| Priority Health | BILLING POLICY<br>No. 031 |
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| **SEPSIS** | |
| **Date of origin: Sept. 2024** | **Review dates: 2/2025, 2/2026** |

## 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 in the range of 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 detail 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 details 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 of 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 validating sepsis diagnosis. SIRS, SEP-1, and SOFA aren't recognized for this validation.

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

## DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

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## CHANGE / REVIEW HISTORY

| Date | Revisions made |
|---|---|
| Feb. 13, 2025 | Added "Disclaimer" section |
| Feb. 23,2026 | Reviewed no changes |