Payment Policy: Sepsis Diagnosis

Reference Number: CC.PP.073
Product Types: ALL
Last Review Date: 06/2026

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
Acute care hospitalizations for sepsis require the most appropriate and most specific level of diagnosis coding. The medical record documentation supporting the diagnosis should be clearly documented by the physician or a licensed independent practitioner, and consistent with current guidelines.

The policy describes the process for pre- and post-pay review to validate correct coding on inpatient claims billed with a sepsis diagnosis but is not applicable to sepsis screening.

Application
Inpatient facility claims for members/enrollees of all products who are ≥ 18 years of age.

Documentation requirements
For purposes of reimbursement of inpatient claims for sepsis, documentation by a physician or licensed independent practitioner in the inpatient hospital medical records should reflect the following criteria:

I. In accordance with The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) health plans affiliated with Centene Corporation® may audit providers on a pre- or post-pay basis regarding diagnosis of sepsis, consistent with established coding guidelines, and its impact on the hospital stay:
   A. For clinical operationalization, sepsis is defined as life-threatening organ dysfunction caused by a dysregulated host response to infection. Organ dysfunction supporting a sepsis diagnosis can be represented by an increase in the Sequential [Sepsis-related] Organ Failure Assessment (SOFA)* score of two points or more from the member/enrollee's baseline;[1]
   B. Medical record documentation includes treatment to address the diagnosis of sepsis, including blood cultures, antibiotics and fluid management to maintain mean arterial pressure > 65 mmHg.[1,2,5]

**Note:*
- See Table 1 below for SOFA tool, or https://www.mdcalc.com/sequential-organ-failure-assessment-sofa-score.
- When baseline SOFA score is not provided, current medical records and the SOFA tool will be used to determine the imputed baseline SOFA score representing the member/enrollee's condition prior to the acute infection coded as sepsis.
- SOFA points due to local infection will not be counted toward the systemic SOFA score for sepsis diagnosis.

- Systemic inflammatory response syndrome (SIRS), the CMS Severe Sepsis and Septic Shock Management Bundle (SEP-1) and quick-SOFA (qSOFA) are not recognized as definitions of sepsis and will not be used to validate sepsis diagnosis.[1,9]

Table 1.[1] Sequential [Sepsis-Related] Organ Failure (SOFA) 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, $x10^3/\mu L$	≥150	<150	<100	<50	<20
Liver Bilirubin, mg/dL (umol/L)	<1.2 (<20)	1.2 to 1.9 (20 to 32)	2.0 to 5.9 (33 to 101)	6.0 to 11.9 (102 to 204)	>12.0 (>204)
Cardiovascular	MAP ≥70 mm Hg	MAP <70 mm Hg	Dopamine ≤5 or dobutamine (any dose)[b]	Dopamine 5.1 to 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 to 14	10 to 12	6 to 9	<6
Renal Creatinine, mg/dL (µmol/L)	<1.2 (<110)	1.2 to 1.9 (110 to 170)	2.0 to 3.4 (171 to 299)	3.5 to 4.9 (300 to 440)	≥5.0 (>440)
Urine output, mL/d				<500	<200

Abbreviations: FIO_2, fraction of inspired oxygen; MAP, mean arterial pressure; $Pa0_2$, partial pressure of oxygen.
[a]Adapted from Vincent et al.[27]
[b]Catecholamine doses are given as µg/kg/min for at least 1 hour.
[c]Glasgow Coma Scale scores range from 3 to 15; higher score indicates better neurological function.

Reimbursement Guidelines

- Claims with a sepsis diagnosis will be reviewed on either a pre- or post-pay basis.
- When a potential billing error is identified, the Health Plan will request medical records to validate the diagnosis and procedure codes billed on the claim.
- Once the medical record is received, certified professional coders and clinicians will clinically validate the documentation to ensure:

a. The medical record contains the necessary information;
b. The diagnosis billed on the claim is supported by the clinical information in the medical record, including medical interventions.

- After review of the medical record, the health plan will issue an audit determination letter to the provider if sepsis was diagnosed/billed in error. The letter will provide a thorough explanation of the determination as well as details for the provider to submit a dispute if they disagree with the determination.
- The clinical validation review will be completed within 60 days from receipt of medical records.
- Explanation codes will be sent to the provider on the Explanation of Payment (EOP) at the conclusion of the review.

Example explanation codes (not all-inclusive):

Explanation Code	Description
CPI01	Denied after review: Incomplete Medical Records Rcvd
CPI02	Medical Records not Received
CPI05	DENIED: Diagnosis not supported
CPI07	DENIED: Incorrect sequencing of diagnosis codes
CPI10	DENIED: Incorrect discharge status submitted
CPI11	DENIED: Incorrect DRG assignment
CPI12	DENIED: Incorrect principal diagnosis
CPI13	DENIED: Incorrect principal procedure
CPI14	DENIED: Missing medical records
CPI16	DENIED: Principal Diagnosis Inappropriately Coded
CPI17	DENIED: Procedure Inappropriately Coded
CPI18	DENIED: Secondary Diagnosis Inappropriately Coded
CPI22	DENIED: Documentation does not support services billed
CPI23	DENIED: Duplicate services billed
CPI27	DENIED: Incorrect billing of date of service
CPI28	DENIED: Incorrect records submitted for review
CPI29	DENIED: Information requested was not received from provider
CPI30	DENIED: Information requested not received from the patient
CPI36	DENIED: Unbundled procedure code
CPI42	DENIED: Incorrect place of service
CPI60	Incorrect provider address
iA	DENY: MEDICAL RECORDS NOT RECEIVED PER PREVIOUS REQUEST
iB	PAY: DRG PAYMENT INCREASE AFTER REVIEW OF MEDICAL RECORDS
iC	PAY: DRG PAYMENT ADJUSTMENT AFTER REVIEW OF MEDICAL RECORDS

Explanation Code	Description
iF	PAY: REINSTATE PAYMENT AFTER REVIEW OF MEDICAL RECORDS
Oi	PEND: MEDICAL RECORDS REQUIRED FOR DRG VALIDATION AUDIT;
Qd/qd	DENY: MEDICAL RECORDS REQUIRED FOR DRG VALIDATION AUDIT;
Qf	PAY: DRG PAYMENT AFTER REVIEW OF MEDICAL RECORDS;

Coding and Modifier Information

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CPT/HCPCS Code	Descriptor
N/A	N/A

APR-DRG	Descriptor
710	Infectious and parasitic diseases including HIV with O.R. procedure
720	Septicemia and disseminated infections

MS-DRG	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

ICD-10 Codes	Descriptor
A02.1	Salmonella sepsis
A20.7	Septicemic plague
A22.7	Anthrax sepsis
A26.7	Erysipelothrix sepsis

ICD-10 Codes	Descriptor
A32.7	Listerial sepsis
A39.1	Waterhouse-Friderichsen syndrome
A39.2	Acute meningococcemia
A39.3	Chronic meningococcemia
A39.4	Meningococcemia, unspecified
A39.89	Other meningococcal infections
A39.9	Meningococcal infection, unspecified
A40.0	Sepsis due to streptococcus, group A
A40.1	Sepsis due to streptococcus, group B
A40.3	Sepsis due to Streptococcus pneumoniae
A40.8	Other streptococcal sepsis
A40.9	Streptococcal sepsis, unspecified
A41.01	Sepsis due to Methicillin susceptible Staphylococcus aureus
A41.02	Sepsis due to Methicillin resistant Staphylococcus aureus
A41.1	Sepsis due to other specified staphylococcus
A41.2	Sepsis due to unspecified staphylococcus
A41.3	Sepsis due to Hemophilus influenzae
A41.4	Sepsis due to anaerobes
A41.50	Gram-negative sepsis, unspecified
A41.51	Sepsis due to Escherichia coli [E. coli]
A41.52	Sepsis due to Pseudomonas
A41.53	Sepsis due to Serratia
A41.54	Sepsis due to Acinetobacter baumannii
A41.59	Other Gram-negative sepsis
A41.81	Sepsis due to Enterococcus
A41.89	Other specified sepsis
A41.9	Sepsis, unspecified organism
A42.7	Actinomycotic sepsis
A54.86	Gonococcal sepsis
B00.7	Disseminated herpesviral disease
B37.7	Candidal sepsis
R57.1	Hypovolemic shock
R57.8	Other shock
R65.20	Severe sepsis without septic shock
R65.21	Severe sepsis with septic shock
R78.81	Bacteremia
T81.44XA	Sepsis following a procedure, initial encounter

Definitions

Sepsis

Life-threatening organ dysfunction caused by a dysregulated host response to infection. What differentiates sepsis from another type of infection is an abnormal or dysregulated host response and the presence of organ dysfunction. It is the primary cause of death from infection, especially

when it is not recognized and treated promptly.[2] Because sepsis presents similarly to many other conditions, it should be considered in any serious presenting infection.[3]

Diagnosis Related Groups (DRG)
Patient classification scheme that relates the type of patients a hospital treats (case mix) to the costs incurred by the hospital. The case mix consists of 1) severity of illness, 2) prognosis, 3) treatment difficulty, 4) need for intervention; and 5) resource intensity.

Inpatient Prospective Payment System
A method of reimbursement in which Medicare payments are based on a predetermined, fixed amount. The payment amount for a specific service is based on how that service is classified, for example, diagnosis related groups (DRG) for inpatient services.

Additional Information
In 2016 a task force of 19 leaders with expertise in sepsis pathobiology, clinical trials, and epidemiology was convened by the Society of Critical Care Medicine (SCCM) and the European Society of Intensive Care Medicine (ESICM) to develop the Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3).[2]

The recommendations of the Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) are as follows: For clinical operationalization, organ dysfunction can be represented by an increase in the Sequential [Sepsis-related] Organ Failure Assessment (SOFA) score of two points or more from baseline, which is associated with an in-hospital mortality greater than 10%. Septic shock should be defined as 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. Patients with septic shock can be clinically 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 (>18 mg/dL) in the absence of hypovolemia.[6] This combination is associated with hospital mortality rates greater than 40%.[1]

The group's recommendations have been endorsed by more than 30 medical societies from six continents, spanning disciplines from critical care and emergency medicine to infectious disease and family practice.[1,5]

Related Documents or Resources
NA

References
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Revision History	
03/01/2022	Policy developed and reviewed by specialist.
08/30/2022	Remove broken link.
03/31/2023	Annual review. Updated Table 1 to include; Bilirubin (umol/L) score 0 added "<" 20 and score 4 added ">" 204; Cardiovascular score 2 changed <5 to ≤5; Creatinine (umol/L) score 0 added "<" 110 and score 4 changed >5.0 to ≥5.0 and added ">" 440. Replaced (-) with "to." Replaced all instances of member with member/enrollee. References reviewed and updated.
10/23	Updated Table 1 formatting for clarity. Updated DRG descriptions. Added code T81.44XA to ICD-10 coding table. References reviewed and updated.
01/24	Added diagnosis code A41.54 to ICD-10 table.

Revision History	
06/13/2024	Conducted annual review, confirmed codes, updated policy
09/24	Annual review. References reviewed and updated. Reviewed by external specialist.
09/25	Annual Review. References reviewed and updated. Reviewed codes and descriptions.
11/25	Clarified in I.A. that the SOFA score is calculated "from the member/enrollee's baseline." Under "reimbursement guidelines," changed language from "registered nurses" reviewing to "clinicians." Minor rewording for clarity.
06/26	Annual Review. Updated documentation requirement under section I.B. changing MAP documentation from 70 to 65mmHg. Updated Coding and Modifier Information section. Reviewed codes and descriptions. Reviewed by external specialist.

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This payment policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

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