Sepsis

Adjudication Guideline

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Approved by:	Responsible:	Related Adjudication Guidelines:
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1. Abstract

1.1 For Members

Sepsis is a life-threatening medical emergency caused by your body's overwhelming response to an infection. Without urgent treatment, it can lead to tissue damage, organ failure and death. Presenting symptoms may include fever or very low body temperature, chills, fast heart rate, rapid or trouble breathing, warm or sweaty skin, confusion, and severe pain. Bacterial infections are the most common cause of sepsis, but it can also be caused by other types of infections

Sepsis can occur in anyone with an infection, but is more common in older adults, infants, pregnant women, or people who are in the hospital or who have a weakened immune system, chronic medical condition, or severe injury or illness.

1.2 For Medical Professionals

Sepsis is defined as life-threatening organ dysfunction caused by a dysregulated host response to an infection.

2. Scope

This adjudication guideline highlights the recommended investigations, documentations required for Sepsis cases along with key reportable activities for the purpose of billing.

3. Adjudication Policy

3.1 Eligibility / Coverage Criteria

- **Early sepsis in Adult:** Infection and bacteremia may be early forms of infection that can progress to sepsis. However, there is no formal definition of early sepsis. Nonetheless, despite the lack of definition, monitoring those suspected of having sepsis is critical for its prevention.
- To bill for early sepsis, provider must document the following, for documentation please refer to section 3.6 below:
    - Suspected or present source of infection
    - The qSOFA score ≥2 see appendix 5.4.

- **Early sepsis in Children:** Clinicians often evaluate children with suspected infection and clinical findings of altered perfusion that are not severe enough to meet the 2024 International Consensus Criteria for sepsis or septic shock, define these children as having evolving sepsis or early sepsis.

  To bill for early sepsis, provider must document the following, for documentation please refer to section 3.6 below:

  - Suspected or present source of infection
  - Quick Pediatric Septic Shock Screening Score (qPS4) ≥2 see appendix 5.5

- **Severe Sepsis in adults:**

  To bill for early sepsis, provider must document the following, for documentation please refer to section 3.6 below:

  - Suspected or present source of infection
  - SOFA score ≥2 or
  - APACHE Score ≥ 20

- **Severe Sepsis in children:**

  To bill for early sepsis, provider must document the following, for documentation please refer to section 3.6 below:

  - Suspected or present source of infection
  - Phoenix score ≥2

Note: Meeting the SOFA score for adults and Phoenix score for pediatrics is mandatory to request sepsis DRGs and activities for sepsis (severe) cases, along with qSOFA for adults and qPS4 criteria for children in early(mild) sepsis cases. Please refer to the following table for details on scoring.

Sepsis, and Septic Shock Criteria
Source of Infection
Suspected or present source of infection
AND
Organ Dysfunction
Organ dysfunction is defined as a change of 2 or more points in the Sequential (or Sepsis-related) Organ Failure Assessment (SOFA) score (refer to Appendix 5.1)
Septic Shock Criteria
co-existence of: persistent hypotension requiring vasopressors to maintain mean arterial pressure ≥65 mmHg; and serum lactate >2 mmol/L (>18 mg/dL).

Pediatric Sepsis, and Septic Shock Criteria
A Phoenix Sepsis Score of 2 points or higher in children with suspected or confirmed infection potentially identifies sepsis with life-threatening organ dysfunction (please refer to appendix 5.3)
Septic Shock Criteria (Sepsis/Cardiovascular Dysfunction)
Septic shock can be identified by a cardiovascular score of at least 1 point in children with sepsis. (please refer to appendix 5.3)

3.2 Coding Controls

If a patient has sepsis and associated acute organ dysfunction or multiple organ dysfunction (MOD), follow the instructions for coding severe sepsis. The coding of severe sepsis requires a minimum of 2 codes: first a code for the underlying systemic infection, followed by a code from subcategory R65.2, Severe sepsis. If the causal organism is not documented, assign code A41.9, Sepsis, unspecified organism, for the infection.

Additional code(s) for the associated acute organ dysfunction is(are) also required. For cases of septic shock, the code for the systemic infection should be sequenced first, followed by code R65.21, Severe sepsis with septic shock or code T81.12, Postprocedural septic shock. Any additional code for the other acute organ dysfunctions should also be assigned.

3.3 Reportable Procedural Codes (Drug/CPT) Examples

- IV/Oral Antimicrobial Administration

In all cases intravenous antibiotics should be given for not less than 2 days and should continue for at least 24 hours after clinical recovery

- Critical Care Services (Examples):
    - ICU care: Codes for continuous monitoring and mechanical ventilation.
    - CPT 99291 (Critical care, first 30-74 minutes).
    - Ventilator CPTs

3.4 Non-Coverage

Non provision of documentation and incorrect application of billing and coding roles will be subject to audit/recovery and non-coverage. Clinician scopes of practice and appropriate billing by the clinicians must be performed and followed.

Non provision of Sofa score/APACHE/Phoenix scores may result in claim denials and recovery.

3.5 Payment and Coding Rules

Please apply regulator payment rules and regulations, as well as relevant coding manuals (ICD and CPT)

3.6 Documentation Requirements

Providers must ensure that the medical record includes investigations pertinent to the patient's condition, such as:

- Clinical Notes:
    - Detailed history and physical examination.
    - Confirmation of sepsis associated infection and organ dysfunction

- Laboratory and Imaging Results:
  - Quantitative CRP, Liver and Renal function testing, including Urea, Electrolytes and
  - Creatinine along with imaging reports supporting the diagnosis.
  - Blood cultures or other microbiological evidence.
  - Elevated lactate levels (>2 mmol/L), blood glucose measurements.
  - Abnormal organ function tests (e.g., creatinine, bilirubin).
  - Pulse oximetry
  - Clotting Screening (PT/APTT/INR)

- Treatment Plan must include:
  - Antibiotics, fluid resuscitation and vasopressors in case of septic shock, and other interventions.
  - Specific treatment/management for organ dysfunction
  - Details of I/V or Oral administered interventions such as broad-spectrum antibiotics, antifungals and/or antivirals utilized and oral/IV antibiotics for early-stage (mild) sepsis.
  - Patients stay: The minimum hospital length of stay is **3 days** for early (mild) sepsis and **5 days** for severe sepsis. Exceptions will apply to cases of LAMA (Leave Against Medical Advice) and deceased patients.
  - Any additional supportive treatment including Oxygen Vasopressors, Inotropes or corticosteroids

4. Denial Codes

Code	Code Description
CLAI-016	Incorrect billing regime

5. Appendices

5.1 Sofa Score

System	Score 0	1	2	3	4
Respiration PaO_2/FiO_2 mmHg (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 µmol/L (mg/dL)	<20 (1.2)	20-32 (1.2 - 1.9)	33-101 (2.0 - 5.9)	102-204 (6.0 - 11.9)	>204 (12.0)
Cardiovascular (catecholamine doses in µg/kg/min for at least 1 hour)	MAP ≥70 mmHg	MAP <70 mmHg	Dopamine <5 or dobutamine (any dose)	Dopamine 5.1-15 or adrenaline ≤0.1 or noradrenaline ≤0.1	Dopamine >15 or adrenaline >0.1 or noradrenaline >0.1
Central nervous system Glasgow Coma Scale score	15	13-14	10-12	6-9	<6
Renal Creatinine µmol/L (mg/dL)	<110 (1.2)	110-170 (1.2 - 1.9)	171-299 (2.0 - 3.4)	300-440 (3.5 - 4.9)	>440 (5.0)
Urine output (mL/day)				<500	<200

5.2 APACHE II Score

The APACHE II Score

Physiologic Variable	High Abnormal Range					Low Abnormal Range			
	+4	+3	+2	+1	0	+1	+2	+3	+4
Rectal Temp (°C)	≥41	39-40.9		38.5-38.9	36-38.4	34-35.9	32-33.9	30-31.9	≤29.9
Mean Arterial Pressure (mmHg)	≥160	130-159	110-129		70-109		50-69		≤49
Heart Rate	≥100	140-179	110-139		70-109		50-69	40-54	≤39
Respiratory Rate	≥50	35-49		25-34	12-24	10-11	6-9		≤5
Oxygenatation a)FIO_2≥0.5 record A-aDO_2 b)FIO_2<0.5 record PaO_2	≥500	350-499	200-349		<200 PO_2>70	PO_2 61-70		PO_2 55-60	PO_2<55
Arterial pH	≥7.7	7.6-7.69		7.5-7.59	7.33-7.49		7.25-7.32	7.15-7.24	<7.15
HCO_3 (mEq/l)	≥52	41-51.9		32-40.9	22-31.9		18-21.9	15-17.9	<15
K (mEq/l)	≥7	6-6.9		5.5-5.9	3.5-5.4	3-3.4	2.5-2.9		<2.5
Na (mEq/l)	≥100	160-179	155-159	150-154	130-149		120-129	111-119	≤110
S. Creat (mqm/dl)	≥3.5	2-3.4	1.5-1.9		0.6-1.4		<0.6		
Hematocrit (%)	≥60		50-59.9	46-49.9	30.45.9		20-29.9		<20
TLC (10^3/cc)	≥40		20-39.9	15-19.9	3-14.9		1-2.9		<1
GCS									

Age -score
<44 → 0
45-54 → 2
55-64 → 3
65-74 → 5
≥75 → 6

GCS:		
15 → 0	14 → 1	13 → 2
12 → 3	11 → 4	10 → 5
9 → 6	8 → 7	7 → 8
6 → 9	5 → 10	4 → 11
3 → 12		

JAMA 1993;270(24):2957-2963

5.3 Phoenix Score

Table. The Phoenix Sepsis Score[a]

Variables	0 Points	1 Point	2 Points	3 Points
Respiratory (0-3 points)				
	Pao_2:Fio_2 ≥400 or Spo_2:Fio_2 ≥292[b]	Pao_2:Fio_2 <400 on any respiratory support or Spo_2:Fio_2 <292 on any respiratory support[b,c]	Pao_2:Fio_2 100-200 and IMV or Spo_2:Fio_2 148-220 and IMV[b]	Pao_2:Fio_2<100 and IMV or Spo_2:Fio_2 <148 and IMV[b]
Cardiovascular (0-6 points)				
		1 Point each (up to 3) for:	**2 Points each (up to 6) for:**	
	No vasoactive medications[d]	1 Vasoactive medication[d]	≥2 Vasoactive medications[d]	
	Lactate <5 mmol/L[e]	Lactate 5-10.9 mmol/L[e]	Lactate ≥11 mmol/L[e]	
Mean arterial pressure by age, mm Hg[f,g]				
<1 mo	>30	17-30	<17	
1 to 11 mo	>38	25-38	<25	
1 to <2 y	>43	31-43	<31	
2 to <5 y	>44	32-44	<32	
5 to <12 y	>48	36-48	<36	
12 to 17 y	>51	38-51	<38	
Coagulation (0-2 points)[h]				
		1 Point each (maximum of 2 points) for:		
	Platelets ≥100 × 10^3/μL	Platelets <100 × 10^3/μL		
	International normalized ratio ≤1.3	International normalized ratio >1.3		
	D-dimer ≤2 mg/L FEU	D-dimer >2 mg/L FEU		
	Fibrinogen ≥100 mg/dL	Fibrinogen <100 mg/dL		
Neurological (0-2 points)[i]				
	Glasgow Coma Scale score >10; pupils reactive[j]	Glasgow Coma Scale score ≤10[j]	Fixed pupils bilaterally	
Phoenix sepsis criteria				
Sepsis	Suspected infection and Phoenix Sepsis Score ≥2 points			
Septic shock	Sepsis with ≥1 cardiovascular point(s)			

Abbreviations: FEU, fibrinogen equivalent units; IMV, invasive mechanical ventilation; INR, international normalized ratio of prothrombin time; MAP, mean arterial pressure; Pao_2:Fio_2, arterial partial pressure of oxygen to fraction of inspired oxygen ratio; Spo_2, oxygen saturation measured by pulse oximetry (only Spo_2 of ≤97%).

SI conversion factor: To convert lactate from mmol/L to mg/dL, divide by 0.111.

[a] The score may be calculated in the absence of some variables (eg, even if lactate level is not measured and vasoactive medications are not used, a cardiovascular score can still be ascertained using blood pressure). It is expected that laboratory tests and other measurements will be obtained at the discretion of the medical team based on clinical judgment. Unmeasured variables contribute no points to the score. Ages are not adjusted for prematurity, and the criteria do not apply to birth hospitalizations, neonates whose postconceptional age is younger than 37 weeks, or those 18 years of age or older.

[b] Spo_2:Fio_2 ratio is only calculated if Spo_2 is 97% or less.

[c] The respiratory dysfunction of 1 point can be assessed in any patient receiving oxygen, high-flow, noninvasive positive pressure, or IMV respiratory support, and includes a Pao_2:Fio_2 ratio of less than 200 and a Spo_2:Fio_2 ratio of less than 220 in children who are not receiving IMV. For children receiving IMV with a Pao_2:Fio_2 less than 200 and Spo_2:Fio_2 less than 220, see criteria for 2 and 3 points.

[d] Vasoactive medications include any dose of epinephrine, norepinephrine, dopamine, dobutamine, milrinone, and/or vasopressin (for shock).

[e] Lactate reference range is 0.5 to 2.2 mmol/L. Lactate can be arterial or venous.

[f] Age is not adjusted for prematurity, and the criteria do not apply to birth hospitalizations, children whose postconceptional age is younger than 37 weeks, or those 18 years or older.

[g] Use measured MAP preferentially (invasive arterial if available or noninvasive oscillometric), and if measured MAP is not available, a calculated MAP (1/3 × systolic + 2/3 × diastolic) may be used as an alternative.

[h] Coagulation variable reference ranges: platelets, 150 to 450 × 10^3/μL; D-dimer, <0.5 mg/L FEU; fibrinogen, 180 to 410 mg/dL. The INR reference range is based on the local reference prothrombin time.

[i] The neurological dysfunction subscore was pragmatically validated in both sedated and nonsedated patients, and those receiving or not receiving IMV support.

[j] The Glasgow Coma Scale score measures level of consciousness based on verbal, eye, and motor response (range, 3-15, with a higher score indicating better neurological function).

5.4 Early Sepsis in adults: qSOFA Criteria:

qSOFA = Quick Sequential Organ Failure Assessment	
AMS	GCS < 15
RR	> 22 bpm
SBP	< 100 mmHg

5.5 Early Sepsis in children: Quick Pediatric Septic Shock Screening Score (qPS4)

Criteria*	Score=0	Score=1
Altered mentation	Alert or GCS=15	Not alert or GCS<15
Respiratory rate		
1-11 mo	≤55	>55
1-2 y	≤47	>47
3-5 y	≤33	>33
6-11 y	≤25	>25
12-17 y	≤21	>21
TAMSI		
1-12 mo	≤2.64	>2.64
1-2 y	≤2.29	>2.29
3-5 y	≤1.96	>1.96
6-11 y	≤1.68	>1.68
12-17 y	≤1.54	>1.54
Capillary refill time	<3 s	≥3s

*This was adapted from the LqSOFA with empirically derived respiratory rate cutoffs and replacement of age-based tachycardia with TAMSI. The "worst" value during observation is used to compute the score.

5.6 References

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5.7 Revision History

Date	Change(s)
22.08.2025	V1.0 Creation of Adjudication Guideline-External Instruction Template.