Sepsis/Septicemia

The ICD-10 Success Series
Webconference I
September 24, 2014
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About Today’s Speaker

Emeric Palmer, MD FACP FHM

• Medical consultant at the Advisory Board Company
• Board certified physician in Internal Medicine and Wound Care and Hyperbaric Medicine.
• Experience in Primary Care and Hospital Medicine with large, nation-wide systems as well as private group practices.
• Served as an Assistant Professor of Medicine at the University of Illinois, Chicago with Advocate Christ Medical Center.
• Earned the Healthcare IT Leadership Certificate from the American College of Physician Executives
• Former chair of the Health Information Management and Physician EHR committees at Meritus Medical Center in Hagerstown, Maryland
• Worked as an Internal Medicine Hospitalist with Kaiser’s Mid Atlantic Permanente group.
• Special areas of interest include process improvement, quality and safety, high reliability, team dynamics, and communication.

For more information, contact:

Emeric Palmer, MD, FACP, FHM
Senior Medical Director
202.266.5600
PalmerE@advisory.com
Brief Overview: The ICD-10 Success Series Webconferences

Across the coming months, the Advisory Board’s Clinical Advisor Team will be hosting numerous Webconferences on a variety of documentation topics critical to a seamless and successful transition to ICD-10. As providers, please take a look at the list of upcoming sessions and save time to attend those most pertinent to your practice. We have created them to be succinct and to the point, and will be presenting lessons you can begin to incorporate into your documentation immediately (in an ICD-9 world). Below is a list of all upcoming sessions:

1. September 24th – Sepsis/Septicemia
2. October 1st – UTI
3. October 8th – Pressure Ulcers
4. October 15th – Stroke
5. October 22nd – Encephalopathy
6. October 29th – AMI & Coronary Artery Disease
7. November 5th – Respiratory Failure, Pneumonia, COPD
8. November 12th – Orthopedic Surgery, Joints, Spine
9. November 19th – Diabetes
10. December 3rd – Anemia
11. December 10th – Cellulitis
12. December 17th – Ambulatory

**All sessions will be hosted from 12:00 – 1:00 pm EST. Recordings will be made available for follow up viewing on the intranet and physician websites.**
Brief Overview: Code Expansion in ICD-10 Requires Greater Documentation Specificity

Expanded Code Set in ICD-10: ~16K to ~150K

Why So Many New Codes?

The main difference between ICD-9 and ICD-10 codes, outside of structural changes, is the SPECIFICITY of the code.

ICD-10 codes specify several components not found in ICD-9, such as stage, laterality, severity, root cause operation, etc.

Key ICD-10 Concepts Required in Documentation

<table>
<thead>
<tr>
<th>Stage or grade of disease</th>
<th>Severity: mild, moderate, severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific anatomical location</td>
<td>Episode of care: initial vs. subsequent</td>
</tr>
<tr>
<td>Acute or chronic</td>
<td>Unilateral or bilateral condition</td>
</tr>
</tbody>
</table>
Road Map for Discussion

1. Key Requirements for Documenting Sepsis in ICD-10
2. Clinical Scenario
3. Upcoming Teleconferences
Proper Documentation of Sepsis is Built on Key “ICD-Agnostic” Concepts

While there are a few changes you should be aware of when documenting sepsis in ICD-10, continue to focus on some of the key concepts you kept top of mind in ICD-9 to ensure the appropriate ICD-10 code and SOI & ROM are assigned.

### Key Lessons Learned in ICD-9 Applicable to Documentation of Sepsis in ICD-10

<table>
<thead>
<tr>
<th>Concept</th>
<th>Key phrases</th>
<th>Key Considerations</th>
<th>Documentation Example</th>
</tr>
</thead>
</table>
| Linking     | “due to” “secondary to” “with” | • Link suspected organism to infection  
• Link a complication of medical care to its suspected cause  
• Lists, commas, and the word “and” do not link conditions | • Sepsis due to Pneumonia  
• Acute respiratory failure due to sepsis  
• MRSA infection due to central venous catheter |
| POA Status  | “present on admission” “likely present on admission” | • Document all known details  
• Include type of encounter (initial, subsequent, sequela)  
• Make sure infection d/t device is clear that it is POA | • Sepsis present on admission  
• Foley POA likely cause of UTI |
A Brief Aside: Revisiting Severity of Illness and Risk of Mortality (SOI & ROM)

Let’s revisit these key quality metrics to ensure all those on the line have a thorough understanding of A) how your documentation directly impacts these metrics and B) how these metrics play a large role in the publicly reported quality scores that are increasingly available to the non-clinical audience out there.

Breakdown of SOI/ROM and their Implication on Quality Measures

Four mutually exclusive SOI/ROM categories exist (1-4), and are determined based on a number of factors including primary and secondary diagnoses, comorbidities, demographics, patient history, treatment/procedure delivered, etc.

<table>
<thead>
<tr>
<th>Level</th>
<th>Assigned SOI/ROM Category</th>
<th>Impact on Expected: LOS, Cost of Care, and Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor</td>
<td>1</td>
<td>Increase in Value</td>
</tr>
<tr>
<td>Moderate</td>
<td>2</td>
<td>Increase in Value</td>
</tr>
<tr>
<td>Major</td>
<td>3</td>
<td>Increase in Value</td>
</tr>
<tr>
<td>Extreme</td>
<td>4</td>
<td>Increase in Value</td>
</tr>
</tbody>
</table>
Linking Sepsis to Associated Causes and Conditions is the Key

Be sure to use words such as “due to”, “with”, and “secondary due”

Sepsis = SIRS linked to an infection

• The word “sepsis” must be documented by the physician
• “Bacteremia” is an abnormal finding with a low SOI
• Always link diseases and document the suspected organism
• “Sepsis due to” is a diagnosis with a higher SOI (i.e., sepsis due to: pneumonia, UTI, bacterial endocarditis, diverticulitis, gangrene of, etc.)

Severe Sepsis = Sepsis linked to organ dysfunction or failure

• Documentation must clearly link sepsis to organ failure (i.e., acute respiratory failure or hypotension due to sepsis)

Septic Shock = Sepsis linked to organ dysfunction or failure and circulatory collapse

• If circulatory collapse present, it must be linked to sepsis in order for septic shock to be coded

Key Considerations

• “Urosepsis” is no longer an acceptable term
• A positive blood culture is not required for the clinical diagnosis of sepsis
Always Document Data & Time of Intubation and Extubation

The duration of intubation and mechanical ventilation must be documented, as it is a direct reflection of the severity of a patient’s condition. Mechanical Ventilation greater than 96 hours shifts DRG assignment and SOI/ROM.

### Key Documentation Concepts Required for Intubation and Mechanical Ventilation

<table>
<thead>
<tr>
<th>Intubation</th>
<th>Mechanical Ventilation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ICD-10 Documentation Concepts</strong></td>
<td><strong>ICD-10 Documentation Concepts</strong></td>
</tr>
<tr>
<td><strong>Root Operation</strong></td>
<td><strong>Root Operation</strong></td>
</tr>
<tr>
<td>Insertion</td>
<td>Performance</td>
</tr>
<tr>
<td><strong>Body Part</strong></td>
<td><strong>Body Part</strong></td>
</tr>
<tr>
<td>Mouth/throat</td>
<td>Respiratory</td>
</tr>
<tr>
<td>Trachea</td>
<td></td>
</tr>
<tr>
<td><strong>Approach</strong></td>
<td><strong>Duration</strong></td>
</tr>
<tr>
<td>Via Natural or Artificial Opening</td>
<td>&lt;24 consecutive hours</td>
</tr>
<tr>
<td></td>
<td>24-96 consecutive hours</td>
</tr>
<tr>
<td></td>
<td>&gt;96 hours</td>
</tr>
<tr>
<td><strong>Device</strong></td>
<td><strong>Function</strong></td>
</tr>
<tr>
<td>Intraluminal Device</td>
<td>Ventilation</td>
</tr>
<tr>
<td>Endotracheal Airway</td>
<td></td>
</tr>
<tr>
<td><strong>Qualifier</strong></td>
<td><strong>Qualifier</strong></td>
</tr>
<tr>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Example:</strong> OBH17EZ</td>
<td><strong>Example:</strong> 5A1935Z</td>
</tr>
<tr>
<td>Insertion, Trachea, Natural Opening, Intraluminal Device, No Qualifier</td>
<td>Performance, Respiratory, &lt;24 consecutive hours, Ventilation, No Qualifier</td>
</tr>
</tbody>
</table>

**Don’t Forget Time of Extubation**

While date and time of intubation is generally well documented, always be sure to document the time of extubation as well.
Signs, Symptoms, & Test Results

Documentation Tip

• Signs, Symptoms and Test Results *do not* impact SOI/ROM

• Medical conditions increase SOI/ROM when *linked* with a related conditions in ICD-10 compliant verbiage

• Reminder: Consultants manage medical conditions, but the Attending physician as the "Captain of the Ship" is responsible for:
  • Documenting all conditions in the discharge summary
  • Resolving conflicts in the documentation
Road Map for Discussion

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Clinical Scenario Highlighting Insufficient Documentation

Elderly woman admitted with diagnosis of fever, leukocytosis, SOB with hypoxia and AMS.

Vitals:
- Temperature 100.9
- Pulse 101
- BP 90/50
- RR 22


The patient’s symptoms improved on the prescribed treatment & discharge home with continued home O2.

Common Insufficient Documentation

“75y/o chronic lunger w/ fever, leukocytosis, SOB with hypoxia and altered mental status.”
Clinical Scenario Highlighting Best Practice Documentation

Elderly woman admitted with diagnosis of fever, leukocytosis, SOB with hypoxia and AMS.

**Vitals:**
- Temperature 100.9
- Pulse 101
- BP 90/50
- RR 22

IV Rocephin, Azithromycin and vancomycin were started. Blood cultures + Staph aureus.

The patient’s symptoms improved on the prescribed treatment & discharge home with continued home O2.

**Best Practice Documentation**

“75 y/o patient with chronic respiratory failure secondary to COPD, with a history of a cellulitis due to MRSA, now admitted with acute pneumonia, probably due to a gram negative organism. Now presents with probable sepsis with acute septic encephalopathy as well.”
Breakdown of ICD-10 code for Sepsis

Show how the words used coded out using the current language

Sepsis due to methicillin resistant Staphylococcus aureus

A 4 1
Other bacterial diseases (Sepsis)

0
Staphylococcus aureus

2
MRSA

Sepsis

Staph Aureus

Unspecified Staph Aureus

Other Staphylococcus

MRSA

MSSA
## Summary of Best Practice Documentation Teaching Points

### Key Lessons Learned

- Always document the word “sepsis” when that is the diagnosis; clinical indicators in the chart are not sufficient.

- Be sure to link sepsis to any associated causes or conditions using phrases such as “due to”, “with”, “secondary to”; it is especially important to link sepsis to organ failure and circulatory collapse.

- Lists of diagnoses/conditions or the word “and” do not link conditions.

- Always document the date/time of intubation and extubation.

- Avoid using the word “urosepsis”.

- Sepsis replaces the word “Septicemia”; there is no separate code in ICD-10.

- Blood test results are not required to diagnose sepsis.
Road Map for Discussion

1. Key Concepts for Documenting Sepsis in ICD-10

2. Clinical Scenario

3. Upcoming Webconferences
Upcoming Webconferences

Through the ICD-10 Success Series, The Valley Hospital will have access to multiple Webconferences that cover a range of ICD-10 Documentation Topics. Please make time to attend topics pertinent to your practice!

**Upcoming Sessions:**

- October 1\(^{st}\) – UTI
- October 8\(^{th}\) – Pressure Ulcers
- October 15\(^{th}\) – Stroke
- October 22\(^{nd}\) – Encephalopathy
- October 29\(^{th}\) – AMI & Coronary Artery Disease
- And more…

*Please reach out to John McConnell, mccoho@valleyhealth.com if you need assistance registering.*

*All sessions are from 12-1pm EST*
https://www.surveymonkey.com/s/ICD-10Sepsis
Questions?

Please do not forget to fill out your CME Survey Link!