OPERATOR INSIGHTS

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COVID-19 and Sepsis:

Demystifying Denials during the Pandemic

Sepsis is a common condition found in many hospitalized patients. It's also a known complication of COVID-19, causing death in many patients during the pandemic. Yet despite its prevalence and morbidity, hospitals are facing a surprising number of denials for sepsis care. How a hospital defines sepsis can have direct impact on patient care, quality scores, and financial ramifications. For a diagnosis with such far reaching implications, it may be surprising to learn that sepsis remains a clinical diagnosis without a true "gold standard" criteria. Let's discuss how hospitals should approach defining the septic patient and demystify why denials are occurring.

Ask your local friendly clinician what sepsis is, and you will likely hear some variation of the Mayo Clinic's definition: ***"Sepsis is a life-threatening complication of an infection that occurs when chemicals released in the bloodstream to fight an infection trigger inflammation throughout the body. This can cause a cascade of changes that damage multiple organ systems."*** While this is the clinical definition, I want to discuss the issue of criteria used by payors versus that used by providers, and how that has resulted in the deluge of denials most hospitals are currently dealing with.

As I mentioned earlier, sepsis criteria has real patient care implications. Make the criteria too stringent, and one might delay diagnosis; make it too loose and many non-septic patients might mistakenly have septic care initiated. It is precisely this variability in criteria that has propelled sepsis to being one of the most denied or downgraded DRG's in hospitals.

Let's talk criteria. You may hear people talk about the "old" and the "new" sepsis criteria. Most of us are referring to Sepsis-2 when speaking of the "old" criteria. Yes, there was a Sepsis-1 criteria that came out 1991. It was updated to Sepsis-2 in 2001. Both had the core concept that sepsis was when there was 1) a source of infection and 2) presence of SIRS (Systemic Inflammatory Response Syndrome). Sepsis-2 did expand the criteria defining SIRS and severe sepsis. In 2016, sepsis criteria had a revolutionary change. After 25 years of SIRS criteria, organ dysfunction due to the body's response to an infection took center stage and SIRS was retired. It became clear that with this "new" criteria, there can be no sepsis without organ damage.

The crux of many sepsis denials is that many hospitals continue to use Sepsis-2 criteria while most payors have moved to Sepsis-3. So why would a hospital not just adopt Sepsis-3 criteria? In my opinion, there may be several reasons. As a former Chief Medical Officer for hospitals and hospital systems, I know all too well the importance of core measures and quality ratings. CMS measures the care of septic patients and timing of bundled care in a way that aligns more with Sepsis-2 criteria. In this scenario, Sepsis-2 may allow more accurate diagnosis capture. As a CMO, I

was in a dilemma. Do I cast a wider net with Sepsis-2, understanding I may catch some non-septic patients (i.e. over-diagnosing), which allows me earlier detection and thus starting sepsis bundles earlier. This could result in decreased mortality (some may disagree) and certainly help my core measures score, right? The downside of course is when payors, applying Sepsis-3, do not find clinical validation of some of my "septic" patients. This results in peer-to-peers, appeals letters, and other time-consuming denials prevention measures. If I moved the hospital to Sepsis-3, I would certainly get less denials and downgrades, but what if this more stringent criteria caused delays in sepsis care?

What is the right answer? I don't know. What I do know is with sepsis, documentation is more important than ever. Specify is this sepsis or septic shock? Specify which organ has dysfunction specifically due to sepsis (by the way, you only need to document "dysfunction", not frank failure). Specify the organism causing the infection. I hope you notice a trend here. Be specific, very specific and you will improve the patient story, which improves care, while simultaneously decreasing denials. Each hospital needs to decide for itself what criteria it will use and understand what the downstream effects of that decision may be, but ultimately it should always put patient care at the core of all its decisions.

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