Hospital Inpatient Quality Reporting (IQR) Program

Inpatient and Outpatient Healthcare Quality Systems Development and Program Support

Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) *Crystalloid Fluid Administration* Data Element Version 5.16 Questions and Answers Question and Answer Summary Document

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

Targeted Volume

Question 1: **Slide 11: The example included in the abstraction guidance on this slide includes an order for 2 liters (L) that is within 10 percent less than the 30 milliliters (mL)/kilogram (kg) volume. If based on the patient's weight, 2,040 mL were required to meet 30 mL/kg, and 2 L was ordered, would you use 100 mL of dilution fluids mixed with an antibiotic toward the targeted volume? Would the target volume of crystalloid fluids then be 2000 mL or 2100 mL?**

In this scenario, the 30 mL/kg volume is 2,040 mL, and the physician ordered 2 L. The 2 L volume is within 10 percent less than 2,040 mL. The ordered volume of 2 L, within 10 percent less than the 30 mL/kg volume, would be acceptable as the target volume.

You would not need to use the dilution fluids that are mixed with the antibiotic in this case: The targeted volume of 2 L is acceptable without using the dilution fluids.

If the 30 mL/kg volume was 2,040 mL and the physician ordered 1,800 mL, then use the dilution fluids to reach an ordered volume of fluids that is within 10 percent less than the 30 mL/kg volume. You would not use the dilution fluids unless you were unable to reach the targeted volume without the dilution fluids.

Question 2: **Does the full targeted volume of crystalloid fluids need to be infused completely within three hours of the triggering event for *Crystalloid Fluid Administration* (*Initial Hypotension* or *Septic Shock Presentation Date* and *Time*) or within three hours of whichever triggering event comes first?**

The abstraction guidance does not require the targeted volume of fluids to be completely infused within three hours of either triggering event. The abstraction guidance only requires that the targeted volume be ordered and started within the six hours before to three hours after the triggering events. There must be documentation that the fluids were completely infused, but it is not required that they be completed within the specified timeframe for the *Crystalloid Fluid Administration* data element.

Lesser Volume

Question 3: **For the "lesser volume" option for crystalloid fluids, as outlined on slide 14, is there a time limit as to when the lesser volume needs to be documented? For example, does it need to be documented within three hours after the triggering event?**

The guidance is clear that the documentation must be by the ordering clinician, but we often see that there is a statement that includes all the appropriate criteria that is documented later in the stay.

The abstraction guidance does not specify a time frame for the physician/advanced practice nurse (APN)/physician assistant (PA) documentation of a lesser volume and reason. While the lesser volume and reason are not required to be documented within a specified time frame, the targeted volume is required to be ordered and started within the specified time frame, and it must be documented that it was administered at greater than 125 mL/hour (hr).

Question 4: **In cases of patients with renal failure or congestive heart failure, for example, the ordering physician must document the reason for administering less than the required fluid. Is there a minimum volume or minimum rate that must be administered to be acceptable?**

There is no minimum volume that is required to be administered. All acceptable fluids, regardless of the targeted volume, used to meet the *Crystalloid Fluid Administration* data element must be administered at a rate of 126 mL/hr or greater. Fluids infused below that rate are considered maintenance fluids and are not considered for fluid resuscitation.

Question 5: **If a patient has heart failure/fluid overload and the physician is hesitant to order fluids, is it acceptable for the physician to indicate the goal volume of fluid is 100 mL and to give 100 mL of an antibiotic that has a start/end time and a rate of greater than 125 mL/hr?**

Yes, the dilution fluids given with the antibiotic would be acceptable based on the physician's documentation of the lesser volume of 100 mL with the reason.

Toward the bottom of the *Crystalloid Fluid Administration* data element, you can find the abstraction guidance related to using dilution fluids mixed with medications.

If the targeted volume is not met by crystalloid fluids that were not used for dilution, then you can use the dilution fluids to meet the target volume.

Question 6: **If the patient is hypotensive, would physician documentation of "no fluids due to volume overload" be accepted?**

No, this documentation does not meet the abstraction guidance for using a lesser volume as the targeted volume. It also does not meet the abstraction guidance for selecting Value 4, "No," which can be acceptable when no fluids were ordered.

The abstraction guidance for using a lesser volume requires physician/APN/PA documentation to include a lesser volume with the reason and for the lesser volume to be ordered.

Question 7: **On slide 16, the order comment of "Hypotensive but improving" does not include a concern for fluid overload. Why is it added to the previous 250 mL?**

This slide is an example of the abstraction guidance that addresses multiple physician/APN/PA orders for lesser volumes with documented reasons. In that scenario, when there are multiple orders that have lesser volumes with documented reasons for those lesser volumes, you would use the total of those lesser volumes that are ordered within the six hours prior through three hours after the triggering event. In the scenario on this slide, you have one order for 250 mL that states a concern for fluid overload. Then, you have a second order for 250 mL that refers to the patient as still hypotensive. Both of those orders for lesser volumes include reasons. Since they're within the specified time frame that's in the abstraction guidance, you would combine those two lesser volumes to use 500 milliliters as the targeted volume.

Question 8: **Would CMS consider only requiring a fluid exception from one provider, even if multiple providers order fluids? We are a teaching hospital with multiple residents, attendings, and handoffs. Multiple providers often order fluid, and we frequently fail the fluid exception even if one of the providers has documented it.**

For Version (V)5.16 of the *Specifications Manual for National Hospital Inpatient Quality Measures* (Specifications Manual), effective for July 1, 2024, through December 31, 2024 discharges, the ordering provider or physician must also be the one that documents the lesser volume and reason for the lesser volume.

However, for V5.17 of the Specifications Manual, which will be effective for January 1, 2025, through December 31, 2025, discharges, the abstraction guidance has been updated to allow for multiple physicians to order and document those lesser volumes and reasons.

Completely Infused

Question 9: **Can you provide any insight on how pre-arrival fluid administration (emergency medical services) can be included within the 30mL/kg if within the fluid resuscitation volume?**

In the *Crystalloid Fluid Administration* data element, there is abstraction guidance on page 1-42 of the Specifications Manual that addresses crystalloid fluids administered prior to arrival:

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.

Fluids administered prior to arrival can be used to meet the 30 mL/kg volume if the documentation requirements included in the abstraction guidance are met. If the documentation requirements are not met (e.g., missing an end time, rate, and/or duration), then you would disregard the prior to arrival fluids and continue reviewing for the fluids administered in the hospital.

Question 10: **Is there any scenario which would allow you to meet the *Crystalloid Fluid Administration* data element when nursing only documents a start time but no stop time?**

If a start time with no end or stop time is documented on the Medication Administration Record (MAR), then you would defer to the ordered infusion rate or duration. It is not a requirement that the stop time or end time be documented on the MAR. For example, if the order included the rate of 1,000 mL/hr or instructions to administer over one hour, that rate or duration would be acceptable for determining when that infusion completed. However, if there is a start time and stop time documented on the MAR, then you would generally use those time stamps to determine when the fluids were administered.

Ideal Body Weight (IBW)

Question 11: **Can the guidelines for fluids ordered within 10 percent of the 30mL/kg also be applied to fluids ordered per IBW for body mass indexes (BMI) greater than 30?**

Yes, you will first determine the targeted volume based on the physician documentation and the patient's weight. In this case, assuming the physician documentation requirements are met to use the IBW to determine the 30 mL/kg volume, you would then review the fluid orders. If the volume ordered was within 10 percent of the patient's 30 mL/kg volume based on the IBW, then that ordered volume that's within 10 percent less than the 30 mL/kg volume based on the IBW would be acceptable.

Question 12: **Slide 39: The provider documented, "The patient is obese." However, the nurse recorded the patient's BMI in the emergency department triage note as less than 30. Can the IBW still be used to determine the targeted ordered volume?**

Yes, since this scenario meets the physician documentation requirements that are included in the abstraction guidance for using the IBW to determine the target volume, the documentation that the patient has obesity or that the BMI is greater than 30 is acceptable.