Administrative Policy

Subject: Sepsis Clinical Validation Review

Effective Date: July 1, 2023

Wellpoint and our contracted vendor, Cotiviti, conduct DRG clinical validation reviews of sepsis claims utilizing Sepsis-3 criteria, in addition to coding and documentation guidelines.

The February 2016 Journal of the American Medical Association (JAMA) publication included a document titled "The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)" that defines sepsis as a life-threatening organ dysfunction caused by a dysregulated host response to infection. The *Surviving Sepsis 2016 Guidelines* recognize the Sepsis-3 definition of sepsis as the definitive definition of sepsis. The Sepsis-3 guidelines have been endorsed by major medical and critical care specialty societies in the United States and internationally (e.g., Society of Critical Care Medicine; European Society of Intensive Care Medicine).

Sepsis is not determined or defined solely on meeting a minimum of two of the four systemic inflammatory response syndrome (SIRS) criteria. Although SIRS criteria are useful in identifying or screening for infection, the criteria by themselves are considered overly sensitive and inadequately specific in verifying sepsis. In addition to meeting the SIRS criteria, the medical records should document the treatment and management of sepsis beyond the initial clinical pathway for sepsis, as outlined in the Surviving Sepsis Campaign. Many patients who qualify for early intervention will not ultimately be diagnosed with sepsis. Sepsis may be ruled out at discharge and noted that the patient was treated for a local infection instead. Utilizing the industry standard definitions found in Sepsis-3 will allow clear decision-making early in the hospital course about whether the patient meets the criteria for sepsis or septic shock or whether those diagnoses were ruled out. Standard coding practice, as found in the *ICD-10-CM Official Guidelines for Coding and Reporting*, does not allow for coding of conditions that have been ruled out at the time of discharge from an inpatient admission.

Sepsis arises when the body's response to any infection injures its own tissues and organs, and this injury is dysfunction/dysregulation. According to the WHO and Sepsis 3 definition of sepsis, dysfunction/ dysregulation is inherent, therefore sepsis cannot be coded in its absence. When sepsis is supported based on the Sepsis-3 definition, the diagnosis code A41.9 (sepsis, unspecified organism) is assigned. Sepsis can further be described as with or without septic shock by assigning secondary diagnosis code R65.20 (severe sepsis without septic shock) or R65.21 (severe sepsis with septic shock).

We support the use of Sepsis-3 criteria since the research-driven definitions for sepsis and septic shock in Sepsis-3 have endorsement from relevant medical entities. Sepsis-3 definitions should serve as the basis on which to assign a final diagnosis of sepsis or septic shock. Despite the fact that treatment protocols recommended by Surviving Sepsis and the CMS SEP-1 quality measure may result in some patients being initially treated as if they had sepsis (Sepsis Suspected), medical claims reimbursement should reflect the actual final diagnosis of the patient as reflected in the industry standard definitions found in Sepsis-3.