Federation of American Hospitals

Charlene K. MacDonald
President and CEO

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VIA ELECTRONIC MAIL
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Mary H. Stanfill, DHI, MBI, ACHIP, RHIS, CCS, CCS-P
Senior Informaticist for Morbidity Classifications
Centers for Disease Control and Prevention
National Center for Health Statistics

Re: Proposed ICD-10-CM Sepsis Coding Revisions (March 17–18, 2026 C&M Meeting)

Dear Ms. Stanfill:

The Federation of American Hospitals (FAH) appreciates the opportunity to provide our comments on the proposed revisions to ICD-10-CM sepsis coding presented at the March 17–18, 2026 ICD-10 Coordination and Maintenance Committee meeting. FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC, and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

We acknowledge and appreciate the important role the ICD-10-CM Coordination and Maintenance Committee plays in keeping coding systems accurate, relevant and operational. However, we have significant concerns that the sepsis proposal put forward in the March meeting, as currently structured, introduces conceptual, clinical, and operational inconsistencies with the foundational principles of ICD-10-CM. We ask that the committee reject the proposal of a single universally applied clinical standard, and offer the following alternative approach:

- Reconvene a multi-stakeholder workgroup to collaborate with NCHS in developing classification updates that align with, rather than precede or influence, clinical documentation and/or practice of medicine; and
- Assess and address unintended impacts of such a proposal to quality reporting and other longitudinal data.

As drafted, the proposal appears to shift ICD-10-CM from a classification system that reflects provider-documented diagnoses to one that implicitly defines diagnoses through clinical criteria, scoring systems, and diagnostic aids. This shift is not only inconsistent with long-standing coding policy, but more importantly it risks introducing variability, confusion, and unintended downstream impacts across coding, compliance, and quality reporting functions. These considerations and concerns are further outlined in our detailed comments below.

Creates Conflict with Established ICD-10-CM Coding Guidance
The proposal conflicts directly with Official Coding Guideline I.A.19, which clearly establishes that the provider is responsible for establishing the diagnosis. By conditioning code assignment on criteria such as SOFA scores or diagnostic aids, the proposal effectively shifts diagnostic authority away from the provider.

This creates ambiguity as to whether coding should follow provider documentation or externally derived criteria. Such ambiguity undermines the integrity and consistency of coded data and introduces risk for inconsistent application across organizations.

Clinical Judgment, Not Scoring Thresholds, Should Guide Sepsis Diagnosis and Intervention
SOFA, pSOFA, and qSOFA were developed as tools for assessing severity and risk, not as diagnostic definitions. Their incorporation into ICD-10-CM risks misapplication of these tools beyond their intended purpose.

Clinical practice relies on physician judgment, supported by a combination of clinical indicators, laboratory data, and patient presentation. The proposed structure risks delaying diagnosis or creating false thresholds where clinical intervention should be guided by judgment rather than scoring systems. Many of the diagnostic values needed for SOFA scoring are not immediately in the ED and/or early inpatient admission.

The Proposal Introduces Non-Standard Diagnostic Constructs into ICD-10-CM
The introduction of "impending sepsis" represents a significant departure from established diagnostic and coding constructs. There is currently no broadly accepted clinical definition of this term, nor endorsement from major clinical organizations. As such, its inclusion risks creating a diagnosis category that lacks clinical standardization and interpretive consistency.

The proposal does not provide sufficient guidance on how "impending sepsis" should be distinguished from suspected sepsis, which is already addressed under existing inpatient coding guidelines. This creates ambiguity in documentation and code assignment, particularly in cases where clinical assessment is evolving.

Further concerns include lack of clarity regarding pathophysiology (e.g., whether cytokine response or early systemic inflammation is included), the appropriateness of organism-specific "impending" status, and how to handle cases where both sepsis and impending sepsis are documented within the same encounter.

The proposed code for "infection with positive sepsis diagnostic aid" further complicates classification by introducing a diagnostic hybrid concept. Diagnostic aids—including laboratory tests, algorithms, or AI tools—support clinical decision-making but do not constitute diagnoses. Embedding such constructs in ICD-10-CM risks conflating clinical processes with diagnostic outcomes.

Impact on Quality Measurement
The proposed changes may impair the ability to accurately capture severe sepsis, which is integral to CMS quality measures. Disruption to existing coding constructs may affect longitudinal data tracking, benchmarking, and performance reporting. This is not only important for coding consistency, but also because inaccurate or inconsistent capture of severe sepsis could undermine the reliability of publicly reported quality metrics, hospital benchmarking, and future payment or accountability programs that rely on these data.

Operational and Compliance Impact
Operationally, the proposal would significantly increase the need for provider queries related to diagnostic clarification, linkage, and clinical validation. This introduces administrative burden, delays in coding, and potential compliance risk due to inconsistent interpretation. The proposal would also require substantial education and retraining for clinicians, coding professionals, clinical documentation integrity teams, and compliance staff to operationalize concepts that currently lack standardized clinical and coding definitions.

Organ Dysfunction Linkage and Classification
Finally, the proposal introduces additional granularity for organ dysfunction but does not clearly define documentation expectations for linkage between sepsis and each dysfunction. This lack of clarity is likely to increase query volume and create inconsistency in coding practices. Additionally, removal or restructuring of established terminology such as "severe sepsis" reduces alignment with current clinical documentation and may impair accurate clinical representation.

We urge the committee to reject the proposal and partner with stakeholders on a path forward. It is imperative that we preserve the provider's diagnostic authority and align with established and universally accepted clinical definitions as changes are considered. Please do not hesitate to reach out to Alyssa Keefe at akeefe@fah.org with questions.

Sincerely,
/s/
Charlene MacDonald
President and CEO