10 things every coder wishes providers knew about sepsis documentation and coding

By Sarah Nehring, CCS, CCDS

From the coding and CDI perspective, sepsis can be one of the trickiest diagnoses. Here are 10 things coders wish physicians knew about sepsis documentation and coding.

10: Urosepsis

Urosepsis isn't sepsis—not from a coding standpoint, at least. Unless you want a query, don't document it. If it was a urinary tract infection (UTI), then document that. If it was sepsis due to a UTI, please say that in your documentation.

9: Catheter-associated UTI

While we're on the subject of UTIs, documentation of "sepsis due to UTI, patient with Foley" is going to prompt a query. Was the UTI due to the Foley? We can't assume; we need you to tell us. This is true of any infections that may be related to a procedure or other medical care. Please remember that from our standpoint, coding a complication isn't an assignment of blame or admission of fault. We have additional codes we can add to indicate if misadventure was involved, and we rarely need to. We do need you to document directly if you suspect that the infection was or may have been related to recent surgery or the presence of a device, and it's important to indicate if that infection was likely present on admission.

8: Bacteremia

Like urosepsis, bacteremia isn't sepsis. Sometimes we see sepsis and bacteremia used interchangeably. From a coding standpoint, bacteremia is an abnormal lab finding—an R code, which means it falls into the Signs and Symptoms chapter of the codebook. It's not ideal as a principal diagnosis on an inpatient admission.

As a secondary diagnosis, bacteremia is what we sometimes refer to as a "junk code": It adds little value.

We realize that sometimes the patient really did just have bacteremia, and in those cases, we're stuck with it. However, if the patient met sepsis criteria, please avoid a query and let us code this as more than just an abnormal lab finding by documenting something like this: "Sepsis due to e-colic bacteremia."

7: Organ dysfunction

If you document sepsis, please document all organ dysfunction related to it. It doesn't have to be organ failure. It's also important that you make the link between any organ dysfunction and sepsis that exists (auditors are favoring Sepsis-3 criteria more and more).

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For example, "elevated creatinine in the setting of sepsis, hypotension" isn't great. It's a lab value mentioned with but not linked to sepsis. "Renal insufficiency due to sepsis" is a better—we've got an organ dysfunction stated and linked to sepsis. Better yet: "acute kidney injury, likely due to sepsis with hypotension." If you really want to make our day, call it acute tubular necrosis due to sepsis, but only if it's clinically supported.

6: Hypotension and elevated lactate

Sometimes, physicians document "sepsis with hypotension and elevated lactate" and note that hypotension didn't resolve with IV fluids, and maybe that vasopressors were required. This documentation is good, but it will likely prompt a query. Often, we know (or suspect) what you're treating—and we know you and your fellow clinicians know—but we can't code it unless you document it in a specific way.

Here, we'd likely ask something like this: "Were you treating the patient for septic shock, hypovolemic shock, or other type of shock, or was shock unlikely/ruled out?" We're not giving you all these options to mess with you, honest. Ethically, we can't lead you by offering only one choice or telling you what to document on a particular case. We have to give all the relevant options we can think of that are supported by evidence in the record.

5: Clinical criteria

If you *didn't* document some kind of organ dysfunction associated with sepsis, please document the clinical criteria you used to make the diagnosis of sepsis. We respect your clinical judgment, but auditors don't have to. Without those criteria and/or your thought process in coming to a documented diagnosis, we may not be able to defend it.

4: Systemic inflammatory response syndrome

Systemic inflammatory response syndrome (SIRS) due to infection used to be coded as sepsis, but not anymore. We have a few options: sepsis with or without organ dysfunction, SIRS due to infection without sepsis, or SIRS of non-infectious etiology with or without organ dysfunction. We don't expect you to know on day one which of these things is most likely, but please document what you suspect it was when you're writing the discharge summary.

3: Discharge summaries

Speaking of the discharge summary, don't forget to mention sepsis—regardless of whether it was resolved on day two or three, or even on day one. If you don't mention it, we're going to query or think it was ruled out and not code it. If we don't query and do code it, an auditor could deny it. If you suspected sepsis early on and then ruled it out, please say so. Mentioning the criteria and organ dysfunctions again is good, too.

If you don't document sepsis until day two, but you suspect it was there all along or the patient met criteria

at admission, save yourself a query and document in the discharge summary that sepsis was likely present on admission or that the patient was "admitted with sepsis." If we don't capture that it was present on admission, we may be looking at a hospital-acquired condition or infection, which isn't good for quality measures.

2: Documenting what you're treating

It helps a lot if you tell us what the sepsis was likely due to, especially if there was more than one suspected/possible source. In the inpatient setting, we don't need you to know with 100% certainty, but we do need you to communicate clearly what you were treating.

We struggle with documentation like "initial concern for sepsis. Infectious workup negative. Patient discharged on [antibiotic name] to complete 10 days." This will likely prompt a query. On the other hand, we can code "infectious workup negative, but given presentation we treated patient for sepsis due to bacterial infection of unknown origin" or "likely viral sepsis."

1: We're on your side

The number one thing every coder would like every provider to know: *CDI and coding staff are on your side*. This one isn't just about sepsis.

We want your patients to look (in coded data) as sick as they were before you healed them. If your patient died, we want the patient to look sick enough to have died despite your best efforts. We want your data and the hospital's data to look good, and to be as thorough and accurate as possible. We want the hospital to be paid for the resources that were used—so you can keep healing people with the best equipment and resources at your disposal.

Accurate documentation and code assignment are vital parts of good patient care. 🙌