HCPro, Inc., presents

Sepsis Coding: Clinical Updates and Communication Strategies

A 90-minute interactive audio conference

Thursday, July 25, 2013

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12:00 p.m.–1:30 p.m. (Central)
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Dear Program Participant,

Thank you for participating in our “Sepsis Coding: Clinical Updates and Communication Strategies” audio conference, featuring speakers Gloryanne Bryant, BS, RHIA, RHIT, CCS, CDIP, CCDS, AHIMA-Approved ICD-10-CM/PCS Trainer, and Robert S. Gold, MD, and moderated by Todd Hutlock.

Our team is excited about the opportunity to interact with you directly. We encourage you to ask our experts your questions during the program. If you would like to submit a question before the audio conference, please send it to the producer, Todd Hutlock, at thutlock@hcpro.com and provide the program date in the subject line. We cannot guarantee that your question will be answered during the program, but we will do our best to include a good cross section of questions.

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Thank you, again, for attending the HCPro program today. We hope you found it to be informative and helpful and that you will continue to rely on HCPro programs as an important resource for pertinent and timely information.

Sincerely,

Elizabeth Petersen
Vice President
HCPro, Inc.
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Agenda

I. Background and review: Medical literature vs. the coding world
   A. Changes in 2004 and 2008
   B. Clinical criteria and indicators

II. Sepsis coding guidelines and AHA Coding Clinic guidance

III. Understanding the current regulatory scrutiny
   A. Practice briefs
   B. 3 DRGs and LOS
   C. Query compliance
   D. Documentation best practices
   E. Coding and data quality best practices

IV. How sepsis and SIRS are handled in ICD-10

V. Review sepsis survey results

VI. Case examples and discussion

VII. Live Q&A
Speaker Profiles

Gloryanne Bryant, BS, RHIA, RHIT, CCS, CDIP, CCDS, AHIMA-Approved ICD-10-CM/PCS Trainer

Gloryanne Bryant has more than 30 years of experience in the HIM profession providing education to coders, physicians, and other hospital staff on IPPS, DRGs, HCCs, ICD-9-CM, CPT coding, clinical documentation improvement, and ICD-10. She is a member of the editorial advisory board for Briefings on Coding Compliance Strategies. In April 2006, she provided testimony in support of ICD-10 implementation for the House Ways and Means Committee, and in 2007 she was awarded the AHIMA Triumph “Champion” award.

Robert S. Gold, MD

Robert S. Gold is founder and CEO of DCBA, Inc., in Atlanta, a nationally recognized provider of physician-to-physician directed clinical documentation improvement programs. He has more than 45 years of experience as a physician, medical director, and consultant. Dr. Gold writes “Clinically Speaking” for Briefings on Coding Compliance Strategies and “Minute for the Medical Staff” for Medical Records Briefing, and is the author of the training handbook, Documentation Strategies to Support Severity of Illness: Ensure an Accurate Professional Profile, all from HCPro.
Exhibit A

Presentation by Gloryanne Bryant, BS, RHIA, RHIT, CCS, CDIP, CCDS, AHIMA-Approved ICD-10-CM/PCS Trainer, and Robert S. Gold, MD
Sepsis Coding: Clinical Updates and Communication Strategies

An HCPro audio conference presented on July 25, 2013

Speakers

• Gloryanne Bryant, BS, RHIA, RHIT, CCS, CDIP, CCDS, AHIMA-Approved ICD-10-CM/PCS Trainer
  – 30-plus year HIM professional
    • Past President, California Health Information Assoc.

• Robert S. Gold, MD
  – Founder and CEO of DCBA, Inc., in Atlanta
Disclaimer

- This material is designed and provided to communicate information about clinical documentation, coding, and compliance in an educational format and manner. The authors are not providing or offering legal advice, but rather practical and useful information and tools to achieve compliant results in the areas of clinical documentation, data quality, and coding.

- Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful. Applying best practice solutions and achieving results will vary in each hospital/facility and clinical situation.

Goals/Objectives

- Provide some background to documentation guidelines
- Describe the importance of the changes in clinical criteria and indicators in 2004 and 2008
  - Review clinical indicators
- Enhance knowledge of coding guidelines
- Discuss the regulatory scrutiny for coding sepsis
- Review survey results
- Explain best practices for documenting sepsis, coding, and achieving data quality
- Review case examples and action to take
- Questions
Background: Clinical Documentation

- Justifies treatment, supports the diagnosis
- Advances regulatory compliance
- Supports patient safety
- Increases accuracy of publicly reported patient care outcomes and physician and hospital profiling
- Captures patient severity and acuity
- Kicks off the revenue cycle and improves reimbursement

Background: Clinical Documentation Is So Important

- Legal ramifications
  - Disciplinary action by licensing body for unprofessional conduct
  - Criminal prosecution by the DA or AG
  - Altering medical records or creating false medical data is a misdemeanor
  - Loss of accreditation from various agencies
  - Loss of funding/reimbursement for the care provided
  - Patient/client loses benefits they are otherwise entitled to
  - Adverse impact on defense in malpractice case

Liability experts are convinced that poor medical records are a leading reason so many questionable malpractice claims are filed and pursued, and why some of these cases ultimately are decided in the plaintiff’s favor. Poor medical records make it difficult to determine whether an adverse outcome resulted from factors beyond the physician’s control or from negligent medical care.
Background: Documentation

The medical record is the main document validating care and treatment provided

- Records decision-making process and results of treatment
- Protects the legal interests of all parties
- Provides continuity of patient care and communication among providers
- Increases accuracy of publicly reported patient care outcomes
- Captures patient severity and acuity

Medical Record Documentation Principles

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include: the date; the reason for the encounter; appropriate history and physical exam in relationship to the patient’s chief complaint; review of lab, x-ray data, and other ancillary services, where appropriate; assessment; and a plan for care (including discharge plan, if appropriate).
3. Past and present diagnoses should be accessible to the treating and/or consulting physician.
4. The reasons for—and results of—x-rays, lab tests, and other ancillary services should be documented or included in the medical record.
5. Relevant health risk factors should be identified.
6. The patient’s progress, including response to treatment, change in treatment, change in diagnosis, and patient noncompliance, should be documented.
7. The written plan for care should include, when appropriate: treatments and medications, specifying frequency and dosage; any referrals and consultations; patient/family education; and specific instructions for follow-up.
8. The documentation should support the intensity of the patient evaluation and/or treatment, including thorough processes and the complexity of medical decision-making as it relates to the patient’s chief complaint for the encounter.
9. All entries to the medical record should be dated and authenticated.
10. The CPT/ICD-9-CM codes reported on the CMS-1500 claim form should reflect the documentation in the medical record.

Source: CMS and TrailBlazer Health Enterprises, LLC.
Principles of Clinical Documentation

Major healthcare and insurance organizations have revealed some principles that should be observed when keeping proper documentation:

• A medical record should be kept clear and legible in compliance with the suggestions of a medical record audit and in line with the established clinical documentation improvement program.

• For the documentation of each patient encounter, the following information should be included: reason for the encounter, date, laboratory and tests data, physical examinations, medical history, assessments, and plan of care.

• The medical professional should make sure that previous and current diagnoses are always accessible to whomever will handle the case.

• Ancillary services should be clear, including the results and/or any intervention initiated.

• All of the following should also be documented regarding patient response: reactions to treatments, changes on the procedures, noncompliance on the part of the patient, and any changes on the diagnosis.

• The action plan for the case should also be clearly documented, including the medications and treatments, dosages, consultations, follow-ups, and patient education.

• A medical record should be accurate enough to support the complexity of care provided, the intensity of patient evaluations, and the thought processes and decisions involved.

• Dates and authentication should always be observed in compliance with the standards set for clinical documentation.

• The corresponding ICD-9/DRG codes should agree with what the medical record indicates. In other words, physicians should describe a certain case in words in the same way coders describe the same case using codes.

• Health risk factors and complications should all be indicated.
Early Identification – Decrease in Mortality

- Much activity in the world since the Surviving Sepsis Campaign (SSC) came out with guidelines worldwide
- Mortality statistics and reporting of sepsis, severe sepsis, and septic shock derived from individual studies in hospitals and national data from ICD coding – rest of the world with ICD-10
- United States, still with ICD-9, redefined sepsis in 2004 (SIRS plus infection)

U.S. Proliferation of Sepsis Cases

- Nationally reported data revealed 310,000 sepsis DRGs (Medicare) in U.S. in 2004, 745,000 cases in 2009 (national all payer studies 350,000 to 810,000 cases).
- Average annual increase in the incidence of severe sepsis was 13% to 13.3% across all methods.
- In-hospital mortality ranged from 14.7% to 29.9% using abstraction methods of Wang et al and Dombrovskiy et al. Using all methods, there was a decrease in in-hospital mortality across the 6-year period (35.2% to 25.6% [Dombrovskiy et al] and 17.8% to 12.1% [Wang et al]).
- Use of ICD-9 sepsis codes more than doubled over the 6-year period (158,722 to 489,632 [995.92 severe sepsis], 131,719 to 303,615 [785.52 septic shock]).

Rest of the world:
- Increase of sepsis cases reported with ICD-10 approximately 3%–5%.
- Decrease in mortality following SSC guidelines 5%–6%.
- We have four times increase in reported cases and triple decrease in mortality for sepsis.
- Why? Many of our reported cases DO NOT HAVE SEPSIS. Definitions changing with ICD-10!
Published Criteria 2004

- Recognition that mortality of severe sepsis excessive
- Early identification of sepsis patient developing septic shock should increase survival, whether in ED or on nursing unit
- Antibiotics, fluids, tissue perfusion, stress steroids as needed in septic shock, evaluation of brain and heart perfusion, use of ventilatory support, glycemic control, prevention of DVT, stress ulcer prophylaxis, specific direction toward the pediatric patient

Published Criteria 2008
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2249616/

- Very similar recommendations as 2004 set
- Added use of recombinant activated protein C for high-risk patients, elevation of head of bed, use of hemodialysis, some more attention to the pediatric patient with steroids for suspected adrenal insufficiency and recombinant activated protein C
Published Criteria 2012

- More specifics about which pressors under specific conditions
- Limitations of stress steroids
- Further attention to mechanics of ventilator use with ARDS or other causes of acute respiratory failure including prone positioning
- More attention to pediatric patient with recommendations about ventilatory support, crystalloid vs. albumin and evaluation for endpoints of fluid resuscitation, limit steroids to “absolute” adrenal insufficiency

Understanding Original Definitions

- **Bacteremia:** defined as presence of viable bacteria in the blood and may or may not be clinically significant – avoid using as the principal/primary diagnosis and use more specific terminology.
- **Septicemia:** generally refers to a systemic disease association with the presence of pathological microorganisms or toxins in the blood, which can include bacteria, viruses, fungi, or other organisms.
- **Systemic inflammatory response syndrome (SIRS):** generally refers to the systemic response to infection, trauma/burns, or other insult (such as cancer) with symptoms that can include fever, tachycardia, tachypnea, and leukocytosis.
  - Be sure to document the underlying case such as the infection or trauma as this is important data to capture.
- **Sepsis:** generally refers to SIRS due to infection.
- **Severe sepsis:** generally refers to sepsis with associated acute organ dysfunction. In some situations the patient can have severe sepsis without organ dysfunction.
- **Septic shock:** sepsis-induced hypotension persisting despite adequate fluid resuscitation.¹

Old Clinical Insights: Sepsis

- Sepsis is clinical evidence of infection and development of systemic inflammatory response syndrome (SIRS).
- Clinical presentation can vary depending on the original site of infection, but also can be nonspecific.
- Common symptoms include fever, tachycardia, tachypnea.
- Common causes are gram negative and positive bacteria, and other microorganisms.
- 400,000–750,000 cases are reported in the U.S. yearly. Sepsis is frequently found in patients with extreme age, patients who are immune compromised, hospitalized patients, and patients who have invasive devices present in their bodies including catheters and tubes.

Clinical Indicators

- SIRS or systemic inflammatory response syndrome can include:
  - Altered mental state
  - Body temperature > 38.3°C or < 36°C
  - Heart rate > 90 beats/min
  - Tachypnea
  - Lactate greater than upper limits of normal lab results
  - White blood cell count > xx

These indicators MUST BE attributed to/caused by the infection and not by other conditions.
Clinical Indicators: Helpful

• The following are some of the clinical indicators that might indicate a sepsis diagnosis. Understanding clinical indicators is important for CDI and the coding professional. The physician still needs to document the definitive diagnosis.
  - Fever
  - Tachypnea
  - Tachycardia
  - Altered mental status

• The coding & CDI professional may query the physician for clarification when these indicators are present without a diagnosis of sepsis or SIRS.

Clinical Indicators: Helpful

• Sepsis and/or SIRS, watch the documentation of the treatment

• Treatment can include:
  - IV antibiotics (broad spectrum)
  - Vasopressors (shock could be occurring)
  - Activated protein C (APC) Xigris
  - Corticosteroids for glucose levels
  - IV fluids

• Clinical manifestations of SIRS may include:
  - Fever of greater than 100.4 or hypothermia with a temperature of less than 96.8
  - Leukocytosis, white blood cell count of greater than 12,000 cells per cubic millimeter or > 10% bands, or
  - Leukopenia, white blood cell count of less than 4,000 cells per cubic millimeter

• Query the physician
  - Cannot lead the physician to a diagnosis, however
Clinical Indicators in Children

Temperature, respiratory rate, white cell count, and heart rate must be normalized for age of the child

- Core temperature > 38.5° or < 36.0°C
- Tachycardia = mean heart rate > 2 SD above normal for age or, for children < 1 year of age, bradycardia < 10th percentile for age
- Mean respiratory rate > 2 SD above normal for age
- WBC elevated or depressed for age or > 10% bands

The Children’s Clinical University Hospital, the risk of developing sepsis: 8% of SIRS patients developed sepsis, 5% severe sepsis, and 2% septic shock

Pediatric Screening for Systemic Inflammatory Response Syndrome (SIRS)

Patient has SIRS if meet two of the following:

- **Temperature:**
  - Less than 36°C (96.8°F) or greater than 38.0°C (100.4°F) orally or rectally
- **Heart rate:**
  - Greater than 180 beats per minute (bpm) in the neonate
  - Greater than 160 bpm in infant 1–12 months
  - Greater than 110 bpm in the child age 1–11 years
  - Greater than 90 bpm in the adolescent and adult
- **Systolic blood pressure:**
  - SBP less than 60 mmHg for the neonate
  - SBP less than 70 mmHg for the child age 1–12 months
  - SBP less than 70 mmHg + 2 (age of child) for child age 1–10 years
  - SBP less than 90 in adolescent or adult, or has dropped by greater than 40 mmHg from baseline
- **Respiratory rate:**
  - Greater than 60 breaths per minute in neonate and infant (newborn–12 months)
  - Greater than 40 breaths per minute in older infants and toddlers (ages 1–3 years)
  - Greater than 34 breaths per minute in preschool-age child (3–5 years)
  - Greater than 30 breaths per minute in school-age child (6–11 years)
  - Greater than 20 breaths per minute in adolescent and adult
- **WBC:** greater than 12,000 cells/mm³, or WBC less than 4,000 cells/mm³, or more than 10% bands
Clinical Indicators and Documentation: Helpful

- Sepsis is frequently found in patients with extreme age, patients who are immune compromised, hospitalized patients, and patients who have invasive devices present in their bodies, including catheters and tubes, and those who have an infection.
- When reading/reviewing the medical record documentation, look for evidence of hypoperfusion of organs and perfusion abnormalities may include, but are not necessarily limited to, an acute alteration in mental status, oliguria, and/or lactic acidosis.
- Review and understanding of documentation

Clinical Insights

- Lactic acidosis: A buildup of lactic acid in the bloodstream, frequently due to decreased perfusion and oxygenation of vital organs in patients with septic shock
- Watching the lactic acidosis level can be helpful in diagnosing early sepsis
- DO NOT code from a lab value

- Blood cultures: positive or negative
- However:
  - Negative or inconclusive blood cultures do not preclude a diagnosis of septicemia or sepsis in patients with clinical evidence of the condition; however, the provider should be queried (AHA Coding Clinic)
- However:
  - Only 28% of patients with sepsis have positive blood cultures
Example 1

- 14-year-old WM developed abd discomfort last night. Awoke with mid-abdom pain 7 AM. Nausea and vomiting at school. Seen by school nurse, who called mom. Taken to hospital. Temp = 102, P = 84, resp = 18, BP = 110/68. Abd flat with tenderness to percussion and rebound referred to RLQ. Rectal shows right pelvic referred pain. WBC – 13,500 w 80% neutro. Called surg consult.

  - Imp: Acute appendicitis
  - ER to OR; given a dose of Levaquin in prep area; laparoscopic appendectomy done
  - Fed next morning; discharged next afternoon
  - Does this patient have sepsis?

Example 2

- 63 yo WF with palpitations while shopping, near syncopal episode. Brought to ED by EMS.
- T = 98.4, P = 182, EKG – AF w RVR, resp = 24, BP = 166/92
- Given 10 mg Cardizem w resolution to pulse 76
- CXR clear, UA = WBC 40–60/hpf, RBC 2/hpf, nitrites pos, denies symptoms, WBC = 18,200 – had second of series of injections of steroid for spinal facet disease
- Admit to Cards for monitoring – AF w RVR, asymptomatic UTI
- Resident’s note:
  - 1. AF w RVR; 2. UTI ; 3. Pt has 2 or 4 criteria of SIRS and UTI – start sepsis protocol
- Does this patient have sepsis?
Example 3

- 82 yo WF w intermittent postprandial mid-abd pain, occurring 4 hours after every meal, lasting 2 hours and resolving spontaneously developed BRB per rectum over last 18 hours, weakness, altered mental status, brought in by daughter
- T = 101, P = 124 and thready, BP = 86/40, skin pale and cool, Foley inserted w 10 cc concentrated urine – bolus 500 cc Ringers, BP still dropping
- Abd rounded, tender midline, LUQ; x-ray shows ileus pattern, A/F levels mid abd w no air seen in colon
- Prob isch colitis – call GI
- Resuscitative efforts on ICU w no response to 1 liter Ringers, started dopamine 6 mcg/min
- Air in wall of bowel identified; BUN 84/Cr 4.6; less responsive
- Imp: Dead bowel
- Is this patient septic?

Example 4

- 6 mo girl awoke screaming at 4 AM, mom felt high temp – measured 104°F – placed in cool bath, fever broke
- Re-awoke at 6:30 screaming, felt hotter than before, came to ED; temp 101 now, neck not stiff, BP 84/60, P = 144, resp 26 and inconsolable
- Left TM bright red, right okay; recent hx of sniffles – brother recovered from cold
- Imp: Left OM – start amoxicillin, baby ASA for fever and tachycardia
- Pain and fever broke that night at home
- 10 days of amoxicillin
- Does this patient have sepsis?
Urosepsis Is NOT Sepsis

- Under the ICD-9-CM classification system, urosepsis is defined as urinary tract infection (599.0)
  - Urosepsis codes to 599.0
- If urosepsis is noted, and sepsis indicators present, querying the physician is a best practice
- If the patient has sepsis (038.x) from a urinary source, then the documentation should state that:
  - Sepsis from UTI
  - UTI causing sepsis
  - Sepsis secondary to a UTI
- Querying the physician for the cause or linkage of the urosepsis is critical
  - Coding and CDI
- ICD-10 no urosepsis term

Urosepsis (cont.)

- Today urosepsis is sometimes stated as the diagnosis even though the condition has progressed to a state in which a localized urinary tract infection has entered the bloodstream (septicemia) or has become a generalized sepsis.
- The physician should be asked/queried if the diagnosis of urosepsis is intended to mean (1) generalized sepsis caused by entry of toxic byproducts into the general vascular circulation, or (2) urine contaminated by bacteria, bacterial byproducts, or other toxic material but without other findings (599.0). Clarify.
- Having a strong query process is key.
  - Coding and CDI
- Physician awareness is key!
Documentation Bacteremia

In some situations, documentation will state “bacteremia”

- **Nonspecific finding**

- Notes have been added to code 790.7, Bacteremia, which instruct the coder to use an additional code to identify the organism and to specifically exclude septicemia. Bacteremia is defined as the presence of bacteria in the blood. Septicemia is defined as systemic disease associated with the presence and persistence of pathogenic microorganisms or their toxins in the blood. The two terms are not synonymous. Bacteremia denotes a laboratory finding, septicemia denotes acute illness. Modifications have also been made to the index that delete subterms under the bacteremia category and refer a coder to septicemia when a patient has bacteremia with sepsis. (4th Qtr 1993)

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Bacteremia: AHA Coding Clinic

- Bacteremia is defined as the presence of bacteria in the blood. Septicemia has been defined as systemic disease associated with the presence of pathological microorganisms or toxins in the blood, which can include bacteria, viruses, fungi, or other organisms. (4th Qtr 2003)

- **Bacteremia**

- Bacteremia is bacteria in the blood, as confirmed by culture, but may be transient. Bacteremia denotes a laboratory finding, septicemia denotes acute illness. Bacteremia progresses to septicemia only when there is a more severe infectious process or an impaired immune system. The coder should be aware of the difference between these two conditions and consult the physician when the diagnosis in not clearly differentiated. (2nd Qtr 2000)
Septicemia Is Not Synonymous With Sepsis

- Distinction finally made in Official Coding Guidelines and in AHA’s Coding Clinic in 2008
- Septicemia is defined as organisms in the bloodstream causing infection of the bloodstream
- Sepsis is a systemic reaction to a localized infection with active kinins in the bloodstream
- “Septicemia” now called obsolete – can be caused by bacteria, viruses, fungi, protozoons causing bloodstream infection

Sepsis Diagnosis: AHA Coding Clinic

**Question:** The patient was transferred to the long-term care hospital (LTCH) following a lengthy hospitalization for sepsis and acute respiratory failure. She was transferred to the LTCH for further intravenous antibiotic treatment and management of her multiple medical problems including resolving coagulase negative staphylococcus sepsis, and respiratory failure. Since the sepsis is resolving, would it be appropriate to code sepsis as the principal diagnosis? The ICD-9-CM Official Guidelines for Coding and Reporting do not address this issue.

**Answer:** The Editorial Advisory Board (EAB) for Coding Clinic has become aware of a pattern of documentation problems concerning patients transferred to the LTCH with a diagnosis of sepsis. Physician advisers reviewing these cases did not agree that these patients were truly septic since they had no clinical indicators. If the documentation is unclear as to whether the patient is still septic, query the provider for clarification. Facilities should work with the medical staff to improve physician documentation and address any documentation issues. Please refer to the Fourth Quarter 2003 issue of Coding Clinic, pages 102–103, for additional information regarding coding and reporting for long-term care hospitals. (2nd Qtr 2012)

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Sepsis Syndrome: AHA Coding Clinic

**Question:** The provider listed “sepsis syndrome” in the final diagnostic statement. How should sepsis syndrome be coded? The only advice we have found on sepsis syndrome was a Coding Clinic reference from Second Quarter 2000 regarding septicemia, septic shock, and sepsis syndrome. Is that advice still valid?

**Answer:** No, the coding advice on sepsis has changed since that Coding Clinic reference was published. The term “sepsis syndrome” is poorly defined. Query the physician to determine the specific condition(s) the patient has. (2nd Qtr 2012)

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Documentation – Organ Dysfunction

- Organ Dysfunctions associated with severe sepsis and septic shock
- Review carefully the documentation regarding the lungs: early fall in arterial PO₂, Acute Respiratory Distress Syndrome (ARDS): capillary-leakage into alveoli; tachypnea, hyperpnea
- Review carefully the documentation regarding the kidneys: (acute renal failure opr acute kidney injury): oliguria, anuria, azotemia, proteinuria
- Review carefully the documentation regarding liver function: (acute hepatic necrosis) elevated levels of serum bilirubin, alkaline phosphatase, cholestatic jaundice
- Review carefully the documentation regarding the digestive tract: nausea, vomiting, diarrhea and ileus
Severe Sepsis and Organ Dysfunction

- Using ICD-9-CM code 995.92 (severe sepsis) when just an elevated lactate does not equate to organ dysfunction ... query the physician
  - AHA Coding Clinic has stated this as an official guidance and directive
- Organ dysfunction must be stated specifically as DUE TO THE SEPSIS ...
  - Acute respiratory failure — Septic shock
  - Acute liver failure — Disseminated intravascular
  - Acute renal failure — Coagulopathy (DIC)
- However, the coding professional can query the physician for clarification of the organ dysfunction
- Educating physicians of this is important so they document the “organ” dysfunction specificity

Documentation – Septic Shock

- Sometimes referred to as multiple organ dysfunction syndrome or MODS – no code for this!
- Shock can be due to an inadequate blood supply to the brain, kidneys, lungs, or heart.
- This can lead to acute renal failure, acute respiratory failure, coma from metabolic encephalopathy, and/or heart failure.
  - Organ dysfunction would be present
- Watch the medications being given.
  - Vasopressors
- Review the documentation carefully. There may be an opportunity to query the physician.
  - Coding and CDI
Coding Accuracy

- Severity of illness (SOI) and risk of mortality (ROM) are based on the ICD-9-CM codes for a given patient
  - Linked to the documentation in the medical record
- The most common methodology used today is APR-DRGs or all-patient refined diagnostic-related groups
- External agencies use the ICD-9-CM codes and apply APR-DRGs: they will publish the ROM scores: i.e., California
- Coding accuracy is important: case-mix index (CMI), risk adjustment, accurate measurement of mortality rate for the sepsis quality collaborative, and good patient care
- Case-mix index is a reflection of the MS-DRG or APR-DRG relative weights for the resources and severity of the grouping
  - The higher the CMI, the more resources and severe the patient is; the more complex the diagnoses, either MS-CMI or APR-CMI
  - CMI is also used to project potential Medicare reimbursement
    - Important to finance and revenue cycle

UHDDS Guidance

- The UHDDS item #11-b defines Other Diagnoses as “all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay.
- Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.”
- The UHDDS definition of the circumstances of admission is based on the time the inpatient order is written, emphasizing that the septicemia code in ICD-9-CM or the sepsis code in ICD-10 cannot be sequenced as the principal Dx unless it is present on admission and that the Guidelines require query if it is not crystal clear that it is present on admission.
- UHDDS: For reporting purposes, the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:
  - Clinical evaluation; or
  - Therapeutic treatment; or
  - Diagnostic procedures; or
  - Extended length of hospital stay; or
  - Increased nursing care and/or monitoring.

Sepsis Coding: Clinical Updates and Communication Strategies
UHDDS Guidance (cont.)

Previous conditions

- If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy.

- However, history codes (V10–V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

- WATCH: CUT/PASTE Practices with EHR

Abnormal findings

- Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

- Note: This differs from the coding practices in the outpatient setting for coding encounters for diagnostic tests that have been interpreted by a provider.

2nd Dx Reporting: Coding Guidelines

- Chronic systemic conditions
  - For chronic systemic conditions identified as secondary diagnoses, the conditions must coexist at the time of admission
    - Hypertension, diabetes, COPD, lupus, etc.
  - Chronic systemic conditions do NOT need to meet the other secondary diagnosis definitions, per AHA Coding Clinic ...

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Note: This content is a continuation from the previous page and provides guidance on coding practices, emphasizing the importance of documenting clinical findings and historical conditions accurately to ensure proper coding and reimbursement.
National Coding Guidelines

- Developed by: American Hospital Association (AHA), Centers for Medicare & Medicaid Services (CMS), National Center for Health Statistics, American Health Information Management Association (AHIMA)
- Considered to be the “official” source
- Update annually

ICD-9-CM Official Guidelines for Coding and Reporting

ICD-9-CM Official Guidelines for Coding and Reporting
Effective October 1, 2011
Narrative changes appear in bold text
Items underlined have been moved within the guidelines since October 1, 2010

The Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government’s Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). These guidelines should be used as a companion document to the official version of the ICD-9-CM as published on CD-ROM by the U.S. Government Printing Office (GPO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-9-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS. These guidelines are included on the official government version of the ICD-9-CM, and also appear in Coding Clinic for ICD-9-CM published by the AHA.
Coding Septicemia 038.x

ICD-9-CM Codes

- Sepsis codes = 038.x & 995.9x
- Organ dysfunction (995.9x) – query if you can’t tell whether it’s related to sepsis
  - Documentation should state the type of organ dysfunction
- Septic shock 785.xx – sequence after systemic infection (038.x) and 995.9x code. Septic shock indicates severe sepsis, so do code 995 even if “severe sepsis” is not documented.
- Septicemia = 038.x AHA Coding Clinic states query physician “does patient have Sepsis, an infection with SIRS?”
ICD-10 Infectious Disease

- Although sepsis and septicemia are determined to be two different entities (local infection with systemic impact through release of kinins from macrophages vs. infection of the bloodstream), both have same code now in ICD-10 = A41
- Bacteremia R78.81, viremia B34.9, fungemia B49 have specific codes, none of which carry severity

The ICD-10 Future Must Be Started Now

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>995.91 Sepsis (SIRS due to infection without organ dysfunction)</td>
<td>*****</td>
</tr>
<tr>
<td>995.92 Severe sepsis (SIRS due to infection with organ dysfunction)</td>
<td>R65.20 Severe sepsis without septic shock</td>
</tr>
<tr>
<td>995.93 SIRS due to noninfection without organ dysfunction</td>
<td>R65.21 Severe sepsis with septic shock</td>
</tr>
<tr>
<td>995.94 SIRS due to noninfection with organ dysfunction</td>
<td>R65.10 SIRS due to noninfection without organ dysfunction</td>
</tr>
<tr>
<td></td>
<td>R65.11 SIRS due to noninfection with organ dysfunction</td>
</tr>
</tbody>
</table>
ICD-10-CM

ICD-10 Specific
"Sepsis/Septicemia"

- Anthrax sepsis A22.7
- Septicemia of plague A20.9
- Salmonella sepsis A02.1
- Listeria sepsis A32.7
- Meningococcemia
  - Acute A39.2
  - Chronic A39.3
- Streptococcal sepsis – specify group
- Toxic shock syndrome A48.3
- Sepsis not specified A41
When and How to Query

The generation of a query should be considered when the health record documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
- Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
- Provides a diagnosis without underlying clinical validation
- Is unclear for present-on-admission indicator assignment

Although open-ended queries are preferred, multiple choice and “yes/no” queries are also acceptable under certain circumstances.

The “yes/no” query format should be constructed to include the additional options associated with multiple choice queries (i.e., “other,” “clinically undetermined,” and “not clinically significant and integral to”).

Yes/no queries may not be used in circumstances where only clinical indicators of a condition are present and the condition/diagnosis has yet to be documented in the health record. Also new diagnoses cannot be derived from a yes/no query.
Regulatory Focus: HHS Regulation

• “A joint effort between the health care provider and the coding professional is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures ...”

• The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation, accurate coding cannot be achieved.

• The entire record should be reviewed to determine the specific reason for encounter and conditions treated.”


• The letter acknowledges that electronic health records are essential to “coordinating care, improving quality, reducing paperwork, and eliminating duplicative tests.” However, the DOJ expressed deep concern that this technology is being used “to game the system, possibly [allowing health care providers] to obtain payments to which they are not entitled.”

• According to the Attorney General and Secretary, early reports have indicated two practices that violators of meaningful use are using to game the system. One refers to the process of cutting and pasting the same information across records, and the other deals with misrepresenting a patient’s condition.

Source: EHR Intelligence.
Regulatory Focus

- Recovery Auditors are using complex reviews to target certain MS-DRGs and coding errors
- Data mining sepsis: Frequency of sepsis MS-DRGs
  - Short LOS in MS-DRG
  - Discharge to home w short LOS
- **Sepsis** (high reimbursement): If a patient has documented sepsis or septicemia, there should be clinical indications to support the diagnosis
  - Hypotension unresponsive to hydration, oliguria, altered mental status, or elevated lactic acidosis
  - **Studies**: Lab may have either very elevated white count or low white count

Regulatory Focus

- Multiple cultures of blood, urine, and other body fluids are ordered; blood cultures may have bacteria in them
- **Treatment**:
  - Medications
    - IV fluids (NS and increased flow rate)
  - Vasopressors
  - Antibiotics (broad spectrum)
  - IV steroids are sometimes used if indicated
- **Support** respirations and circulation
Regulatory Focus:
3 MS-DRGs for Sepsis

MS-DRG 870 Septicemia or severe sepsis with mechanical ventilation 96+ hrs (GMLOS 12.6)

MS-DRG 871 Septicemia or severe sepsis without mechanical ventilation 96+ hrs with MCC (GMLOS 5.2)

MS-DRG 872 Septicemia or severe sepsis without mechanical ventilation 96+ hrs without MCC (GMLOS 4.2)

- Although correct coding is essential, proper sequencing of the codes is just as important because it affects MS-DRG assignment and payment
- Sequencing is sometimes a challenge because the circumstances of admissions are often somewhat debatable, leading to questions of the principal diagnosis

Query Compliance

- CMS: The query form can/should be used “to the extent it provides clarification and is consistent with other medical record documentation.”
- The query form should be phrased such that the physician is allowed to specify the correct diagnosis. It should not indicate the financial impact of the response.
- The form should not be designed so that the only thing required is a signature.
- Queries should improve documentation of unique clinical situations and provide assurance that if codes are assigned, the documentation in the record supports them.
Query Compliance (cont.)

- Excessive use of queries may indicate trends of poor documentation that should be addressed.

- The query can list “all clinically reasonable choices regardless of the impact on reimbursement or quality reporting” and give physicians a space to write “other” or “unable to determine.” (AHIMA 3/2010)

Query Compliance (cont.)

- “A non-leading query clarifies the specificity of current diagnoses and/or procedures based on relevant, pertinent clinical facts within the medical record, such as signs, symptoms, findings, and test results; the treatment rendered including clinical pathways specific to a condition/diagnosis; and the patient’s risk factors including the patient’s current stable conditions, past medical history, medications, and overall risk based on his or her total health status picture. According to the AHIMA physician query practice brief:

‘Queries that appear to lead the provider to document a particular response could result in allegations of inappropriate upcoding. The query format should not sound presumptive, directing, prodding, probing, or as though the provider is being led to make an assumption.’”

Case Example #1

“I have a question about the sequencing of sepsis as the principal diagnosis:

- In an inpatient acute care setting, if sepsis and a localized infection are both present on admission and there is documentation of a cause-and-effect relationship with the localized infection and the sepsis, is the sepsis assigned as principal diagnosis in every one of these situations? For example, there was documentation that the pneumonia was the cause of admission and documentation also supported that patient did have sepsis and sepsis was present on admission. What is the appropriate principal diagnosis?”

Case Example #2

- A 74-year-old male patient is admitted to the hospital due to acute MI and traumatic injury to hip. The physician documents the patient has SIRS due to both conditions. The patient also has a history of hypertension and has a BMI of 29.

- The appropriate code and sequence assignment is:
Case Example #3

- A 58-year-old female patient presents to the ED with high WBC, tachycardia, tachypnea, and shaking chills. A blood culture is drawn, which the physician documents as being positive for MRSA. MRSA sepsis is documented in the progress notes by the attending physician. Antibiotics are changed based on the blood culture and the patient is treated with appropriate antibiotics.

- Due to poor vascular access, a central venous catheter is inserted and antibiotics are infused through this access.

- The patient responded slowly to treatment and CVC access becomes red and inflamed. The catheter is removed and cultured. The physician documents this to be an infection due to MRSA.

- How would the diagnosis codes be assigned for this inpatient stay?

HCPro Sepsis Survey Results

- We conducted an online survey on sepsis documentation and coding issues.

- 700 respondents!

- Example: Are you experiencing ongoing “coding issues” surrounding the coding of sepsis?
Survey SAYS ...

2. If you answered yes to question 1, please indicate which of the following best captures the issues you are having (otherwise, skip to question 4):

<table>
<thead>
<tr>
<th>Issue</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation</td>
<td>68.3%</td>
<td>558</td>
</tr>
<tr>
<td>Coding issues</td>
<td>1.1%</td>
<td>7</td>
</tr>
<tr>
<td>Coding guidelines</td>
<td>10.5%</td>
<td>67</td>
</tr>
</tbody>
</table>

Comments: 75

Survey (cont.)

3. If you answered that "Documentation" is an issue, please indicate one or more of the following if they apply (otherwise, skip to question 4)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical indicators are not documented but diagnosis of sepsis is listed</td>
<td>64.8%</td>
<td>196</td>
</tr>
<tr>
<td>Clinical indicators are contrasting with diagnosis of sepsis</td>
<td>47.7%</td>
<td>239</td>
</tr>
<tr>
<td>Documentation is only in the ED note and not by the attending</td>
<td>34.0%</td>
<td>203</td>
</tr>
<tr>
<td>Clinical criteria for SIRS are documented, but not the word 'suspicion'</td>
<td>60.5%</td>
<td>303</td>
</tr>
<tr>
<td>EMR Documentation is &quot;outdated&quot; from another encounter or the patient transferred to another department</td>
<td>15.4%</td>
<td>107</td>
</tr>
</tbody>
</table>

Comments: 98

More survey results available on the materials download page
Action and/or Metrics to Assess Capture of Sepsis

- Clinical documentation improvement staff and HIM coding should meet monthly and review records
- Regular auditing/review followed by education to coding staff of clinical indicators and when to query the physician
- All inpatient deaths should be reviewed within 2–3 days of discharge for complete documentation and coding sepsis, organ failure, etc.
  - Flag and audit these cases
  - External or internal auditing resources
- Have a physician champion available to help review and communicate to other physicians
- Access MedPAR data and compare to national frequency of certain MS-DRGs
- Understand and educate on APR-DRGs
- Build a strategy and plan

Action and/or Metrics to Assess Capture of Sepsis

- Inpatients with principal Dx of UTI 599.0
  - Run a report on these cases
  - Audit/review and determine if sepsis was not documented or not coded
    - Watch the LOS
- Inpatient with sepsis principal diagnosis
  - Audit charts and determine if sepsis was not documented thoroughly enough
    - Clinical indicators present
  - Run a report by DRG or by principal Dx
    - LOS 1, 2, and 3 days
    - Review the discharge disposition of home
  - Check for 2nd pneumonia diagnosis, cellulitis, or other infectious process
  - Utilize internal or external resources
**Action: Physician Advisor**

- Establish and use a physician advisor, liaison, or champion
- Role to educate physicians and medical staff departments to link ICD-9-CM coding guidelines with clinical terminology
- Work with CDI and HIM personnel
- Review selected health records concurrently or retrospectively
- Explain common or repeat documentation issues such as urosepsis, sepsis, respiratory failure, types of heart failure, etc.
- Assist with developing (constructing) clinically appropriate provider queries
- Communicate with third-party payers to address DRG modifications and other issues

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**Data Quality**

- Documentation and coding is critical
- Review AHA *Coding Clinic* issues
  - Demand for quality healthcare data
  - Coded data that is credible, reliable, and accurate
- Data is used for internal purposes such as utilization review, quality assurance, physician education and monitoring, assessing competitors, marketing, and strategic planning
  - Monitor your own data: MS-DRGs
- This is imperative!
Summary

- Review the documentation carefully
- Understand the coding rules
- Discuss clinical indicators with coding staff and CDI
  - **Collaboration with CDI & HIM/coding**
- Self-audit
  - Run a data report
  - Establish a corrective action plan
- Know the AHIMA Practice Brief from February
- Physician awareness and leadership

Summary (cont.)

- Monitor RAC, MAC, and other regulatory focus and targets
- Work with your RAC coordinator/committee
  - Review the trends on requests
  - Review the results and outcomes
- Monitor and track frequency of MS-DRGs
References/Resources

- UHDDS Guidelines
- 2013 AHIMA Practice Brief – Guidelines for Achieving Compliant Query Practice
  http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050018.hcsp?dDocName=bok1_050018
- 2010 AHIMA Practice Brief – Guidance for CDI Programs
- 2010 AHIMA CDI toolkit
- 2008 AHIMA Practice Brief – Managing an Effective Query Process

References/Resources

- 2008 AHIMA Standards of Ethical Coding
- 2001 AHIMA Practice Brief – Developing a Physician Query Process
- ICD-9-CM Official Guidelines for Coding and Reporting
- AHA Coding Clinic on ICD-9-CM
- ACDIS CDI Handbook
- ICD-10 Code Book
- http://clinicaldocumentation.net/cdi/10-principles-of-clinical-documentation
Questions?

To ask our speakers questions today, press *1 on your telephone keypad. This will place you in our electronic queue. We will un-mute you and notify you when it is time to ask your question. When asking a question, please be sure to un-mute your speakerphone. You may also submit a question to the following email address: thutlock@hcpro.com.

This information is also listed in the instruction email where you found the dial-in information for the program.

Thank you!

Please note: Continuing education credits are available for this program. For instructions on how to claim your credits, please visit the materials download page at www hcpro.com/downloads/11179.
Exhibit B


*Source: For full list of coding guidelines, see http://www.cdc.gov/nchs/data/icd9/icgguide10.pdf*
classifiable elsewhere, but complicating the pregnancy, childbirth or the puerperium, followed by 042 and the code(s) for the HIV-related illness(es). Codes from Chapter 15 always take sequencing priority.

Patients with asymptomatic HIV infection status admitted (or presenting for a health care encounter) during pregnancy, childbirth, or the puerperium should receive codes of 647.6X and V08.

(h) Encounters for testing for HIV
If a patient is being seen to determine his/her HIV status, use code V73.89, Screening for other specified viral disease. Use code V69.8, Other problems related to lifestyle, as a secondary code if an asymptomatic patient is in a known high risk group for HIV. Should a patient with signs or symptoms or illness, or a confirmed HIV related diagnosis be tested for HIV, code the signs and symptoms or the diagnosis. An additional counseling code V65.44 may be used if counseling is provided during the encounter for the test.

When a patient returns to be informed of his/her HIV test results use code V65.44, HIV counseling, if the results of the test are negative.

If the results are positive but the patient is asymptomatic use code V08, Asymptomatic HIV infection. If the results are positive and the patient is symptomatic use code 042, HIV infection, with codes for the HIV related symptoms or diagnosis. The HIV counseling code may also be used if counseling is provided for patients with positive test results.

b. Septicemia, Systemic Inflammatory Response Syndrome (SIRS), Sepsis, Severe Sepsis, and Septic Shock

1) SIRS, Septicemia, and Sepsis

(a) The terms septicemia and sepsis are often used interchangeably by providers, however they are not considered synonymous terms. The following descriptions are provided for reference but do not preclude querying the provider for clarification about terms used in the documentation:

(i) Septicemia generally refers to a systemic disease associated with the presence of
pathological microorganisms or toxins in the blood, which can include bacteria, viruses, fungi or other organisms.

(ii) Systemic inflammatory response syndrome (SIRS) generally refers to the systemic response to infection, trauma/burns, or other insult (such as cancer) with symptoms including fever, tachycardia, tachypnea, and leukocytosis.

(iii) Sepsis generally refers to SIRS due to infection.

(iv) Severe sepsis generally refers to sepsis with associated acute organ dysfunction.

(b) The Coding of SIRS, sepsis and severe sepsis

The coding of SIRS, sepsis and severe sepsis requires a minimum of 2 codes: a code for the underlying cause (such as infection or trauma) and a code from subcategory 995.9 Systemic inflammatory response syndrome (SIRS).

(i) The code for the underlying cause (such as infection or trauma) must be sequenced before the code from subcategory 995.9 Systemic inflammatory response syndrome (SIRS).

(ii) Sepsis and severe sepsis require a code for the systemic infection (038.xx, 112.5, etc.) and either code 995.91, Sepsis, or 995.92, Severe sepsis. If the causal organism is not documented, assign code 038.9, Unspecified septicemia.

(iii) Severe sepsis requires additional code(s) for the associated acute organ dysfunction(s).

(iv) If a patient has sepsis with multiple organ dysfunctions, follow the instructions for coding severe sepsis.

(v) Either the term sepsis or SIRS must be documented to assign a code from subcategory 995.9.

(vi) See Section I.C.17.g), Injury and poisoning, for information regarding systemic inflammatory response syndrome (SIRS) due to trauma/burns and other non-infectious processes.

ICD-9-CM Official Guidelines for Coding and Reporting
Effective October 1, 2010
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(c) Due to the complex nature of sepsis and severe sepsis, some cases may require querying the provider prior to assignment of the codes.

2) Sequencing sepsis and severe sepsis

(a) Sepsis and severe sepsis as principal diagnosis

If sepsis or severe sepsis is present on admission, and meets the definition of principal diagnosis, the systemic infection code (e.g., 038.xx, 112.5, etc) should be assigned as the principal diagnosis, followed by code 995.91, Sepsis, or 995.92, Severe sepsis, as required by the sequencing rules in the Tabular List. Codes from subcategory 995.9 can never be assigned as a principal diagnosis. A code should also be assigned for any localized infection, if present.

If the sepsis or severe sepsis is due to a postprocedural infection, see Section I.C.1.b.10 for guidelines related to sepsis due to postprocedural infection.

(b) Sepsis and severe sepsis as secondary diagnoses

When sepsis or severe sepsis develops during the encounter (it was not present on admission), the systemic infection code and code 995.91 or 995.92 should be assigned as secondary diagnoses.

(c) Documentation unclear as to whether sepsis or severe sepsis is present on admission

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.

3) Sepsis/SIRS with Localized Infection

If the reason for admission is both sepsis, severe sepsis, or SIRS and a localized infection, such as pneumonia or cellulitis, a code for the systemic infection (038.xx, 112.5, etc) should be assigned first, then code 995.91 or 995.92, followed by the code for the localized infection. If the patient is admitted with a localized infection, such as pneumonia, and sepsis/SIRS doesn’t develop until after admission, see guideline I.C.1.b.2.b).
If the localized infection is postprocedural, see Section I.C.1.b.10 for guidelines related to sepsis due to postprocedural infection.

**Note:** The term urosepsis is a nonspecific term. If that is the only term documented then only code 599.0 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.

4) **Bacterial Sepsis and Septicemia**
In most cases, it will be a code from category 038, Septicemia, that will be used in conjunction with a code from subcategory 995.9 such as the following:

(a) **Streptococcal sepsis**
If the documentation in the record states streptococcal sepsis, codes 038.0, Streptococcal septicemia, and code 995.91 should be used, in that sequence.

(b) **Streptococcal septicemia**
If the documentation states streptococcal septicemia, only code 038.0 should be assigned, however, the provider should be queried whether the patient has sepsis, an infection with SIRS.

5) **Acute organ dysfunction that is not clearly associated with the sepsis**
If a patient has sepsis and an acute organ dysfunction, but the medical record documentation indicates that the acute organ dysfunction is related to a medical condition other than the sepsis, do not assign code 995.92, Severe sepsis. An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code. If the documentation is not clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, query the provider.

6) **Septic shock**

(a) **Sequencing of septic shock**
Septic shock generally refers to circulatory failure associated with severe sepsis, and, therefore, it represents a type of acute organ dysfunction.

For all cases of septic shock, the code for the systemic infection should be sequenced first, followed by codes 995.92 and 785.52. Any additional codes for other acute organ dysfunctions should also be assigned. As
noted in the sequencing instructions in the Tabular List, the code for septic shock cannot be assigned as a principal diagnosis.

(b) **Septic Shock without documentation of severe sepsis**

Septic shock indicates the presence of severe sepsis.

Code 995.92, Severe sepsis, must be assigned with code 785.52, Septic shock, even if the term severe sepsis is not documented in the record. The “use additional code” note and the “code first” note in the tabular support this guideline.

7) **Sepsis and septic shock complicating abortion and pregnancy**

Sepsis and septic shock complicating abortion, ectopic pregnancy, and molar pregnancy are classified to category codes in Chapter 11 (630-639).

*See section I.C.11.i.7. for information on the coding of puerperal sepsis.*

8) **Negative or inconclusive blood cultures**

Negative or inconclusive blood cultures do not preclude a diagnosis of septicemia or sepsis in patients with clinical evidence of the condition, however, the provider should be queried.

9) **Newborn sepsis**

*See Section I.C.15.j for information on the coding of newborn sepsis.*

10) **Sepsis due to a Postprocedural Infection**

(a) **Documentation of causal relationship**

As with all postprocedural complications, code assignment is based on the provider’s documentation of the relationship between the infection and the procedure.

(b) **Sepsis due to postprocedural infection**

In cases of postprocedural sepsis, the complication code, such as code 998.59, Other postoperative infection, or 674.3x, Other complications of obstetrical surgical wounds should be coded first followed by the appropriate sepsis codes (systemic infection code and either code 995.91 or 995.92). An additional code(s) for
any acute organ dysfunction should also be assigned for cases of severe sepsis.

11) **External cause of injury codes with SIRS**

Refer to Section I.C.19.a.7 for instruction on the use of external cause of injury codes with codes for SIRS resulting from trauma.

12) **Sepsis and Severe Sepsis Associated with Non-infectious Process**

In some cases, a non-infectious process, such as trauma, may lead to an infection which can result in sepsis or severe sepsis. If sepsis or severe sepsis is documented as associated with a non-infectious condition, such as a burn or serious injury, and this condition meets the definition for principal diagnosis, the code for the non-infectious condition should be sequenced first, followed by the code for the systemic infection and either code 995.91, Sepsis, or 995.92, Severe sepsis. Additional codes for any associated acute organ dysfunction(s) should also be assigned for cases of severe sepsis. If the sepsis or severe sepsis meets the definition of principal diagnosis, the systemic infection and sepsis codes should be sequenced before the non-infectious condition. When both the associated non-infectious condition and the sepsis or severe sepsis meet the definition of principal diagnosis, either may be assigned as principal diagnosis.

*See Section I.C.1.b.2.a. for guidelines pertaining to sepsis or severe sepsis as the principal diagnosis.*

Only one code from subcategory 995.9 should be assigned. Therefore, when a non-infectious condition leads to an infection resulting in sepsis or severe sepsis, assign either code 995.91 or 995.92. Do not additionally assign code 995.93, Systemic inflammatory response syndrome due to non-infectious process without acute organ dysfunction, or 995.94, Systemic inflammatory response syndrome with acute organ dysfunction.

*See Section I.C.17.g for information on the coding of SIRS due to trauma/burns or other non-infectious disease processes.*
Exhibit C

Sepsis coding survey results

Available at a separate link on the materials download page: www.hcpro.com/downloads/11179

Source: HCPro, Inc.
Exhibit D

List of useful industry acronyms

Source: HCPro, Inc.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAPC</td>
<td>American Academy of Professional Coders</td>
</tr>
<tr>
<td>ABN</td>
<td>Advance beneficiary notice</td>
</tr>
<tr>
<td>ACDIS</td>
<td>Association of Clinical Documentation Improvement Specialists</td>
</tr>
<tr>
<td>ADR</td>
<td>Additional documentation request</td>
</tr>
<tr>
<td>AHA</td>
<td>American Hospital Association</td>
</tr>
<tr>
<td>AHIMA</td>
<td>American Health Information Management Association</td>
</tr>
<tr>
<td>AHRQ</td>
<td>Agency for Healthcare Research and Quality</td>
</tr>
<tr>
<td>AMI</td>
<td>Acute myocardial infarction</td>
</tr>
<tr>
<td>AOA</td>
<td>American Osteopathic Association</td>
</tr>
<tr>
<td>APCs</td>
<td>Ambulatory payment classifications</td>
</tr>
<tr>
<td>ARRA</td>
<td>American Recovery and Reinvestment Act of 2009</td>
</tr>
<tr>
<td>ASC</td>
<td>Ambulatory surgery center</td>
</tr>
<tr>
<td>ASP</td>
<td>Average sales price</td>
</tr>
<tr>
<td>AWP</td>
<td>Average wholesale price</td>
</tr>
<tr>
<td>CAH</td>
<td>Critical access hospital</td>
</tr>
<tr>
<td>CC</td>
<td>Complication and comorbidity</td>
</tr>
<tr>
<td>CCHIT</td>
<td>Certification Commission for Health Information Technology</td>
</tr>
<tr>
<td>CCR</td>
<td>Continuity of care record/Cost-to-charge ratio</td>
</tr>
<tr>
<td>CDI</td>
<td>Clinical documentation improvement</td>
</tr>
<tr>
<td>CDM</td>
<td>Charge description master</td>
</tr>
<tr>
<td>CERT</td>
<td>Comprehensive Error Rate Testing</td>
</tr>
<tr>
<td>CPI</td>
<td>Consumer price index</td>
</tr>
<tr>
<td>CMI</td>
<td>Case-mix index</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>CMSA</td>
<td>Consolidated Metropolitan Statistical Area</td>
</tr>
<tr>
<td>CPI</td>
<td>Consumer price index</td>
</tr>
<tr>
<td>CPT</td>
<td>Current procedural terminology</td>
</tr>
<tr>
<td>CRNA</td>
<td>Certified registered nurse anesthetist</td>
</tr>
<tr>
<td>CT</td>
<td>Computed tomography</td>
</tr>
<tr>
<td>CY</td>
<td>Calendar year</td>
</tr>
<tr>
<td>DED</td>
<td>Dedicated emergency department</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnosis-related group</td>
</tr>
<tr>
<td>DSH</td>
<td>Disproportionate share hospital</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency department</td>
</tr>
<tr>
<td>EDMS</td>
<td>Electronic Document Management System</td>
</tr>
<tr>
<td>EHR</td>
<td>Electronic health records</td>
</tr>
<tr>
<td>E/M</td>
<td>Evaluation and management</td>
</tr>
<tr>
<td>EMR</td>
<td>Electronic medical records</td>
</tr>
<tr>
<td>EOB</td>
<td>Explanation of benefits</td>
</tr>
<tr>
<td>ePHI</td>
<td>Electronic protected health information</td>
</tr>
<tr>
<td>FDA</td>
<td>U.S. Food and Drug Administration</td>
</tr>
<tr>
<td>FFY</td>
<td>Federal fiscal year</td>
</tr>
<tr>
<td>FI</td>
<td>Fiscal intermediary</td>
</tr>
</tbody>
</table>
### HIM Acronyms to Know

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY</td>
<td>Fiscal year</td>
</tr>
<tr>
<td>GAF</td>
<td>Geographic adjustment factor</td>
</tr>
<tr>
<td>GME</td>
<td>Graduate medical education</td>
</tr>
<tr>
<td>H&amp;P</td>
<td>History and physical</td>
</tr>
<tr>
<td>HAC</td>
<td>Hospital-acquired condition</td>
</tr>
<tr>
<td>HCCA</td>
<td>Health Care Compliance Association</td>
</tr>
<tr>
<td>HCFA</td>
<td>Health Care Financing Administration</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
</tr>
<tr>
<td>HCRIS</td>
<td>Hospital Cost Report Information System</td>
</tr>
<tr>
<td>HHA</td>
<td>Home health agency</td>
</tr>
<tr>
<td>HHS</td>
<td>U.S. Department of Health and Human Services</td>
</tr>
<tr>
<td>HIC</td>
<td>Health insurance card</td>
</tr>
<tr>
<td>HIMSS</td>
<td>Healthcare Information and Management Systems Society</td>
</tr>
<tr>
<td>HINN</td>
<td>Hospital-Issued Notice of Non-Coverage</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act of 1996</td>
</tr>
<tr>
<td>HIS</td>
<td>Health information system/services</td>
</tr>
<tr>
<td>HIT</td>
<td>Healthcare information technology</td>
</tr>
<tr>
<td>HITECH Act</td>
<td>Health Information Technology for Economic and Clinical Health Act</td>
</tr>
<tr>
<td>HMO</td>
<td>Health maintenance organization</td>
</tr>
<tr>
<td>HSA</td>
<td>Health savings account</td>
</tr>
<tr>
<td>HSRVcc</td>
<td>Hospital-specific relative value cost center</td>
</tr>
<tr>
<td>HQA</td>
<td>Hospital Quality Alliance</td>
</tr>
<tr>
<td>HQI</td>
<td>Hospital quality initiative</td>
</tr>
<tr>
<td>ICD-9-CM</td>
<td>International Classification of Diseases, 9th Revision, Clinical Modifications</td>
</tr>
<tr>
<td>ICD-10-PCS</td>
<td>International Classification of Diseases, 10th Revision, Procedure Coding System</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive care unit</td>
</tr>
<tr>
<td>IHS</td>
<td>Indian Health Service</td>
</tr>
<tr>
<td>IOM</td>
<td>Institute of Medicine</td>
</tr>
<tr>
<td>IPF</td>
<td>Inpatient psychiatric facility</td>
</tr>
<tr>
<td>IPPS</td>
<td>Inpatient prospective payment system</td>
</tr>
<tr>
<td>IRF</td>
<td>Inpatient rehabilitation facility</td>
</tr>
<tr>
<td>IT</td>
<td>Information technology</td>
</tr>
<tr>
<td>JCAHO</td>
<td>Joint Commission on Accreditation of Healthcare Organizations</td>
</tr>
<tr>
<td>LCD</td>
<td>Local coverage determination</td>
</tr>
<tr>
<td>LTC-DRG</td>
<td>Long-term care diagnosis-related group</td>
</tr>
<tr>
<td>LTCH</td>
<td>Long-term care hospital</td>
</tr>
<tr>
<td>MAC</td>
<td>Medicare Administrative Contractors</td>
</tr>
<tr>
<td>MCC</td>
<td>Major complication and comorbidity</td>
</tr>
<tr>
<td>MCO</td>
<td>Managed care organization</td>
</tr>
<tr>
<td>MCV</td>
<td>Major cardiovascular</td>
</tr>
<tr>
<td>MDC</td>
<td>Major diagnostic category</td>
</tr>
<tr>
<td>MDH</td>
<td>Medicare dependent hospital (small rural)</td>
</tr>
<tr>
<td>MedPAC</td>
<td>Medicare Payment Advisory Commission</td>
</tr>
<tr>
<td>MedPAR</td>
<td>Medicare Provider Analysis and Review</td>
</tr>
</tbody>
</table>
## HIM Acronyms to Know

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIC</td>
<td>Medicaid Integrity Contractors</td>
</tr>
<tr>
<td>MRHFP</td>
<td>Medicare Rural Hospital Flexibility Program</td>
</tr>
<tr>
<td>MS-DRG</td>
<td>Medicare Severity DRG</td>
</tr>
<tr>
<td>NAHIT</td>
<td>National Alliance for Health Information Technology</td>
</tr>
<tr>
<td>NCCI</td>
<td>National Correct Coding Initiative</td>
</tr>
<tr>
<td>NCD</td>
<td>National coverage determination</td>
</tr>
<tr>
<td>NCHS</td>
<td>National Center for Health Statistics</td>
</tr>
<tr>
<td>NCQA</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>NCVHS</td>
<td>National Committee on Vital and Health Statistics</td>
</tr>
<tr>
<td>NHIN</td>
<td>National Health Information Network</td>
</tr>
<tr>
<td>NICU</td>
<td>Neonatal intensive care unit</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
</tr>
<tr>
<td>NQF</td>
<td>National Quality Forum</td>
</tr>
<tr>
<td>NVHRI</td>
<td>National Voluntary Hospital Reporting Initiative</td>
</tr>
<tr>
<td>OCE</td>
<td>Outpatient code editor</td>
</tr>
<tr>
<td>OCR</td>
<td>Office for Civil Rights</td>
</tr>
<tr>
<td>OES</td>
<td>Occupational employment statistics</td>
</tr>
<tr>
<td>OIG</td>
<td>Office of Inspector General</td>
</tr>
<tr>
<td>OMB</td>
<td>Office of Management and Budget</td>
</tr>
<tr>
<td>OPPS</td>
<td>Outpatient prospective payment system</td>
</tr>
<tr>
<td>OR</td>
<td>Operating room</td>
</tr>
<tr>
<td>OSCAR</td>
<td>Online Survey Certification and Reporting (System)</td>
</tr>
<tr>
<td>PHR</td>
<td>Personal health record</td>
</tr>
<tr>
<td>PO</td>
<td>By mouth</td>
</tr>
<tr>
<td>POA</td>
<td>Present on admission</td>
</tr>
<tr>
<td>PPI</td>
<td>Producer price index</td>
</tr>
<tr>
<td>PPS</td>
<td>Prospective payment system</td>
</tr>
<tr>
<td>PRA</td>
<td>Per resident amount</td>
</tr>
<tr>
<td>PRM</td>
<td>Provider Reimbursement Manual</td>
</tr>
<tr>
<td>PRRB</td>
<td>Provider Reimbursement Review Board</td>
</tr>
<tr>
<td>PS&amp;R</td>
<td>Provider Statistical and Reimbursement (System)</td>
</tr>
<tr>
<td>QIO</td>
<td>Quality Improvement Organization</td>
</tr>
<tr>
<td>RA</td>
<td>Remittance advice</td>
</tr>
<tr>
<td>RAC</td>
<td>Recovery Audit Contractor</td>
</tr>
<tr>
<td>RBC</td>
<td>Red blood cell</td>
</tr>
<tr>
<td>RC</td>
<td>Revenue code</td>
</tr>
<tr>
<td>RHC</td>
<td>Rural health clinic</td>
</tr>
<tr>
<td>RHIO</td>
<td>Regional health information organization</td>
</tr>
<tr>
<td>ROI</td>
<td>Release of information (OR return on investment)</td>
</tr>
<tr>
<td>RY</td>
<td>Rate year</td>
</tr>
<tr>
<td>SAF</td>
<td>Standard analytic file</td>
</tr>
<tr>
<td>SCH</td>
<td>Sole community hospital</td>
</tr>
</tbody>
</table>
### HIM Acronyms to Know

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNF</td>
<td>Skilled nursing facility</td>
</tr>
<tr>
<td>SOCs</td>
<td>Standard occupational classifications</td>
</tr>
<tr>
<td>SSA</td>
<td>Social Security Administration</td>
</tr>
<tr>
<td>SSI</td>
<td>Supplemental Security Income</td>
</tr>
<tr>
<td>ST</td>
<td>Status indicator</td>
</tr>
<tr>
<td>TAG</td>
<td>Technical Advisory Group</td>
</tr>
<tr>
<td>UHDDS</td>
<td>Uniform Hospital Discharge Data Set</td>
</tr>
<tr>
<td>WBC</td>
<td>White blood cell</td>
</tr>
<tr>
<td>ZPIC</td>
<td>Zone Program Integrity Contractor</td>
</tr>
</tbody>
</table>
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<th>Price</th>
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<tr>
<td>Shipping* (see below)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sales tax (see below)**</td>
<td></td>
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<td></td>
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<tr>
<td>Grand total</td>
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</tbody>
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