SEPSIS AND CODING: Show me the money!

Dr Fatima Khalid-CMT  Dr Sarika Kapoor-FY2, Dr Micayla Telfer-Consultant Macclesfield Hospital

INTRODUCTION
Clinical coding is the translation of clinical terminology as written by a clinician in the case notes into statistical code following certain principles and rules. Correct diagnosis of sepsis is vital for the appropriate treatment of patients. A stand-alone diagnosis of pneumonia, once coded, receives a tariff of £883, while pneumonia with sepsis receives £3050. This higher payment is the same regardless of the severity of sepsis as seen below. Accurate payment requires accurate coding and this is derived from good documentation.

AIM
To determine how inadequate documentation of sepsis and therefore coding impacts on income in cases of community acquired pneumonia (CAP).

METHODS
The notes of all adult patients aged under 60 years who had a coded diagnosis of CAP but not sepsis admitted between April 2014 and July 2015 were requested. 128 patients were identified in this cohort and we were able to obtain and analyse 47 of them. We assessed whether patients had met criteria for a diagnosis of sepsis (based on infection and the presence of SIRS criteria) and whether this was documented at any point from admission up until post take ward round, where the coding is primarily derived from.

We considered whether patients met criteria for sepsis but without the appropriate documentation were passed to the coding department for re-coding and a new payment analysis. This audit was performed prior to the change in sepsis definitions in July 2016.

RESULTS
Of the 47 patients, 28 had clinical evidence of sepsis of some severity which was not documented in the notes. The coders were therefore unable to code its presence and the resulting tariff was lower than the severity of illness suggested. Patients with more co-morbidities or who received more invasive tests tended to enter a different Healthcare Resource Group (HRG) which are used to derive the tariff. We lose £2167 for failing to document sepsis in the notes for a previously well patient with simple pneumonia and sepsis.

The total loss of income in this cohort was £31,778. If we extrapolate this to the original population of 128 patients we estimate a loss of £86,260.

CONCLUSION
The trust loses a considerable amount of money solely due to under-documentation of sepsis in the case notes for pneumonia. Education on the importance of coding and its relation to income has been provided to all grades of medical staff and to the clinical coders. Previous external audit of our coding department has confirmed our coders do an excellent job. The responsibly to improve documentation lies with the Consultant body as the post take ward round is the main source of data for the coders.

Further audit will be challenging due to the new Sepsis-3 definitions.

We wonder how big the loss of income is if we consider all infection diagnoses across all age groups and all specialities?

Let’s all document well to “Show Me The Money!”.

ICD-10 Description HRG Tariff

J189 Pneumonia, unspecified DZ11C £883
J189 Pneumonia, unspecified DZ11A £3050
A409 Streptococcal sepsis, unspecified
J189 Pneumonia, unspecified DZ11A £3050
A419 Sepsis, unspecified DZ11A
J189 Pneumonia, unspecified DZ11A £3050
R650 SIRS of infectious origin without organ failure
J189 Pneumonia, unspecified DZ11A £3050
SIRS of infectious origin with organ failure
J189 Pneumonia, unspecified DZ11A £3050
R572 Septic shock

Average of £1135 per patient
60% of 128 = 76 patients
76 x £1135 = TOTAL LOSS of £86,260