The phrase “sepsis syndrome” is starting to appear in medical records these days, but unfortunately it’s a term that requires further clarification. When it’s used, CDI staff/coders should query the physician to clarify the condition being treated. That’s the latest guidance from AHA’s Coding Clinic for ICD-9-CM released in Second Quarter 2012 (pp. 21–22).

“Sepsis is something we all struggle with,” says Katy Good, RN, BSN, CCDS, CCS, AHIMA-Approved ICD-10-CM/PCS Trainer and CDI program coordinator at Flagstaff (Ariz.) Medical Center. Physicians at Flagstaff understand the documentation requirements related to sepsis, she says. And her CDI staff doesn’t typically have to query for clarification, although it does sometimes need additional specificity to identify the underlying cause of the infection.

However, the latest guidance which calls out “sepsis syndrome” poses new difficulties for Good and her team. “We were never even aware that physicians used the term ‘sepsis syndrome’ before, and now it is popping up in documentation all over the place,” Good says. “It’s interesting, from time to time some rogue physician will start using a term and if you don’t catch it, all of a sudden everyone is using it.”

The original definition of sepsis syndrome was “septic shock,” says ACDIS Advisory Board member Robert S. Gold, MD, CEO of DCBA, Inc., in Atlanta. “The term has been played with and manipulated and now has little resemblance to the original intent of the clinical language. Just as the term ‘urosepsis’ evolved, so has this and many physicians consider it merely equivalent to systemic inflammatory response syndrome,” says Gold.

The trick is how to ask physicians to provide clarification without appearing to lead them to a diagnosis of “sepsis” or “septic shock.”

Querying for urosepsis is easier, says Good, because there are clearly other options for the physician. However, in this instance, simply posing the question could be seen as leading. “Physicians want to be helpful and compliant. I am nervous we’ll end up with a situation where we query for sepsis syndrome because the physician doesn’t understand why we’re asking the question. He or she will think we are looking for something completely different, document that in the record, and we will end up with something else entirely that is not clinically supported at all,” Good says.

To resolve the matter, Good and her team have revised their sepsis-related query templates. Unified templates provide one way to ensure that the whole team communicates the same message in the same method. “It makes it more defensible on our side when either physicians raise questions about the clinical aspect of the query or if the results of the record are contested by auditors,” says Good.

But drafting a consensus-driven template takes time. In the interim, Flagstaff CDI specialist used its typical sepsis query form.

Gold offers similar advice. Specifically, he recommends reviewing the sample sepsis query included in AHIMA’s Guidelines for an Effective Query Process. “If your medical staff doesn’t know what sepsis syndrome is, and you introduce the term, then all you’re doing is leading them down potentially dangerous garden paths,” Gold says.

However, understanding the specific condition—such as simple pneumonia or sepsis due to pneumonia, or whether the patient has a simple urinary tract infection or sepsis due to an indwelling urinary catheter, or whether the patient...
has simple pancreatitis or a pancreatic abscess—will help the CDI staff draft a more accessible query and enable the team to solicit the needed information from the physician, Gold says.

Although Coding Clinic guidance clearly spells out the need to query the physician when the term “sepsis syndrome” appears, it does not dictate when or how to query. At times, says Good, physicians may write “sepsis syndrome” in the medical record but in the discharge summary simply document “sepsis” or “septic shock,” which the coder can then use to code the condition. She suggests that queries for “sepsis syndrome” might best be left for situations where the phrase is used in the discharge summary.

Like so many other situations, providing clarity may come down to education.

“We simply need to educate the physicians not to use this term, just the way we did with urosepsis, because the guidance says sepsis syndrome lacks specificity,” says Good.

She created a quick poster and hung it around the facility (see below). You can use the emergence of “sepsis syndrome” as an opportunity, Good says. Explain that this term is not an adequate term to code sepsis, and inform physicians that you will have to query for clarification if that phrase is documented. Add some additional reminder language regarding guidance around documentation for systemic inflammatory response syndrome, septicemia, and septic shock, too. ☝

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**Documentation Tip**

**The Tip for this Week is:** **Sepsis Syndrome**

- Per coding guidelines, the term "SEPSIS SYNDROME" is not adequate to code SEPSIS.
- If possible, please refrain from using this phrase when referring to the subset of symptoms generally associated with SEPSIS.
- When this phrase is seen in the documentation, the CDS or Coder will be required to submit a query to the physician to clarify the diagnosis.

As a reminder, Systemic Inflammatory Response Syndrome (SIRS) is defined as two or more of the following:

1. Fever
2. Tachycardia
3. Tachypnea
4. Leukocytosis

SIRS with a (suspected) infectious source = SEPSIS
SEPSIS with Organ Dysfunction = SEVERE SEPSIS

Suggested documentation of Sepsis is (for example): "patient presents with leukocytosis and fever, suspect UTI as source, meets criteria for Sepsis".

Questions?

Call/E-mail

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Source: Katy Good, RN, BSN, CCDS, CCS, CDI program coordinator at Flagstaff (Ariz.) Medical Center.