

Payment Policy

cmi_171676

Title	Inpatient Sepsis Coding		
Number	CP.PP.428.v1.0		
Last Approval Date	10/07/25	Original Effective Date	02/06/26
Replaces			
Cross Reference	<i>Hospital or Hospital System Readmissions</i>		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose/ Application	To define how the plan will reimburse all facility claims for adults billed with a sepsis related DRG.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products.
Definitions	MAP- Mean arterial pressure. Sepsis- life-threatening organ dysfunction caused by a dysregulated host response to Infection. Septic Shock- a subset of sepsis in which particularly profound circulatory, cellular, and metabolic abnormalities are associated with a greater risk of mortality than with sepsis alone. SIRS – Systemic Inflammatory Response Syndrome is an inflammatory response that can occur due to varying triggers such as but not limited to infection, trauma, or surgery. SIRS is not an adequate definition for coding of sepsis.
Policy	The Plan requires appropriate coding for Sepsis-related hospitalization to ensure accurate reimbursement. Related claims for adults ages 19 and older may be denied unless the following requirements are met: Documentation must include ONE of the following: ○ Infection with a bacterium, virus, fungus, protozoan, or helminth is suspected, and both of the following are documented: • A reasonable suspicion of infection is described and documented as suspected at the time of discharge. • A compatible clinical illness OR ○ Infection with a bacterium, virus, fungus, protozoan, or helminth is documented in the medical records to be clinically significant by one or more laboratory methods, and is not considered a contaminant: • Cultivation of bacteria and fungi on growth medium.

	• Detection of a specific immune response (antibody). • Detection of antigens (immunohistochemistry) or nucleic acid sequences. (in situ hybridization, or amplification by polymerase chain reaction). • Identification of the agent biochemically, antigenically, or genetically. • Isolation of viruses in cell culture. • Visualization of an organism in infected tissue. AND Organ dysfunction supporting sepsis diagnosis is documented by one of the following: ○ Septic shock identified by a vasopressor requirement to maintain a mean arterial pressure of 65 mm Hg or greater and serum lactate level greater than 2 mmol/L (greater than 18 mg/dL) in the absence of hypovolemia. OR ○ An increase in the Sequential [Sepsis-related] Organ Failure Assessment (SOFA) score of 2 points or more as reflected in the codes and coding guidelines section.																																																											
Codes and Coding Guidelines	Sequential [Sepsis-Related] Organ Failure Assessment Score^a (SOFA) Table: <table><tr><th rowspan="2">System</th><th colspan="4">Score</th><th></th></tr><tr><th>0</th><th>1</th><th>2</th><th>3</th><th>4</th></tr><tr><td colspan="5">Respiration</td><td></td></tr><tr><td>PaO₂/FIO₂, mm Hg (kPa)</td><td>≥400 (53.3)</td><td><400 (53.3)</td><td><300 (40)</td><td><200 (26.7) with respiratory support</td><td><100 (13.3) with respiratory support</td></tr><tr><td colspan="5">Coagulation</td><td></td></tr><tr><td>Platelets, ×10³/μL</td><td>≥150</td><td><150</td><td><100</td><td><50</td><td><20</td></tr><tr><td colspan="5">Liver</td><td></td></tr><tr><td>Bilirubin, mg/dL (μmol/L)</td><td><1.2 (20)</td><td>1.2–1.9 (20–32)</td><td>2.0–5.9 (33–101)</td><td>6.0–11.9 (102–204)</td><td>>12.0 (204)</td></tr><tr><td colspan="5">Cardiovascular</td><td></td></tr><tr><td>Hypotension</td><td>MAP ≥70 mm Hg</td><td>MAP <70 mm Hg</td><td>Dopamine <5 or dobutamine (any dose)^b</td><td>Dopamine 5.1–15 or epinephrine ≤0.1 or</td><td>Dopamine >15 or epinephrine >0.1 or norepinephrine >0.1^b</td></tr></table>	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, ×10 ³ /μL	≥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						Hypotension	MAP ≥70 mm Hg	MAP <70 mm Hg	Dopamine <5 or dobutamine (any dose) ^b	Dopamine 5.1–15 or epinephrine ≤0.1 or	Dopamine >15 or epinephrine >0.1 or norepinephrine >0.1 ^b
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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	
*Abbreviations: FIO₂, fraction of inspired oxygen; MAP, mean arterial pressure; PaO₂, partial pressure of oxygen. ^aAdapted from Vincent et al.²⁷ ^bCatecholamine doses are given as μg/kg/min for at least 1 hour. ^cGlasgow Coma Scale scores range from 3–15; higher score indicates better neurological function. • Providers are expected to adhere to current coding and documentation guidelines. • Claims must contain coding that accurately describes the services rendered. • Sepsis should not be coded when the condition is being ruled out or easily explained by another infection/diagnosis						
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be determined by the Plan.					
Exceptions	Inpatient facility claims that are reimbursed under a methodology other than DRGs					
	Exceptions to the policy may also be made where a provider contract dictates otherwise.					
Laws, Regulations & Standards						
References and Resources	• Medicare Claims Processing Manual, Chapter 23, Fee Schedule Administration and Coding Requirements, section 10.1 - General Rules for Diagnosis Coding and 10.2 – Inpatient Claim Diagnosis Reporting • Singer M, Deutschman CS, Seymour CW, et al. The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3). JAMA. 2016;315(8):801–810. doi:10.1001/jama.2016.0287 • Vincent JL, Moreno R, Takala J, et al. Working Group on Sepsis-Related Problems of the European Society of Intensive Care Medicine. The SOFA (Sepsis-related Organ Failure Assessment) score to describe organ dysfunction/failure. Intensive Care Med. 1996;22(7):707–710. doi: 10.1007/BF01709751.					

	• Walker DH. Principles of Diagnosis of Infectious Diseases. Pathobiology of Human Disease. 2014:222–5. doi: 10.1016/B978-0-12-386456-7.01713-5. Epub 2014 Aug 21. PMCID: PMC7149376. • Bone RC, Sibbald WJ, Sprung CL. The ACCP-SCCM Consensus Conference on Sepsis and Organ Failure, Chest, Volume 101, Issue 6, 1992, p. 1481-1483, ISSN 0012-3692, https://doi.org/10.1378/chest.101.6.1481. • Levy, Mitchell M. MD, FCCP; Fink, Mitchell P. MD, FCCP; Marshall, John C. MD; et al, For the International Sepsis Definitions Conference. 2001 SCCM/ESICM/ACCP/ATS/SIS International Sepsis Definitions Conference. Critical Care Medicine 31(4):p 1250-1256, April 2003. • Evans, Laura; Rhodes, Andrew; Alhazzani, Waleed; Antonelli, et al. Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock 2021. Critical Care Medicine 49(11):p e1063-e1143, November 2021.
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