News Alert: Sepsis Redefined
What Coders and CDI Specialists Need to Know

Issued by: Administrative Consultant Service, LLC

Important updates to the definitions for sepsis and septic shock were published on February 23, 2016 in the Journal of the American Medical Association. Since 1991, the International Consensus Definitions for Sepsis have been referenced for clinical documentation and coding in the health record. This latest definition has significant implications when establishing hospital query indicators and clinically validating documentation for coding of sepsis and septic shock.

Why were changes made?[1]

"Considerable advances have since been made into the pathobiology (changes in organ function, morphology, cell biology, biochemistry, immunology, and circulation), management, and epidemiology of sepsis, suggesting the need for reexamination."

"Limitations of previous definitions included an excessive focus on inflammation, the misleading model that sepsis follows a continuum through severe sepsis to shock, and inadequate specificity and sensitivity of the systemic inflammatory response syndrome (SIRS) criteria."

"These updated definitions and clinical criteria should replace previous definitions, offer greater consistency for epidemiologic studies and clinical trials, and facilitate earlier recognition and more timely management of patients with sepsis or at risk of developing sepsis."

New definitions:[1]

"Sepsis should be defined as life-threatening organ dysfunction caused by a dysregulated host response to infection. For clinical operationalization, organ dysfunction can be represented by an increase in the Sequential [Sepsis-related] Organ Failure Assessment (SOFA) score of 2 points or more, which is associated with an in-hospital mortality greater than 10%.

Septic shock should be defined as a subset of sepsis in which particularly profound circulatory, cellular, and metabolic abnormalities are associated with a greater risk of mortality than with sepsis alone. Patients with septic shock can be clinically identified by a vasopressor requirement to maintain a mean arterial pressure of 65mmHg or greater and serum lactate level greater than 2 mmol/L (>18mg/dL) in the absence of hypovolemia."

What should you do?

1. Obtain a copy of the article: The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) JAMA February 23, 2016 Volume 315, Number 8.
2. Review the new criteria with CDI staff, physician advisors, medical staff leadership, inpatient coders, and the hospital's quality manager.
3. Determine the impact of the new sepsis definition on quality measure reporting.
4. Develop an internal plan for dissemination of information to the medical staff.
5. Set a date to begin using the new criteria.
6. Update hospital query guidelines and references used by CDI and coding staff.
7. Watch for updates to the ACS CDI Toolkit.
8. Watch for guidance from ICD-10 *Coding Clinic* or other official ICD-10-CM coding changes. The current JAMA article recommendation for reporting of sepsis with R65.20 (Severe sepsis without septic shock) is not permitted under existing coding guidelines without physician documentation of severe sepsis. The JAMA article indicates "the task force concluded the term *severe sepsis* was redundant."
    a. Coders and CDI specialists should continue to query the physician for documentation of "severe sepsis" so that the ICD-10-CM codes can correctly portray the patient's condition.

[1]Source: The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) JAMA February 23, 2016 Volume 315, Number 8