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Area	Clinical Services - All
Lines Of Business	All Lines of Business

Sepsis

PURPOSE:

To provide further information on the clinical criteria used to identify patients with sepsis. This policy will also support compliance with the coding and billing of a claim submitted with the diagnosis of sepsis or an initial diagnosis at the time of admission, to ensure accurate reimbursement.

DEFINITIONS:

Sepsis is defined as life-threatening organ dysfunction caused by a dysregulated host response to infection. Septic shock is a subset of sepsis in which underlying circulatory and cellular/metabolic abnormalities are profound enough to substantially increase mortality.

OVERVIEW AND CRITERIA:

In 2016, The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) was developed. Sepsis-3 provides the most clinically relevant definitions of sepsis with a Sequential [Sepsis-related] Organ Failure Assessment (SOFA) score of 2 or more as an adjunct in the clinical diagnosis of sepsis (Table 1). The baseline Sequential [Sepsis- related] Organ Failure Assessment (SOFA) score should be assumed to be zero unless the patient is known to have preexisting (acute or chronic) organ dysfunction before the onset of infection. qSOFA, termed for quick SOFA incorporates altered mentation, systolic blood pressure of 100 mm Hg or less, and respiratory rate of 22/min or greater, provides simple bedside criteria to identify adult patients with suspected infection who are likely to have poor outcomes (Table 2).
qSOFA criteria should be used to prompt clinicians to further investigate for organ dysfunction, to initiate or escalate therapy as appropriate, and to consider referral to critical care.

Table 1. Sequential [Sepsis-Related] Organ Failure Assessment Score[a]

System	Score 0	1	2	3	4
Respiration					
Pao_2/Fio_2, mm Hg (kPa)	≥400 (53.3)	<400 (53.3)	<300 (40)	<200 (26.7) with respiratory support	<100 (13.3) with respiratory support
Coagulation					
Platelets, $\times 10^3/\mu L$	≥150	<150	<100	<50	<20
Liver					
Bilirubin, mg/dL (μmol/L)	<1.2 (20)	1.2-1.9 (20-32)	2.0-5.9 (33-101)	6.0-11.9 (102-204)	>12.0 (204)
Cardiovascular	MAP ≥70 mm Hg	MAP <70 mm Hg	Dopamine <5 or dobutamine (any dose)[b]	Dopamine 5.1-15 or epinephrine ≤0.1 or norepinephrine ≤0.1[b]	Dopamine >15 or epinephrine >0.1 or norepinephrine >0.1[b]
Central nervous system					
Glasgow Coma Scale score[c]	15	13-14	10-12	6-9	<6
Renal					
Creatinine, mg/dL (μmol/L)	<1.2 (110)	1.2-1.9 (110-170)	2.0-3.4 (171-299)	3.5-4.9 (300-440)	>5.0 (440)
Urine output, mL/d				<500	<200

Table 2. qSOFA (Quick SOFA) Criteria

Respiratory rate ≥ 22/min

Altered Mentation

Systolic blood pressure ≤ 100 mm Hg

PROCESS:

The Health Plan will apply these sepsis guidelines issued by the Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) as a screening tool for inpatient hospital admissions as well as Rehabilitation, Skilled Nursing Facility and Long-Term Acute Care services for validation that sepsis was present and sepsis treatment services were appropriately rendered. Documentation submitted must support the diagnosis of Sepsis. Failure to adhere to the correct coding and billing may impact claims processing and reimbursement.

POST- SERVICE REVIEWS:

The Health Plan conducts Diagnosis- Related Group (DRG) clinical validation reviews both pre-payment and post-payment to confirm DRG assignments and appropriate payment. This helps to ensure that claims represent the services provided to our members and billing and reimbursement is compliant with federal and state regulations as well as applicable standards, rules, laws, policy, and contract provisions. The Health Plan will apply the sepsis guidelines issued by The International Consensus Definitions for Sepsis and Septic Shock (Sepsis- 3) to reviews for clinical validation that sepsis was present and sepsis treatment services were appropriately rendered. Hospital claims with a sepsis DRG will be denied if the hospital admission did

not meet Sepsis-3 guidelines. The Health Plan will determine if sepsis and sepsis treatment services are unsupported based upon the Sepsis-3 definition and criteria. Appeals can still be submitted when there's a denial of sepsis on an inpatient hospital admission or hospital claim that has been submitted to The Health Plan.

Codes referenced in this sepsis policy are for information purposes only. Inclusion or exclusion of codes does not guarantee coverage.

Diagnosis Related Group (DRG) Codes	Descriptor
853	Infectious and parasitic diseases with O.R. procedures with MCC
854	Infectious and parasitic diseases with O.R. procedures with CC
855	Infectious and parasitic diseases with O.R. procedures without CC/MCC
870	Septicemia or severe sepsis with MV >96 hours
871	Septicemia or severe sepsis without MV >96 hours with MCC
872	Septicemia or severe sepsis without MV >96 hours without MCC

REFERENCES:

The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis- 3).JAMA. 2016; 315(8):801-810. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4968574/

Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual. Chapter 23- Fee Schedule Administration and Coding Requirements. Rev. 12823; Issued: September 5 ,2024. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf

All Revision Dates

6/8/2026, 3/31/2026, 2/2/2026, 12/2/2024

Attachments

- Inpatient Sepsis Denial Letter.pdf
- Sepsis Criteria Form.pdf