SEPTICEMIA AND SEPSIS ARE NOT SYNONYMOUS!

MS-DRGs distinguish between patients admitted with sepsis due to pneumonia, or septic shock, and sepsis due to other infections such as UTI or cellulitis, giving credit for increased severity of illness for patients with an “MCC” or major complication / comorbid condition. Operational definitions referenced by the Cooperating Parties on behalf of the American Hospital Association (AHA), National Center for Health Statistics (NCHS), Centers for Medicare and Medicaid Services (CMS), and American Health Information Management Association (AHIMA) are consistent with criteria published within the medical literature. See Dellinger RP, Levy MM, et al: Surviving Sepsis Campaign: International guidelines for management of severe sepsis and septic shock: 2012 Crit Care Med 2013; Vol 41, No 2.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Bacteremia</td>
<td>Presence of bacteria in the blood, as confirmed by culture, but may be transient. Bacteremia denotes a laboratory finding. Bacteremia progresses to septicemia only when there is a more severe infectious process or an impaired immune system.</td>
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<tr>
<td>Septicemia (query for presence of sepsis)</td>
<td>Systemic disease associated with the presence of pathological microorganisms or their toxins in the blood, which can include bacteria, viruses, fungi, or other organisms.</td>
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<tr>
<td>Systemic Inflammatory Response Syndrome (SIRS)</td>
<td>Systemic response to infection or trauma, with symptoms which include some of the following: Tachycardia: Pulse &gt; 90 Tachypnea: Respirations &gt; 20 Temperature: &gt;101 (38.3 C) or &lt;96.8 (36 C) WBC &gt; 12,000 or &lt; 4,000 or &gt;10% bands Glucose &gt; 140 without diabetes Acute Altered Mental Status Significant edema / positive fluid balance Hyperlactatemia Elevated Plasma C-Reactive Protein Elevated Procalcitonin</td>
</tr>
<tr>
<td>Sepsis with Underlying</td>
<td>Sepsis with underlying infection such as pneumonia, cellulitis, UTI Report also underlying infection when known</td>
</tr>
<tr>
<td>Severe Sepsis</td>
<td>Sepsis with associated organ dysfunction (&gt;1 organ), hypoperfusion or hypotension Report also organ dysfunction</td>
</tr>
<tr>
<td>Septic Shock</td>
<td>Sepsis with hypotension, a failure of the cardiovascular system. Report also organ dysfunction</td>
</tr>
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</table>

In This Issue
- Guidelines for physician query
- Keys to Documentation
- Examples
Guidelines for Physician Query

1) If the physician documents “septicemia”, and the patient exhibits symptoms of sepsis, query the physician so that the case can be properly coded. CC03Q4

2) “Urosepsis” is a nonspecific term. “If that is the only term documented then only code 599.0 (UTI) should be assigned based on the default for the term in the ICD-9-CM index, in addition to the code for the causal organism if known.” If the physician documents “urosepsis”, query the physician to determine whether the patient has a simple UTI or generalized septicemia caused by leakage of urine or toxic urine by-products into the general vascular circulation. NOTE: A diagnosis of “urosepsis” does not exist in ICD-10-CM, and therefore documentation of this condition will always result in physician query for clarification of the intended diagnosis.

3) There is not an ICD-9-CM code for sepsis syndrome. Physicians usually mean severe sepsis, but the query should be based on the clinical evidence documented in the record.

4) “Sepsis or severe sepsis may be present on admission but the diagnosis may not be confirmed until sometime after admission. If the documentation is not clear whether the sepsis or severe sepsis was present on admission, the provider should be queried.” Official Coding Guideline I.C.1.b.

Reporting References

Septic shock is caused principally by the pooling of the blood in small vessels. The pooling results from the dysfunction of cells and tissues injured by the circulating toxic bacterial products. Shock usually involves hypotension despite adequate fluid resuscitation with perfusion abnormalities that may consist of, but are not limited to lactic acidosis, oliguria, and acute alteration in mental status.

Although blood is often drawn for culturing during the initial work-up, treatment (including antibiotics) must be started quickly and before the results of the culture are known. A patient may show clinical evidence of septicemia, the blood culture may be negative due to difficulty in culturing fastidious organisms from blood, growth inhibitory factors in the blood, or initiation of specific antibiotic therapy before laboratory test samples are taken.
SIRS due to Non-Infectious Process?

A systemic inflammatory response syndrome (SIRS) can develop as a result of a non-infectious disease process, such as trauma, malignant neoplasm, or pancreatitis. In these instances, the non-infectious process is the principal diagnosis followed by the appropriate SIRS code. If the patient also has acute organ dysfunction, please clarify whether it is associated with SIRS or due to another condition.

Sepsis MSDRGs as of 10/1/14

**MS-DRG 870** Sepsis w/ mechanical vent 96+ hr
RW 5.8698 $32,284

**MS-DRG 871** Sepsis w/o mechanical vent 96+ hr w/ MCC
RW 1.8082 $ 9,939

**MS-DRG 872** Sepsis w/o mechanical vent 96+ hr w/o MCC
RW 1.0528 $ 5,790

Document to establish Severity of the Patient’s Illness

- Distinguish between sepsis and severe sepsis
- Document the link between sepsis and the underlying infection (i.e. sepsis due to pneumonia)
- Document if SIRS is due to noninfectious process
- Document the patient’s underlying conditions

Assignment of the Principal Diagnosis Depends on Whether:

- SIRS was due to infection (sepsis) or a non-infectious process;
- The non-infectious process led to infection and sepsis;
- Sepsis or non-infectious process were present on admission;
- Sepsis was due to the presence of a device (Foley, VAD, etc), tracheostomy, gastrostomy, etc.

Physician Documentation is the Key!

In FY2013, MS-DRGs for sepsis were among the top 5 most frequently reported DRGs among the Medicare population. Given their higher relative weight, complexity of associated reporting guidelines and high volume, they are also a frequent target for validation review by recovery audit contractors (RAC) and other CMS contractors.

Was the patient's sepsis present on admission?

If not documented on admission, please clarify in subsequent notes / discharge summary when, after study, the presenting signs / symptoms are felt to be due to sepsis.
## SIRS due to Non-Infectious Process

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>MS-DRG</th>
<th>Payment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pancreatitis w/ SIRS</td>
<td>439</td>
<td>$4,989</td>
<td></td>
</tr>
</tbody>
</table>
Prepare your Documentation!

**Urosepsis:**
This term does not exist in ICD-10 and therefore is not a codeable condition! Physicians will have to be queried every time this term is documented. “Should a provider use this term, he/she must be queried for clarification.” *ICD-10-CM Guidelines for Coding and Reporting*

**SIRS due to...:**
Documentation such as “SIRS due to pneumonia” implies a diagnosis of sepsis, since clinically the patient has SIRS with associated infectious process. However in ICD-10, the documentation must clearly state “sepsis” due to pneumonia. There is not an equivalent ICD-10 code for SIRS due to infection.

**Bacteremia:**
Bacteremia is in the series titled “Abnormal findings on examination of blood, without diagnosis”.

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