PAYMENT POLICY ID NUMBER 24-083

Original Effective Date: 10/17/2024

Revised: N/A

Sepsis Policy

THIS PAYMENT POLICY IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS PAYMENT POLICY APPLIES TO ALL LINES OF BUSINESS AND PROVIDERS OF SERVICE. IT DOES NOT ADDRESS ALL POTENTIAL ISUES RELATED TO PAYMENT FOR SERVICES PROVIDED TO FLORIDA BLUE MEMBERS AS LEGISLATIVE MANDATES, PROVIDER CONTRACT DOCUMENTS OF THE MEMBER'S BENEFIT COVERAGE MAY SUPERSEDE THIS POLICY. *THE EFFECTIVE DATE OF THIS POLICY DOES NOT CHANGE OUR STANDARD AUDITING CRITERIA THAT WAS EFFECTIVE JANUARY 01, 2019*.

DESCRIPTION:

The purpose of this payment policy is to communicate Florida Blue's policy regarding the payment of inpatient claims received with a diagnosis of Sepsis.

Sepsis is a life-threatening medical emergency caused by the body's extreme response to an infection. In 2016, a task force of specialists, convened by the Society of Critical Care Medicine (SCCM) and the European Society of Intensive Care Medicine (ESICM), proposed a new definition (Sepsis-3). The new definition no longer recognizes Systemic Inflammatory Response Syndrome (SIRS) criteria in identification of sepsis. The definition also consolidates the three sepsis categories into two categories. The new definitions were published as the Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) in the Journal of the American Medical Association (JAMA) in February 2016. The definitions have since been implemented in the latest version of the International Classification of Diseases (ICD), ICD-11, effective January 2022.

REIMBURSEMENT INFORMATION:

Florida Blue uses evidence-based clinical guidelines from nationally recognized professional organizations that are widely accepted and endorsed by the medical community.

To promote accurate billing and coding of sepsis, prevent claim processing delays, and maintain consistency, Florida Blue is formally documenting our longstanding review process for sepsis. Because Florida Blue uses evidence-based clinical guidelines from nationally recognized professional organizations, claims historically have been and will continue to be reviewed using the most recent evidence-based

definition of sepsis, which is currently the Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3). Sepsis-3 defines sepsis as follows:

- Sepsis is defined as life-threatening organ dysfunction caused by a dysregulated host response to infection. Organ dysfunction can be identified as an acute change in total Sequential [sepsis-related] Organ Failure Assessment (SOFA) score of greater than or equal to 2 points consequents to the infection.

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 a sepsis diagnosis.

Our certified coders, licensed clinicians and/or physicians follow Sepsis-3 criteria to clinically evaluate medical records. Diagnosis-related group (DRG) validation of clinical records allows Florida Blue to confirm that clinical evidence supports the codes in a submitted claim and reflects the clinical scenario for Sepsis 3. Florida Blue requires all claims for payment to include diagnoses that can be clinically validated. Sepsis-3 is one of those diagnoses. The medical record must support the conditions billed by the facility.

Inpatient claims with a diagnosis of sepsis can be reviewed using the Sepsis-3 definition to validate that sepsis was present and that sepsis-related services were appropriately submitted. At discharge, clinicians and facilities should apply the Sepsis-3 criteria to determine if their patient's clinical course supports the reporting and billing of sepsis. If the medical records show a lack of clinical evidence and/or criteria to support a sepsis diagnosis based on the Sepsis-3 criteria, claims may be subject to DRG adjustments.

BILLING/CODING INFORMATION:

Providers should reference the most up-to-date sources of coding guidance prior to the submission of claims for reimbursement. The coding of sepsis, when prevented, does not meet ICD-10-CM Official Guidelines for Coding and Reporting, General Coding Guidelines. Code any condition described at the time of discharge as "impending" or "threatened" as follows:

- If it did occur, code as confirmed diagnosis.
- If it did not occur, reference the Alphabetic Index to determine if the conditions have a subentry term for "impending" or "threatened."
- If the subterms are listed, assign the given code.
- If the subterms are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.

REFERENCES:

1. 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. 3. https://jamanetwork.com/journals/jama/fullarticle/2492881
2. ICD-10-CM Official Guidelines for Coding and Reporting https://www.cms.gov/files/document/fy-2024-icd-10-cm-coding-guidelines.pdf
3. CMS, Program Integrity Manual, Chapter 6, 6.5.3 DRG Validation Review https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c06.pdf

GUIDELINE UPDATE INFORMATION:

10/17/2024	Policy published.