

Documentation and Coding: Sepsis

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At Healthfirst, we are committed to helping providers accurately document and code their patients' health records. Proper ICD-10 coding can provide a comprehensive view of a patient's overall health. This tip sheet is intended to assist providers and coding staff with the documentation and ICD-10-CM selection on services submitted to Healthfirst. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Coverage decisions are based on the terms of the applicable evidence of coverage and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.

This tip sheet will offer guidance on how to submit a diagnosis code with greater specificity for coding **sepsis**.

Sepsis – Chapter-specific guidelines state, "If the type of infection or causal organism is not further specified, assign code A41.9, Sepsis, unspecified organism." **When this diagnosis is reported, the patient's blood culture was negative for any causative organism.**

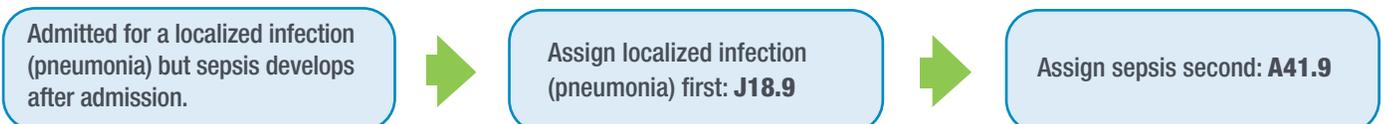
ICD-10-CM	Description
A41.9	Sepsis, unspecified organism; Septicemia NOS

Please note: Not all ICD-10-CM codes are listed

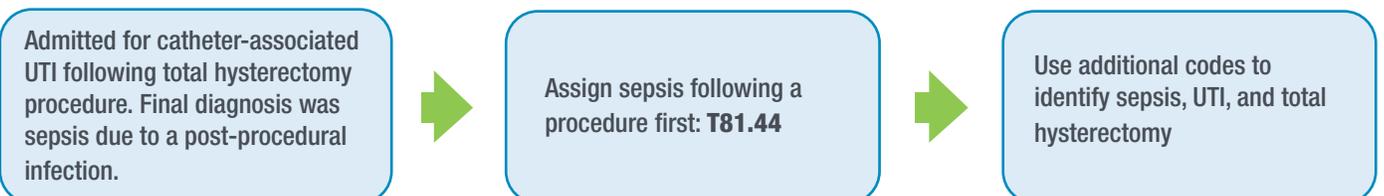
Sepsis due to localized infection



Localized infection progresses to sepsis

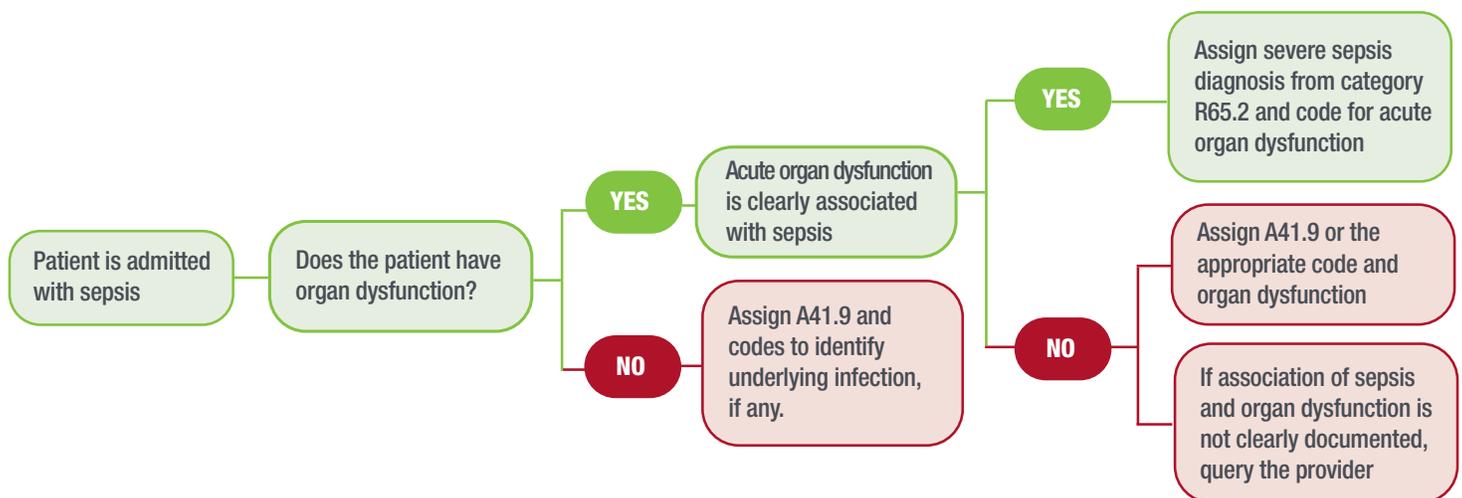
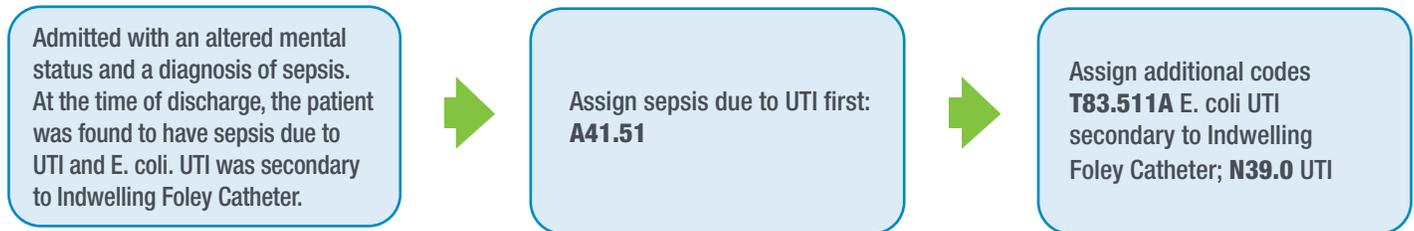


Sepsis due to post-procedural infection



Documentation and Coding: Sepsis

Sepsis due to device, implant, and graft



What documentation is needed to report sepsis?

- Documented diagnosis of sepsis
- Severity of illness and improvement/worsening of patient status
- Criteria met to arrive at the diagnosis and infection type
- Specification of causative organism, if known (e.g., sepsis due to pneumonia, implant, graft, etc.)
- Sequential Organ Failure Assessment (SOFA) or quick SOFA (QSOFA) score
- Clinical findings (e.g., high fever, tachycardia, hypotension, elevated white count, altered mental status, etc.)
- Past medical history or active history of any comorbidities
- Presence of risk factors and/or complications such as organ failure or dysfunction
- Treatment plan, orders, prescriptions, and referrals (include how the condition is being monitored, evaluated, and/or treated)
- Clear documentation regarding whether the condition was present on admission (POA)

Documentation Tips

- Diagnosis of sepsis cannot be made based solely on labs or bloodwork findings.
- It is best practice for the documentation of sepsis to be specific, consistent, and clear.
- Only “severe sepsis due to infection” or “sepsis with acute organ dysfunction” are represented by codes for sepsis with the **R65.2** subcategory.
- The “with” guideline in the Official Coding Guidelines (Section 1.A.15) does not apply to sepsis and organ failure dysfunction; the physician must make the link.
- The physician must document the systemic infection. If it is not clear that sepsis or severe sepsis was or was not present on admission, query the physician for clarification.
- **SIRS (does not equate to sepsis)**
 - Do not assume a link when the documentation states SIRS and an infection is present. Query the etiology of the SIRS; if no other information is available, report a code from subcategory **R65.1**.
 - If SIRS is secondary to a localized infection such as pneumonia without organ dysfunction, code only the localized infection, since there is no separate code for SIRS due to an infectious process in ICD-10-CM.
- **Terms that are not sufficient to code sepsis**
 - “Septicemia” – There is no ICD-10-CM code for this term.
 - “History of sepsis” – This indicates the condition is already resolved.
 - “Urosepsis” – This is a nonspecific term and should not be considered synonymous with sepsis.
 - “Septic/Toxic” – These are adjectives and not diagnoses; use full terms such as “septic shock” instead.

Questions?

Contact us at [#Risk_Adjustments_and_clinical_Documentation@healthfirst.org](mailto:Risk_Adjustments_and_clinical_Documentation@healthfirst.org).

For additional documentation and coding guidance, please visit the Coding section at hfproviders.org.

References: AHIMA.org; [ICD-10-CM Official Guidelines for Coding and Reporting FY 2021](#); [Mayo Clinic Q and A: Understanding sepsis and septic shock](#)