Required Provider Documentation for the New CMS Sepsis Core Measure

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Significance and Relevance

- **October 1st 2015: Sepsis Management is a CMA Core Measure**
  - Reimbursement related to documentation

- UCHealth has Sepsis Coordinators.
  - Goals are formal system collaboration to improved sepsis mortality outcomes.
  - Metro Denver Sepsis Coordinator is Nicole Huntley, MS, ACCNS-AG, RN.
  - Abstractions for this new Core Measure beginning October, 2015.
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## Sepsis “Time Zero” per CMS

<table>
<thead>
<tr>
<th>ED</th>
<th>Inpatient</th>
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</thead>
<tbody>
<tr>
<td>• ED*: Time Zero is noted as the time of triage</td>
<td>• Time Zero is noted as the time of provider documentation of Severe Sepsis and/or Septic Shock</td>
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</tbody>
</table>

*Patients admitted from Out Side Hospital (OSH) are not included in our CMS reporting*

OR

• If it is noted “suspect infection from ___”, then within 6 hours documentation must include:
  • 2 or more SIRS criteria AND
  • Evidence of organ dysfunction
After documentation of Time Zero the Clock starts!

- **Severe Sepsis**: Three Hour and Six Hour Counters
- **Septic Shock**: Three Hour and Six Hour Counters

<table>
<thead>
<tr>
<th>SEP-1</th>
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<tbody>
<tr>
<td><strong>TO BE COMPLETED WITHIN 3 HOURS OF TIME OF PRESENTATION †:</strong></td>
<td></td>
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<tr>
<td>1. Measure lactate level</td>
<td></td>
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<tr>
<td>2. Obtain blood cultures prior to administration of antibiotics</td>
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<tr>
<td>3. Administer broad spectrum antibiotics</td>
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<tr>
<td>4. Administer 30ml/kg crystalloid for hypotension or lactate ≥4mmol/L</td>
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† “time of presentation” is defined as the time of earliest chart annotation consistent with all elements severe sepsis or septic shock ascertained through chart review.

<table>
<thead>
<tr>
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<tr>
<td><strong>TO BE COMPLETED WITHIN 6 HOURS OF TIME OF PRESENTATION:</strong></td>
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<tr>
<td>5. Apply vasopressors (for hypotension that does not respond to initial fluid resuscitation) to maintain a mean arterial pressure (MAP) ≥65mmHg</td>
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<tr>
<td>6. In the event of persistent hypotension after initial fluid administration (MAP &lt; 65 mm Hg) or if initial lactate was ≥4 mmol/L, re-assess volume status and tissue perfusion and document findings according to table 1.</td>
</tr>
<tr>
<td>7. Re-measure lactate if initial lactate elevated.</td>
</tr>
</tbody>
</table>

† ‘time zero’ as described on previous slide

(Table 1 content is on next two slides)
**TABLE ONE**: Repeat Volume Status and Tissue Perfusion Assessment must consist of **EITHER**:

- A focused exam including:
  - Vital signs, **AND**
  - Cardiopulmonary exam, **AND**
  - Capillary refill evaluation, **AND**
  - Peripheral pulse evaluation, **AND**
  - Skin examination

- Any two of the following four:
  - Central venous pressure measurement
  - Central venous oxygen measurement
  - Bedside Cardiovascular Ultrasound
  - Passive Leg Raise or Fluid Challenge

Charting Requirements for each element are on the following slide.
Documented Repeat Physical Exam

Requirements:

Criteria for Data Abstraction

- Expected response: yes/no ("yes" meaning a complete exam is recorded)
- Requirements: Clinical exam components within 6 hours of the presentation of septic shock and must include each of the following:
  - **Vital signs** (including temperature, heart rate, blood pressure, respiratory rate: all four must be present)
  
  and
  
  - Presence of a **cardiopulmonary exam**: typically documented as “HEART:” and “LUNGS:”
  
  and
  
  - **Documentation examples**: HEART- “RRR,” “Irregular,” “S1, S2, S3, S4”, “murmur;” or other LUNG - “clear,” “crackles,” “diminished,”” dull,” or other language
  
  and
  
  - Presence of **peripheral pulses** examination typically “PULSES:” with findings
    
    **Documentation examples**: “1+,” or “2+,” or “absent,” or other language
  
  and
  
  - Presence of documentation of **capillary refill**
    
    **Documentation examples**: “brisk,” “< 2 seconds,” “> 2 seconds,” or other language
  
  and
  
  - Presence of a **skin examination**
    
    **Documentation examples**: “mottled,” “not mottled,” “knee caps clear/mottled,” or other language

Document this exam **OR** 2 of the 4 elements on the next slide
*TWO of the these 4 clinical elements must be documented within 6 hours of severe sepsis or septic shock presentation*

- **Measure CVP**
  
  **Criteria for Data Abstraction**
  - Expected response: yes/no (yes meaning CVP was checked)
  - Requirements:
    - CVC placed in superior vena cava; OR
    - Right heart (Swan-Ganz) catheter placement
    - Measurement occurs within six hours of the presentation of septic shock
  
  - Cannot be from a PICC or midline

- **Measure SvO2 or Scvo2**
  
  **Criteria for Data Abstraction**
  - Expected response: yes/no ("yes" meaning ScvO2 was measured and documented)
  - Requirements:
    - CVC placed in superior vena cava (ScvO2); OR
    - Right heart catheter (Swan-Ganz) Catheter placement (SvO2)
    - Measurement occurs within six hours of the presentation of septic shock

- **Perform Bedside CV Ultrasound**
  
  **Criteria for Data Abstraction**
  - Expected response: yes/no ("yes" meaning an appropriate ultrasound was done)
  - Requirements – Ultrasound occurs within six hours of the presentation of septic shock
  
  - TTE (trans-thoracic echocardiogram)
  - TEE (trans-esophageal echocardiogram)
  - IVC US (Inferior Vena Cava ultrasound)
  - Esophageal Doppler monitoring

- **Perform Passive Leg Raise**
  
  **Criteria for Data Abstraction**
  - Expected response: yes/no ("yes" meaning a passive leg raise is documented or administration of a fluid challenge is documented)
  - Requirements:
    - Passive leg raise or fluid challenge occurs within six hours of the presentation of septic shock
    - No documentation of lower extremity amputation in the case of passive leg raise
    - Presence of a passive leg raise test typically documented as “PASSIVE LEG RAISE (PLR),” with findings “positive,” “negative,” “fluid responsive,” “not fluid responsive,” or other language