If a conflict arises between a Clinical Payment and Coding Policy ("CPCP") and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSIL may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSIL has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Sepsis Policy

Policy Number: CPCP041

Version 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: May 22, 2023

Plan Effective Date: May 22, 2023

Description

This policy is intended to provide coding and billing guidance for sepsis related services and treatment claims. Appropriate coding correctly describing the appropriate services rendered should be submitted. The information in this policy is not intended to be all inclusive.

Claims will be reviewed using documentation in the member's medical records and the most recent criteria identified for sepsis as outlined in this policy as a basis. Claims are reviewed on a case-by-case basis for evidence of infection, evidence of end-organ dysfunction triggered by a dysregulated host response to the infection, and a treatment course consistent with the type of infection present.

The plan reserves the right to request supporting documentation. Documentation submitted must support the diagnosis billed. Failure to adhere to coding and billing polices may impact claims processing and reimbursement.

The Plan uses the following definitions and terms in accordance with guidance from The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)[1] in conjunction with guidance from CMS ICD-10-CM Official Guidelines for Coding and Reporting, Section C Chapter- Specific Coding Guidelines, 1) Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99), U07.1, U09.9, (d) Sepsis, Severe Sepsis, and Septic Shock Infections resistant to antibiotics, 1) through 6)[2].

Definitions/Terms:

MAP- Mean arterial pressure

Sepsis- Life-threatening organ dysfunction caused by a dysregulated host response to infection. In lay terms, sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs.

Septic Shock- Subset of sepsis in which underlying circulatory and cellular/metabolic abnormalities are profound enough to substantially increase mortality.

SIRS- Systemic inflammatory response syndrome. SIRS may be appropriate for screening but not adequate for coding of sepsis.

Reimbursement Information:

Coding and Billing Information

Codes referenced in this policy are for informational purposes only. The inclusion or the exclusion of a code below does not guarantee reimbursement.

The following additions to the CMS ICD-10-CM Official Guidelines for Coding and Reporting were added by the Plan:

Additional Information	
Coding of sepsis and severe sepsis	1. Negative or inconclusive blood cultures and sepsis- The evidence of infection must be noted in the provider statement for conditions such as viremia or fungemia. 2. Sepsis or organ dysfunction- Organ dysfunction is a component of the sepsis definition. Organ dysfunction should not be coded separately from

	sepsis.
Coding of Septic shock	1. Septic shock generally refers to circulatory failure associated with severe sepsis, and therefore, it represents a type of organ dysfunction as evidenced by hypoperfusion and/or hypotension. 2. In cases of septic shock, the code for the systemic infection should be sequenced first, then followed by code R65.21 or code T81.12. Any other additional code(s) for the other acute organ dysfunctions should additionally be assigned. A code from subcategory R65.2 can never be assigned as a principal diagnosis.

MS-DRG Codes

The following diagnosis-related group (DRG) codes are subject to review by the plan. The diagnoses submitted (principal and secondary) affecting the DRG will be reviewed. This is not an all-inclusive list:

MS-DRG	Description
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
856	Postoperative or post-traumatic infections with O.R. procedures with MCC
857	Postoperative or post-traumatic infections with O.R. procedures with CC
858	Postoperative or post-traumatic infections 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

Additional Resources:

Clinical Payment and Coding Policy:

CPCP029 Medical Record Documentation

References:

[1]JAMA Network. Special Communication. Caring for the Critically Ill Patient. February 23, 2016. The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3). Accessed 3/6/23. https://jamanetwork.com/journals/jama/fullarticle/2492881

[2]CMS.gov. ICD-10-CM Official Guidelines for Coding and Reporting. Section C. Chapter-Specific Coding Guidelines, 1.d. Sepsis, Severe Sepsis, and Septic Shock Infections resistant to antibiotics 1) through 6). Accessed 3/6/23. https://www.cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelines-updated-01/11/2023.pdf

ICD-10 International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM for diagnoses

CMS ICD-10-CM/PCS MS-DRG v40.0 Definitions Manual. Accessed 4/21/202 https://www.cms.gov/icd10m/FY2023-version40-fullcode-cms/fullcode_cms/P0002.html

Policy Update History:

05/22/2023	New policy