Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) v5.8 Measure Updates

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

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

June 19, 2020

Agenda

The purpose of this event is to:

- Clarify the changes and rationale behind the updates to the SEP-1 measure and guidance in version 5.8 of the specifications manual.

- Discuss updates to SEP-1 for patient cases with COVID-19

- Respond to frequently asked questions.

Acronyms   2

Objective

At the end of the presentation, participants will be able to understand and interpret the updated guidance in version 5.8 of the specifications manual to ensure successful reporting for the SEP-1 measure.

Acronyms and Abbreviations

AKI	acute kidney injury	**INR**	International Normalized Ratio	**PICC**	peripherally inserted central catheter
APN	advanced practice nurse	**IV**	intravenous	**PNA**	pneumonia
BMI	body mass index	**kg**	kilogram	**PO**	oral
BP	blood pressure	**L**	liter	**POA**	present on admission or present on arrival
CE	Continuing education	**lbs**	pounds	**Pt**	patient
C. diff/ C. difficile	Clostridium difficile	**MAP**	mean arterial pressure	**QD**	once a day
CMS	Centers for Medicare & Medicaid Services	**MD**	Medical doctor	**r/t**	related to
CT	CAT scan	**mg**	milligram	**SBP**	systolic blood pressure
CXR	chest x-ray	**mL**	milliliter	**SEP**	sepsis
ED	emergency department	**mmHg**	milliliter of mercury	**SIRS**	systemic inflammatory response syndrome
EMS	Emergency Medical Services	**mmol**	millimoles	**UO**	urinary output
GI	gastrointestinal	**Nitro**	Nitroglycerin	**UTD**	unable to determine
I&O	Intake and Output	**NS**	normal saline	**v**	version
IBW	ideal body weight	**PA**	physician assistant	**VIQR**	Value, Incentives, and Quality Reporting

Back

Noel Albritton, MSN, RN and Jennifer Witt, RN
Behavioral Development and Inpatient and Outpatient
Measure Maintenance Support Contractor

Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) v5.8 Measure Updates

Broad Spectrum or Other Antibiotic Administration Selection New Guidance v5.8

- If the patient has C. difficile, and IV antibiotic(s) from Table 5.0 or an appropriate combination of IV antibiotics from Table 5.1 are not started within the 3 hours following presentation of severe sepsis, and the following conditions are met, choose Value "1."

  o There is physician/APN/PA documentation within 24 hours prior to the antibiotic start time identifying the presence of C. difficile. Documentation that C. difficile is suspected or likely is acceptable.

  o Any one of the treatments below is initiated within 3 hours following severe sepsis presentation:

    ▪ Oral vancomycin with or without oral or IV metronidazole (Flagyl)

    ▪ Rectal vancomycin with or without IV metronidazole (Flagyl)

    ▪ IV metronidazole (Flagyl) monotherapy

    ▪ Oral fidaxomicin (Dificid)

Broad Spectrum or Other Antibiotic Administration Selection v5.8 Question #1

Q. Would you select Value "1" (Yes) for the *Broad Spectrum or Other Antibiotic Administration Selection* data element based on the physician documentation below for administration of oral Dificid within three hours after severe sepsis presentation?

- Severe Sepsis Presentation Date/Time: 7/4/2020 1100

- Physician Note 7/4/2020 0600: "suspect C. diff"

- Dificid (PO): start date/time: 7/4/2020 1230

A. Yes, select Value "1" (Yes). There is physician documentation within the 24 hours prior to the antibiotic start time identifying the presence of C.diff and oral Dificid was administered within 3 hours after the *Severe Sepsis Presentation Time.*

Acronyms

Crystalloid Fluid Administration New Guidance v5.8

- Physician/APN/PA can use Ideal Body Weight (IBW) to determine the target ordered volume if all of the following conditions are met. <mark>Other acceptable weight terms include predicted weight, dosing weight, and adjusted body weight.</mark>

  - o Physician/APN/PA documents the patient is obese (defined BMI >30).

  - o Physician/APN/PA documents IBW is used to determine target ordered volume.

  - o IBW must be present in the medical record, abstractors should not calculate the IBW.

Knowledge Check: Crystalloid Fluid Administration

If all the following weights are documented in the medical record, which would you use to determine the target ordered volume if the physician fluid order states, "NS IV 30 mL/kg over 2 hours, BMI >30, use adjusted body weight"?

A. **IBW 69 kg**

B. **Adjusted Body Weight 75 kg**

C. **Weight 190 lbs**

D. **Predicted Weight 68 kg**

Knowledge Check: Crystalloid Fluid Administration

If all the following weights are documented in the medical record, which would you use to determine the target ordered volume if the physician fluid order states, "NS IV 30 mL/kg over 2 hours, BMI >30, use adjusted body weight"?

A. **IBW 69 kg**

B. **Adjusted Body Weight 75 kg**

C. **Weight 190 lbs**

D. **Predicted Weight 68 kg**

Use the adjusted body weight of 75 kg because there is physician documentation of obesity and direction to use the adjusted body weight to determine the target ordered volume.

Acronyms

Initial Hypotension
New Guidance v5.8

○ If hypotension (SBP <90 mmHg or MAP <65 mmHg) is due to the following, it should not be used. Inferences should not be made. The abnormal value or reference to the abnormal value must be in the same documentation <mark>(i.e., same sentence or paragraph)</mark>.

- Normal for that patient
- Is due to a chronic condition
- Is due to a medication

Initial Hypotension
v5.8 Question #1

Q. Would you use the hypotensive value based on the below physician documentation to establish *Initial Hypotension*?

"Administering 30 mL/kg based on hypotension. This is not abnormal for her due to diabetes."

A. No, do not use the hypotensive blood pressure readings to establish *Initial Hypotension* because the reference to the abnormal value is included in the same documentation (i.e., same paragraph) as the chronic condition.

Initial Hypotension
v5.8 Question #2

Q. Would you use the hypotensive value based on the below physician documentation to establish *Initial Hypotension*?

> ED Diagnosis: Hypotension

> MD Orders: Nitro Sublingual 0.4 mg

A. Yes, use the hypotensive blood pressure readings to establish *Initial Hypotension* because the reference to the abnormal value (hypotension) is NOT included in the same documentation (i.e., same sentence or paragraph) as the medication.

Acronyms 13

Initial Hypotension
New Guidance v5.8

o If a hypotensive value is due to an acute condition that has a non-infectious source/process, it should not be used (Refer to *Severe Sepsis Present* criteria "a" to determine if the source of the acute condition is an infection).

Examples:

- "BP 85/50 r/t blood loss" "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).

Initial Hypotension
New Guidance v5.8

- Use of documentation in pre-hospital records (e.g., ambulance records, nursing home records) that is considered part of the medical record is acceptable for determining *Initial Hypotension*. <mark>If the criteria for determining *Initial Hypotension* were met prior to arrival and the patient is not hypotensive on arrival to the ED or hospital, select Value "2" (No).</mark>

Knowledge Check:
Initial Hypotension

Which value would you select for *Initial Hypotension* if EMS documentation includes blood pressures of 85/51 at 1530 and 84/53 at 1545 and a blood pressure of 92/60 was documented in the ED on arrival?

A. Value "1" (Yes)

B. Value "2" (No)

Knowledge Check: Initial Hypotension

Which value would you select for *Initial Hypotension* if EMS documentation includes blood pressures of 85/51 at 1530 and 84/53 at 1545, and a blood pressure of 92/60 was documented in the ED on arrival?

A. Value "1" (Yes)

B. Value "2" (No)

Select Value "2" (No) because the patient was hypotensive prior to arrival but not hypotensive on arrival to the ED.

Acronyms   17

Initial Hypotension Date and Time New Guidance v5.8

- Exception for Prior to Arrival:
  - o 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.
  - o 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.

Acronyms   18

Initial Hypotension Time
v5.8 Question #1

Q. What date and time would you use from the below documentation to establish the *Initial Hypotension Date* and *Initial Hypotension Time*?

Urgent Care:	Ambulance:
1415: BP = 83/51	1430: BP = 85/54
ED Arrival:	ED Flow Sheet:
1442	1443: BP = 86/53

A. Use 1442 for the *Initial Hypotension Time* because the patient met *Initial Hypotension* prior to arrival to the ED and remains hypotensive upon arrival.

Initial Lactate Level Result New Guidance v5.8

- For the following, physician/APN/PA documentation prior to or within 24 hours after *Severe Sepsis Presentation Time* is required.
  - If the elevated lactate is due to the following, select Value "1." Inferences should not be made. 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

Initial Lactate Level Result New Guidance v5.8

o If the elevated lactate is due to an acute condition that has a non-infectious source/process, select Value "1." (Refer to *Severe Sepsis Present* criteria "a" to determine if the source of the acute condition is an infection).

Example:

- "Lactate 4.3 r/t seizure" "Seizure post brain injury" (seizure is the acute condition and brain injury is the non-infectious source).

Initial Lactate Level Result v5.8 Question #1

Q. Would you select Value "1" (<=2) for the *Initial Lactate Level Result* data element based only on the below APN documentation?

    APN Note: "Lactic acidosis r/t alcohol consumption, infection not suspected."

A. Yes, select Value "1" because the reference to the elevated lactate (lactic acidosis) is documented as due to alcohol consumption and not due to an infection.

Initial Lactate Level Result
New Guidance v5.8

o If the elevated lactate should not be used based on the above guidance, all instances of less severe values should not be used.

o If the elevated lactate is due to the following, the elevated lactate value should be used.

  ▪ Acute condition

  ▪ Acute on chronic condition

  ▪ Infection

Initial Lactate Level Result
New Guidance v5.8

- Documentation of a term that represents or is defined by an elevated lactate is acceptable in place of an abnormal value when 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.
  Examples:
  - Hyperlactatemia
  - Lactic Acidosis

Acronyms 24

Knowledge Check:
Initial Lactate Level Result

Which value would you select for the *Initial Lactate Level Result* if the result of the initial lactate was 3.3 and the PA documented "lactic acidosis secondary to metformin use."

A. **Value "1" (<=2)**

B. **Value "2" (>2 and <4.0)**

C. **Value "3" (>=4)**

Knowledge Check:
Initial Lactate Level Result

Which value would you select for the *Initial Lactate Level Result* if the result of the initial lactate was 3.3 and the PA documented "lactic acidosis secondary to metformin use."

A. Value "1" (<=2)

B. Value "2" (>2 and <4.0)

C. Value "3" (>=4)

Select Value "1" because the PA documentation attributes the elevated lactate (lactic acidosis) to be due to a medication.

Initial Lactate Level Result
New Guidance v5.8

- If within the same physician/APN/PA documentation, there is conflicting documentation indicating the elevated lactate is normal for the patient, or due to a chronic condition or medication AND due to or possibly due to an infection, Severe Sepsis, or Septic Shock, the criteria value should be used.

- If within 24 hours *after Severe Sepsis Presentation Time* there is conflicting information within two or more separate pieces of physician/APN/PA documentation indicating the elevated lactate is normal for the patient, or due to a chronic condition or medication AND due to or possibly due to an infection, Severe Sepsis, or Septic Shock, abstract based on the latest piece of documentation within the 24-hour period.

Acronyms 27

Persistent Hypotension New Guidance v5.8

2 (No **or UTD**)   Persistent hypotension or new onset of hypotension was not present within one hour of the conclusion of crystalloid fluid administration at the target ordered volume **or Unable to Determine**.

Persistent Hypotension New Guidance v5.8

o If there are more than two blood pressures documented, refer to the last two consecutive blood pressures within the hour:

- ▪ If there is a normal blood pressure followed by another normal blood pressure, select Value "2."
- ▪ If there is a normal blood pressure followed by a low blood pressure, select Value "2."

Persistent Hypotension v5.8 Question #1

Q. Which allowable value would you select for *Persistent Hypotension*?

- Hour to assess for *Persistent Hypotension* is from 0950 to 1050

- BP readings at 1020 is SBP = 92 and 1045 SBP = 84

A. Select Value "2" (No). There is a normal blood pressure followed by a low blood pressure.

Repeat Lactate Level Collection New Guidance v5.8

Definition: Documentation of obtaining a repeat lactate level ==within== the ==specified== time window.

Suggested Data Collection Question: Was a repeat lactate level drawn ==within== the ==specified== time window?

Allowable Values: 1 (Yes) A repeat lactate level was drawn ==within== the ==specified== time window.

2 (No) A repeat lactate level was not drawn ==within== the ==specified== time window, or unable to determine.

Acronyms

Repeat Lactate Level Collection New Guidance v5.8

- A repeat lactate level is the next lactate level drawn after the initial lactate level if the initial lactate is elevated (>2.0 mmol/L). The specified time window for the repeat lactate collection begins after the *Initial Lactate Level Collection Time* and ends 6 hours after the *Severe Sepsis Presentation Time.*

- If a repeat lactate level was drawn but not in the time window beginning after the *Initial Lactate Level Collection Time* and ending 6 hours after the *Severe Sepsis Presentation Time*, choose Value "2."

Acronyms

Knowledge Check:
Repeat Lactate Level Collection

Which allowable value would you select for the *Repeat Lactate Level Collection* data element if the *Initial Lactate Level Result* was 4.4 and collected at 1300, the *Severe Sepsis Presentation Time* was 1530, and the only other lactate collection occurred at 1500 with a result of 3.2?

A. **Value "1" (Yes)**

B. **Value "2" (No)**

Knowledge Check:
Repeat Lactate Level Collection

Which allowable value would you select for the *Repeat Lactate Level Collection* data element if the *Initial Lactate Level Result* was 4.4 and collected at 1300, the *Severe Sepsis Presentation Time* was 1530, and the only other lactate collection occurred at 1500 with a result of 3.2?

A. Value "1" (Yes)

B. Value "2" (No)

Select Value "1" (Yes) because the lactate collection at 1500 occurred within the specified time window for the *Repeat Lactate Level Collection* data element beginning after the *Initial Lactate Level Collection Time* and ending 6 hours after the *Severe Sepsis Presentation Time*.

Acronyms   34

Repeat Volume Status and Tissue Perfusion New Guidance v5.8

- Urine Output (UO)
    - Physician/APN/PA documentation must reference urine output (e.g., increased or decreased urine output, oliguria, anuria, urine concentration, urine color).

Repeat Volume Status and Tissue Perfusion New Guidance v5.8

Q. Does the documentation below meet the urine output parameter for one of the five parameters to suffice the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element?

PA Note: "I&Os reviewed"

A. No, the PA documentation "I&O's reviewed" is not acceptable documentation to meet the urine output parameter. Acceptable documentation should reference the urine output rather than "I&O's" or "output" alone.

Acronyms 36

Septic Shock Present
New Guidance v5.8

- In order to establish the presence of Septic Shock by clinical criteria, one of following two criteria (a or b) must be met:

  a. Severe Sepsis Present

    AND

Persistent Hypotension evidenced by:

  - Persistent hypotension or new onset of hypotension was present within one hour after the target ordered volume of crystalloid fluids was completely infused.

Acronyms   37

Septic Shock Present v5.8 Question #1

Q. Which allowable value would you select for *Septic Shock Present* based only on the documentation below?

      Severe Sepsis Presentation Time: 1700

      Target ordered volume completed:1800

      Blood pressures documented: 1810 = 93/59

                            1825 = 82/50

      Levophed via PICC start time: 1905

A. Select Value "1" (Yes). Based on the two blood pressure readings, including the hypotensive reading at 1825 and the administration of a vasopressor, you would select Value "1" (Yes) for *Persistent Hypotension.* Therefore, *Septic Shock Present* clinical criteria (*Severe Sepsis Present* and *Persistent Hypotension*) were met at 1825.

Acronyms   38

Septic Shock Present
New Guidance v5.8

- If clinical criteria for Septic Shock are NOT met, and the only physician/APN/PA documentation of Septic Shock indicates that Septic Shock is due to a viral, fungal, or parasitic infection, choose Value "2."

Septic Shock Present
v5.8 Question #2

Q. Which allowable value would you select for the *Septic Shock Present* data element based only on the below documentation when septic shock clinical criteria were not met?

APN Note: "Pt with septic shock r/t influenza."

A. Select Value "2" (No) because septic shock clinical criteria were not met, and the only documentation of septic shock indicates that it is related to a viral infection.

Acronyms   40

Septic Shock Presentation Date & Time New Guidance v5.8

- If septic shock is in a physician/APN/PA note without a specific date documented within the note or documented using the acronym POA, the following apply:
  - If it is the only documentation of septic shock in the note, use the time the note was started or opened.
    - If a timestamp reflecting the note opened or started time is unavailable, use the following sources in priority order.
      1. Provider Patient Care Initiated time (e.g. Seen date, Contact date, etc.)
      2. Scribe time
      3. Earliest time at the beginning of the note reflecting when the note was opened or started

Septic Shock Presentation Date and Time v5.8 Question #1

Q. Which date and time would you use for the *Septic Shock Presentation Date* and *Time* based only on the documentation below if a specified time and note opened timestamp was not available?

PA Note: "septic shock secondary to pneumonia."

- Contact date/time: 8/1/2020 1600

- Scribe date/time: 8/1/2020 1620

- Unspecified date/time at top of note: 8/1/2020 1545

A. Use the contact date/time of 8/1/2020 at 1600 because this timestamp has the highest priority based on the guidance when a specified time and note opened timestamp are not available.

Severe Sepsis Present
COVID-19 New Guidance v5.8

Exclusion for patients with suspected or confirmed COVID-19 effective discharges starting 7/1/2020.

- Select Value "2" if there is physician/APN/PA documentation that coronavirus or COVID- 19 is suspected or present.

Severe Sepsis Present
New Guidance v5.8

- If documentation of an infection is in a physician/APN/PA, nursing, or pharmacist note without a specific date and time or documented using the acronym POA, use the date and time the note was started or opened.

  o If a timestamp reflecting the note opened or started time is unavailable, use the following sources in priority order.

    1. Provider Patient Care Initiated Time (e.g., Seen Time, Contact Time, etc.)

    2. Scribe Time

    3. Earliest time at the beginning of the note reflecting when the note was opened or started

Severe Sepsis Present
New Guidance v5.8

- If physician/APN/PA documentation within 6 hours following the initial documentation of the infection indicates that the infection is not present, disregard the initial documentation of the infection.

  Examples:

  - ED APN documents "sepsis" at 0800. PA notes "does not meet sepsis criteria" at 0930. Disregard APN documentation of "sepsis."

  - MD notes "pneumonia" at 1200. At 1500 MD notes "no clear source of infection." Disregard the documentation of pneumonia.

Severe Sepsis Present
New Guidance v5.8

- If physician/APN/PA documentation within 6 hours following the initial documentation of an infection indicates that the infection is due to a viral, fungal, or parasitic source, disregard the initial documentation of the infection.

Acronyms

Severe Sepsis Present v5.8 Question #1

Q. Would you use the infection documentation below at 1300 to establish *Severe Sepsis Present* criteria A?

ED MD Note at 1300: "Obtaining CXR, likely pneumonia."

Hospitalist Note at 1430: "CXR with PNA r/t influenza."

A. No, disregard the infection documentation of pneumonia at 1300 because of the physician documentation within 6 hours after 1300 attributes pneumonia to a viral infection.

Acronyms | 47

Severe Sepsis Present
New Guidance v5.8

- For the following, physician/APN/PA documentation prior to or within 24 hours after *Severe Sepsis Presentation Time* is required.

  o If the SIRS criteria or a sign of organ dysfunction is due to the following, it should not be used. Inferences should not be made. 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

Acronyms   48

Severe Sepsis Present v5.8 Question #2

Q. Would you use the elevated INR value based on the below physician documentation to establish *Severe Sepsis Present* organ dysfunction?

"INR this AM 2.3, sending to CT now, will recheck INR in AM. Continue Coumadin 2.5 QD for now."

A. No, do not use the INR of 2.3 to establish organ dysfunction because the abnormal value and medication are included in the same documentation (i.e., same paragraph).

Acronyms 49

Severe Sepsis Present
New Guidance v5.8

o If SIRS criteria or a sign of organ dysfunction is due to an acute condition that has a non-infectious source/process, it should not be used (Refer to *Severe Sepsis Present* criteria "a" to determine if the source of the acute condition is an infection).

Examples:

- "Lactate 4.3 r/t seizure" "Seizure post brain injury" (seizure is the acute condition and brain injury is the non-infectious source).

- "AKI, not due to infection, creatinine 3.8." (AKI is the acute condition and "not due to infection" is the non-infectious source).

Acronyms

Severe Sepsis Present v5.8 Question #3

Q. Would you use the low platelet count to establish *Severe Sepsis Present* criteria C (organ dysfunction) based only on the documentation below that is within the specified timeframe?

PA Note: "anemia with thrombocytopenia, infection not suspected."

A. No, the low platelets are attributed to anemia (acute condition) and an infection is not suspected (non-infectious source).

Severe Sepsis Present
New Guidance v5.8

- Choose Value "2" if <mark>at the same time or</mark> within 6 hours after documentation meeting clinical criteria or physician/APN/PA documentation of severe sepsis there is additional physician/APN/PA documentation indicating:

  - Patient is not septic.

  - Patient does not have Sepsis or Severe Sepsis.

  - Patient does not have Septic Shock, and Severe Sepsis was met by physician/APN/PA documentation that Septic Shock was present.

  - Severe Sepsis or Septic Shock is due to a viral, fungal, or parasitic infection.

Acronyms 52

Knowledge Check: Severe Sepsis Present

Which allowable value would you select for the *Severe Sepsis Present* data element if the PA documented "no sepsis" at 0730 and all three severe sepsis clinical criteria were met at 0730?

A. **Value "1" (Yes)**

B. **Value "2" (No)**

Knowledge Check:
Severe Sepsis Present

Which allowable value would you select for the *Severe Sepsis Present* data element if the PA documented "no sepsis" at 0730 and all three severe sepsis clinical criteria were met at 0730?

A. Value "1" (Yes)

B. Value "2" (No)

Select Value "2" (No). The severe sepsis clinical criteria were met at the same time as the PA documentation indicating the patient did not have sepsis.

Severe Sepsis Presentation Date and Time New Guidance v5.8

- If severe sepsis or septic shock is documented in a physician/APN/PA note without a specific time or documented using the acronym POA, the following apply:

  o If it is the only documentation of severe sepsis or septic shock in the note, use the time the note was started or opened.

    ▪ If a timestamp reflecting the note opened or started time is unavailable, use the following sources in priority order.

      1. Provider Patient Care Initiated time (e.g. Seen date, Contact date, etc.)
      2. Scribe time
      3. Earliest time at the beginning of the note reflecting when the note was opened or started

Webinar Questions

Please email any questions that are pertinent to the webinar topic to the *QualityNet* Inpatient Questions and Answers tool, at https://cmsqualitysupport.servicenowservices.com/qnet_qa. If your question pertains to a specific slide, please include the slide number.

If you have a question unrelated to the current webinar topic, we recommend that you first search for it in the *QualityNet* Inpatient Questions and Answers tool. If you do not find an answer, then submit your question to us via the same tool.

Continuing Education (CE) Approval

This program has been approved for [CE credit](#) for the following boards:

- **National credit**
  - Board of Registered Nursing (Provider #16578)
- **Florida-only credit**
  - Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling
  - Board of Registered Nursing
  - Board of Nursing Home Administrators
  - Board of Dietetics and Nutrition Practice Council
  - Board of Pharmacy

Note: To verify CE approval for any other state, license, or certification, please check with your licensing or certification board.

Disclaimer

This presentation was current at the time of publication and/or upload onto the *Quality Reporting Center* and *QualityNet* websites. Medicare policy changes frequently. Any links to Medicare online source documents are for reference use only. In the case that Medicare policy, requirements, or guidance related to this presentation change following the date of posting, this presentation will not necessarily reflect those changes; given that it will remain as an archived copy, it will not be updated.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. Any references or links to statutes, regulations, and/or other policy materials included in the presentation are provided as summary information. No material contained therein is intended to take the place of either written laws or regulations. In the event of any conflict between the information provided by the presentation and any information included in any Medicare rules and/or regulations, the rules and regulations shall govern. The specific statutes, regulations, and other interpretive materials should be reviewed independently for a full and accurate statement of their contents.

Acronyms   58