

SEPSIS

Date of origin: Sept. 2024

Review dates: None yet recorded

APPLIES TO

All products

DEFINITION

This policy provides billing and coding guidelines for sepsis-related services. Claims will be reviewed on a case-by-case basis, and documentation may be required to support the diagnosis billed.

The audit process is carried out using Sepsis-3 criteria.

- **Sepsis:** Life-threatening organ dysfunction caused by a dysregulated host response to infection
- **Septic shock:** Subset of sepsis in which underlying circulatory and cellular/metabolic abnormalities are profound enough to substantially increase mortality

POLICY SPECIFIC INFORMATION

Hospitalizations associated with acute care for sepsis require specific documentation for accurate and appropriate specificity in diagnosis coding. This allows us to validate whether a sepsis diagnosis is accurately aligned to DRG reimbursement.

- Most sepsis codes are listed A40-A41.9.
- If the specific organism causing sepsis is identified, the combination code for sepsis including that organism should be coded.
- When coding septic shock, the code for the underlying infection should be coded first, followed by the code for septic shock. The code for septic shock can't be the principal diagnosis.
- Sepsis and each organ dysfunction should be coded as separate diagnoses.

Claims with a sepsis diagnosis are subject to pre- and post-pay audit validation to ensure documentation supports correct coding on inpatient claims.

If a coding error is identified or the claim is selected for audit, documentation to validate the diagnosis and procedures billed on claim will be requested.

Following claim review, a detailed response will be provided via an audit determination letter. This letter will contain details for facilities to submit a dispute if there's a disagreement with the audit findings. Pay close attention to the letter as this details address / contact information for dispute submission.

Clinical validation review will be completed within 60 days of medical record receipt. Failure to submit medical records will result in denial.

Documentation requirements

Documentation requirements for inpatient services associated with sepsis must have specific detail for accurate reimbursement. We'll use standards set by The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) for both pre-pay logic and post-pay audits when sepsis is diagnosed, along with coding guidelines and the impact the diagnosis of sepsis has on the inpatient stay.

- Organ dysfunction supported by a sepsis diagnosis can be represented with an increase in the Sequential [Sepsis-related] Organ Failure Assessment (SOFA) score of two points or more.
- Documentation details treatment to address sepsis, which includes antibiotics, blood cultures and fluid management for maintaining mean arterial pressure.

Sepsis diagnosis coding guidelines can also be located in the [Apr. 1, 2024, ICD-10-CM Guidelines](#).

Documentation **must** include the following:

- Documented or suspected infection **AND**
- An acute increase of ≥ 2 SOFA points due to a dysregulated response to infection which is considered a proxy for organ dysfunction.

SOFA variables include: PaO₂.FiO₂ ratio; Glasgow Coma Scale score; Mean arterial pressure; Administration of vasopressors with type and dose rate of infusion; Serum creatinine or urine output; Bilirubin; Platelet count

If the base SOFA score isn't documented or provided, the medical records and SOFA tool will be used to impute a SOFA score prior to an acute infection being coded as sepsis.

Local infections aren't points for SOFA and won't count toward a systemic SOFA score for sepsis diagnosing.

We'll use SOFA for scoring and validation of sepsis diagnosis. SIRS, SEP-1 and SOFA aren't recognized for this validation.

SOFA scoring/assessment tools are available online or through vendors applications.

CHANGE / REVIEW HISTORY

Date	Revisions made