note was started/opened (Refer to Severe Sepsis Presentation Datetime). A2: According to both DOH/CMS (2018 & 2019)* dictionary, use the datetime of the Physician/APN/PA note to document severe sepsis (i.e. resident is a physician). Datetime of when the first physician (i.e. resident) who started the note should be reported (For the example provided, report 10am, not 10:30am.) **DOH 5.1*/CMS 5.4 (2018) & DOH 6.3/CMS 5.6 (2019)*
Re: Mean Arterial Pressure (MAP) Q: Do we calculate the MAP or use only documented MAP? There is no mention on data dictionary that we need to calculate the MAP.	A: During the validation process, reviewers validate severe sepsis/septic shock presentation and datetime, organ dysfunction, initial hypotension and persistent hypotension. Acceptable readings for hypotension include systolic blood pressure <90, mean arterial pressure (MAP) <65, or a decrease in systolic blood pressure of >40 mmHg. While hospital abstractors are not expected to calculate MAP, the reviewer may calculate a MAP (MAP= (SBP+2*DBP)/3) if the data submission reflective of hypotension cannot otherwise be validated, in order to validate an entry of severe sepsis/septic shock, initial hypotension and/or persistent hypotension. **DOH 5.1*/CMS 5.4 (2018) & DOH 6.3/CMS 5.6 (2019)*
Re: SIRS criteria Q: If there is WBC>12 and Band>10, does this count as one or two SIRS criteria?	A: According to both DOH/CMS (2018 & 2019)* dictionary, leukocyte criterion is 1 of 4 SIRS criteria. And leukocyte criterion is met by either: white blood cell (WBC) count >12,000 or <4,000 or >10% bands. - WBC>12K or <4K or Band>10% qualifies for only 1 SIRS criteria (i.e. leukocyte criterion) **DOH 5.1*/CMS 5.4 (2018) & DOH 6.3/CMS 5.6 (2019)*
Re: Elevated Lactate Reason Q: If the physician note states elevated lactate secondary to seizure due to possible sepsis, can we answer '2' to the elevated lactate question?	A: According to DOH (2018 & 2019)* dictionary, for **Elevated Lactate Reason**, select: - Value '1' (Yes): There is **Physician/APN/PA** documentation prior to or within 24 hours after the initial lactate level result that indicates the

	initial lactate value is due to a condition that is not an infection. - Value '2' (No): There is no **Physician/APN/PA** documentation prior to or within 24 hours after the initial lactate level result that indicates the initial lactate value is due to a condition that is not an infection, or is due to a medication, or unable to determine. For this example provided, the answer will be '2'. - However, note on the example provided, patient's elevated lactate may also be attributed to seizure, infection or both. **DOH 5.1*/CMS 5.4 (2018) & DOH 6.3/CMS 5.6 (2019)*
Re: Elevated Lactate criterion for severe sepsis/organ dysfunction Q: If the physician note states elevated lactate secondary to seizure due to possible sepsis, can we use this elevated lactate (i.e. lactate >2mmol/l) for organ dysfunction criteria for severe sepsis?	A: According to DOH/CMS (2018 & 2019)*, if the medical resource indicates the source of the acute condition might be infectious, there must be explicit **Physician/APN/PA** documentation in the medical record indicating that the acute condition has a non-infectious source or process. - i.e. if written that the elevated lactate is secondary to seizure (acute condition) post brain injury (noninfectious source), **do NOT** use elevated lactate for severe sepsis/organ dysfunction - i.e. if written that the elevated lactate is secondary to seizure (acute condition) without documentation of noninfectious source, one should **use** the elevated lactate for severe sepsis/organ dysfunction[1] Based on the example provided, physician note indicating elevated lactate secondary to seizure (acute condition) and due to possible sepsis, this does not provide us the "noninfectious source". - Thus, elevated lactate should be used for organ dysfunction criteria for severe sepsis. **DOH 5.1*/CMS 5.4 (2018) & DOH 6.3/CMS 5.6 (2019)*

[1] Please refer to CMS 5.4 page 1-174