# Coding Sepsis vs. Septic Shock



By Melanie Endicott

The definitions and clinical criteria of sepsis and septic shock have been revised, per an article published February 23, 2016 in the *Journal of the American Medical Association* (*JAMA*). The recommendations from the 19 physician members of the task force that wrote the new definitions were:

- "Sepsis should be defined as a life-threatening organ dysfunction caused by dysregulated host response to infection."
- "Septic shock should be defined as a subset of sepsis in which particularly proud circulator, cellular, and metabolic abnormalities are associated with a greater risk of mortality than with sepsis alone."

The table below shows the new clinical criteria:

| Sepsis (ICD-10-CM code R65.20 | Septic Shock (ICD-10-CM code R65.21 |
|---|---|
| • Suspected or documented infection<br>• An acute increase of ≥ 2 SOFA points[1] | • Sepsis<br>• Vasopressor therapy needed to elevate MAP[2] ≥ 65 mm Hg<br>• Lactate > 2 mmol/L (18 mg/dL) despite adequate fluid resuscitation |

[1]SOFA — Sequential (Sepsis-related) Organ Failure Assessment
[2]MAP — mean arterial pressure

What does this change mean for the coding professional? Coders still need to be assigning codes based on physician documentation. What might change is the clinical validation portion of sepsis and septic shock by both CDI and coding professionals. Facilities may need to adopt (or revise existing) internal policies on how to consistently and compliantly code sepsis and septic shock based on these new definitions.

How is your facility dealing with this definition and clinical criteria change? Has this impacted your coding or CDI staff at all?

Read the article "The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)" published in *JAMA* here.

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