MISSOURI HOSPITAL ASSOCIATION

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Donna Pickett, RHIA
Co-Chair ICD-10 Coordination and Maintenance Committee
Centers for Disease Control and Prevention
National Centers for Health Statistics
Office of Planning and Extramural Programs
3311 Toledo Road
Hyattsville, MD 20782

Dear Ms. Pickett:

On behalf of its 141 member hospitals, the Missouri Hospital Association appreciates the opportunity to comment on the ICD-10-CM code change proposals presented at the September 10, Coordination and Maintenance Committee for fiscal year 2021 implementation. Recently, numerous Missouri hospitals have expressed concerns regarding payment denials and down coding practices from insurers who state claims do not meet the Sepsis-3 definition. MHA is concerned the changes to the IDC-10-CM related to sepsis will have unintended consequences that undermine the recognition of work that occurs to identify and treat patients with sepsis.

The Sepsis-3 criteria formulated by the Sepsis Definitions Task Force are not consistent with the Sepsis-2 criteria that otherwise have been universally adopted, most notably by the Centers for Medicare & Medicaid Services. In fact, several national organizations,[1] including CMS, reviewed the Sepsis-3 criteria and determined they have not gone through the real-world application testing needed to assess reliability, feasibility and usability. Additionally, Sepsis-3 was created as a mortality measure tool for use in the delivery of ICU care. According to an article in JAMA in 2016, Sepsis-3 was designed as a research definition to help classify patients for academic study in mortality prediction. Our member hospitals and the physicians they employ follow Sepsis-2 criteria as they are aligned with the CMS' core measure criteria, Surviving Sepsis Campaign initiative.

The use of sepsis definitions and criteria that do not align with accepted practice could lead to confusion, potential misdiagnoses and patient harm. The nationally recognized Sepsis-2 protocol is grounded in recognition of sepsis on systemic inflammatory response criteria, which empowers clinicians to engage a sepsis diagnosis earlier in the advancement of the disease. By prompting clinicians to initiate monitoring and treatment protocols, downstream challenges, such as organ failure, morbidity and mortality, can be avoided. The ICD-10-CM changes essentially would eliminate the Severe Sepsis diagnosis minimizing the accepted Sepsis-2 criteria. The Sepsis-3 criteria – although supporting the identification of patients with a likelihood for a poor outcome – fail to support the diagnostic work, collaboration and care that clinicians and providers employ for early identification and treatment of patients.

A group of Missouri physicians recently shared the following regarding the current use of the Sepsis-2 bundles and the challenges presented by adoption of the Sepsis-3 criteria.

1 American College of Emergency Physicians, Society for Academic Emergency Medicine, Infectious Disease Society of America

"The inherent goal [of using the Sepsis-2 definition] is to capture and prevent patient death in as broad a patient population as possible. A great deal of investment has been made by our system and others to respond appropriately to these guidelines. As a community, we are working diligently to achieve success. We are now being presented with new rules from private payers. They are using their influence to supplant the physician and define what Sepsis is, forcing the medical experts to think two different ways about the same patient. This presents several problems and provides a great disservice to patients with Sepsis."

Accurate measurement of outcomes is dependent upon reproducible documentation criteria and coding. The use of primary diagnosis codes for sepsis using ICD-10-CM classification and official CMS coding guidelines promotes standardization of information. Accurate documentation and care provided by physicians that is aimed at early recognition and treatment have resulted in improved outcomes for sepsis patients. The diagnosis codes used with Sepsis-3 criteria are not consistent with CMS requirements nor are they considered primary diagnosis codes. The introduction of another process to comply with billing and outcomes requirements would be acceptable if there was benefit to patient outcomes, and utilization of healthcare resources including the downstream impact of late diagnosis and delayed treatment. However, this is not the case. We believe that significant restricting of the diagnosis coding system would negatively impact the quality of data collection our members use to evaluate effective treatment modalities including antibiotic selection, timeliness of recognition and intervention and ultimately their ability to save lives where quality of life can still occur. The Sepsis-3 criteria may have a place in identifying those patients with the highest likelihood of poor outcomes; however, it has not been found to be reliable for diagnosis, coding, early detection of sepsis and improved patient outcomes.

Hospitals and clinicians seek and deserve as much certainty as possible when treating patients. This point is best articulated by the group of physicians referenced earlier. They stated that, "Providers are working every day to save the lives of sepsis patients only to be given an additional barrier that is not providing any benefit to the patients."

We must do all we can to eliminate barriers to the delivery of high quality patient care. Payment for quality care and outcomes is a cornerstone principle, which stands to benefit patients, providers and payers, and for which we strive to have common ground. We urge your organization to consider the value of using consistent and validated standards for identification and treatment of sepsis by aligning your policy with nationally recognized and tested criteria.

If you would like to discuss further, I may be reached at 573-893-3700, ext. 1304 or swillson@mhanet.com.

Sincerely,

Sarah Willson, BSN, MBA, FACHE
VP of Regulatory and Clinical Affairs

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