



Sepsis: Mitigating Denials
Amid Definition Disparity

CODING ELEVATED

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Sepsis Criteria at a Glance

The Society of Critical Care Medicine (SCCM) met in 2016 to update the definition of sepsis. During this Summit, it was determined that the presence of Systemic Inflammatory Response Syndrome (SIRS) markers in response to an infectious source may just be a normal physiologic response and not a sufficient indicator of sepsis. Instead, SCCM determined sepsis should be what clinicians, coders and others in the medical community have historically termed "severe sepsis," meaning the infection is critical enough to result in organ dysfunction.

This 2016 SCCM decision launched a conundrum of coding, clinical documentation and denial issues.

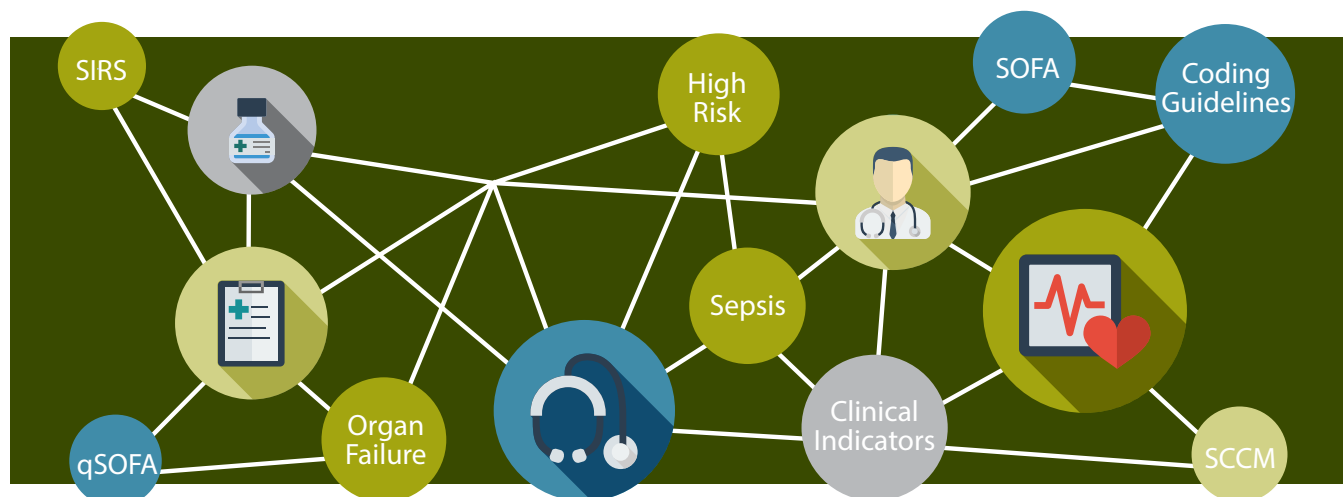
- SCCM physicians updated sepsis criteria in 2016, but other stake holders such as CDI specialists and clinical coders were not part of the conversation.
- The consequences from recognizing multiple sepsis criteria sets has adverse effects on documentation, coding, billing and reimbursement.
- Denials for sepsis cases increased as auditors use the updated SCCM criteria while providers continue with established coding guidelines for sepsis.

INTRODUCTION

The definition of sepsis is a moving target in health-care. Every time sepsis criteria shifts, confusion results for physicians, clinical documentation improvement (CDI) specialists and health information management coders. In 2016, the Society for Critical Care Medicine (SCCM) revised the definition of sepsis and the Third International Consensus for Sepsis and Septic Shock (Sepsis-3) was released, which supported the implementation of new definitions, causing a ripple effect in the entire healthcare community. Along with disruption came a new window of opportunity for payers and recovery audit contractors (RACs) to deny hospitals' sepsis claims. Here's why:

While members of the SCCM achieved consensus on sepsis, the cooperating parties have not yet formalized the new definition into coding criteria or guidelines—causing incongruence between healthcare providers and payers. With definitions in flux, now is the time for healthcare organizations to proactively revisit their sepsis documentation and coding practices to prevent reimbursement loss.

This white paper reviews the SCCM's revised sepsis criteria and resulting impacts on clinical coding, billing and denials. New disconnects between physicians, CDI specialists and clinical coders are identified and coping strategies shared.



Varying Sepsis Guidance Opens the Door for Denials

SCCM now defines sepsis as “life-threatening organ dysfunction caused by a dysregulated host response to infection.” In addition, SCCM updated the description of septic shock, which is now considered “a subset of sepsis in which profound circulatory, cellular, and metabolic abnormalities are associated with a greater risk of mortality than with sepsis alone.”

This is a departure from the current practice where correct coding guidelines are based on the widely used SIRS clinical indicators. Under the new SCCM criteria, a patient admitted from the emergency department and considered septic based on SIRS criteria, would only be termed “high risk” for sepsis under the SCCM definition.

The biggest issue for healthcare providers is that until the new SCCM criteria trickle down to coding criteria and guidelines, physicians and coders will use traditional SIRS criteria for substantiating a diagnosis of sepsis—while payers have already moved ahead to the new SCCM definition. This gap opens the door for increased payer denials and reimbursement risk.

“Now that third party payers and RAC auditors are using the new sepsis criteria, many sepsis cases coded using SIRS criteria will be flagged, audited and denied.” - Jonathan LaFleur, BSN, RN, CCS

New Guidelines for Sepsis: Sepsis-Related Organ Failure (SOFA) and Quick Sepsis-Related Organ Failure (qSOFA) Explained

In his June 2016 President’s Message, Todd Dorman, MD, FCCM, describes SCCM’s new definitions as an “attempt to advance the field” using data analysis instead of the traditional Delphi approach. Dorman recognizes that all sepsis is severe and positions new definitions as a way to investigate and better understand which diagnostic and therapeutic steps are being used to treat infections across the United States.

While he admits that additional studies are warranted, Dorman and the SCCM’s consensus is that non-ICU patients can be screened as high risk for sepsis by identifying an infection plus two of the following three quick SOFA (qSOFA) criteria:

Altered mental status (GCS <15), tachypnea (>22 breaths/minute), or hypotension (<100mmHg systolic)

To correctly “rule-in” for sepsis, there must be an infection plus two or more sepsis-related organ failure (SOFA) points that deviate from the patient’s baseline as defined on the below SOFA scale:

Table 1. Sequential [Sepsis-Related] Organ Failure Assessment Score^a

| System | Score | 0 | 1 | 2 | 3 | 4 |
|--|-------|---------------|-------------------|--|---|--|
| Respiration | | | | | | |
| PaO ₂ /FIO ₂ , mm Hg (kPa) | | ≥400 [53.3] | <400 [53.3] | <300 [40] | <200 [26.7] with respiratory support | <100 [13.3] with respiratory support |
| Coagulation | | | | | | |
| Platelets, ×10 ³ /μ | | ≥150 | <150 | <100 | <50 | <20 |
| Liver | | | | | | |
| Bilirubin, mg/dL (μmol/L) | | <1.2 [20] | 1.2-1.9 [20-32] | 2.0-5.9 [33-101] | 6.0-11.9 [102-204] | >12.0 [204] |
| Cardiovascular | | | | | | |
| | | MAP ≥70 mm Hg | MAP <70 mm Hg | Dopamine <5 or dobutamine (any dose ^b) | Dopamine 5.1-15 or epinephrine ≤0.1 or norepinephrine ≤0.1 ^b | Dopamine >15 or epinephrine >0.1 or norepinephrine >0.1 ^b |
| Central nervous system | | | | | | |
| Glasgow Coma Scale score ^c | | 15 | 13-14 | 10-12 | 6-9 | <6 |
| Renal | | | | | | |
| Creatinine, mg/dL (μmol/L) | | <1.2 [110] | 1.2-1.9 [110-170] | 2.0-3.4 [171-299] | 3.5-4.9 [300-440] | >5.0 [440] |
| Urine output, mL/d | | | | | <500 | <200 |

Abbreviations: FIO₂, fraction of inspired oxygen; MAP, mean arterial pressure; PaO₂, partial pressure of oxygen.

^a Adapted from Vincent et al.

^b Catecholamine doses are given as μg/kg/min for at least 1 hour.

^c Glasgow Coma Scale scores range from 3-15; higher score indicates better neurological function.

Helping Stakeholders Make the Shift

To successfully shift from the sepsis indicators of today to the SCCM criteria of tomorrow, hospitals must recognize the present-day impact on stakeholders while also building bridges through awareness and education.

Impact on Clinical Coders

For coding professionals, the correct current guideline for assigning a diagnosis code of sepsis is published in two Coding Clinics: Coding Clinic 2nd Q 2000 page 3 for clinical evidence of Sepsis: temperature $>38^{\circ}\text{C}$ or $<36^{\circ}\text{C}$; heart rate > 90 beats per minute; respiratory rate > 20 breaths per minute; $\text{PaCO}_2 < 32$ mmHG; white blood count (WBC) $> 12,000$ cells/mm 3 ; < 4000 cells/mm 3 ; and/or $> 10\%$ immature (band) forms and Coding Clinic 3rd Q 1999 pages 5 to 6 which states: Sepsis can be diagnosed when patients demonstrate two or more signs of SIRS in the setting of a disorder known to cause endothelial inflammation and in the absence of any other known cause for such abnormalities.

In summary, current correct coding guidelines state there must be a source of infection plus leukocytosis or leukopenia, fever or hypothermia, tachycardia, and/or tachypnea.

Until official coding guidance is released based on the new SCCM criteria, coders face a unique challenge. They are obliged to assign codes based on physician documentation within the medical record, much of which remains based on old language and definitions. Physicians may document sepsis when, according to new criteria, the patient is only at risk for sepsis.

“Coders face a particularly difficult scenario for short-stay sepsis cases. Sepsis is a life-threatening disease and doesn’t justify a quick discharge home from an acute care facility—regardless of what the physician documents.”

Kimberly Janet Carr, RHIT, CCS, CDIP, CCDS, AHIMA-Approved ICD-10-CM/PCS Trainer



Impact on Coding Auditors

Coding auditors have the ability to influence their organization’s shift to the new sepsis criteria. Auditors should take on the responsibility for educating all stakeholders by actively pushing out the new SCCM definitions to all involved personnel, including, but not limited to:

- Clinical coders
- Medical staff (including emergency services)
- Clinical documentation improvement (CDI) specialists
- Registration, billing and revenue cycle staff
- Denial management teams

Impact on Denial Management

Denial auditors have already begun to use the new Sepsis-3 criteria. In some facilities, every case containing a sepsis code is being flagged for additional documentation review. To mitigate denial risk, organizations should begin conducting pre-bill reviews of all sepsis cases where full compliance with the new criteria may not be completely met. Organizations should ensure that the information gleaned from the reviews is communicated to their physicians and education on the impact of this disparity is provided.

CONCLUSION

Sepsis is a life-threatening organ dysfunction due to dysregulated host response to infection. Until there is education to ensure accurate and consistent physician documentation, doctors will continue to assign a diagnosis of sepsis based on obsolete criteria—increasing the number of denials, audits and revenue recoupments.

Today's sepsis cases must document expansion of the disease signs and symptoms beyond the original infection AND have a new focus on organ dysfunction or failure to be considered sepsis.

RAC audits and third party payer denials are not going away, but with updated criteria and focused education, healthcare providers can effectively mitigate the risk of denials for their sepsis patients.

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i SCCM: Sepsis Definitions. 2016. Multiple sources available online at: www.sccm.org

ii President's Message: Sepsis is Severe: Dorman, Todd, MD, FCCM (June 3, 2016) <http://www.sccm.org/Communications/Critical-Connections/Archives/Pages/President's-Message---Sepsis-Is-Severe.aspx>