



# CDI AND CODING ISSUES RELATED TO SEPSIS

August 15, 2018

# CONTINUING EDUCATION

- The link for the evaluation of today's program is: <https://www.surveymonkey.com/r/LN82CTD>.
- Please be sure to access the link, complete the evaluation form, and request your certificate. The evaluation process will remain open **two weeks** following the webinar date.
- If you have any questions please contact Dorothy Aldridge (Dorothy.Aldridge@ohiohospitals.org)
- We will no longer be utilizing a fax submission option.

# Clinical Documentation Improvement and Coding of Sepsis

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# CDC

## Are hospitals really capturing sepsis?



More than 1.5 million people get sepsis each year in the U.S.

About 250,000 Americans die from sepsis each year.

**1** in **3**

One in three patients who die in a hospital have sepsis.

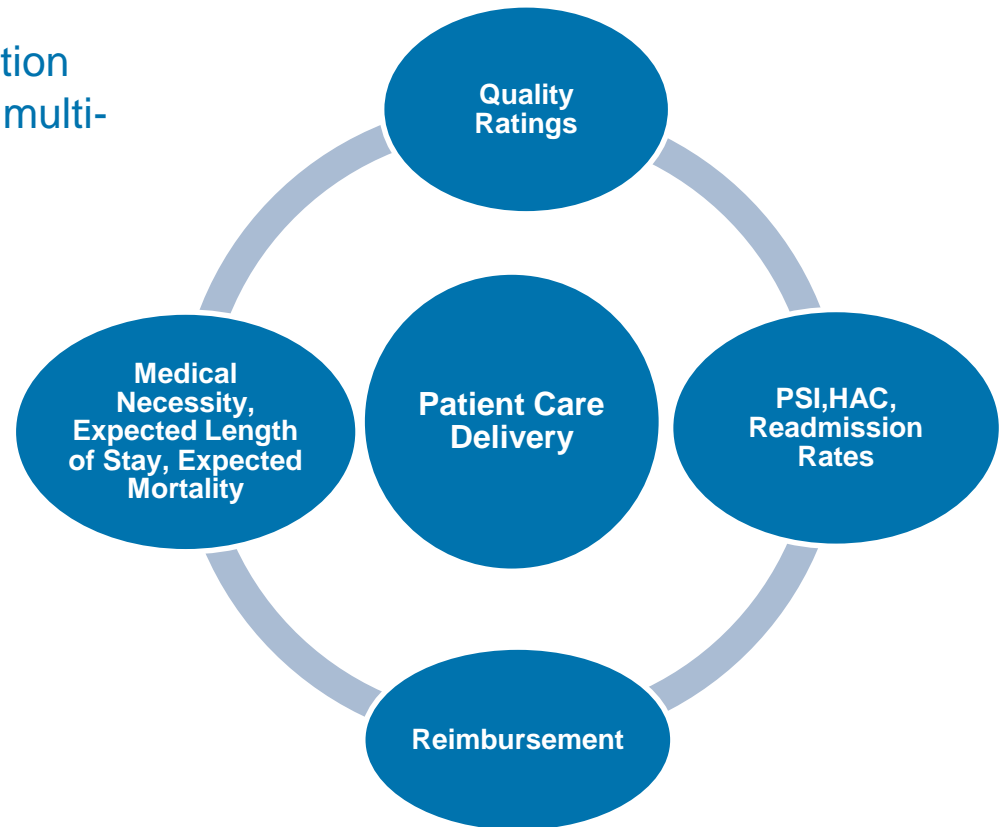
# Documentation is Crucial

## Patient Care Delivery:

- Improve patient care and care coordination
- Additional specificity of disease type for multi-disciplinary care communication



- Increased specificity in documentation of procedures and treatments
- Additional analytics of clinical outcomes



# Sepsis Definitions

## Sepsis:

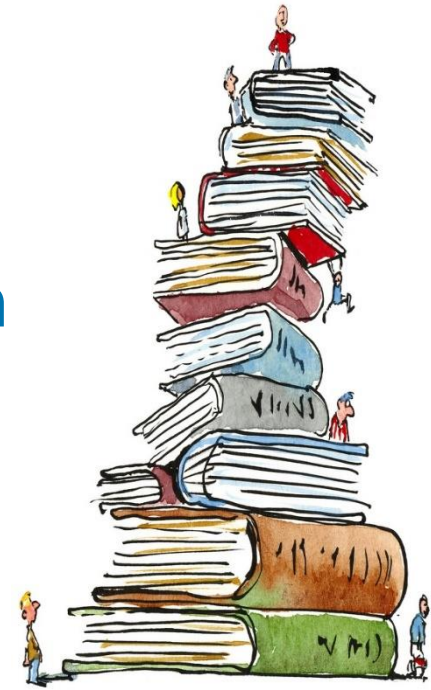
- SIRS x2 + source

## Severe Sepsis:

- SIRS X2 + source + organ dysfunction

## Septic Shock:

- Severe Sepsis with lactate  $\geq 4$
- Hypotension unresolved after fluids



By HikingArtist

# What happened to severe sepsis?

**Sepsis** is redefined as: “life-threatening organ dysfunction caused by a dysregulated host response to infection.” JAMA, February 23, 2016: Sepsis-3, New Criteria for defining sepsis

- **Sepsis:**
  - Suspected or documented infection and
  - Acute increase of  $\geq 2$  SOFA (a proxy for organ dysfunction)
- **Septic Shock:**
  - Sepsis *and*
  - Vasopressor therapy needed to elevate MAP  $\geq 65$  mm Hg and
  - Lactate  $> 2$  mmol/L (18 mg/dl) despite adequate fluid resuscitation

# Time Zero

- 2 of 4 SIRS
- Organ dysfunction
- Documented source of infection
- Time of the last criteria met within 6-hour window





# SEP-1 Bundle

## To Be Completed within 3 Hours:

1. Measure lactate level
2. Obtain blood cultures prior to administrative of antibiotics
3. Administer broad spectrum antibiotics
4. Administer 30 ml/kg crystalloid for hypotension or lactate  $\geq 4$  mmol/L
  - \*Time of presentations” is defined as the time of triage in the emergency department or, if presenting from another care venue, from the earliest chart annotation consistent with all elements of severe sepsis or septic shock ascertained through chart review.

## To Be Completed within 6 Hours:

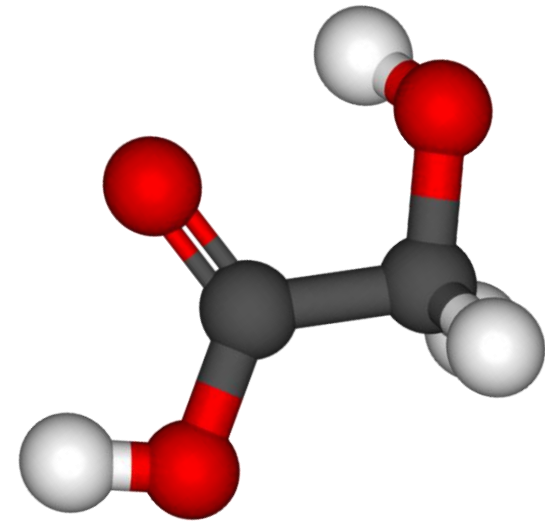
5. Apply vasopressors (for hypotension that does not respond to initial fluid resuscitation) to maintain a mean arterial pressure (MAP)  $\geq 65$  mm Hg.
6. In the event of persistent hypotension after initial fluid administration (MAP  $< 65$  mm Hg) or initial lactate was  $\geq 4$  mmol/L, re-assess volume status and tissue perfusion and document findings
7. Re-measure lactate if initial lactate elevated.

# Lactic Acidosis

**Serum lactate level > 2 mmol/L is indicative of tissue hypoxia in sepsis**

## **Other conditions that can cause lactatemia:**

- Hypotension/shock caused by other conditions: cardiogenic, hypovolemic, etc.
- Medications: epinephrine, propofol, acetaminophen, theophylline, metformin, etc.
- Alcohol, cocaine, cyanide, carbon monoxide toxicity
- Necrotizing soft tissue infections
- Burns
- Trauma
- Seizures, heavy exercise, excessive work of breathing
- Malignancy
- Liver failure
- Thiamine deficiency
- Mitochondrial disease



# ICD-10 Codes Sampled:

Code	Description
A021	Salmonella sepsis
A227	Anthrax sepsis
A267	Erysipelothrix sepsis
A327	Listerial sepsis
A400	Sepsis due to streptococcus, group A
A401	Sepsis due to streptococcus, group B
A403	Sepsis due to Streptococcus pneumoniae
A408	Other streptococcal sepsis
A409	Streptococcal sepsis, unspecified
A4101	Sepsis due to Methicillin susceptible Staphylococcus aureus
A4102	Sepsis due to Methicillin resistant Staphylococcus aureus
A411	Sepsis due to other specified staphylococcus
A412	Sepsis due to unspecified staphylococcus
A413	Sepsis due to Hemophilus influenzae
A414	Sepsis due to anaerobes
A4150	Gram-negative sepsis, unspecified

Code	Description
A4151	Sepsis due to Escherichia coli [E. coli]
A4152	Sepsis due to Pseudomonas
A4153	Sepsis due to Serratia
A4159	Other Gram-negative sepsis
A4181	Sepsis due to Enterococcus
A4189	Other specified sepsis
<b>A419</b>	<b>Sepsis, unspecified organism</b>
A427	Actinomycotic sepsis
A5486	Gonococcal sepsis
B377	Candidal sepsis
<b>R6520</b>	<b>Severe sepsis without septic shock</b>
<b>R6521</b>	<b>Severe sepsis with septic shock</b>

# DRG - Diagnosis Related Groups

- MS DRG (Medical Severity) adjust for the severity of the primary illness. Levels of severity based on secondary diagnosis codes:
  - **MCC** (major complication/comorbidity), highest level of severity
  - **CC** (complication/comorbidity)
  - **Non-CC** no affect severity of illness and resource use
- APR DRG (All Patient Refined)
  - 4 severity levels
  - Patient age used in severity leveling

# Sepsis DRGs (sepsis is principal diagnosis)

DRG	Diagnosis	RW	GMLOS
870	Septicemia or Severe Sepsis w MV >96 Hours	6.09	12.5
871	Septicemia or Severe Sepsis w/o MV <96 Hours w MCC	1.82	4.9
872	Septicemia or Severe Sepsis w/o MV <96 Hours w/o MCC	1.05	3.7

*Example: 870 Sepsis POA due to pneumonia, on vent for >96 hours*

*Example: 871 Sepsis POA due to Pneumonia with acute respiratory failure, without or with a vent <96 hours*

*Example: 872 Sepsis POA due to pneumonia with acute kidney injury*

DRG	Diagnosis	RW	GMLOS
853	Infectious & Parasitic Diseases w OR Procedure w MCC	5.13	10.3
854	Infectious & Parasitic Diseases w OR Procedure w CC	2.39	6.3
855	Infectious & Parasitic Diseases w OR Procedure w/o CC/MCC	1.44	3.4

*Example: 853- sepsis POA with pneumonia and BAL-Broncho alveolar lavage completed*

*Example: 854- sepsis POA with cellulitis of lower leg with a debridement, sepsis POA due to UTI and DVT, PVC filter completed*

*Example: 855- sepsis POA due to cellulitis of the toe with a debridement*

# Sepsis as a MCC

(source of the sepsis is linked to postop wound or post traumatic wound)

DRG	Diagnosis	RW	GMLOS
862	Postoperative & Posttraumatic Infections w MCC	1.83	5.1
863	Postoperative & Posttraumatic Infections w/o MCC	1.01	3.6

*Example: Readmitted with postop/post procedure or wound infection, sternal wire infections, infected post op seroma or abscess and sepsis is MCC*

DRG	Diagnosis	RW	GMLOS
856	Postoperative or Post-Traumatic Infections w OR Procedures w MCC	4.45	9.3
857	Postoperative or Post-Traumatic Infections w OR Procedures w CC	1.99	5.3
858	Postoperative or Post-Traumatic Infections w OR Procedures w/o CC/MCC	1.35	3.7

*Example: Surgical procedure current admission (debridement, IVC filter, BAL-Broncho alveolar lavage) and sepsis is MCC*

# Sepsis as a MCC (sepsis linked to an infection from a device)

DRG	Diagnosis	RW	GMLOS
698	Other Kidney & Urinary Tract Diagnoses w MCC	1.59	4.9
699	Other Kidney & Urinary Tract Diagnoses w CC	1.05	3.5
700	Other Kidney & Urinary Tract Diagnoses w/o CC/MCC	0.78	2.6

*Example: UTI due to Foley catheter with sepsis, urinary stent with sepsis (Sepsis linked to device)*

DRG	Diagnosis	RW	GMLOS
314	Other Circulatory System Diagnoses w MCC	1.96	4.8
315	Other Circulatory System Diagnoses w CC	0.97	2.9
316	Other Circulatory System Diagnoses w/o CC/MCC	0.74	2.0

*Example: Infections related to vascular devices, AV fistula, PICC line, infected valve prosthesis (Sepsis is MCC)*

DRG	Diagnosis	RW	GMLOS
559	Aftercare, Musculoskeletal System & Connective Tissue w MCC	1.68	4.7
560	Aftercare, Musculoskeletal System & Connective Tissue w CC	1.08	3.8
561	Aftercare, Musculoskeletal System & Connective Tissue w/o CC/MCC	0.77	2.6

*Example: Readmitted with Infected joint prosthesis, infection due to orthopedic device*

# Adding Severity of Illness and Risk of Mortality

## *Comorbidity & Complications (cc)*

- Atelectasis
- COPD Exacerbation
- Morbid (Severe) Obesity
- Cardiomyopathy
- Chronic Systolic & Diastolic Heart Failure
- Demand Ischemia
- Acute Kidney Injury
- CKD stages IV, V
- Anoxic Encephalopathy
- C Diff Enteritis
- Chronic Pancreatitis
- Acute Blood Loss Anemia
- Pancytopenia
- Hyponatremia or Hypernatremia
- Undernourishment
- Abscess

## *Major Comorbidity & Complications (mcc)*

- Acute Respiratory Failure
- Pneumonia
- Aspiration Pneumonia
- Type II NSTEMI
- Acute Systolic & Diastolic Heart Failure
- DIC
- ATN
- ESRD
- Cerebral Edema
- Metabolic Encephalopathy
- Unconsciousness
- Acute Pancreatitis
- Biliary obstruction
- Shock Liver
- Pancytopenia due to Chemotherapy
- Severe Protein-Calorie Malnutrition
- Pressure Ulcer, Stage III or IV (specify POA location)
- Gas Gangrene



# Documentation Terms

## Use these:

- Likely\*
- Suspected\*
- Possible\*
- Probable\*
- Concern for\*
- Resolved
- Ruled out

*\*Carry through to discharge summary*

## Not these:

- Versus (vs)
- Unable to rule out
- Questionable



# CDI/Coding Conundrum

- Clarify SIRS, sepsis, severe sepsis, septic shock
- POA status clarity
- Etiology specified
- Supporting documentation present
- Consistent documentation (attending provider)
- Conflicting documentation clarified
- Linking documentation between conditions/ diagnoses



# Sepsis Challenges

- Coding and billing unsupported diagnoses
  - Invites outside audits
- Denials
  - Increased hours spent defending care delivery
- Quality scores
- Loss of revenue
- Risk Adjustment
  - Severe Sepsis changes SOI
  - Septic shock is an MCC
  - Hierarchical Condition Code (HCC) 2

# Sepsis - Coding Guidelines

Sepsis may be coded if documented

Assign code A41.9 unless the organism for the systemic infection is documented and a code with higher specificity may be assigned.

# Severe Sepsis- Coding Guidelines

Severe sepsis may be coded when  
documentation of severe sepsis exists

or

Sepsis and an associated acute organ  
dysfunction is documented.

# Severe Sepsis Documentation

- If assigning severe sepsis based on documentation of *sepsis alone* and documentation of an acute organ dysfunction:
- Acute organ dysfunction/failure must be associated with the sepsis diagnosis.
  - If the link between the acute organ dysfunction and sepsis isn't provided in the documentation, query the provider for clarification.

# Sepsis Complications

- Postoperative sepsis or other complications of care (i.e. Catheter)
- Documentation reminders for complications of care:
  - Not all conditions that occur during or following medical care or surgery are classified as complications.
  - A cause-and-effect relationship must be documented between the care provided and the post-op condition.
  - Query the provider for clarification not clearly documented.
  - Reminder- POA status of No = HAC

# Complication of Care

- 55 yo male presented to the ED from an SNF with complaints of fever and multiple days of nausea/vomiting. He was admitted a month prior for Candidemia related to his groshong catheter. He requires TPN for short gut syndrome necessitating the need for central access. Clinical indicators include:
  - Temperature 100.1
  - WBC 23.7
  - Tachycardic- 109 BPM
  - Respiratory Rate- 20
- Admitted as inpatient with Sepsis –
  - “Suspect line sepsis with clean urine and CXR. Will wait on cultures before removing central line. (H&P)
- Treated with Vancomycin and Zosyn
- Blood cultures positive for mixed staph and klebsiella.
- Sepsis clarified as secondary to CLABSI and groshong removed. Line replaced
- LOS – 13 Days



# Code Assignment & Clinical Criteria

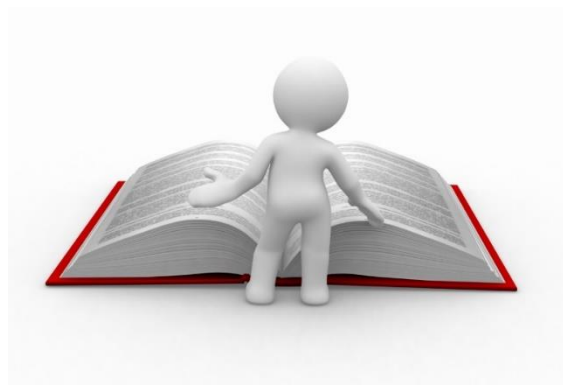
- New Coding Guideline in October 2017
  - Diagnosis code assignment is based on the provider's diagnostic statement that the condition exists.
  - The provider's statement that the patient has a particular condition is sufficient.
  - From the coders' prospective, code assignment is not based on clinical criteria used by the provider to establish the diagnosis.
    - Coders knowledge

# References for Code Assignment

**Official Coding Guidelines for Coding & Reporting**  
2018 Edition

## **Coding Clinic**

Most recent publications used per subject.



# POSITIVE SIRS – SEPSIS RULED OUT

- 64 yo male admitted with metastatic bladder cancer, AKI, dyspnea
- ED provider states “meets sepsis criteria”
- Hospitalist admitted with tachycardia, tachypnea, elevated white count elevated lactate and hypotension. SOB exertional and at rest - since starting immunotherapy
- Other documentation: possible PNA, sepsis, immunotherapy induced pneumonitis

Noted diagnosis of Sepsis in the ED notes but SIRS documented in the H&P.

**Clinical Indicators:**

- Per ED notes Sepsis due to unspecified organism
- Per Resp note on 4/21 Suspect stress response due to respiratory distress however sepsis is also possible.
- Admit labs WBC 13.16, Lactate 2.3; Procalcitonin on 4/25 3.98
- Initial vitals T 97.9, P 105-131, R 22-46, BP as low as 68/39
- Oncology notes Myelosuppression previous chemo; recovering for recent CAP
- Urology note                    Sepsis

**Please specify in the progress notes the status of the diagnosis of sepsis in the progress notes.**

**For Example:**

- Sepsis was present on admission and is now resolved
- Sepsis was ruled out; SIRS with associated AKI
- Other (please specify)
- Unable to determine

Sepsis ruled out – SIRS associated with AKI (DRG 682 Renal Failure with MCC)

# SEPSIS *LINKED* TO ORGAN DYSFUNCTION = SEVERE SEPSIS

95 yo female with acute pancreatitis, bilateral pleural effusions, UTI, AKI. Hx of CKD4.

Noted 1st documentation of sepsis > 24 hours after admit.

Clinical Indicators:

5/21 PN: "Sepsis- tachycardia, tachypnea, leukocytosis, no lactate on admit"

VS on arrival: 134/82, 107, 16, 93%, 98.0 (HR sustained > 90 x 24 hours)

WBC on arrival: 19.49

Please clarify based on the above if:

- Sepsis was present on admission
- Sepsis was not present on admission
- Unable to determine

Noted documentation of sepsis on admit and AKI.

Clinical Indicators:

- PN: "Acute renal failure on CKD- Cr 1.77 BUN 39 unknown baseline but consistent with acute renal injury given presentation"
- Source of sepsis is UTI , tx includes Invanz

Please clarify if the AKI is due to the sepsis.

For Example:

- AKI due to sepsis
- AKI not due to sepsis
- Other (please specify)
- Unable to determine

**Final coding moved from DRG 438 Disorders of Pancreas to DRG 871 Sepsis (impacting Severity of Illness: severe sepsis captured)**

# PRESENT ON ADMISSION-INPATIENT CHANGING TO OBSERVATION

- 28 yo female admitted OBS for back pain, Hx: polysubstance abuse status changed to inpatient after 2 days for septic joint arthritis and abscess

Patient admitted for obs on 6/4 and converted to I/P on 6/7 for left sacroiliac abscess. Noted documentation of sepsis or \_\_\_\_\_ in the progress notes.

**After study, please clarify if sepsis or early sepsis was likely present on admission when patient converted to inpatient status in the progress notes.**

## Clinical Indicators:

- Neutrophil count 82.5 on 6/4.....Sed rate 82 on 6/4.....CRP 277.4 on 6/5
- WBC 11.23 on 6/4; steadily decreased to 5.88 on 6/7; WBC 2.26 on 6/8
- AMS on 6/7 "Acute Delirium likely due to drug use...will need transferred to stepdown.....Acute Encephalopathy on 6/8.
- Platelets 88 on 6/7.....lactic acid 2.4 on 6/8
- Current diagnoses include septic shock with MRSA bacteremia, acute respiratory failure

## For Example:

- Sepsis was present on admission
- Sepsis developed after admission
- Other \_\_\_\_\_ (please specify)
- Unable to determine

Final coding moved from DRG 548 Septic Arthritis w MCC to 853 Infectious & Parasitic Diseases with OR procedure w MCC (bronchial alveolar lavage of RLL)

# LINKING ORGAN DYSFUNCTION TO SEPSIS

83 yo female admitted from SNF with SOB, pneumonia, hypoxia, acute respiratory failure, CHF, Sepsis

Noted monitoring of lactic acid.]

The following abnormal test results appear on this patient's record:Lactic Acid

4/4/2018 15:18 2.6 (H)

4/4/2018 20:08 2.4 (H)

4/5/2018 03:59 1.7

**Please document in the progress a diagnosis reflective of these findings, even if resolved.**

**For Example:**

- Lactic acidosis
- Lactic acidemia
- Elevated lactic acid is not clinically significant
- Unable to determine

**Clinical Indicators:**

- Presented with sepsis, pneumonia, bacteremia, and acute respiratory failure
- H&P: "Chronic diastolic heart failure...hold Lasix...gentle IV fluid"

Noted documentation of acute respiratory failure, sepsis, and pneumonia.

**Clinical Indicators:**

- HMS 4/5: Hypoxic on presentation, requiring BiPAP, Bilateral PNA, Influenza B
- 4/4 ED: "Denies any underlying lung pathology"

**Please clarify the most likely cause(s) of the acute respiratory failure in the progress notes.**

**For Example:**

- Acute respiratory failure due to sepsis and pneumonia
- Acute respiratory failure due to pneumonia
- Other (please specify)
- Unable to determine the cause of the respiratory failure

Final coding DRG of 871 Sepsis w MCC was not changed but lactic acidosis increased ROM from 3 to 4 (APR DRG) and severe sepsis captured by linking sepsis to respiratory failure

# SEPSIS WITH SEPTIC SHOCK POA (1)

45 yo female admitted for perforated esophagus, Cdiff, sacral decubitus, respiratory disease. s/p cardiac arrest, concern for anoxic brain injury, vented at outside facility

Noted documentation on arrival :

"Unresponsive on arrival, high pressor requirements." with WBC 14.99, temperature 96.1 HR 114 , BP 86/51 per A line.

Clinical Indicators:

- Transfer from another facility for evaluation of suspected perforated esophagus with leaked contents into pleural cavity.
- Cardiac arrest at outside facility prior to transport.
- 6/1 trauma H&P:" Given esophageal perforation with leaked contents into pleural cavity- broad spectrum coverage with vanc, cefepime (no zosyn 2/2 penicillin allergy per pharmacy) and diflucan"
- 6/1 trauma note : "Patient is a chronically ill patient with is wheelchair bound at an ECF with significant history of respiratory disease, anemia, malnutrition and a sacral decubitus ulcer with osteomyelitis. Patient is also Cdiff positive."
- 6/2 : @0000- MAR Cefepime indication: sepsis of unknown origin. , Vancomycin indication: sepsis of unknown origin.

Please specify the diagnosis reflective of the above indicators in the progress notes.

For Example:

- Sepsis with septic shock , present on admit
- Sepsis, source unclear, present on admit.
- SIRS, present on admit.
- Shock following cardiac arrest.
- Hypotension.
- Other (please specify)
- Unable to determine

# SEPSIS WITH SEPTIC SHOCK POA (2)

Noted documentation of mechanical ventilation in patient with pleural effusions , bilateral chest tubes and perforated esophagus.

## Clinical Indicators:

- 6/1 Transfer from outside facility for further evaluation and treatment after cardiac arrest and suspected perforated esophagus.
- Arrived intubated with ABG on arrival : 7.31/31.3/310/15.2/99.5%
- 6/1 Left chest tube placed outside facility, 6/3 right chest tube placed at Grant.
- 6/4 -Trauma note : "CXR 6/1 shows CT in adequate position with improved left effusion, moderate R pleural effusion"
  
- 6/4 -Continues on mechanical ventilation with vent settings : Fio2 35% rate 16 , TV 420 , Peep 5 and ABG : 7.31/35.5/100/17.5/97.5%
- Weaning noted to be limited by agitation.

Please clarify the patients respiratory status in the progress notes.

## For Example:

- Acute respiratory failure.
- Arrived intubated from outside facility, remains on mechanical ventilation for respiratory failure secondary to pleural effusions and esophageal perforation.
- Mechanical ventilation for airway protection.
- Other (please specify)
- Unable to determine

Final coding: DRG 853 Infectious & Parasitic Diseases with OR procedure (peg and esophageal stent)



# Query Assistance for the CDS

-----FOR CDS USE ONLY-----

Sepsis or severe sepsis must be documented to use this query

If physician is documenting severe sepsis, continue physician's language of severe sepsis in the query

If the organ dysfunction has multiple etiologies, list multiple etiologies in your query:

i.e. Respiratory failure due to sepsis and pneumonia

Can be added when appropriate:

Please note: Severe sepsis is acute organ dysfunction associated with sepsis.

**Examples of organ dysfunction:**

Organ dysfunction listed in ICD 10 book:

- Septic shock
- Acute kidney failure or AKI
- Acute respiratory failure
- Critical illness myopathy
- Critical illness polyneuropathy
- Disseminated intravascular coagulopathy (DIC)
- Encephalopathy (metabolic) (septic)
- Hepatic failure

**Severe sepsis** must be documented and linked with lactic acidosis, thrombocytopenia, Hypotension, hyperbilirubinemia, elevated INR (see chart below for criteria) in order to capture severe sepsis (R6520).

May add "severe" as a qualifier to sepsis if appropriate.

Hepatic failure (shock liver) as evidenced by "elevations in liver enzymes and bilirubin, coagulation defects, and failure to excrete toxins such as ammonia, which lead to worsening encephalopathy"

# Benefits of CDI and Coding Collaboration

## Ohio Health Sepsis Denial Statistics

*FY 17*

32 = Total Sepsis Denials (4%)

**FY18**

22 = Total Sepsis Denials (3%)

# Sepsis Denial #1, cont'd

- 52 yo female presented to the ED with weakness, fatigue and abdominal pain. Clinical Indicators include:
  - Hypotensive- 66/46
  - Hypothermic-95.2
  - WBC 18.79
  - Heart rate - 74 BPM
  - Respiratory Rate- 16
- Admitted as inpatient with Severe Sepsis.
- Consistent documentation throughout record indicating severe sepsis improving and resolved.
- Treated with Vancomycin and Zosyn
- Blood Cultures -Negative
- Discharge Summary- Severe Sepsis and Colitis (likely infectious)
- 5 Day LOS

# Sepsis Denial #1

- **Auditor's Recommendation:** Remove sepsis and utilize colitis as PDx
- **Auditor's Rationale**
  - The clinical evidence in the medical *record doesn't support the assignment of sepsis & severe sepsis*. It was noted that the *physician documented sepsis in the ED, H&P, progress notes and discharge summary*. The medical record is examined for consistent documentation, evidence that the patient's presentation *cannot be explained by the local infection alone* or other non-infectious process and evidence of organ dysfunction caused by dysregulated response to infection.
  - Clinical evidence in the record includes: WBC 18.7, temperature of 100.1 and heart rate 107 which indicates no systemic response to the infection.
    - (Please note: in review of the record patient temperature was 100 after 24 hours of admission.)
- **Denial Response -Pending**

# Sepsis Denial #2

- 59 yo male presents to a FSED with low blood pressures, fever and was found to have a soft tissue mass of his abdomen per CT. Transferred to OLH with concerns for sepsis Clinical indicators on admission:
  - Hypotensive- 70/32
  - WBC 26.6
  - Heart Rate - 77 BPM
  - Respiratory Rate- 16
- Inpatient admission. Documentation of bacteremia, intra-abdominal abscess (determined to be due to a prior procedure) and acute kidney injury.
- Treatment included Cipro & Flagyl on admit with Vancomycin added within 24 hours.
- Bacteremia due to strep intermedius documented on day 3.
- Concurrent query sent by CDI for clarification of bacteremia diagnosis based on sepsis documented in ED & clinical indicators observed. Attending physician clarified the bacteremia as sepsis due to strep intermedius.
- LOS- 5 Days

# Sepsis Denial #2, cont'd

- **Auditor's Recommendation:** Remove the secondary code for sepsis
- **Auditors Rationale**
  - Patient presented to **outside ED** (freestanding) with fever and hypotension thus **treated for sepsis with improvement to blood pressure**. A soft tissue mass was found through CT exam which was concerning for phlegmon vs. hematoma vs. abscess. **Patient transferred to OLH for IP admission for surgery workup and evaluation**. Documentation **of bacteremia likely related to the intra-abdominal abscess found in H&P and progress notes** but **no documentation of sepsis or treatment of sepsis** during the inpatient admission.
- **Appeal Rationale**
  - Supporting Documentation provided for clinical indicators for sepsis .
  - Supporting documentation of the query response which clarified the bacteremia as sepsis was provided as evidence to support our appeal.
- **Denial Response- Overturned**

# Sepsis Denial #3

- 77 yo presents with sepsis and encephalopathy secondary to pneumonia. Clinical indicators include:
  - Fever 102.5
  - Lactate 1.3
  - Tachycardic- 108 BPM
  - Respiratory Rate- 22
- Patient admitted as inpatient with pneumonia and metabolic encephalopathy.
- Treated with Levaquin and IV Fluids
- Sepsis wasn't documented until 29 hours into the admission with confirmation of the POA status by the provider. Sepsis is stated as resolved within 52 hours of admission.
- Consistent documentation of sepsis from progress notes through the discharge summary.
- Encephalopathy clarified as delirium due to the pneumonia.
- LOS- 4 Days

# Sepsis Denial #3, cont'd

- **Auditor's Recommendation:** Remove sepsis and use pneumonia as PDx
- **Auditors Rationale**
  - Medical record examined for ***consistent documentation***, evidence that the patient's presentation cannot be explained by the local infection alone or other non-infectious process and evidence of organ dysfunction caused by dysregulated response to infection. The patient noted to have a ***temperature of 102.5, HR of 108, RR of 22 but these are expected with pneumonia***. In this case, there was ***no evidence provided for a dysregulated systemic response*** to systems remote from the site of the infection.
- **Appeal Rationale**
  - Supporting Documentation provided for clinical indicators for sepsis .
  - Emphasis on the consistent documentation throughout the record.
  - Reference to coding guideline I.A.19 for diagnosis code assignment based upon diagnostic statement that the condition exists not clinical criteria.
- **Denial Response-** Initial audit findings upheld



# Sepsis Denial #3, continued

- **Auditor's Rationale for Appeal Denial**
  - We acknowledge that the 2017 IPPS final rule and Coding Guidelines specify ***code assignment is based on the physician's diagnostic statements.*** However this **guideline does not negate other long-standing industry norms.** ***The distinction between coding and clinical validation is an additional process that may be performed along with DRG validation.***
- **Second Appeal**
  - This case has been escalated with the auditor due to the consistency of documentation and the clinical indicators described in previous slides.
- **Denial Status-** Response Pending

# Questions?



# Appendix

# Provider Education Tools

## Severe Sepsis Documentation - TIP Sheet

- Severe sepsis is defined as sepsis with sepsis-induced acute organ dysfunction or tissue hypoperfusion.
- Documentation that links sepsis to the associated acute organ dysfunction (such as acute renal failure, respiratory failure, encephalopathy, shock liver, DIC) will capture an increase in severity of illness.
- Documentation that only includes SIRS, Sepsis Alert, Sepsis Screening or Sepsis Syndrome does not capture the diagnosis of Sepsis.

### Severe Sepsis Documentation should include ALL conditions and corresponding diagnosis

Source	Any 2 SIRS Criteria	Organ Dysfunction – Include Diagnosis associated with clinical indicators below:
Confirmed or Suspected	<ul style="list-style-type: none"> <li>• Temp &gt; 100.9°F or &lt; 96.8°F</li> <li>• HR &gt; 90</li> <li>• RR &gt; 20</li> <li>• WBC &gt; 12,000 or &lt; 4,000 or &gt; 10% bands</li> </ul>	<ul style="list-style-type: none"> <li>• SBP &lt; 90 or MAP &lt; 65 or SBP drop &gt; 40 points</li> <li>• Acute respiratory failure as evidenced by invasive or non-invasive ventilation (BiPAP)</li> <li>• Cr &gt; 2.0 or urine output &lt; 0.5 ml/kg/hr for 2 hrs</li> <li>• Bilirubin &gt; 2 mg/dL (34.2 mmol/L)</li> <li>• Platelet &lt; 100,000</li> <li>• INR &gt; 1.5 or aPTT &gt; 60 sec</li> <li>• Lactate &gt; 2.0 (Indicates Severe Sepsis)</li> <li>• Lactate ≥ 4.0 (Indicates Septic Shock)</li> </ul>

### Documentation examples of SEVERE SEPSIS

- Acute respiratory failure due to sepsis with pneumonia (organ dysfunction linked to sepsis)
- Acute renal failure due to sepsis and UTI (organ dysfunction linked to sepsis)
- Dehydration due to C-diff and UTI with septic shock (organ dysfunction “septic shock” linked to sepsis)
- DIC due to C-diff and sepsis (organ dysfunction linked to sepsis)
- Severe sepsis documentation can capture severity of illness when it is linked to risk factors such as: lactic acidosis, hypotension, elevated INR (coagulopathy), or thrombocytopenia. (severe sepsis with lactic acidosis; the word “severe” is essential when sepsis is documented with risk factors)

### Clinical Example

#### Documentation of sepsis without link to organ dysfunction

1. Sepsis: Pneumonia, prognosis guarded.
2. Acute Kidney Injury: Creatinine 2.58, IV fluids.
3. Acute Respiratory failure: Pneumonia, continue BiPAP

#### Documentation of sepsis with link to sepsis-induced organ dysfunction

1. Sepsis: With gram negative pneumonia, prognosis guarded.
2. Acute Kidney Injury: Due to Sepsis. Creatinine 2.58, IV fluids.
3. Acute respiratory failure: Due to Sepsis and pneumonia, continue BiPAP

Additional information on eSource CDI site: <https://ohesource.ohiohealth.com/departments/clindocspec/default.aspx>