

CDI Tip Sheet #3

Sepsis:

The definition of Sepsis has evolved over time. Initially SIRS plus a source of infection equaled sepsis (Sepsis 1). Then the guidelines established that 1 specific organ dysfunction due to an infection equaled sepsis (Sepsis 2). Over the last couple of years, the guidelines have further defined sepsis as a systemic response with acute organ dysfunction due to a localized infection (Sepsis 3) and utilized a scoring system called a SOFA (Sequential/Sepsis -Related Organ Failure Assessment) score. Not only is the different definitions of sepsis challenging for providers and hospitals, but also the fact that different payors sometimes use different guidelines for billing and denials. These challenges have led to Sepsis being one of the most denied diagnosis. To assist with prevention of denials and encourage continuity of documentation among all providers we have created this tip sheet and included a short article written by a physician on prevention of sepsis denials.

Sepsis: Life-threatening organ dysfunction caused by a dysregulated host response to infection that cannot be easily explained by another co-existing reason or condition.

Organ Dysfunction: Evidenced by an increase in the Sequential (Sepsis-Related) Organ Failure Assessment (SOFA) score of 2 or more points.

Septic Shock: Sepsis + hypotension requiring vasopressors + lactate >2

SOFA: Sequential Organ Failure Assessment

System	Score				
	0	1	2	3	4
Respiration					
PaO ₂ /FiO ₂ , mmHg (kPA)	≥400 (53.3)	<400 (53.3)	<300 (40)	<200 (26.7) with respiratory support	<100 (13.3) with respiratory support
Coagulation					
Platelets, x10 ³ /μl	≥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)	Dopamine 5.1-15 or epinephrine ≥0.1 or norepinephrine ≥0.1	Dopamine >15 or epinephrine >0.1 or norepinephrine >0.1
Central Nervous System					
Glasgow Coma Scale score	15	13-14	10-12	6-9	<6
Renal					
Creatinine, mg/dL (μmol)	<1.2 (110)	1.2-1.9 (110-170)	2.0-3.4 (171-299)	3.5-4.9 (300-400)	>5.0 (440)
Urine output, mL/d				<500	<200

Helpful Hints:

- Including a SOFA score with your diagnosis of sepsis assists with prevention of denials. The CDI specialist can calculate this for you and send per messenger to include in your note if you wish.
- Linking appropriate organ dysfunctions to the sepsis assists with providing supporting clinical indicators. Watch for metabolic encephalopathy, AKI/ATN, acute respiratory failure, shock liver, NSTEMI, type 2 MI, etc. due to sepsis.
- Present on admission status and the source of the sepsis should be noted. If the infection is due to a device please document the link. Documentation should be clear, consistent, and supported by clinical indicators.
- Careful use of copy and paste and preformatted notes. Watch for conflicting documentation throughout notes and between consults and clarify if possible.
- The diagnosis of sepsis should carry through the chart to the discharge summary. Dropped or unclear diagnoses may trigger a query/clarification to see if the sepsis is resolved or ruled out. Possible, probable, or likely diagnoses can be captured, in the inpatient world, if not ruled out and are documented on the D/C summary.
- SIRS due to an infection does not automatically equal sepsis in the coding world. In fact, if a patient has SIRS and an infection the SIRS is not coded per coding guidelines. SIRS due to an infection triggers the CDI specialist to look for clinical support and organ dysfunction (calculate a SOFA score) for possible sepsis.
- + blood cultures or bacteremia does not in itself equal sepsis but may be a supporting clinical indicator or source of infection.
- Urosepsis does not have an I10 code. Clarification may be requested to verify if the patient has sepsis due to an UTI or is the sepsis ruled out and the pt has an UTI.
- Listing additional clinical indicators of sepsis (with the SOFA score and associated organ dysfunction), if appropriate, assists with denial prevention. For example: elevated procalcitonin, elevated CRP, hyperglycemia (in non-diabetic) due to sepsis.
- As always, the CDI specialist and the Coding team defer to the expertise of the physicians caring for the patients. Please keep in mind we are not questioning the clinical judgment and we are not asking questions to “pad” the chart. In our ever-changing world, we are trying to be proactive and prevent denials. Part of CDI is assisting providers with capturing impacting diagnoses to reflect the Risk of Mortality (ROM), Severity of illness (SOI) and show the unitization of resources to care for the patients. We are trying to accurately capture the acuity of the patient and reflect the exceptional care provided.