# Simple Strategies: Team Approach to Improving Sepsis Reimbursement and Reputation

## Think About It!

According to the Centers for Disease Control and Prevention (CDC), each year, 1.7 million U.S. adults develop sepsis and about 30% will not survive. Given the severity and variability of sepsis care, payors, regulatory agencies and reputation programs have used payment penalties, accreditation requirements and public reporting to hold hospitals accountable for improving the quality and safety of care provided.

## Take Action!

Staff in Billing, Coding, Quality, Clinical Documentation Integrity, Utilization Review, Information Technology, Nursing and Physician Services have key roles in the administrative processes of sepsis.

Interdisciplinary collaboration between these roles can help ensure standardized processes are developed to avoid unnecessary impacts to reimbursement and reputation.

**Use this resource to prompt discovery of current practices and potential opportunities for improvement.**

### Sepsis Documentation Needs

**Sepsis:** *2 or more SIRS criteria listed + Suspected infection. Example:*

- Fever of > 38°C (100.4°F) or < 36°C (96.8°F)
- Heart rate > 90 beats per minute
- Respiratory rate > 20 breaths per minute or arterial carbon dioxide tension (PaCO2) < 32 mm Hg
- Abnormal white blood cell count (< 4,000/µL or >12,000/µL or >10% immature [band] forms)

**Severe Sepsis:** *Sepsis (as listed above) + sepsis-induced organ dysfunction and/or tissue hypoperfusion*

- Evidence of organ dysfunction or tissues hypoperfusion includes:
  - Hypoxemia, oliguria, acute kidney injury, coagulopathy, ileus, thrombocytopenia, hyperbilirubinemia, altered mental status, lactate ≥ 2.0 mmol/L, or hypotension

**Septic Shock:** *Hypoperfusion despite fluid resuscitation or lactate ≥ 4.0 mmol/L*

- Subset of sepsis in which particularly profound circulatory, cellular and metabolic abnormalities are associated with a greater risk of mortality than with sepsis alone. Clinically identified by a serum lactate level greater than 2 mmol/L (>18 mg/dL) in the absence of hypovolemia OR vasopressor requirement to maintain MAP of 65 mm Hg or greater.

### EMR Documentation Prompts

**Best Practice:** *When it comes to sepsis denials, common documentation defects noted within the patient's chart will often times revolve around missing supporting documentation. Documentation prompts to help avoid these issues can revolve around:*

- Sepsis has been documented - was the SIRS/ SOFA criteria listed or was the condition ruled out?
- Sepsis has been documented - was a localized infection documented and directly connected to sepsis in the patient's chart.
- Sepsis has been documented - was a pathogen directly associated with sepsis?

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## When to Query for Sepsis

**Best Practice:** *With stringent coding guidelines surrounding sepsis, a disconnect between clinician documentation and medical coding guidelines is inevitable. This means that query opportunities are of great importance. Opportunities for a query:*

- When the "Present on Admission" (POA) status is unclear.
  - Guideline I.C.1.d.1.b Severe Sepsis
- When an acute organ dysfunction does not have a clearly documented relationship with sepsis.
  - Guideline I.C.1.d.1.a.iv
- When postprocedural sepsis (or postprocedural septic shock) is present and a link between the infection and the procedure is not clearly documented.
  - Guideline I.C.1.d.5.a
- When the term "Urosepsis" is used to identify the presence of sepsis. There is no code for "Urosepsis."
  - Guideline I.C.1.d.1.a.ii
- When supporting clinical evidence (ex.: SIRS Criteria, SOFA/ qSOFA scores, etc.) is not documented.

## Postoperative Sepsis (Patient Safety Indicator 13)

**Best Practice:** *If postoperative sepsis is coded, consider notifying an interdisciplinary review team for validation prior to final billing. If a postprocedural infection directly leads to postprocedural septic shock, the necessary codes for sepsis due to a postprocedural infection need to be assigned.*

- This should be followed by code T81.12, Postprocedural septic shock.
- Do not assign code R65.21 in this situation, severe sepsis with septic shock in these circumstances. Additional code(s) should be assigned for any acute organ dysfunction.
  - ICD-10-CM Official Guidelines for Coding and Reporting, FY 2021, Page 24-26 of 126

## Common Denial Reasons

**Best Practice:** *When it comes to sepsis denials, an auditor's reasoning will vary from situation to situation. In order for your organization to avoid denials, it is helpful to understand what auditors are listing as denial reasons. The following are documented sepsis account denials:*

- "Lack of clinical indicators documented in the medical record."
- "The clinical evidence in the medical record did not support the assignment of sepsis. It was noted the physician documented sepsis in the discharge summary. There was insufficient clinical evidence and supportive documentation in the record available for review to substantiate the coding of sepsis."
- "While sepsis is documented in the medical record, there is no clinical evidence found to support SOFA criteria."
- "Although we agree that the physician documented sepsis in the provided medical record, we do not agree that two or more SIRS criteria clinically support a diagnosis of sepsis."
  - Reasons for Denials and Prevention | Sepsis Series

## DNR and Comfort Care Status

**Best Practice:** *When it comes to a patient's DNR (Z66) status and Encounter of Palliative Care (Z51.5) codes, these will always be important to pick up. The ICD-10-CM Guidelines for Coding and Reporting instruct us to code all coexisting comorbidities, especially those part of medical decision-making (MDM). DNR and Palliative Care make a drastic impact on the MDM. These codes should always be picked up, when available.*

- Z Codes: Who's on the First? - AAPC Knowledge Center
- Note that mortality and risk adjustment methodologies vary and the use of DNR, palliative, and hospice codes may or may not impact sepsis coding and quality measures. Seek guidance from your interdisciplinary review team for your specific scenario.

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