DOCUMENTATION OF SEPSIS

CDI Education

February 2020

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Learning Objectives

- List three reasons for insurance denials of payment for sepsis patients
- Differentiate between the three types of sepsis: Sepsis, Severe Sepsis, Septic Shock
- Discuss the importance of documentation of clinical indicators to support a diagnosis

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Sepsis is one of the most common causes of Mortality and Morbidity at Sharp Healthcare and healthcare systems nationwide

SEPSIS DOCUMENTATION PEARLS

- ✓ Use Sharp Definition of Sepsis for clinical indicators and state "Sepsis, Severe Sepsis, or Septic Shock" based upon clinical indicators
- ✓ Link organ dysfunction to "Severe Sepsis and/or Septic Shock"
- ✓ State if Sepsis has been ruled out or resolved
- ✓ Ensure the patient is documented to look "Sick, Toxic, and/or Septic" and that the clinical picture within the record is consistent with that description
- ✓ Link treatment to sepsis as appropriate
- ✓ State if clinical indicators for sepsis are present, but due to another causes
- ✓ Follow the "Sepsis Order-Set" bundle for "Severe Sepsis and Septic Shock" patients

IMPORTANCE OF PROPER DOCUMENTATION

Accurate and appropriate documentation of the diagnosis of Sepsis is important to ensure appropriate care, quality indicators and compliance with Core indicators of Sepsis

Insurance companies are issuing denials and downgrading payments when the documentation does not support the diagnosis of sepsis

Denials are often due to:

- *The diagnosis of "Sepsis" with appropriate treatment only noted in the ED notes*
- *Weak clinical indicators of sepsis*
- *Templates with conflicting information*
- *Sepsis diagnosis only documented in a query and not carried through to Progress Notes and/or Discharge Summary*
- *Patient does not appear "toxic, sick or septic" or documentation states "appears non-toxic"*
- *Diagnoses of "Urosepsis" or "Sepsis Syndrome" which are not able to be coded per Centers for Medicare Services (CMS)*
- *No documented link between the organ failure and sepsis*
- *Patient receives fluids and vasopressors for hypotension, but "septic shock" not stated*
- *Sepsis initially documented but then omitted from Provider documentation without being "ruled out or resolved"*

SEPSIS/SEVERE SEPSIS/SEPTIC SHOCK
Definitions and Documentation Guide

DEFINITIONS

- **Septic shock –** Severe sepsis or sepsis resulting in one (1) of the following:
  - **Persistent hypotension –** SBP < 90 mm Hg or MAP < 65 mm Hg despite fluid resuscitation with 30 mL/kg crystalloid) **OR**
  - **Vasopressor use** to maintain MAP >= 65 mm Hg **OR**
  - **Lactate >= 4 mmol/mL** unless it is explicitly documented to be due to another cause

  Cause and effect must be explicitly documented
- **Severe Sepsis –**Infection and/or sepsis resulting in one (1) of the following:
  - **Hypoxemia (< 60 mm Hg or SpO_2 < 90)** requiring high flow oxygen support, noninvasive (CPAP, BiPAP) or invasive ventilation support
    - **Acute respiratory failure**
  - **Oliguria or serum Cr of 2.0 mg/dl**
    - Acute kidney injury and, if present, acute tubular necrosis
  - **INR > 1.5 or aPTT > 60 not due to anticoagulation or other diseases**
    - Secondary coagulopathy ± DIC
  - **Thrombocytopenia (< 100)**
    - Secondary thrombocytopenia ± DIC
  - **Bilirubin > 2 mg/dl**
    - Jaundice and/or acute hepatic failure ("shock liver")
  - **Altered mental status (a delirium)**
    - Septic (metabolic) encephalopathy
  - **Critical illness myopathy or neuropathy**
  - **Ileus**
  - **Lactate > 2.0 mmol/mL**
    - Tissue hypoperfusion ± Lactic acidosis (w/low HCO_3 or pH)

  Be certain to state the associated disease is "due to" severe sepsis or if due to another cause (e.g. ATN 2° gentamicin; ileus 2° autonomic neuropathy).
  If possible, please document "severe sepsis" in preference to sepsis alone.
- **Sepsis –** Documented or suspected infection plus 2 or more of the following in a documented "sick appearing", "toxic appearing", "septic appearing" patient:
  - **Temperature < 36° C (96° F) or > 38° (100.4° F)**
  - **Heart rate > 90**
  - **RR > 20 (or pCO_2 < 32 mm Hg)**
  - **WBC < 4,000 or > 12,000 or "Bandemia" (>10% early forms)**
  - **Lactate > 1 mmol/mL**

  Criteria must not be reasonably due to another cause (e.g. leukemia)

CLARIFICATIONS:

- **Avoid the terms "urosepsis", "sepsis syndrome", or "SIRS 2° infection"**
  - Uncodeable in ICD-10-CM; a query WILL be rendered if you do
- **Bacteremia is not sepsis unless criteria is met.** Document the appropriate term based on clinical criteria and suspected underlying cause
- **Document all acute diagnoses three times, when possible:**
  - When established
  - A second time to state if better or worse (the more the better)
  - In the discharge summary (e.g. Admitted for severe sepsis w/septic encephalopathy that improved with severe sepsis protocol)
- **If admitted to "rule out sepsis", state later if "ruled in" or "ruled out"**
- **OK to state "borderline", "suspected", "probable", "likely" or other terms of uncertainty** in one's medical decision making in describing a diagnosis; however, if the physician is reasonably certain that the condition is present, these can be coded ONLY if documented at the time of discharge (i.e. acute delirium likely due to septic encephalopathy in the setting of severe sepsis; likely septic shock with lactate of 5.0 mmol/mL due to UTI)

Summary of SEP-1 Requirements

Severe Sepsis

Within 3 hours of meeting severe sepsis criteria
- Draw lactate
- Draw Blood Cultures
- Initiate appropriate IV antibiotics

Within 6 hours
- Repeat lactate if initial >2
- If initial hypotension (BP<90 or MAP <65), give 30 ml/kg NS or LR

Septic Shock

Within 3 hours of meeting septic shock criteria
- Give 30ml/kg NS or LR (if not already given)
- Vasopressors for persistent hypotension post IV fluids

Within 6 hours
Perfusion reassessment

Consider using Septic Shock Perfusion Reassessment Attestation order – meets Perfusion Reassessment documentation requirements

Support: Pamela Stence – pamela.stence@sharp.com – (858) 499-4736

January 2019

Case Review - Mortality

Emergency Department (ED) Note

Chief Complaint:
Altered mental status

History of Present Illness:
96-year-old female brought in by ambulance for altered mental status and respiratory distress. Patient had been in her normal state of health until 2 days ago, when she started complaining of cough, generalized weakness, and generalized body aches. Tonight, the family found her to be lethargic, tachypneic, essentially unresponsive. The patient was brought in by EMS, bagging the patient. Patient herself is minimally responsive, but is taking spontaneous respirations.

03/05/19 22:16

Chemistry

Lactic Acid Lvl	**2.3 H**

Chemistry

Anion Gap	**18 H**
Sodium Lvl	**140**
Potassium Lvl	**3.5**
Chloride	**98**
CO2	**24**
Glucose Lvl	**214 H**

Medications, IV's and Blood Products Ordered
Sodium Chloride 0.9% (Sodium Chloride 0.9% Bolus) 1,060 mL/kg once IV Bolus, Reason for Infusion = Sepsis
oseltamivir (Tamiflu) 75 mg = 12.5 mL once PO
oseltamivir (Tamiflu) 30 mg = 5 mL Q24H PO

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Emergency Department (ED) Note Continued

Medical Decision Making:

Differential diagnoses considered but not limited to in this patient are acute stroke, acute TIA, acute sepsis, acute pneumonia, acute UTI, acute uremia, acute hepatic encephalopathy, acute electrolyte imbalance, acute anemia, acute seizure, acute pseudoseizure, acute psychotic break, acute alcohol intoxication, acute drug intoxication

Impression:

1. Acute sepsis secondary to influenza A
2. Acute influenza A infection
3. Acute respiratory failure secondary to influenza A
4. Critical care by ED physician

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History and Physical

CHIEF COMPLAINT:
Unresponsiveness

HISTORY OF PRESENT ILLNESS:
96-year-old Filipino female, with hypertension, presenting with acute respiratory failure and unresponsiveness.

Information is from the daughter at bedside.

The patient was found unresponsive around 8:50 PM tonight. She was sitting in her bedside commode in her room.
The daughter immediately called 911.

Per EMS, patient had pinpoint pupils. Patient was given Narcan however no effect noted. Reportedly, patient was having agonal breathing and ambo bagging was done.

In the ER, patient still with agonal breathing. She is on BiPAP on my exam. CT head negative. Chest x-ray normal. She tested positive for influenza A.

Per daughter, patient has been having dry cough for several days now. She was also complaining of diffuse body aches and myalgia. No noted fever.

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History and Physical Continued

GENERAL: Unresponsive and agonal breathing
HEENT: Normocephalic. No oropharyngeal lesions. Clear throat.
NECK: Supple. No lymphadenopathy. No JVD.
CHEST: Coarse bilaterally. Symmetrical chest expansion.
CARDIAC: Regular rate and rhythm. No murmurs rubs or gallops.
ABDOMEN: Soft. Normal active bowel sounds. Nontender. Nondistended. No organomegaly.
EXTREMITIES: No edema. No clubbing or cyanosis. Good pulses.
NEUROLOGIC EXAM: Unresponsive, pinpoint pupils

ASSESMENT AND PLAN:

Acute respiratory failure
Acute influenza A infection/bronchitis
Chest x-ray normal
Was given Tamiflu in the ER
However, by the time of my examination, clinical status continues to decline rapidly
Patient is now DNR/DNI
Continue with BiPAP for now
Family has requested for a priest

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Discharge Summary

Refer to my H and P earlier

Patient was already agonal breathing on presentation and with rapid decline in clinical status. She is unresponsive.

Family immediately decided DNR DNI during discussion with ER physician.

Patient was seen by priest per family request.
Patient expired.

Diagnosis:

Acute respiratory failure due to Influenza A bronchitis

Coding Summary Based upon Documentation

MDC Code	MDC Text		
004	**DISEASES & DISORDERS OF THE RESPIRATORY SYSTEM**		
DRG Code	DRG Text		
193	**SIMPLE PNEUMONIA & PLEURISY W MCC**		
HCFA Weight	Average LOS	Geometric Mean LOS	DRG Weight
1.3167	**5.2000**	**4.2000**	**1.3167**
APR MDC Code	APR MDC Text		
003	**EAR, NOSE, MOUTH, THROAT AND CRANIOFACIAL DISEASES AND DISORDERS**		
APR DRG Code	APR DRG Text		
113	**Infections of upper respiratory tract**		
APR SOI	APR ROM		
3	**3**		

Admit DX	*Admit Diagnosis Text*
J101	**Influenza due to other identified influenza virus with other respiratory ma**

Prin DX	*Principle Diagnosis Text*	*POA*	*HAC*	*PPC*
J101	**Influenza due to other identified influenza virus with other respiratory ma**	**Y**		

DX Code	*Secondary DX Text*	*POA*	*HAC*	*PPC*
J9600	Acute respiratory failure, unspecified whether with hypoxia or hypercapnia	Y		
Z66	Do not resuscitate	Y		
I10	Essential (primary) hypertension	Y		
F0390	Unspecified dementia without behavioral disturbance	Y		

PX Code	*Procedure Text*	*Date*	*Provider*

Additional Documentation ED Nursing Note

General

Affect/Behavior : Other: Unresponsive.

ED Narrative : Patient lethargic and responsive to painful stimuli only.

Neurological Strengths Grid

	Left Upper Extremity Row	Right Upper Extremity Row	Left Lower Extremity Row	Right Lower Extremity Row
Motor :	Flaccid	Flaccid	Flaccid	Flaccid
	Calderon, Levi - 3/6/2019 0:45 PST	Calderon, Levi - 3/6/2019 0:45 PST	Calderon, Levi - 3/6/2019 0:45 PST	Calderon, Levi - 3/6/2019 0:45 PST

Glasgow Coma

Eye Opening Response Glasgow : To pain (2)

Best Verbal Response Glasgow : Incomprehensible sounds (2)

Best Motor Response Glasgow : Flaccid (1)

Glasgow Coma Score : 5 (LOW)

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Initial Improvement in Coding

Medicare DRG and MDC Information

189	PULMONARY EDEMA & RESPIRATORY FAILURE CMS wt 1.2353 A/LOS 4.8 G/LOS 3.8
004	DISEASES & DISORDERS OF THE RESPIRATORY SYSTEM

APR (all versions) DRG and MDC Information

133	Respiratory failure APR wt 1.4075 Low Trim 1 High Trim 24 ALOS 6.49 GLOS 4.94 Status: LOS Inlier
004	DISEASES AND DISORDERS OF THE RESPIRATORY SYSTEM
4	Extreme Severity of Illness
4	Extreme Risk of Mortality

Diagnosis Code Detail

Code	Description	Affect	MCC	CC	SOI	ROM	Sort
J9600	Principal Acute respiratory failure, unspecified whether with hypoxia or hypercapnia	✓			P	P	
R402312	Coma scale, best motor response, none, at arrival to emergency department		✓		4	4	
R402122	Coma scale, eyes open, to pain, at arrival to emergency department		✓		4	4	
R402222	Coma scale, best verbal response, incomprehensible words, at arrival to emergency department		✓		4	4	
J101	Influenza due to other identified influenza virus with other respiratory manifestations				1	1	
Z66	Do not resuscitate				1	1	
I10	Essential (primary) hypertension				1	1	
F0390	Unspecified dementia without behavioral disturbance				1	2	

Procedure Code Detail

Code	Description	Affect	SP
5A09357	Principal Assistance with Respiratory Ventilation, Less than 24 Consecutive Hours, Continuous Positive Airway Pressure		

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More to add – What Diagnoses?

Vitals View	03/06/2019 1:10 PST	03/06/2019 1:05 PST	03/06/2019 0:33 PST	03/06/2019 0:15 PST	03/06/2019 0:00 PST	03/05/2019 23:30 PST	03/05/2019 23:00 PST	03/05/2019 21:55 PST	03/05/2019 21:42 PST	03/05/2019 21:40 PST	03/05/2019 21:26 PST
Measurements											
Dosing Weight											35.38
BSA			1.2342								1.2342
Body Mass Index											14.73
Height/Length											155
Vital Signs											
Temperature Rectal									37.2		
Peripheral Pulse Rate									86		104 H
Heart Rate Monitored	0 L	50 L	80		90	90	88				
Cardiac Rhythm		Atrial fibrillati	Atrial fibrillati						Sinus tachyca		
SBP/DBP Cuff											
Systolic Blood Pressure		76 L	148 H		200 H	189 H	172 H		179 H		171 H
Diastolic Blood Pressure		57 L	76		96 H	95 H	89		87		96 H
Mean Arterial Pressure		63	100		131	126	117		118		121
Respiratory Rate	0 L	8 L	10 L		31 H	24 H	22 H		23 H		8 L
SpO2		44	90	42	92	99	99	99	99	93	99
FiO2								40, 40			
Oxygen Therapy		BIPAP	BIPAP		Non-rebreath	BIPAP	BIPAP		BIPAP		

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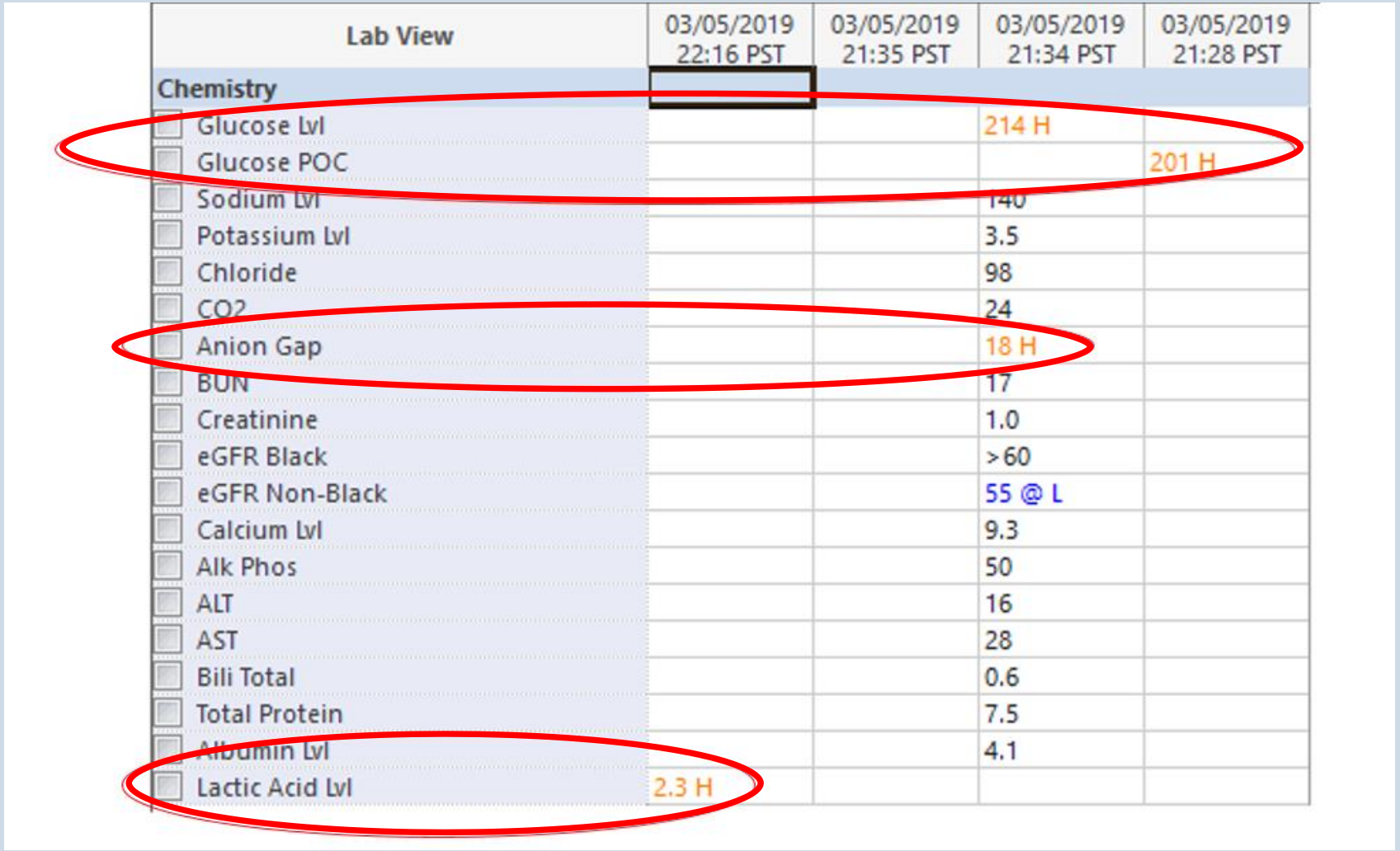
Labs



Lab View	03/05/2019 22:16 PST	03/05/2019 21:35 PST	03/05/2019 21:34 PST	03/05/2019 21:28 PST
Chemistry				
Glucose Lvl			214 H	
Glucose POC				201 H
Sodium Lvl			140	
Potassium Lvl			3.5	
Chloride			98	
CO2			24	
Anion Gap			18 H	
BUN			17	
Creatinine			1.0	
eGFR Black			>60	
eGFR Non-Black			55 @ L	
Calcium Lvl			9.3	
Alk Phos			50	
ALT			16	
AST			28	
Bili Total			0.6	
Total Protein			7.5	
Albumin Lvl			4.1	
Lactic Acid Lvl	2.3 H			

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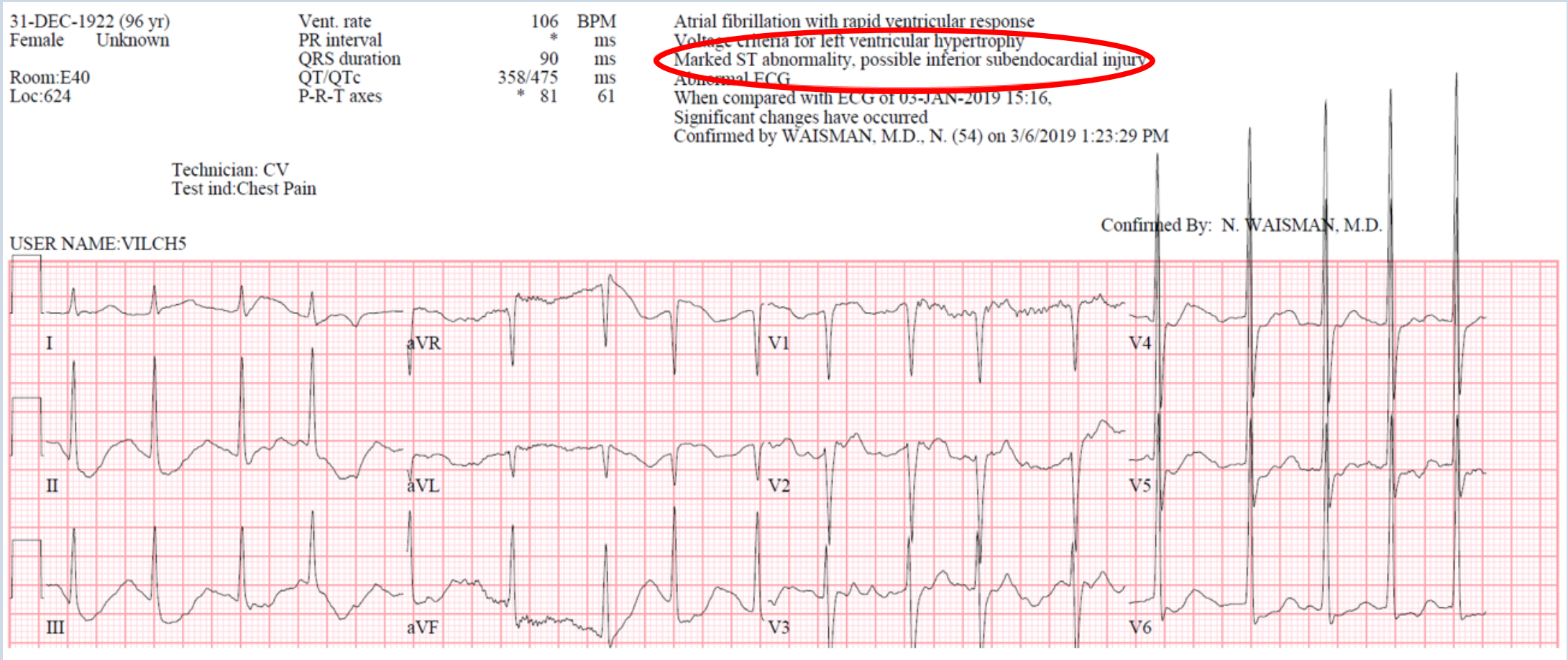
EKG


31-DEC-1922 (96 yr)
Female Unknown
Room:E40
Loc:624
Vent. rate 106 BPM
PR interval * ms
QRS duration 90 ms
QT/QTc 358/475 ms
P-R-T axes * 81 61
Atrial fibrillation with rapid ventricular response
Voltage criteria for left ventricular hypertrophy
Marked ST abnormality, possible inferior subendocardial injury
Abnormal ECG
When compared with ECG of 03-JAN-2019 15:16,
Significant changes have occurred
Confirmed by WAISMAN, M.D., N. (54) on 3/6/2019 1:23:29 PM
Technician: CV
Test ind:Chest Pain
Confirmed By: N. WAISMAN, M.D.
USER NAME:VILCH5
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6

Potential Final Coding Outcome

Medicare DRG and MDC Information

871	**SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC** CMS wt 1.8564 A/LOS 6.3 G/LOS 4.8 Length of stay, discharge to a post-acute care provider, and home health service condition codes can significantly impact reimbursement for this DRG.
018	**INFECTIOUS & PARASITIC DISEASES, SYSTEMIC OR UNSPECIFIED SITES**

APR (all versions) DRG and MDC Information

720	**Septicemia & disseminated infections** APR wt 1.6170 Low Trim 1 High Trim 28 ALOS 7.82 GLOS 5.98 Status: LOS Inlier
018	**INFECTIOUS AND PARASITIC DISEASES, SYSTEMIC OR UNSPECIFIED SITES**
4	**Extreme Severity of Illness**
4	**Extreme Risk of Mortality**

Diagnosis Code Detail

Code	Description	Affect	MCC	CC	SOI	ROM	Sort
A4189	Principal Other specified sepsis	✓			P	P	
R6521	Severe sepsis with septic shock	✓	✓		3	4	
J9600	Acute respiratory failure, unspecified whether with hypoxia or hypercapnia		✓		4	4	
R402312	Coma scale, best motor response, none, at arrival to emergency department		✓		4	4	
R402122	Coma scale, eyes open, to pain, at arrival to emergency department		✓		4	4	
R402222	Coma scale, best verbal response, incomprehensible words, at arrival to emergency department		✓		4	4	
J101	Influenza due to other identified influenza virus with other respiratory manifestations				1	1	
Z66	Do not resuscitate				1	1	

Procedure Code Detail

Code	Description	Affect	SP
5A09357	Principal Assistance with Respiratory Ventilation, Less than 24 Consecutive Hours, Continuous Positive Airway Pressure		

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Summary

Adding the additional diagnoses of Sepsis, Septic Shock, including Possible MI, GCS score had the following outcomes:

Principle Diagnosis	LOS	Severity of Illness	Risk of Mortality	Relative Weight	Reimbursement
Simple Pneumonia	4.2 days	3	3 Unexpected Death	1.1367	$8,970.12
Sepsis/Severe Sepsis w/o Mech Vent >96 hours	4.8 days	4	4 Expected Death	1.8564	$14,544.56

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Questions?

Contact:

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OR

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Need an interactive refresher?

Check out *SHC Sharp Sepsis Definitions:* www.sharp.com/cmeportal

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5. Select **Content**