

Alphabetical Data Dictionary

The General Abstraction Guidelines explain the different sections of the data element definitions and provide direction for common questions and issues that arise in medical record abstraction. Instructions in the specific data elements in this Data Dictionary should **ALWAYS** supersede those found in the General Abstraction Guidelines.

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Data Element Name: *Administrative Contraindication to Care, Septic Shock*

Collected For CMS: SEP-1

Definition: Documentation of refusal of blood draw, IV fluid administration, or vasopressor administration within the specified time frame.

Suggested Data Collection Question: Is there documentation that the patient or authorized patient advocate refused either a blood draw, IV fluid administration, or vasopressor administration within the specified time frame?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

- 1 (Yes) There is documentation by a physician/APN/PA or nurse that the patient or authorized patient advocate has refused either blood draw, IV fluid administration, or vasopressor administration within the specified time frame.
- 2 (No) There is no physician/APN/PA or nurse documentation that the patient or authorized patient advocate has refused either blood draw, IV fluid administration, or vasopressor administration within the specified time frame, or unable to determine.

Notes for Abstraction:

- Only acceptable sources are physician/APN/PA or nursing documentation.
- The specified time frame for physician/APN/PA or nurse documentation is before or within six hours after the *Septic Shock Presentation Time*.
- Select Value “1” if there is specific documentation indicating patient or authorized patient advocate has refused the following:
 - Blood draws
 - IV or IO fluid administration
 - Vasopressors
- Select Value “1” if there is more general documentation of refusal of care (e.g., central line, PICC, IO access) or documentation of patient non-compliance with care (e.g., pulling out IV) that could result in the following not being administered. **Select Value “1” if any of the following are administered but occur after the specified time window due to refusal of care or patient non-compliance.**
 - Blood Draws
 - IV or IO fluid administration
 - Vasopressors
- For refusal of blood draws:
 - Documented refusal of blood draws is acceptable.
 - Refusal of specific blood draws or blood tests that do not impact the ability to meet the requirements of the SEP-1 measure data elements should not be used.

Examples:

Patient refused HIV blood test.

Patient refused arterial blood gas (ABG).

- For purposes of abstraction only, an authorized patient advocate is someone who is authorized to make decisions on behalf of the patient when the patient is not able to. This includes someone who is legally designated and empowered to make medical decisions on the patient's behalf when the patient is unable to themselves.

Examples:

- Family members
- Medical power of attorney
- Health care power of attorney
- Durable power of attorney for health care
- Someone documented as an agent for the patient
- Attorney-in-fact
- Select Value "1" if there is a signed AMA form or documentation by a physician/APN/PA or nurse within the specified time frame indicating the patient left AMA.

- Explicit "left against medical advice" documentation is not required.

Example:

"Patient is refusing to stay for continued care" select Value "1."

- Documentation suggesting that the patient left before discharge instructions could be given does not count as leaving against medical advice.
- An AMA form signed by the patient is not required, for the purposes of this data element.
- Do not consider AMA documentation and other disposition documentation as "contradictory." Select Value "1" if any source states the patient left against medical advice, regardless of whether the AMA documentation was written last.

Example:

AMA form signed and discharge instruction sheet states "Discharged home with belongings" select Value "1."

Suggested Data Sources:

- Consultation reports
- History and physical
- Nursing Notes
- Physician/APN/PA notes

Inclusion Guidelines for Abstraction:

- Declined
- Does not want
- Refused
- Requests not to be given

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Administrative Contraindication to Care, Severe Sepsis*

Collected For CMS: SEP-1

Definition: Documentation of refusal of blood draw, IV fluid administration, or IV antibiotic administration within the specified time frame.

Suggested Data Collection Question: Is there documentation that the patient or authorized patient advocate refused either a blood draw, IV fluid administration, or IV antibiotic administration within the specified time frame?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

- 1 (Yes) There is documentation by a physician/APN/PA or nurse that the patient or authorized patient advocate has refused either blood draw, IV fluid administration, or IV antibiotic administration within the specified time frame.
- 2 (No) There is no physician/APN/PA or nurse documentation that the patient or authorized patient advocate has refused either blood draw, IV fluid administration, or IV antibiotic administration within the specified time frame, or unable to determine.

Notes for Abstraction:

- Only acceptable sources are physician/APN/PA or nursing documentation.
- The specified time frame for physician/APN/PA or nurse documentation is before or within six hours after the *Severe Sepsis Presentation Time*.
- Select Value “1” if there is specific documentation indicating patient or authorized patient advocate has refused the following:
 - Blood draws
 - IV or IO fluid administration
 - IV or IO antibiotic
- Select Value “1” if there is more general documentation of refusal of care or documentation of patient non-compliance with care (e.g., pulling out IV) that could result in the following not being administered. **Select Value “1” if any of the following are administered but occur after the specified time window due to refusal of care or patient non-compliance.**
 - Blood draws
 - IV or IO fluid administration
 - IV or IO antibiotic
- For refusal of blood draws:
 - Documented refusal of blood draws is acceptable.
 - Refusal of specific blood draws or blood tests that do not impact the ability to meet the requirements of the SEP-1 measure data elements should not be used.

Examples:

Patient refused HIV blood test.

Patient refused arterial blood gas (ABG).

- For purposes of abstraction only, an authorized patient advocate is someone who is authorized to make decisions on behalf of the patient when the patient is not able to. This includes someone who is legally designated and empowered to make medical decisions on the patient's behalf when the patient is unable to themselves.

Examples:

- Family members
- Medical power of attorney
- Health care power of attorney
- Durable power of attorney for health care
- Someone documented as an agent for the patient
- Attorney-in-fact
- Select Value “1” if there is a signed AMA form or documentation by a physician/APN/PA or nurse within the specified time frame indicating the patient left AMA.
 - Explicit “left against medical advice” documentation is not required.
Example:
“Patient is refusing to stay for continued care” select Value “1.”
 - Documentation suggesting that the patient left before discharge instructions could be given does not count as leaving against medical advice.
 - An AMA form signed by the patient is not required, for the purposes of this data element.
 - Do not consider AMA documentation and other disposition documentation as “contradictory.” Select Value “1” if any source states the patient left against medical advice, regardless of whether the AMA documentation was written last.
Example:
AMA form signed and discharge instruction sheet states “Discharged home with belongings” select Value “1.”

Suggested Data Sources:

- Consultation reports
- History and physical
- Nursing Notes
- Physician/APN/PA notes

Inclusion Guidelines for Abstraction:

- Declined
- Does not want
- Refused
- Requests not to be given

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Admission Date*

Collected For CMS: All Records

Definition: The month, day, and year of admission to acute inpatient care.

Suggested Data Collection Question: What is the date the patient was admitted to acute inpatient care?

Format:

Length: 10 – MM-DD-YYYY (includes dashes)

Type: Date

Occurs: 1

Allowable Values:

MM = Month (01-12)

DD = Day (01-31)

YYYY = Year (20xx)

Note: Only dates that are equal to or less than 120 days from the *Discharge Date* will be accepted into the CMS Clinical Data Warehouse.

Refer to the Data Transmission section of this manual for further guidance related to data transmission.

Notes for Abstraction:

- The intent of this data element is to determine the date that the patient was actually admitted to acute inpatient care. Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date from billing is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.
- If using claim information, the ‘Statement Covers Period’ is not synonymous with the ‘Admission Date’ and should not be used to abstract this data element. These are two distinctly different identifiers:
 - The Admission Date is purely the date the patient was admitted as an inpatient to the facility.
 - The Statement Covers Period (“From” and “Through” dates) identifies the span of service dates included in a particular claim. The “From” Date is the earliest date of service on the claim.
- For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.

Example:

Medical record documentation reflects that the patient was admitted to observation on 04-05-20xx. On 04-06-20xx the physician writes an order to admit to acute inpatient effective 04-05-20xx. The *Admission Date* would be abstracted as 04-06-20xx; the date the determination was made to admit to acute inpatient care and the order was written.

- The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used.

Example:

Preoperative Orders are dated as 04-06-20xx with an order to admit to Inpatient. Postoperative Orders dated 05-01-20xx, state to admit to acute inpatient. All other documentation supports that the patient presented to the hospital for surgery on 05-01-20xx. The *Admission Date* would be abstracted as 05-01-20xx.

- If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted.
- For newborns that are born within this hospital, the *Admission Date* would be the date the baby was born.

Suggested Data Sources:

Note: The physician order is the priority data source for this data element. If there is not a physician order in the medical record, use the other only allowable sources to determine the *Admission Date*.

ONLY ALLOWABLE SOURCES:

1. Physician orders
2. Face Sheet
3. UB-04

Excluded Data Sources:

UB-04 “From” and “Through” dates

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

- Admit to observation
- Arrival date

Data Element Name: *Birthdate*

Collected For CMS: All Records

Definition: The month, day, and year the patient was born.

Note: Patient's age (in years) is calculated by *Admission Date* minus *Birthdate*. The algorithm to calculate age must use the month and day portion of admission date and birthdate to yield the most accurate age.

Suggested Data Collection Question: What is the patient's date of birth?

Format:

Length: 10 – MM-DD-YYYY (includes dashes)

Type: Date

Occurs: 1

Allowable Values:

MM = Month (01-12)

DD = Day (01-31)

YYYY = Year (1880-Current Year)

Notes for Abstraction:

Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the birthdate is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, she/he should default to the date of birth on the claim information.

Suggested Data Sources:

- Emergency Department record
- Face sheet
- Registration form
- UB-04

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Blood Culture Collection*

Collected For CMS: SEP-1

Definition: Documentation of the collection of a blood culture.

Suggested Data Collection Question: Was a blood culture collected in the specified time frame?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

1 (Yes) A blood culture was collected in the specified time frame.

2 (No) A blood culture was not collected in the specified time frame or unable to determine.

Notes for Abstraction:

- If the Broad Spectrum or Other Antibiotic Administration Time **is not** within the 24 hours before the Severe Sepsis Presentation Time, the specified time frame is:
 - 24 hours before the *Severe Sepsis Presentation Date and Time* through three hours following the *Severe Sepsis Presentation Date and Time*.
- If the Broad Spectrum or Other Antibiotic Administration Time is within the 24 hours before the Severe Sepsis Presentation Time, the specified time frame is:
 - 24 hours before the *Broad Spectrum or Other Antibiotic Administration Time* through three hours following the *Severe Sepsis Presentation Date and Time*.
- Use documentation specifying a blood culture was actually drawn or collected. Do not use “Labs Drawn” or similar documentation, as it is not specific to blood culture.
- Select Value “1” if a blood culture was ordered and there was an attempt to collect it, but the attempt resulted in failure to collect the specimen (too dehydrated to get a vein) or the specimen was contaminated during or after the draw.
- Select Value “1” if there was documentation indicating that a blood culture was collected during the specified time frame (e.g., “BC sent to lab,” “blood culture received time”). Use the earliest mention of a blood culture.
- Do not use physician orders to determine a blood culture was collected, as they do not demonstrate collection of the blood culture.

Suggested Data Sources:

- Emergency Department record
- History and physical
- Laboratory report
- Microbiology report
- Nursing notes
- Physician/APN/PA Progress notes

Inclusion Guidelines for Abstraction:

- BC
- Blood cultures
- Blood cultures collected

Exclusion Guidelines for Abstraction:

- Blood sent to lab
- Lab here
- Labs drawn

Data Element Name: *Blood Culture Collection Acceptable Delay*

Collected For CMS: SEP-1

Definition: Documentation supporting there was an acceptable delay in the collection of a blood culture.

Suggested Data Collection Question: Is there documentation supporting an acceptable delay in collecting a blood culture?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

1 (Yes) There is documentation supporting an acceptable delay in the collection of a blood culture.

2 (No) There is no documentation supporting an acceptable delay in the collection of a blood culture, or unable to determine.

Notes for Abstraction:

- **Only** the following situations demonstrate an acceptable delay where the blood culture was drawn after the *Broad Spectrum or Other Antibiotic Administration Date and Time*. Select Value “1” if there is an acceptable delay.
 - Surgical patients who receive a pre-op or post-op prophylactic antibiotic within 24 hours before severe sepsis was identified and had a blood culture drawn after the prophylactic antibiotic was started.
 - Antibiotics were started in the hospital for an infection within 24 hours before severe sepsis was identified, and a blood culture was drawn sometime after the antibiotic dose was started.
 - Antibiotics were started prior to hospital arrival within 24 hours before severe sepsis was identified, and a blood culture was drawn after the pre-hospital antibiotics were started.
 - A physician/APN/PA documented reason for the delay that makes it clear that waiting to start the antibiotic would be detrimental to the patient.
- **Examples:**
 - ED Physician Note: Patient condition worsening, IV Vanco ordered stat, blood and urine cultures ordered, awaiting CXR.
 - Hospitalist Progress Note: Patient’s deteriorating condition concern for rapidly advancing infection, starting IV antibiotics now, lab on way to collect blood cultures.
- Obstetric patients given prophylactic antibiotics for ruptured membranes, group B strep, or prior to a caesarean section.
- Select Value “2” if there is no documentation supporting an acceptable delay in the collection of a blood culture.

Suggested Data Sources:

- Emergency Department record
- History and physical
- Laboratory report
- Medication Administration Records
- Microbiology report
- Nursing notes
- Progress notes

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

Oral (PO) Antibiotics

Data Element Name: *Blood Culture Collection Date*

Collected For CMS: SEP-1

Definition: The date on which a blood culture was collected within the specified time frame.

Suggested Data Collection Question: On what date was the blood culture collected?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD

Type: Date

Occurs: 1

Allowable Values:

MM = Month (01-12)

DD = Day (01-31)

YYYY = Year (20xx)

UTD = Unable to Determine

Notes for Abstraction:

- Refer to the *Blood Culture Collection* data element for the specified time frame to abstract this data element.
- Use documentation specifying a blood culture was actually drawn or collected. Do not use “Labs Drawn” or similar documentation, as it is not specific to the blood culture.
- Use the date of documentation indicating that a blood culture was collected during the specified time frame (e.g., “BC sent to lab,” “blood culture received time”). Use the date of the earliest mention of a blood culture.
- Do not use physician orders to determine that a blood culture was collected, as they do not demonstrate collection of the blood culture.
- Use the date of an unsuccessful attempt if there was a failure to collect the blood culture specimen (too dehydrated to get a vein) or the specimen was contaminated during or after the draw.
- Use the date of the earliest blood culture collection if multiple blood cultures were drawn or attempted within the specified time frame.

Suggested Data Sources:

- Laboratory documentation
- Nursing notes
- Physician/APN/PA Progress Notes

Inclusion Guidelines for Abstraction:

- Blood culture drawn
- Blood culture to lab
- Blood culture received

Exclusion Guidelines for Abstraction:

- Blood sent to lab
- Lab here
- Labs drawn

Data Element Name: *Blood Culture Collection Time*

Collected For CMS: SEP-1

Definition: The time at which a blood culture was collected within the specified time frame.

Suggested Data Collection Question: What time was the blood culture collected?

Format:

Length: 5 - HH:MM (with or without colon) or UTD

Type: Time

Occurs: 1

Allowable Values:

HH = Hour (00-23)

MM = Minutes (00-59)

UTD = Unable to Determine

Time must be recorded in military time format.

With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight – 00:00	Noon – 12:00
5:31 am – 05:31	5:31 pm – 17:31
11:59 am – 11:59	11:59 pm – 23:59

Notes for Abstraction:

- Refer to the *Blood Culture Collection* data element for the specified time frame to abstract this data element.
- Use documentation specifying a blood culture was actually drawn or collected. Do not use “Labs Drawn” or similar documentation, as it is not specific to the blood culture.
- Use the time of documentation indicating that a blood culture was collected during the specified time frame (e.g., “BC sent to lab,” “blood culture received”). Use the time of the earliest mention of a blood culture.
- Do not use physician orders to determine that a blood culture was collected, as they do not demonstrate collection of the blood culture.
- Use the time of an unsuccessful attempt if there was a failure to collect the blood culture specimen (too dehydrated to get a vein) or the specimen was contaminated during or after the draw.
- Use the time of the earliest blood culture collection if multiple blood cultures were drawn or attempted within the specified time frame.

Suggested Data Sources:

- Laboratory documentation
- Nursing notes
- Physician/APN/PA Progress Notes

Inclusion Guidelines for Abstraction:

- Blood culture drawn
- Blood culture received
- Blood culture to lab

Exclusion Guidelines for Abstraction:

- Blood sent to lab
- Lab here
- Labs drawn

Data Element Name: *Broad Spectrum or Other Antibiotic Administration*

Collected For CMS: SEP-1

Definition: Documentation of administration of a broad spectrum or other antibiotic within the specified time frame.

Suggested Data Collection Question: Was a broad spectrum or other antibiotic administered within the specified time frame?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

1 (Yes) A broad spectrum or other antibiotic was administered within the specified time frame.

2 (No) No antibiotic was administered within the specified time frame, or unable to determine.

Notes for Abstraction:

- The specified time frame for administration of a broad spectrum or other antibiotic is 24 hours before or three hours after the *Severe Sepsis Presentation Time*.

EXCEPTION:

Select Value “1” if antibiotics were administered via intramuscular (IM) or intraosseous (IO) within the specified time frame and there is documentation indicating IV access could not be established.

- Select Value “1” if the patient started on an antibiotic within the 24 hours before or three hours after the *Severe Sepsis Presentation Date and Time*.
- Select Value “2” if no antibiotic was started within the 24 hours before or three hours after the *Severe Sepsis Presentation Date and Time*.
- Only abstract antibiotic administration information from documentation that demonstrates actual administration of the antibiotic (i.e., antibiotic name, route, date and time).
- A physician/APN/PA order for antibiotics is not sufficient unless the antibiotic ordered was marked as “started” with date/time noted.
- Do not cross reference between different sources to infer that an antibiotic was started if it was documented only with name/date/time given but no route was indicated. You cannot use the route on the MAR for an antibiotic.
- The method of designation of administration on hand-written or pre-printed forms such as MARs or eMARs, with pre-printed scheduled times for administration, must be clearly designated as started.
- Do not abstract test doses of antibiotics.
- Do not abstract antibiotics from sources that do not represent actual administration.

Examples that **do not** represent actual administration:

- Pre-Op Checklist states:

- IV Started at 1730
 - Preop Antibiotic Given at 1800
 - Operative report states:
 - IV antibiotics were given prior to procedure.
 - IV antibiotics given at 0900 prior to incision.
- Do not abstract antibiotics from narrative charting unless there is no other documentation that reflects that the same antibiotic was given during the specified time frame.
- Do not use an antibiotic dose if the antibiotic name, route, date or time is missing.
- You may use pre-hospital records (e.g., ambulance records, nursing home records) that are considered part of the medical record for abstracting antibiotics.

Suggested Data Sources:

- Anesthesia record
- Entire Emergency Department record
- ICU flow sheet
- IV flow sheet
- Medication administration record
- Nurses notes
- Operating room record
- PACU/recovery room record
- Perfusion record
- Physician/APN/PA notes
- Pre-arrival documentation that is part of the medical record

Inclusion Guidelines for Abstraction:

- Antibiotic administered via intravenous route
- Intramuscular or IM
- Intraosseous or IO
- Intravenous
- IV Bolus
- IV infusion

Exclusion Guidelines for Abstraction:

- Give antibiotic stat
- Hang antibiotic
- Order for xx antibiotic

Data Element Name: *Broad Spectrum or Other Antibiotic Administration Date*

Collected For CMS: SEP-1

Definition: The earliest date on which an antibiotic was started within the specified time frame.

Suggested Data Collection Question: What was the earliest date on which an antibiotic was started within the specified time frame?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD

Type: Date, Numeric

Occurs: 1

Allowable Values:

MM = Month (01-12)

DD = Day (01-31)

YYYY = Year (20xx)

UTD = Unable to Determine

Notes for Abstraction:

- The specified time frame for the administration of a broad spectrum or other antibiotic is 24 hours before or three hours after the *Severe Sepsis Presentation Time*.
EXCEPTION:
Use the date of antibiotic administered via intramuscular (IM) or intraosseous (IO) started within the specified time frame if there is documentation indicating IV access could not be established.
- Use the date of the earliest dose if one or more antibiotic were started in the 24 hours before the *Severe Sepsis Presentation Time* and none of those same antibiotics were started more than 24 hours before presentation.
- Use the earliest date an antibiotic was started if one or more antibiotics were administered within 24 hours before the *Severe Sepsis Presentation Time*. This may be the same date as the date of presentation or may be a date before presentation. Do not review for antibiotic doses started more than 72 hours before *Severe Sepsis Presentation Time*.

Examples:

More than 24 hours Before Presentation (Max. lookback 72 hrs.)	24 hours Before Presentation	Severe Sepsis	3 Hours After Presentation	Antibiotic Dose to Abstract
	<u>A</u> A A			First dose of A
	<u>B</u> C C			Antibiotic B
G	<u>A</u> A A			First dose of A
<u>B</u>	B B			First dose of B
<u>C</u>	D C C			First dose of C

- Use the date of the dose started closest to the *Severe Sepsis Presentation Time* if one or more antibiotics were started within the three hours after presentation of severe sepsis and no antibiotics were started in the 24 hours before severe sepsis presentation.

Examples:

More than 24 hours Before Presentation (Max. lookback 72 hrs. from presentation)	24 hours Before Presentation	Severe Sepsis	3 Hours After Presentation	Antibiotic Dose to Abstract
E			<u>L</u>	Antibiotic L
K			<u>K</u> A	Dose of K in 3 hr. period

- Use the date of the earliest antibiotic started if antibiotics were administered both 24 hours before and within three hours after the *Severe Sepsis Presentation Time*. This may be the same date as the date of presentation or may be a date before presentation. Do not review for antibiotic doses started more than 72 hours before the *Severe Sepsis Presentation Time*.

Examples:

More than 24 hours Before Presentation (Max. lookback 72 hrs. from presentation)	24 hours Before Presentation	Severe Sepsis	3 Hours After Presentation	Antibiotic Dose to Abstract
	<u>D</u> D		D	First dose of D
	<u>E</u>		F	Antibiotic E
<u>E</u>	E E		L	First dose of E
M	<u>A</u> B A		M	First dose of A
<u>M</u>	A B M A		M	First dose of M

- Stop abstracting three hours after the presentation of severe sepsis.
- Select "UTD" if no antibiotic was started in the 24 hours before or three hours after the severe sepsis presentation.

- Do not cross reference between different sources to infer that an antibiotic was started if it was documented only with name/date/time given but no route indicated. The route on the MAR for an antibiotic cannot be used as the route for a dose of the same antibiotic on another form.
- Do not use an antibiotic dose if the antibiotic name, route, date or time is missing.
- Only abstract antibiotic administration information from documentation that demonstrates actual administration of the specific antibiotic within the specified time frame.

Examples:

- A physician order for IV antibiotics is not sufficient unless the antibiotic ordered was marked as “started” with date/time noted.
- Do not collect antibiotics documented on an operative report unless the surgeon states that the surgeon actually administered the dose.
- Specific documentation by one person that another person administered the antibiotic is acceptable for determining the date and time of administration.

Example:

OR nurse, S. Smith RN, documents, “Cefazolin 1 gm IV given on 1/7/20xx at 0500 per J Doe RN.” You can abstract this dose as given if it is not documented by the person that gave the dose.

- The method of designation of administration on hand-written or pre-printed forms such as MARs or eMARs, with pre-printed scheduled times for administration, must be clearly designated as started.
- Do not abstract test doses of antibiotics.
- Do not abstract antibiotics from sources that do not represent actual administration.

Examples that *do not* represent actual administration:

Pre-Op Checklist states:

IV Started at 1730

Preop Antibiotic Given at 1800

Lab on Chart

Operative report states: IV antibiotics were given prior to procedure.

- Do not abstract antibiotics from narrative charting unless there is no other documentation that reflects that the same antibiotic was started during the specified time frame.

Example:

Narrative states: “Ancef 1 gram given IV prior to incision.” No other doses of Ancef are documented. You should abstract the dose in the narrative using UTD for missing data (no date and time).

- You may use pre-hospital records (e.g., ambulance records, nursing home records) that are considered part of the medical record for abstracting antibiotics.

Suggested Data Sources:

- Anesthesia record
- Entire Emergency Department record
- ICU flow sheet
- IV flow sheet
- Medication administration record
- Nurses notes

- Operating room record
- PACU/recovery room record
- Perfusion record
- Physician/APN/PA notes
- Pre-arrival documentation that is part of the medical record

Inclusion Guidelines for Abstraction:

- Antibiotic administered via intravenous route
- Intramuscular or IM
- Intraosseous or IO
- Intravenous
- IV Bolus
- IV infusion

Exclusion Guidelines for Abstraction:

- Give antibiotic stat
- Hang antibiotic
- Order for xx antibiotic

Data Element Name: *Broad Spectrum or Other Antibiotic Administration Time*

Collected For CMS: SEP-1

Definition: The earliest time at which an antibiotic was started within the specified time frame.

Suggested Data Collection Question: What was the earliest time at which an antibiotic was started within the specified time frame?

Format:

Length: 5 – HH:MM (with or without colon) or UTD

Type: Time

Occurs: 1

Allowable Values:

HH = Hour (00-23)

MM = Minutes (00-59)

UTD = Unable to Determine

Time must be recorded in military time format.

With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight – 00:00	Noon – 12:00
5:31 am – 05:31	5:31 pm – 17:31
11:59 am – 11:59	11:59 pm – 23:59

Notes for Abstraction:

- The specified time frame for the administration of a broad spectrum or other antibiotic is 24 hours before or three hours after the Severe Sepsis Presentation Time.

EXCEPTION:

Use the time of antibiotics administered via intramuscular (IM) or intraosseous (IO) started within the specified time frame if there is documentation indicating IV access could not be established.

- Use the time of the earliest dose started if one or more antibiotic were started in the 24 hours before the *Severe Sepsis Presentation Time* and none of those same antibiotics were started more than 24 hours before presentation.
- Use the earliest time an antibiotic was started if one or more antibiotics were administered within 24 hours before the *Severe Sepsis Presentation Time*. This may be the same time as the time of presentation or may be a time before presentation. Do not review for antibiotic doses started more than 72 hours before the *Severe Sepsis Presentation Time*.

Examples:

More than 24 hours Before Presentation (Max. lookback 72 hrs.)	24 hours Before Presentation	Severe Sepsis	3 Hours After Presentation	Antibiotic Dose to Abstract
	<u>A</u> A A			First dose of A
	<u>B</u> C C			Antibiotic B
G	<u>A</u> A A			First dose of A
<u>B</u>	B B			First dose of B
<u>C</u>	D C C			First dose of C

- Use the time of the dose started closest to the *Severe Sepsis Presentation Time* if one or more antibiotics were started within the three hours after the presentation of severe sepsis and no antibiotics were started in the 24 hours before severe sepsis presentation.

Examples:

More than 24 hours Before Presentation (Max. lookback 72 hrs. from presentation)	24 hours Before Presentation	Severe Sepsis	3 Hours After Presentation	Antibiotic Dose to Abstract
E			<u>L</u>	Antibiotic L
K			<u>K</u> A	Dose of K in 3 hr. period

- Use the time of the earliest antibiotic started if antibiotics were administered both 24 hours before and within three hours after the time of presentation of severe sepsis. This may be the same time as the time of presentation or may be a time before presentation. Do not review for antibiotic doses started more than 72 hours before the *Severe Sepsis Presentation Time*.

Examples:

More than 24 hours Before Presentation (Max. lookback 72 hrs. from presentation)	24 hours Before Presentation	Severe Sepsis	3 Hours After Presentation	Antibiotic Dose to Abstract
	<u>D</u> D		D	First dose of D
	<u>E</u>		F	Antibiotic E
<u>E</u>	E E		L	First dose of E
M	<u>A</u> B A		M	First dose of A
<u>M</u>	A B M A		M	First dose of M

- Stop abstracting three hours after the presentation of severe sepsis.

- Select “UTD” if no antibiotic was started in the 24 hours before or three hours after the Severe Sepsis Presentation Time.
- Do not cross reference between different sources to infer that an antibiotic was started if it was documented only with name/date/time given but no route indicated. Do not use the route on the MAR for an antibiotic as the route for a dose of the same antibiotic on another form.
- Do not use an antibiotic dose if the antibiotic name, route, date or time is missing.
- Only abstract antibiotic administration information from documentation that demonstrates actual administration of the specific antibiotic within the specified time frame.

Examples:

- A physician order for IV antibiotics is not sufficient unless the antibiotic ordered was marked as “started” with date/time noted.
- Do not collect antibiotics documented on an operative report unless the surgeon states that the surgeon actually administered the dose.
- Specific documentation by one person that another person administered the antibiotic is acceptable for determining the date and time of administration.

Example:

OR nurse, S. Smith RN, documents, “Cefazolin 1 gm IV given on 1/7/20xx at 0500 per J Doe RN.” You can abstract this dose as given if it is not documented by the person that gave the dose.

- The method of designation of administration on hand-written or pre-printed forms such as MARs or eMARs, with pre-printed scheduled times for administration, must be clearly designated as started.
- Do not abstract test doses of antibiotics.
- Do not abstract antibiotics from sources that do not represent actual administration.

Examples that *do not* represent actual administration:

Pre-Op Checklist states:

IV Started at 1730

Preop Antibiotic Given at 1800

Lab on Chart

Operative report states: IV antibiotics were given prior to procedure

- Do not abstract antibiotics from narrative charting unless there is no other documentation that reflects that the same antibiotic was started during the specified time frame.

Example:

Narrative states: “Ancef 1 gram given IV prior to incision.” No other doses of Ancef are documented. You should abstract the dose in the narrative using “UTD” for missing data (no date and time).

- You may use pre-hospital records (e.g., ambulance records, nursing home records) that are considered part of the medical record for abstracting antibiotics.

Suggested Data Sources:

- Anesthesia record
- Entire Emergency Department record
- ICU flow sheet
- IV flow sheet

- Medication administration record
- Nurses notes
- Operating room record
- PACU/recovery room record
- Perfusion record
- Physician/APN/PA notes
- Pre-arrival documentation that is part of the medical record

Inclusion Guidelines for Abstraction:

- Antibiotic administered via intravenous route
- Intramuscular or IM
- Intraosseous or IO
- Intravenous
- IV Bolus
- IV infusion

Exclusion Guidelines for Abstraction:

- Give antibiotic stat
- Hang antibiotic
- Order for xx antibiotic

Data Element Name: *Clinical Trial*

Collected For CMS: SEP-1

Definition: Documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied.

Suggested Data Collection Question: During this hospital stay, was the patient enrolled in a clinical trial in which patients with the same condition as the measure set were being studied?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

Y (Yes) There is documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied.

N (No) There is no documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied, or unable to determine from medical record documentation.

Notes for Abstraction:

- To select “Yes” to this data element, BOTH of the following must be true:
 1. **There must be a signed consent form for clinical trial.** For the purposes of abstraction, a clinical trial is defined as an **experimental study** in which research subjects are recruited and assigned a treatment/intervention and their outcomes are measured based on the intervention received. Treatments/interventions most often include use of drugs, surgical procedures, and devices. Often a control group is used to compare with the treatment/intervention. Allocation of different interventions to participants is usually randomized.
 2. **There must be documentation on the signed consent form that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied.** Patients may either be newly enrolled in a clinical trial during the hospital stay or enrolled in a clinical trial prior to arrival and continued active participation in that clinical trial during this hospital stay.
- In the following situations, select “No”:

1. There is a signed patient consent form for an observational study only. Observational studies are non-experimental and involve no intervention (e.g., registries). Individuals are observed (perhaps with lab draws, interviews, etc.), data is collected, and outcomes are tracked by investigators. Although observational studies may include the assessment of the effects of an intervention, the study participants are not allocated into intervention or control groups.
 2. It is not clear whether the study described in the signed patient consent form is experimental or observational.
 3. It is not clear which study population the clinical trial is enrolling. Assumptions should not be made if it is not specified.
- Only capture patients enrolled in clinical trials studying patients with sepsis, severe sepsis or septic shock (treatment and interventions).

Suggested Data Sources:

ONLY ACCEPTABLE SOURCES

Signed consent form for clinical trial

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Crystalloid Fluid Administration*

Collected For CMS: SEP-1

Definition: Documentation of initiation of crystalloid fluids within the specified time frame AND complete infusion of the target ordered volume.

Suggested Data Collection Question: Were crystalloid fluids initiated within the specified time frame AND completely infused based on the target ordered volume?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

- | | |
|---------|--|
| 1 (Yes) | Target volume of crystalloid fluids were ordered AND initiated within the specified time frame. Additionally, the target ordered volume was completely infused. |
| 2 (No) | Less than the target volume of crystalloid fluids were ordered OR initiated within the specified time frame. The target ordered volume was not completely infused. |
| 3 (No) | The target volume of crystalloid fluids was NOT initiated within the specified time frame, or unable to determine. |
| 4 (No) | There is documentation the patient has an implanted Ventricular Assist Device (VAD) OR documentation of the patient or authorized patient advocate refusal of IV fluids. |

Notes for Abstraction:

- The specified time frame for abstraction of crystalloid fluids is within six hours prior through three hours after either of the following trigger events. If both are present, use the earliest trigger event within the specified time frame.
 - Initial Hypotension Date and Time
 - Septic Shock Presentation Date and Time
- Crystalloid fluid volumes ordered that are equivalent to 30 mL/kg or a lesser volume with a reason for the lesser volume specifically documented by the physician/APN/PA are the target ordered volume.
- A physician/APN/PA order for a volume of crystalloid fluids that is within 10% less than 30 mL/kg is acceptable for the target ordered volume. Documentation of a reason for a volume that is within 10% less than 30 mL/kg is not required.

Example:

2000 mL of normal saline was ordered and initiated in the ED. The patient's weight is not available or documented at the time of the order. After admission to critical care a weight is obtained of 74 kg. Based on this weight 30 mL/kg is 2220 mL. The

target ordered volume is 2000 mL because it is within 10% less than 2220 mL (2220 mL – 222 mL = 1998 mL).

- A physician/APN/PA order for less than 30 mL/kg of crystalloid fluids is acceptable for the target ordered volume if all of the following criteria were met:
 - There is a physician/APN/PA order for the lesser volume of crystalloid fluids as either a specific volume (e.g., 1500 mL) or a weight-based volume (e.g., 25 mL/kg).
 - The ordering physician/APN/PA documented within a single note in the medical record all of the following:
 - The volume of fluids to be administered as either a specific volume (e.g., 1500 mL) or a weight-based volume (e.g., 25 mL/kg).
 - AND a reason for ordering a volume less than 30 mL/kg of crystalloid fluids. Reasons include and are not limited to:
 - concern for fluid overload
 - heart failure
 - renal failure
 - blood pressure responded to lesser volume
 - a portion of the crystalloid fluid volume was administered as colloids (if a portion consisted of colloids, there must be an order and documentation that colloids were started or noted as given)
 - All other applicable requirements for the *Crystalloid Fluid Administration* data element are met.
- Examples:**
- Physician documentation: Lactate 5.0, heart failure concerns, 20 mL/kg NS start now, then reevaluate.
Orders: NS 0.9% IV, 20 mL/kg over 2 hours.
MAR: NS 0.9% IV 20 mL/kg, Start time 1500, Completed time 1700
Select Value “1” based on the physician documentation meeting the requirements and identifying 20 mL/kg as the target ordered volume of crystalloid fluids for this patient.
 - Physician documentation: septic shock, renal failure, 1500 mL NS evaluate for response
Orders: 1500 mL NS IV at 1000 mL/hr
MAR: IV NS 1500 mL at 1000 mL/hr start time 0800
Patient weight is 74 kg, 30 mL/kg is 2220 mL
Select Value “1” based on the physician documentation meeting the requirements for a lesser volume and identifying 1500 mL as the target ordered volume of crystalloid fluids for this patient.
- The target ordered volume must be ordered and initiated within the specified time frame if initial hypotension or septic shock is present.
 - To select Value “1,” the target ordered volume must be documented as completely infused.
 - The target ordered volume does NOT need to be completely infused within the specified time frame.
 - If the target ordered volume is not completely infused, select Value “2.”

- To determine the target ordered volume, if a specific volume of fluid is not ordered and a volume per unit of body weight is ordered (e.g., 30 mL/kg, 20 mL/kg):
 - Use the patient weight in kilograms (kg) if documented.
 - If not documented in kg, divide the weight in pounds by 2.2; that yields the weight in kg. Round the weight to the nearest whole number.
 - Multiply the weight in kg by 30 mL, or a lesser volume if specified by a physician/APN/PA; the result is the number of mL of IV fluid that should be specified in the physician/APN/PA order(s).
 - Round the volume of IV fluid (mL) to the nearest whole number.

Examples:

 - Patient weight is 160 pounds. $160/2.2 = 72.72$ kg. Round to 73 kg. $73 \times 30 = 2190$ (mL). Physician order is “Infuse 2400 mL 0.9% Normal Saline over the next two hours.” This is acceptable because 2400 mL is greater than 2190.
 - Patient weight is 160 pounds. $160/2.2 = 72.72$ kg. Round to 73 kg. $73 \times 30 = 2190$ (mL). Physician order is “Give 1000 mL Lactated Ringers over the next 4 hours.” This is not acceptable because 1000 mL is less than 2190 and a reason for ordering less than 30 mL/kg was not documented.
- To calculate the appropriate target ordered volume use the actual or estimated weight in the following priority order.
 - Weight documented in the crystalloid fluid order
 - Weight documented closest to and prior to the order for crystalloid fluids
 - Weight documented closest to and after the order for crystalloid fluids
- Physician/APN/PA can use ideal body weight (IBW) to determine the target ordered volume if all of the following conditions are met. Other acceptable weight terms include predicted weight, dosing weight, and adjusted body weight.
 - Physician/APN/PA documents the patient is obese (defined as BMI >30).
 - Physician/APN/PA documents IBW is used to determine target ordered volume.
 - IBW is present in the medical record, abstractors should not calculate the IBW.
- If the total volume of crystalloid fluids ordered is less than the target ordered volume, select Value “2.”
- If there is documentation the infusion was stopped prior to reaching the target ordered volume, select Value “2.”
- Documentation of fluid initiation:
 - Medical record documentation must be clear that crystalloid fluids were initiated (i.e., date and time of administration is noted).
 - Do not use physician/APN/PA orders as equivalent to actual initiation of fluids as they are not specific to initiation.
- Crystalloid fluid orders:
 - Physician/APN/PA orders are required for the fluids.
 - The order must include the type of fluid, the volume of fluid, and a rate or time over which the fluids are to be given.
 - The terms bolus, wide-open, or open are acceptable for a rate or infusion duration.

- If the type of fluid, volume of fluid, rate or infusion duration is missing, do not use the order toward the target ordered volume.
 - The target ordered volume may be in a single order or a series of multiple orders.
 - If crystalloid fluids are initiated via multiple physician/APN/PA orders, only abstract crystalloid fluids initiated within the specified time frame.
 - If crystalloid fluids are initiated via multiple physician/APN/PA orders, begin with abstracting the earliest crystalloid fluids ordered that are initiated within the specified time frame. Evaluate all crystalloid fluids ordered and include the fluids if they contribute to the target ordered volume and are initiated within the specified time frame.
 - **Exception for Prior to Arrival:** Documentation of crystalloid fluids administered prior to arrival to the hospital (e.g., ambulance, nursing home) that are part of the medical record are acceptable if the documentation of fluid administration contains the type, volume, start time, and either a rate, duration, or end time of the fluid infusion. A physician/APN/PA order for fluids administered prior to arrival is not required.
 - **Exception for Operating Room (OR):** Crystalloid fluids administered in the OR by a physician/APN/PA are acceptable without an order if a fluid type, volume, an infusion start time, and an infusion rate or infusion end time is documented.
 - To determine if the target ordered volume was completely infused, one of the following must be documented along with the infusion start time. If one of the following is not documented, do not use the fluids toward the target ordered volume:
 - Infusion rate (e.g., 1000 mL/hr)
 - Infusion duration or time over which to infuse (e.g., 1000 mL over 30 minutes)
 - Infusion end or completion time (e.g., MAR documentation of 1000 mL End Time 12:00)
- Examples:**
- Order for 1500 mL (30 mL/kg) of normal saline over 1 hour started at 08:00. There is no infusion end time documented, and no documentation indicating the 1500 mL was not infused. The infusion end time can be determined based on the duration in the order. Select Value “1.”
 - Order for 1000 mL (30 mL/kg) normal saline bolus started at 09:30. The nurse documented an infusion rate of 1000 mL/hour. There is no fluid bolus end time documented, and no documentation indicating the 1000 mL was not infused. The infusion end time can be determined based on the rate. Select Value “1.”
 - Order for 2000 mL (30 mL/kg) normal saline bolus started at 08:30. There is no infusion rate documented and no fluid bolus end time documented. An infusion end time cannot be determined. Choose Value “2.”
- If the ordered rate or duration to infuse fluids is different from the rate or duration over which the fluids were actually administered, use the rate, duration, or end time over which the fluids were actually administered.

Example:

- Fluid Order: 0.9% NS 1000 mL bolus at 150 mL/hr
- Nurse documents a start time of 1500 and end time of 1800 for the 1000 mL bolus
 - Use the start and stop time documented by nursing that reflects the duration over which the fluids were actually administered.
- Only include crystalloid fluids given at a rate greater than 125 mL/hour towards the target ordered volume. Do not use crystalloid fluids given at 125 mL/hr or less toward the target ordered volume.
- Acceptable fluids are crystalloid or balanced crystalloid solutions.
- Crystalloid fluids or balanced crystalloid fluids that are given to dilute medications may be used toward the target ordered volume. If the volume infused without dilution fluids is the same as the target ordered volume, fluids used for diluting medications do not need to be counted.
- Crystalloid fluid volumes to which the following electrolytes have been added may be counted toward the target ordered volume requirement: potassium, magnesium, calcium, lactate, acetate, or gluconate.
- Only abstract fluids administered through the intravenous or intraosseous route.
- Select Value “3” if no crystalloid fluids were ordered or initiated within the specified time frame or the volume is unable to be determined.
- Select Value “4” if there is documentation that the patient has an implanted ventricular assist device (VAD) prior to or at the time of identifying the need for crystalloid fluids, regardless of the volume and rate of crystalloid fluids ordered.
- Select Value “4” if physician/APN/PA or nursing documentation indicates patient or authorized patient advocate has refused IV fluid administration prior to or within six hours following presentation of septic shock.
- For purposes of abstraction only, an authorized patient advocate is someone who is authorized to make decisions on behalf of the patient when the patient is not able to. This includes someone who is legally designated and empowered to make medical decisions on the patient's behalf when the patient is unable to themselves. Examples:
 - Family members
 - Medical power of attorney
 - Health care power of attorney
 - Durable power of attorney for health care
 - Someone documented as an agent for the patient
 - Attorney-in-fact

Suggested Data Sources:

- Ambulance or transport vehicle records
- Entire ED record
- Input and Output (I&O) flowsheet
- IV therapy record
- Medication Administration Record
- Patient weight record
- Physician/APN/PA orders

Inclusion Guidelines for Abstraction:

- 0.9% saline solution

- 0.9% Sodium Chloride Solution
- Isolyte
- Lactated Ringers Solution
- normal saline
- Normosol
- PlasmaLyte

Exclusion Guidelines for Abstraction:

Crystalloid solutions that are given to flush other medications or IV lines

Data Element Name: *Crystalloid Fluid Administration Date*

Collected For CMS: SEP-1

Definition: The earliest date on which crystalloid fluids were initiated within the specified time frame.

Suggested Data Collection Question: What was the earliest date on which crystalloid fluids were initiated within the specified time frame?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD

Type: Date

Occurs: 1

Allowable Values:

MM = Month (01-12)

DD = Day (01-31)

YYYY = Year (20xx)

UTD = Unable to Determine

Notes for Abstraction:

- Crystalloid fluid volumes ordered that are equivalent to 30 mL/kg, within 10% less than 30 mL/kg, or a volume less than 30 mL/kg with the required physician/APN/PA documentation are considered the target ordered volume.
- The specified time frame for abstraction of crystalloid fluids is within six hours prior through three hours after either of the following trigger events. If both are present the specified time frame is determined by the earliest trigger.
 - Initial Hypotension Date and Time
 - Septic Shock Presentation Date and Time
- If a single order is written for the target ordered volume, use the date the crystalloid solution was started as an IV infusion.
- If a single order is written for the target ordered volume and the infusion is given over multiple infusions, use the start date of the first crystalloid fluid infusion.
- If using multiple orders toward the target ordered volume, use the start date of the crystalloid fluid infusion that completed the target ordered volume.
- If multiple infusions end on the same date, and complete the target ordered volume, use the start date of the infusion that was started last.

Example:

30 mL/kg = 2500 mL

Order 1: NS 2000 mL over 2 hours - started 1/2/2021

Order 2: NS 500 mL over 30 minutes - started 1/3/2021

Because both infusions end on 1/3/2021, use 1/3/2021, the date of the infusion that was started last, for the *Crystalloid Fluid Administration Date*.

- If a crystalloid infusion is running at a maintenance rate (125 mL/hour or less) and the rate is increased to administer the target ordered volume, use the date the infusion rate is increased.

- Do not abstract the date that fluids were ordered or the date that IV access was started. Abstract the date that the crystalloid fluid infusion began.
- Do not use physician orders as fluid administration start date and time; use the date and time that the fluid infusion was initiated.
- Documentation of crystalloid fluids administered prior to arrival to the hospital (e.g., ambulance, nursing home) that are part of the medical record are acceptable if the documentation of fluid administration contains the type, volume, start time, and rate, duration, or end time of the fluid infusion. A physician/APN/PA order for fluids administered prior to arrival is not required.

Suggested Data Sources:

- Ambulance or transport vehicle records
- Entire ED record
- IV therapy records or flow sheet
- Medication Administration Record

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Crystalloid Fluid Administration Time*

Collected For CMS: SEP-1

Definition: The earliest time at which crystalloid fluids were initiated within the specified time frame.

Suggested Data Collection Question: What was the earliest time at which crystalloid fluids were initiated within the specified time frame?

Format:

Length: 5 - HH:MM (with or without colon) or UTD

Type: Time

Occurs: 1

Allowable Values:

HH = Hour (00-23)

MM = Minutes (00-59)

UTD = Unable to Determine

Time must be recorded in military time format.

With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight – 00:00	Noon – 12:00
5:31 am – 05:31	5:31 pm – 17:31
11:59 am – 11:59	11:59 pm – 23:59

Notes for Abstraction:

- Crystalloid fluid volumes ordered that are equivalent to 30 mL/kg, within 10% less than 30 mL/kg, or a volume less than 30 mL/kg with the required physician/APN/PA documentation are considered the target ordered volume.
- The specified time frame for abstraction of crystalloid fluids is within six hours prior through three hours after either of the following trigger events. If both are present the specified time frame is determined by the earliest trigger.
 - Initial Hypotension Date and Time
 - Septic Shock Presentation Date and Time
- If a single order is written for the target ordered volume, use the time the crystalloid solution was started as an IV infusion.
- If a single order is written for the target ordered volume and the infusion is given over multiple infusions, use the start time of the first crystalloid fluid infusion.
- If using multiple orders toward the target ordered volume, use the start time of the crystalloid fluid infusion that completed the target ordered volume.
- If multiple infusions end at the same time, and complete the target ordered volume, use the start time of the infusion that was started last.

Example:

30 mL/kg = 2500 mL

Order 1: NS 2000 mL over 2 hours - started 0800

Order 2: NS 500 mL over 30 minutes - started 0930

Because both infusions end at 10:00, use 09:30, the time of the infusion that was started last, for the *Crystalloid Fluid Administration Time*.

- If a crystalloid infusion is running at a maintenance rate (125 mL/ hour or less) and the rate is increased to administer the target ordered volume, use the time the infusion rate is increased.
- Do not abstract the time that fluids were ordered or the time that IV access was started. Abstract the time that the crystalloid fluid infusion began.
- Do not use physician orders as fluid administration start date and time; use the date and time that the fluid infusion was initiated.
- Documentation of crystalloid fluids administered prior to arrival to the hospital (e.g., ambulance, nursing home) that are part of the medical record are acceptable if the documentation of fluid administration contains the type, volume, start time, and rate, duration, or end time of the fluid infusion. A physician/APN/PA order for fluids administered prior to arrival is not required.

Suggested Data Sources:

- Ambulance or transport vehicle records
- Entire ED record
- IV therapy records or flow sheet
- Medication Administration Record

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Directive for Comfort Care or Palliative Care, Septic Shock*

Collected For CMS: SEP-1

Definition: Physician/APN/PA documentation of comfort measures only, palliative care, or another acceptable inclusion term within the specified time frame.

Comfort Care refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient's family. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).

Palliative Care is the identification, prevention, and treatment of suffering by means of assessment of the physical, psychosocial, intellectual, and spiritual needs of the patient with a goal of supporting and optimizing the patient's quality of life. Palliative care ensures a partnership between practitioner, patient, and family to provide support in decision making at any stage in the patient's care.

Suggested Data Collection Question: Is there physician/APN/PA documentation of comfort measures only, palliative care, or another inclusion term?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

- | | |
|---------|---|
| 1 (Yes) | There is physician/APN/PA documentation of an inclusion term within an acceptable context within the specified time frame . |
| 2 (No) | There is not physician/APN/PA documentation of an inclusion term within an acceptable context within the specified time frame or unable to determine from medical record documentation. |

Notes for Abstraction:

- The specified time frame for physician/APN/PA documentation of comfort measures only, palliative care, or another inclusion term is before or within six hours after the presentation of septic shock.
- Only accept terms identified in the list of inclusions. Do not accept any other terminology.
- Only use physician/APN/PA documentation of an inclusion term documented in the following contexts:
 - Comfort measures only recommendation
 - Order for consultation or evaluation by a hospice care service
 - Patient or patient representative request for comfort measures only
 - Plan for comfort measures only
 - Referral to hospice care service

- Do not use documentation of an inclusion term if it is not documented in one of the acceptable contexts.

Examples of unacceptable contexts:

- “Discussion of comfort measures”
- “Consider palliative care”
- State-authorized portable orders (SAPOs):
 - SAPOs are specialized forms or identifiers authorized by state law that translate a patient’s preferences about specific end-of-life treatment decisions into portable medical orders.

Examples:

- DNR-Comfort Care form
- MOLST (Medical Orders for Life-Sustaining Treatment)
- POLST (Physician Orders for Life-Sustaining Treatment)
- Out-of-Hospital DNR (OOH DNR)
- Select Value “1” if there is an SAPO in the record that is dated and signed prior to arrival with an option in which an inclusion term is found that is checked.
- Select Value “1” if an SAPO lists different options for CMO and any CMO option is checked.
- Use the most recent SAPO if one or more dated SAPOs are included in the record (and signed by the physician/APN/PA). Do not use undated SAPOs.
- For cases where there is a SAPO in the record with a CMO option selected:
 - Do not use the SAPO if there is documentation on the day of arrival up to septic shock presentation indicating the patient or patient representative does not want CMO, and there is no other documentation regarding CMO found in the record.

Example:

Patient has a POLST dated prior to arrival in his chart and ED physician states in current record “Patient is refusing comfort measures, wants to receive full treatment and be a full code.”

- Do not use an inclusion term documented in the following situations. Continue to review the remaining physician/APN/PA documentation for acceptable inclusion terms. Select Value “2” if the **ONLY** documentation found is an inclusion term in the following situations.

- Documentation (other than SAPOs) that is dated prior to arrival or documentation which refers to the pre-arrival time period.

Examples:

- Comfort measures only or palliative care order in previous hospitalization record.
- “Pt. on hospice at home” in MD ED note.
- Inclusion term clearly described as negative or conditional.

Examples:

- “No comfort care”
- “Not appropriate for hospice care”
- “Comfort care would also be reasonable - defer decision for now”
- “DNRCCA” (Do Not Resuscitate – Comfort Care Arrest)
- “Family requests comfort measures only should the patient arrest.”

- Do not use documentation of “CMO” if documentation makes clear it is not being used as an acronym for Comfort Measures Only (e.g., “hx dilated CMO” – Cardiomyopathy context).
- Select Value “1” if there is physician/APN/PA documentation of an acceptable inclusion term in one source that indicates the patient is Comfort Measures Only or Palliative Care, AND there is physician/APN/PA documentation of an inclusion term in another source that indicates the patient is NOT CMO or Palliative Care. Use the source that indicates the patient is CMO or Palliative Care.

Suggested Data Sources:

PHYSICIAN/APN/PA DOCUMENTATION ONLY

- Consultation notes
- Discharge summary
- DNR/MOLST/POLST forms
- Emergency Department record
- History and physical
- Physician orders
- Progress notes

Excluded Data Sources:

Restraint order sheet

Inclusion Guidelines for Abstraction:

- Brain dead
- Brain death
- Comfort care
- Comfort measures
- Comfort measures only (CMO)
- Comfort only
- DNR-CC
- End of life care
- Hospice
- Hospice care
- Organ harvest
- Palliative Care
- Palliative Consult
- Terminal care
- Terminal extubation
- Withdraw care
- Withhold care

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Directive for Comfort Care or Palliative Care, Severe Sepsis*

Collected For CMS: SEP-1

Definition: Physician/APN/PA documentation of comfort measures only, palliative care, or another acceptable inclusion term before or within the specified time frame.

Comfort Care refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient's family. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).

Palliative Care is the identification, prevention, and treatment of suffering by means of assessment of the physical, psychosocial, intellectual, and spiritual needs of the patient with a goal of supporting and optimizing the patient's quality of life. Palliative care ensures a partnership between practitioner, patient, and family to provide support in decision making at any stage in the patient's care.

Suggested Data Collection Question: Is there physician/APN/PA documentation of comfort measures only, palliative care, or another inclusion term?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

1 (Yes) There is physician/APN/PA documentation of an inclusion term within an acceptable context within the specified time frame.

2 (No) There is not physician/APN/PA documentation of an inclusion term within an acceptable context within the specified time frame, or unable to determine from medical record documentation.

Notes for Abstraction:

- The specified time frame for physician/APN/PA documentation of comfort measures only, palliative care, or another inclusion term is before or within six hours after the presentation of severe sepsis.
- Only accept terms identified in the list of inclusions. Do not accept any other terminology.
- Only use physician/APN/PA documentation of an inclusion term documented in the following contexts:
 - Comfort measures only recommendation
 - Order for consultation or evaluation by a hospice care service
 - Patient or patient representative request for comfort measures only
 - Plan for comfort measures only
 - Referral to hospice care service

- Do not use documentation of an inclusion term if it is not documented in one of the acceptable contexts.
Examples of unacceptable contexts:
 - “Discussion of comfort measures”
 - “Consider palliative care”
- State-authorized portable orders (SAPOs):
 - State-authorized portable orders (SAPOs):
 - SAPOs are specialized forms or identifiers authorized by state law that translate a patient’s preferences about specific end-of-life treatment decisions into portable medical orders.
Examples:
 - DNR-Comfort Care form
 - MOLST (Medical Orders for Life-Sustaining Treatment)
 - POLST (Physician Orders for Life-Sustaining Treatment)
 - Out-of-Hospital DNR (OOH DNR)
 - Select Value “1” if there is an SAPO in the record that is dated and signed prior to arrival with an option in which an inclusion term is found that is checked.
 - Select Value “1” if an SAPO lists different options for CMO and any CMO option is checked.
 - Use the most recent SAPO if one or more dated SAPOs are included in the record (and signed by the physician/APN/PA). Do not use undated SAPOs.
 - For cases where there is a SAPO in the record with a CMO option selected: Do not use the SAPO if there is documentation on the day of arrival up to severe sepsis presentation indicating the patient or patient representative does not want CMO, and there is no other documentation regarding CMO found in the record.
Example:
 Patient has a POLST dated prior to arrival in his chart and ED physician states in current record “Patient is refusing comfort measures, wants to receive full treatment and be a full code.”
- Do not use an inclusion term documented in the following situations. Continue to review the remaining physician/APN/PA documentation for acceptable inclusion terms. Select Value “2” if the **ONLY** documentation found is an inclusion term in the following situations.
 - Documentation (other than SAPOs) that is dated prior to arrival or documentation which refers to the pre-arrival time period.
Examples:
 - Comfort measures only or palliative care order in previous hospitalization record.
 - “Pt. on hospice at home” in MD ED note.
 - Inclusion term clearly described as negative or conditional.
Examples:
 - “No comfort care”
 - “Not appropriate for hospice care”
 - “Comfort care would also be reasonable - defer decision for now”
 - “DNRCCA” (Do Not Resuscitate – Comfort Care Arrest)

- “Family requests comfort measures only should the patient arrest.”
 - Do not use documentation of “CMO” if documentation makes clear it is not being used as an acronym for Comfort Measures Only (e.g., “hx dilated CMO” – Cardiomyopathy context).
- Select Value “1” if there is physician/APN/PA documentation of an inclusion term in one source that indicates the patient is Comfort Measures Only or Palliative Care, AND there is physician/APN/PA documentation of an inclusion term in another source that indicates the patient is NOT CMO or Palliative Care. Use the source that indicates the patient is CMO or Palliative Care would be used.

Suggested Data Sources:

PHYSICIAN/APN/PA DOCUMENTATION ONLY

- Consultation notes
- Discharge summary
- DNR/MOLST/POLST forms
- Emergency Department record
- History and physical
- Physician orders
- Progress notes

Excluded Data Sources:

Restraint order sheet

Inclusion Guidelines for Abstraction:

- Brain dead
- Brain death
- Comfort care
- Comfort measures
- Comfort measures only (CMO)
- Comfort only
- DNR-CC
- End of life care
- Hospice
- Hospice care
- Organ harvest
- Palliative Care
- Palliative Consult
- Terminal care
- Terminal extubation
- Withdraw care
- Withhold care

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Discharge Date*

Collected For CMS: All Records

Definition: The month, day, and year the patient was discharged from acute care, left against medical advice, or expired during this stay.

Suggested Data Collection Question: What is the date the patient was discharged from acute care, left against medical advice (AMA), or expired?

Format:

Length: 10 – MM-DD-YYYY (includes dashes)

Type: Date

Occurs: 1

Allowable Values:

MM = Month (01-12)

DD = Day (01-31)

YYYY = Year (20xx)

Note: The CMS Clinical Data Warehouse only allows data containing dates applicable to a specified quarter of data transmission. Data submitted for discharge quarters outside of the current submission deadline will be rejected.

Refer to the Data Transmission section of this manual for further guidance related to data transmission.

Notes for Abstraction:

Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.

Suggested Data Sources:

- Discharge summary
- Face sheet
- Nursing discharge notes
- Physician orders
- Progress notes
- Transfer note
- UB-04

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Discharge Disposition*

Collected For CMS: SEP-1

Definition: The final place or setting to which the patient was discharged on the day of discharge.

Suggested Data Collection Question: What was the patient's discharge disposition on the day of discharge?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

- 1 Home
- 2 Hospice - Home
- 3 Hospice – Health Care Facility
- 4 Acute Care Facility
- 5 Other Health Care Facility
- 6 Expired
- 7 Left Against Medical Advice/AMA
- 8 Not Documented or Unable to Determine (UTD)

Notes for Abstraction:

- Only use documentation written on the day prior to discharge through 30 days after discharge when abstracting this data element.

Example:

Documentation in the discharge planning notes on 04-01-20xx state that the patient will be discharged back home. On the day of discharge 04-06-20xx, the physician orders and nursing discharge notes indicate that the patient is being transferred to skilled care. Select Value "5" (Other Health Care Facility) based on the latest documentation from 04-06-20xx.

- Abstract the medical record as documented (taken at "face value"). Inferences should not be made based on internal knowledge.
- If there is documentation that further clarifies the level of care, that documentation should be used to determine the correct value to abstract. Use the latest documentation if documentation is contradictory.

Examples:

- Discharge summary on day of discharge states patient went "home." Physician note two days after discharge further clarifies that the patient went

- "home with hospice." Select Value "2" ("Hospice - Home") based on the latest documentation.
 - Discharge planning note from day before discharge states "XYZ Nursing Home." Discharge order from day of discharge states "Discharge home." Select Value "1" ("Home") based on the latest documentation.
 - Physician order on discharge states "Discharge to ALF." Discharge instruction sheet completed after the physician order states patient discharged to "SNF." Select Value "5" ("Other Health Care Facility") based on the latest documentation.
- Select the disposition ranked highest (top to bottom) in the following list if the documentation is contradictory, and you are unable to determine the latest documentation. See Inclusion lists for examples.
 - Acute Care Facility
 - Hospice – Health Care Facility
 - Hospice – Home
 - Other Health Care Facility
 - Home
- Hospice (Values "2" and "3") includes discharges with hospice referrals and evaluations.
- Select Value "4" ("Acute Care Facility") if the medical record only states that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving.
- Select Value "1" ("Home") if the medical record states the patient is being discharged to assisted living care or an assisted living facility (ALF) and the documentation also includes nursing home, intermediate care or skilled nursing facility.
- Select Value "5" ("Other Health Care Facility") if the medical record states the patient is being discharged to nursing home, intermediate care or skilled nursing facility without mention of assisted living care or assisted living facility (ALF).
- Select Value "5" ("Other Health Care Facility") if the medical record identifies the facility the patient is being discharged to by name only (e.g., "Park Meadows"), and does not reflect the type of facility or level of care.
- Select Value "1" ("Home") if the medical record states only that the patient is being "discharged" and does not address the place or setting to which the patient was discharged.
- When determining whether to select Value "7" ("Left Against Medical Advice/AMA"):
 - Explicit "left against medical advice" documentation is not required. E.g., "Patient is refusing to stay for continued care" – Select Value "7."
 - Documentation suggesting that the patient left before discharge instructions could be given is not acceptable to select Value "7".
 - A signed AMA form is not required, for the purposes of this data element.
 - Do not consider AMA documentation and other disposition documentation as "contradictory." If any source states the patient left against medical advice, select Value "7," regardless of whether the AMA documentation was written last. E.g., AMA form signed and discharge instruction sheet states "Discharged home with belongings" – Select Value "7."

Suggested Data Sources:

- Discharge instruction sheet
- Discharge planning notes
- Discharge summary
- Nursing discharge notes
- Physician orders
- Progress notes
- Social service notes
- Transfer record

Excluded Data Sources:

- Any documentation prior to the last two days of hospitalization
- Coding documents
- UB-04

Inclusion Guidelines for Abstraction:

Home (Value 1):

- Assisted Living Facilities (ALFs) – Includes ALFs and assisted living care at: nursing home, intermediate care, and skilled nursing facilities
- Court/Law Enforcement – includes detention facilities, jails, and prison
- Home – includes board and care, foster or residential care, group or personal care homes, retirement communities, and homeless shelters
- Home with Home Health Services
- Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs and Partial Hospitalization

Hospice – Home (Value 2):

- Hospice in the home (or other “Home” setting as above in Value 1)

Hospice – Health Care Facility (Value 3):

- Hospice - General Inpatient and Respite
- Hospice - Residential and Skilled Facilities
- Hospice - Other Health Care Facilities

Acute Care Facility (Value 4):

- Acute Short Term General and Critical Access Hospitals
- Cancer and Children’s Hospitals
- Department of Defense and Veteran’s Administration Hospitals

Other Health Care Facility (Value 5):

- Extended or Intermediate Care Facility (ECF/ICF)
- Long Term Acute Care Hospital (LTACH)
- Nursing Home or Facility including Veteran’s Administration Nursing Facility
- Psychiatric Hospital or Psychiatric Unit of a Hospital
- Rehabilitation Facility including, but not limited to: Inpatient Rehabilitation Facility/Hospital, Rehabilitation Unit of a Hospital, Chemical Dependency/Alcohol Rehabilitation Facility
- Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed
- Transitional Care Unit (TCU)
- Veterans Home

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Discharge Time*

Collected For CMS: SEP-1

Definition: The time the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay.

Suggested Data Collection Question: What time was the patient discharged?

Format:

Length: 5 - HH:MM (with or without colon) or UTD

Type: Time

Occurs: 1

Allowable Values:

HH = Hour (00-23)

MM = Minutes (00-59)

UTD = Unable to Determine

Time must be recorded in military time format.

With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight – 00:00	Noon – 12:00
5:31 am – 05:31	5:31 pm – 17:31
11:59 am – 11:59	11:59 pm – 23:59

Notes for Abstraction:

- Abstract the earliest documented time of the following:
 - Discharge from acute inpatient care
 - Left against medical advice (AMA)
 - Expired
- **Select “UTD”** if the time the patient was discharged from acute inpatient care, left AMA, or expired is unable to be determined from medical record documentation.
- **Abstract** the medical record as documented (taken at “face value”). **Select “UTD”** when the time documented is obviously **an** error (not a valid time/format) **and** no other documentation is found that provides this information.

Example:

Documentation indicates the patient expired at **3300**. No other documentation in the medical record provides a valid time. Since the Time Expired is outside of the range listed in the Allowable Values for “Hour,” it is not a valid time and the abstractor should select “UTD.”

- **Use the time the patient was pronounced** if the patient expired and there are multiple times, such as a time the patient was pronounced in physician notes and an administrative time the patient was discharged.
- **Use the discharge time** if the patient expired and there is not a pronounced time but there is a discharge time.

- **Use the time the patient actually left** if the patient was discharged from acute inpatient care, left AMA, or transferred out to another facility. **Do not use** the time the order was written.
- **Use the earliest time** if there are multiple times documented when the patient was discharged from acute inpatient care or left AMA.

Suggested Data Sources:

- Death certificate
- Discharge summary
- Nurses Notes
- Progress Notes
- Resuscitation records

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *First Name*

Collected For CMS: All Records (Optional Element)

Definition: The patient's first name.

Suggested Data Collection Question: What is the patient's first name?

Format:

Length: 30

Type: Character

Occurs: 1

Allowable Values:

Enter the patient's first name. Up to 30 letters, numbers, and/or special characters can be entered.

Note: Only the following special characters will be allowed:

~ ! @ # \$ % ^ * () _ + { } | : ? ` - = [] \ ; ' . , / and space

Notes for Abstraction:

None

Suggested Data Sources:

- Emergency Department record
- Face sheet
- History and physical

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Hispanic Ethnicity*

Collected For CMS: All Records

Definition: Documentation that the patient is of Hispanic, Latino, or Spanish ethnicity.

Suggested Data Collection Question: Is the patient of Hispanic, Latino, or Spanish Ethnicity?

Format:

Length: 1

Type: Character

Occurs: 1

Allowable Values:

Y (Yes) Patient is of Hispanic, Latino, or Spanish ethnicity.

N (No) Patient is not of Hispanic, Latino, or Spanish ethnicity or unable to determine from medical record documentation.

Notes for Abstraction:

The data element, *Race*, is required in addition to this data element.

Suggested Data Sources:

- Emergency Department record
- Face sheet
- History and physical
- Nursing admission assessment
- Progress notes

Inclusion Guidelines for Abstraction:

A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term “Spanish origin” can be used in addition to “Hispanic or Latino.”

Examples:

- Black-Hispanic
- Chicano
- Columbian
- Ecuadorian
- Dominican
- Guatemalan
- H
- Hispanic
- Latin American
- Latino/Latina
- Mexican-American

- Salvadoran
- Spaniard
- Spanish
- White-Hispanic

Exclusion Guidelines for Abstraction:

None

Data Element Name: *ICD-10-CM Other Diagnosis Codes*

Collected For CMS: All Records

Definition: The other or secondary ICD-10-CM codes associated with the diagnosis for this hospitalization.

Suggested Data Collection Question: What were the ICD-10-CM other diagnosis codes selected for this medical record?

Format:

Length: 3-7 (without decimal point or dot)

Type: Character (upper or lower case)

Occurs: 24

Allowable Values:

Any valid diagnosis code as per the CMS ICD-10-CM master code table (Code Descriptions in Tabular Order):

<https://www.cms.gov/Medicare/Coding/ICD10/index.html>

Notes for Abstraction:

None

Suggested Data Sources:

- Discharge summary
- Face sheet
- UB-04

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *ICD-10-PCS Other Procedure Codes*

Collected For CMS: All Records

Definition: The other or secondary ICD-10-PCS codes identifying all significant procedures other than the principal procedure.

Suggested Data Collection Question: What were the ICD-10-PCS code(s) selected as other procedure(s) for this record?

Format:

Length: 3-7 (without decimal point or dot)

Type: Character (upper or lower case)

Occurs: 24

Allowable Values:

Any valid procedure code as per the CMS ICD-10-PCS master code table (PCS Long and Abbreviated Titles): <https://www.cms.gov/Medicare/Coding/ICD10/index.html>

Notes for Abstraction:

None

Suggested Data Sources:

- Discharge summary
- Face sheet
- UB-04

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *ICD-10-PCS Other Procedure Dates*

Collected For CMS: All Records

Definition: The month, day, and year when the associated procedure(s) was (were) performed.

Suggested Data Collection Question: What were the date(s) the other procedure(s) were performed?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD

Type: Date

Occurs: 24

Allowable Values:

MM = Month (01-12)

DD = Day (01-31)

YYYY = Year (20xx)

UTD = Unable to Determine

Notes for Abstraction:

- If the procedure date for the associated procedure is unable to be determined from medical record documentation, select “UTD.”
- The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care [after *Discharge Date*]) **and** no other documentation is found that provides this information, the abstractor should select “UTD.”

Examples:

- Documentation indicates the *ICD-10-PCS Other Procedure Dates* was 02-**42**-20xx. No other documentation in the medical record provides a valid date. Since the *ICD-10-PCS Other Procedure Dates* is outside of the range listed in the Allowable Values for “Day,” it is not a valid date and the abstractor should select “UTD.”
- Patient expires on 02-12-20xx and documentation indicates the *ICD-10-PCS Other Procedure Dates* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *ICD-10-PCS Other Procedure Dates* is after the *Discharge Date* (death), it is outside of the parameters of care and the abstractor should select “UTD.”

Note: Transmission of a case with an invalid date as described above will be rejected from the CMS Clinical Data Warehouse. Use of “UTD” for *ICD-10-PCS Other Procedure Dates* allows the case to be accepted into the warehouse.

Suggested Data Sources:

- Consultation notes
- Diagnostic test reports
- Discharge summary
- Face sheet
- Operative notes
- Procedure notes
- Progress notes
- UB-04

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *ICD-10-CM Principal Diagnosis Code*

Collected For CMS: All Records

Definition: The ICD-10-CM diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization.

Suggested Data Collection Question: What was the ICD-10-CM code selected as the principal diagnosis for this record?

Format:

Length: 3-7 (without decimal point or dot)

Type: Character (upper or lower case)

Occurs: 1

Allowable Values:

Any valid diagnosis code as per the CMS ICD-10-CM master code table (Code Descriptions in Tabular Order):

<https://www.cms.gov/Medicare/Coding/ICD10/index.html>

Notes for Abstraction:

None

Suggested Data Sources:

- Discharge summary
- Face sheet
- UB-04

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *ICD-10-PCS Principal Procedure Code*

Collected For CMS: All Records

Definition: The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

Suggested Data Collection Question: What was the ICD-10-PCS code selected as the principal procedure for this record?

Format:

Length: 3-7 (without decimal point or dot)

Type: Character (upper or lower case)

Occurs: 1

Allowable Values:

Any valid procedure code as per the CMS ICD-10-PCS master code table (PCS Long and Abbreviated Titles):

<https://www.cms.gov/Medicare/Coding/ICD10/index.html>

Notes for Abstraction:

None

Suggested Data Sources:

- Discharge summary
- Face sheet
- UB-04

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *ICD-10-PCS Principal Procedure Date*

Collected For CMS: All Records

Definition: The month, day, and year when the principal procedure was performed.

Suggested Data Collection Question: What was the date the principal procedure was performed?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD

Type: Date

Occurs: 1

Allowable Values:

MM = Month (01-12)

DD = Day (01-31)

YYYY = Year (20xx)

UTD = Unable to Determine

Notes for Abstraction:

- If the principal procedure date is unable to be determined from medical record documentation, select “UTD.”
- The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid date/format or is outside of the parameters of care [after Discharge Date]) and no other documentation is found that provides this information, the abstractor should select “UTD.”

Examples:

- Documentation indicates the *ICD-10-PCS Principal Procedure Date* was 02-42-20xx. No other documentation in the medical record provides a valid date. Since the *ICD-10-PCS Principal Procedure Date* is outside of the range listed in the Allowable Values for “Day,” it is not a valid date and the abstractor should select “UTD.”
- Patient expires on 02-12-20xx and documentation indicates the *ICD-10-PCS Principal Procedure Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *ICD-10-PCS Principal Procedure Date* is after the *Discharge Date* (death), it is outside of the parameter of care and the abstractor should select “UTD.”

Note: Transmission of a case with an invalid date as described above will be rejected from the CMS Clinical Data Warehouse. Use of “UTD” for *ICD-10-PCS Principal Procedure Date* allows the case to be accepted into the warehouse.

Suggested Data Sources:

- Consultation notes
- Diagnostic test reports
- Discharge summary
- Face sheet
- Operative notes
- Procedure notes
- Progress notes
- UB-04

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Initial Hypotension*

Collected For CMS: SEP-1

Definition: Documentation of the presence of initial hypotension within the specified time frame and prior to the completion of the target ordered volume of crystalloid fluids.

Suggested Data Collection Question: Was initial hypotension present within the specified time frame?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

1 (Yes) Initial Hypotension was present within the specified time frame.

2 (No) Initial Hypotension was not present within the specified time frame or unable to determine from medical record documentation.

Notes for Abstraction:

- The specified time frame for assessing *Initial Hypotension* is six hours before to six hours following the *Severe Sepsis Presentation Date and Time*.
- Determine *Initial Hypotension* using the following criteria:
 - Two hypotensive blood pressure readings from measurements taken at different times within the specified time frame. The hypotensive blood pressure readings do not need to be consecutive but need to be within three hours of each other. Acceptable readings are:
 - systolic blood pressures <90, or
 - mean arterial pressures (MAP) <65 or
 - a decrease in systolic blood pressure by >40 mm/Hg.Physician/APN/PA documentation must be present in the medical record indicating a >40 mmHg decrease in SBP has occurred and is related to infection or severe sepsis and not to other causes.
- Use the time the hypotensive blood pressures were taken or obtained. If time taken or obtained is not available, use recorded or documented time. Do not abstract hypotensive values from narrative charting unless no other documentation reflects the time that the same hypotensive values were obtained.
- **Do not use** hypotensive BPs obtained in the operating room (OR), in interventional radiology, during active delivery, during cardiopulmonary arrest (code), or during procedural/conscious sedation.
- **Do not use** hypotensive BPs documented from an orthostatic BP evaluation.
- **Do not use** hypotensive BPs documented during a dialysis procedure.
- For the following, physician/APN/PA documentation before or within 24 hours after *Severe Sepsis Presentation Time* **is required**.

- If hypotension (SBP <90 mmHg or MAP <65 mmHg) is due to the following, **do not use it**. Do not make inferences. The abnormal value or reference to the abnormal value must be in the same documentation (i.e., same sentence or paragraph).
 - Normal for that patient
 - Is due to a chronic condition
 - Is due to a medication

Example:
“Hypotensive after pain meds”
- If a hypotensive value is due to an acute condition that has a non-infectious source/process, **do not use it** (refer to *Severe Sepsis Present* criterion “a” to determine if the source of the acute condition is an infection).

Examples:

 - “BP 85/50 r/t blood loss” and “2 liters lost via GI bleed” (blood loss is the acute condition and GI bleed is the non-infectious source).
 - “Hypotension, related to dehydration, not sepsis” (dehydration is the acute condition and “not sepsis” is the non-infectious source).
- If a hypotensive value should not be used based on the above guidance, **do not use any** instances of less severe values.

Example:
“BP 80/50 secondary to Lasix” (systolic blood pressures \geq 80 would not be used).
- If a hypotensive value is due to the following, **use** the criterion value.
 - Acute condition

Example:
Progress Note: “Hypotension r/t dehydration.”
 - Acute on chronic condition

Example:
H&P: “Hypotension due to acute exacerbation of chronic heart failure.”
 - Infection

Example:
Physician Note: “Sepsis, hypotensive.”
- Physician/APN/PA documentation of a term that is defined by an SBP <90 mmHg or MAP <65 mmHg is acceptable in place of an abnormal value when the term is documented as normal for the patient, due to a chronic condition, due to a medication, or due to an acute condition that has a non-infectious source/process.

Example:
Hypotension (Systolic blood pressure <90 mmHg).
- Use the criterion value if there is conflicting documentation within the same physician/APN/PA documentation indicating hypotension is:
 - normal for the patient, due to a chronic condition or medication, or due to an acute condition with a non-infectious source
 - AND
 - due to or possibly due to an infection, severe sepsis, or septic shock.

Example:
“Hypotensive post medications, possibly r/t sepsis.”
In this example, use the hypotensive readings.

- Abstract based on the latest piece of documentation within 24 hours after *Severe Sepsis Presentation Time* if there is conflicting information within **two or more separate** pieces of physician/APN/PA documentation indicating hypotension is:
 - normal for the patient, due to a chronic condition or medication, or due to an acute condition with a non-infectious source
AND
 - due to or possibly due to an infection, severe sepsis, or septic shock

Example:
 Note 1200: “Antihypertensive discontinued due to hypotension.”
 Note 1600: “Sepsis with hypotension and SIRS criteria.”

 - In this example, use the hypotensive readings.
 - Abstract based on the documentation closest to the *Severe Sepsis Presentation Time* if there is conflicting information before the *Severe Sepsis Presentation Time* within two or more separate pieces of physician/APN/PA documentation indicating hypotension is:
 - normal for the patient, due to a chronic condition or medication, or due to an acute condition with a non-infectious source
AND
 - due to or possibly due to an infection, severe sepsis, or septic shock
 - Select Value “2” if the target ordered volume of crystalloid fluids was completely infused before the hypotensive readings.
 - Select Value “1” if the hypotension readings were present within six hours prior to or within six hours following *Severe Sepsis Presentation Date and Time*.
 - Select Value “2” if the hypotension readings were not present within six hours prior to or within six hours following *Severe Sepsis Presentation Date and Time*.
 - If within 24 hours of the *Severe Sepsis Presentation Time* there is physician/APN/PA or nursing documentation indicating a hypotensive reading is invalid, erroneous or questionable, **do not use** that reading when determining the presence of *Initial Hypotension*.
 - If there is physician/APN/PA documentation indicating the patient does not have hypotension and the documentation is referencing a specific time period in which there was one or more hypotensive values recorded, **do not use** the hypotensive value(s). The documentation must be within 24 hours following the low blood pressure value(s).
- Example:**
- Progress note: “Not hypotensive in ED.”
 - Do not use hypotensive values from the ED.
- To determine the presence of *Initial Hypotension*, you may use documentation in pre-hospital records (e.g., ambulance records, nursing home records) that are considered part of the medical record. Select Value “2” if the criteria for determining *Initial Hypotension* were met prior to arrival and the first blood pressure reading upon arrival to the ED or hospital was not hypotensive.

Suggested Data Sources:

- Entire ED record
- Nurses notes
- Physician/APN/PA notes
- Vital signs record or flow sheet

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Initial Hypotension Date*

Collected For CMS: SEP-1

Definition: The date of the documentation of initial hypotension in the six hours prior to or within six hours following *Severe Sepsis Presentation Date and Time* and prior to the completion of the target ordered volume of crystalloid fluids.

Suggested Data Collection Question: On which date was initial hypotension present six hours prior to or within six hours following *Severe Sepsis Presentation Date and Time*?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD

Type: Date

Occurs: 1

Allowable Values:

MM = Month (01-12)

DD = Day (01-31)

YYYY = Year (20xx)

UTD = Unable to Determine

Notes for Abstraction:

- Use the earliest date of the second hypotensive blood pressure documented within the time period of six hours prior to or within six hours following *Severe Sepsis Presentation Date and Time* (to determine the second hypotensive blood pressure, see the *Initial Hypotension* data element).
- For patients with more than two hypotensive blood pressures in the time period of six hours prior to or within six hours following *Severe Sepsis Presentation Date and Time*, use the date of the second hypotensive blood pressure documented within the time period.
- Use the date documented for when hypotensive blood pressure was taken or obtained. If date taken or obtained is not available, use recorded or documented date.
- **Exception for Prior to Arrival:**
 - For patients who met criteria for *Initial Hypotension* prior to arrival and remain hypotensive when they arrive at the Emergency Department (ED), use the earliest documented ED arrival date.
 - For patients who met criteria for *Initial Hypotension* prior to arrival and remain hypotensive when they arrive to the hospital, use the earliest documented date when the patient arrives to floor or unit.

Suggested Data Sources:

- Entire ED record
- Nurses notes
- Physician/APN/PA notes

- Vital signs record or flow sheet

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Initial Hypotension Time*

Collected For CMS: SEP-1

Definition: The time of the documentation of initial hypotension in the six hours prior to or within six hours following *Severe Sepsis Presentation Date and Time* and prior to the completion of the target ordered volume of crystalloid fluids.

Suggested Data Collection Question: At which time was initial hypotension present six hours prior to or within six hours following *Severe Sepsis Presentation Date and Time*?

Format:

Length: 5 - HH:MM (with or without colon) or UTD

Type: Time

Occurs: 1

Allowable Values:

HH = Hour (00-23)

MM = Minutes (00-59)

UTD = Unable to Determine

Time must be recorded in military time format.

With the exception of midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight – 00:00	Noon – 12:00
5:31 am – 05:31	5:31 pm – 17:31
11:59 am – 11:59	11:59 pm – 23:59

Notes for Abstraction:

- Use the earliest time of the second hypotensive blood pressure documented within the time period of six hours prior to or within six hours following *Severe Sepsis Presentation Date and Time* (to determine the second hypotensive blood pressure, see the *Initial Hypotension* data element).
- For patients with more than two hypotensive blood pressures in the time period of six hours prior to or within six hours following *Severe Sepsis Presentation Date and Time*, use the time of the second hypotensive blood pressure documented within the time period.
- Use the time documented for when hypotensive blood pressure was taken or obtained. If time taken or obtained is not available, use recorded or documented time.
- **Exception for Prior to Arrival:**

- For patients who met criteria for *Initial Hypotension* prior to arrival and remain hypotensive when they arrive at the Emergency Department (ED), use the earliest documented ED arrival time.
- For patients who met criteria for *Initial Hypotension* prior to arrival and remain hypotensive when they arrive to the hospital, use the earliest documented time when the patient arrives to floor or unit.

Suggested Data Sources:

- Entire ED record
- Nurses notes
- Physician/APN/PA notes
- Vital signs record or flow sheet

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Initial Lactate Level Collection*

Collected For CMS: SEP-1

Definition: Documentation of collection of an initial lactate level within the specified time frame.

Suggested Data Collection Question: Was an initial lactate level drawn within the specified time frame?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

- 1 (Yes) An initial lactate level was drawn within the specified time frame.
- 2 (No) An initial lactate level was not drawn within the specified time frame, or unable to determine.

Notes for Abstraction:

- The specified time frame within which an initial lactate must be drawn is within six hours prior through three hours following severe sepsis presentation.
 - If multiple lactate levels are drawn within the specified time frame, use the highest lactate level drawn from the *Severe Sepsis Presentation Time* to six hours before. Use a lactate level drawn at the same time as the *Severe Sepsis Presentation Time* if it has the highest level.
 - If multiple lactate levels are drawn ONLY in the three hours after the *Severe Sepsis Presentation Time*, use the lactate drawn with the HIGHEST level within this time frame.
- If there is more than one time of documentation for the *Initial Lactate Level Collection*, use the following order to determine which time to abstract.
 1. Laboratory documentation indicating date and time lactate was drawn.
 2. Date and Time the lactate is documented as drawn in a non-narrative location (e.g., sepsis flowsheet, checklist, screening).
 3. Narrative note indicating lactate is drawn with an associated date and time.
- If there is no documentation indicating a lactate was drawn or collected, but there is supportive documentation that a lactate was drawn, use the earliest supportive documentation (e.g., lactate sent to lab, lactate received, lactate result).
- If within 24 hours of the *Severe Sepsis Presentation Time* there is physician/APN/PA or nursing documentation that a lactate value is invalid, erroneous or questionable, disregard that value.
- Use documentation specifying a lactate was actually drawn or collected. Do not use documentation such as “Labs Drawn” as it is not specific for lactate level.
- Do not use a physician order for lactate levels as it does not specify that lactate level was drawn; however, you may use a physician order that has a notation “drawn” or “collected” next to it.

- If a lactate level is ordered and there is an attempt to collect it, but the attempt results in failure to collect the specimen (too dehydrated to get a vein) or the specimen was contaminated during or after the draw, select Value “1.”
- If a lactate level is drawn but there are no results in the record, choose Value “1.”

Suggested Data Sources:

- Laboratory Reports
- Nursing Notes
- Physician/APN/PA notes or orders

Inclusion Guidelines for Abstraction:

- Lactate drawn
- Lactate level collected
- Lactic acid drawn

Exclusion Guidelines for Abstraction:

Labs drawn

Data Element Name: *Transfer From Another Hospital or ASC*

Collected For CMS Only: SEP-1

Definition: Documentation that the patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center (ASC).

Suggested Data Collection Question: Was the patient received as a transfer from an inpatient, outpatient or emergency/observation department of an outside hospital or from an ambulatory surgery center?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

Y (Yes) Patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center.

N (No) Patient was not received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center, or unable to determine from medical record documentation.

Notes for Abstraction:

- Select **“Yes”** if a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital.
 - This applies even if the emergency department or observation unit is part of your hospital’s system (e.g., your hospital’s free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity.
- Select **“Yes”** if the patient is transferred to your hospital from an outside hospital where they were an inpatient or outpatient.
 - This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record.
- Select **“Yes”** in the following types of transfers:
 - Long term acute care (LTAC): Any LTAC hospital or unit (outside or inside your hospital)
 - Acute rehabilitation: Rehab unit in outside hospital, free-standing rehab hospital/facility/pavilion outside your hospital, OR rehab hospital inside your hospital
 - Psychiatric: Psych unit in outside hospital, free-standing psych hospital/facility/pavilion outside your hospital, OR psych hospital inside your hospital

- Cath lab, same day surgery, or other outpatient department of an outside hospital
- Disaster Medical Assistance Team (DMAT): Provides emergency medical assistance following catastrophic disaster or other major emergency
- Select **“No”** in the following types of transfers:
 - Urgent care center
 - Psych or rehab unit inside your hospital
 - Dialysis center (unless documented as an outpatient department of an outside hospital)
 - Same Day Surgery or other outpatient department inside your hospital
 - Clinic (outside or inside your hospital)
 - Hospice facility (outside or inside your hospital)
 - Assisted living facilities and nursing homes
 - Skilled nursing facility (SNF) care:
 - Any facility or unit (outside or inside your hospital) providing SNF level of care to patient
- Select **“No”** if there is conflicting documentation in the record, and you are unable to determine whether or not the patient was transferred from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center, UNLESS there is supporting documentation for one setting over the other.

Examples:

 - One source reports patient was transferred from an outside hospital’s ED, another source reports patient was transferred in from an urgent care center. There is no additional documentation. Select “No.”
 - One source states patient came from physician office, another source reports patient was transferred from an outside hospital’s ED, and transfer records from the outside hospital’s ED are included in the record. Select “Yes.”
- In cases other than conflicting documentation, if you are unable to determine whether or not the patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center, select “No.” (e.g., “Transferred from Park Meadows” documented – documentation is not clear whether Park Meadows is a hospital or not.)

Suggested Data Sources:

- Ambulance record
- Any DMAT documentation
- Emergency Department record
- Face sheet
- History and physical
- Nursing admission assessment
- Progress notes
- Transfer sheet

Inclusion Guidelines for Abstraction:

None

Data Element Name: *Vasopressor Administration Time*

Collected For CMS: SEP-1

Definition: The time at which an intravenous or intraosseous vasopressor was administered within **the specified time frame**.

Suggested Data Collection Question: What was the time at which an intravenous or intraosseous vasopressor was administered within **the specified time frame**?

Format:

Length: 5 - HH:MM (with or without colon) or UTD

Type: Time

Occurs: 1

Allowable Values:

HH = Hour (00-23)

MM = Minutes (00-59)

UTD = Unable to Determine

Time must be recorded in military time format.

With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight – 00:00	Noon – 12:00
5:31 am – 05:31	5:31 pm – 17:31
11:59 am – 11:59	11:59 pm – 23:59

Notes for Abstraction:

- The specified time frame for administration of a vasopressor starts at *Septic Shock Presentation Time* and ends six hours after the *Septic Shock Presentation Time*.
- Acceptable vasopressors are provided in Appendix C, Table 5.2. These are the only medications that can be abstracted.
- Only abstract a vasopressor given via the IV or intraosseous (IO) route.
- Only abstract vasopressor administration information from documentation that demonstrates actual administration of the vasopressor.
 - Do not abstract doses from a physician order unless they are clearly designated as given on the physician order form.
 - Acceptable examples of administration include: “vasopressor running” and “vasopressor given.”
- Abstract the time the vasopressor was started if a vasopressor was infusing at the time of presentation of septic shock, or a vasopressor was infusing at the time of septic shock and multiple doses were subsequently given.

Example:

