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Health Insurance for New Yorkers

Documentation and Coding: **Severe 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 **Severe sepsis**.

Two codes, at a minimum, are needed to report **severe sepsis without septic shock**. Chapter-specific guidelines state, "First code for the underlying systemic infection, followed by a code R65.20, 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 are also required."

ICD-10-CM	Description
R65.20	Severe sepsis without septic shock (this code can never be assigned as primary diagnosis)

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

Coding Example:

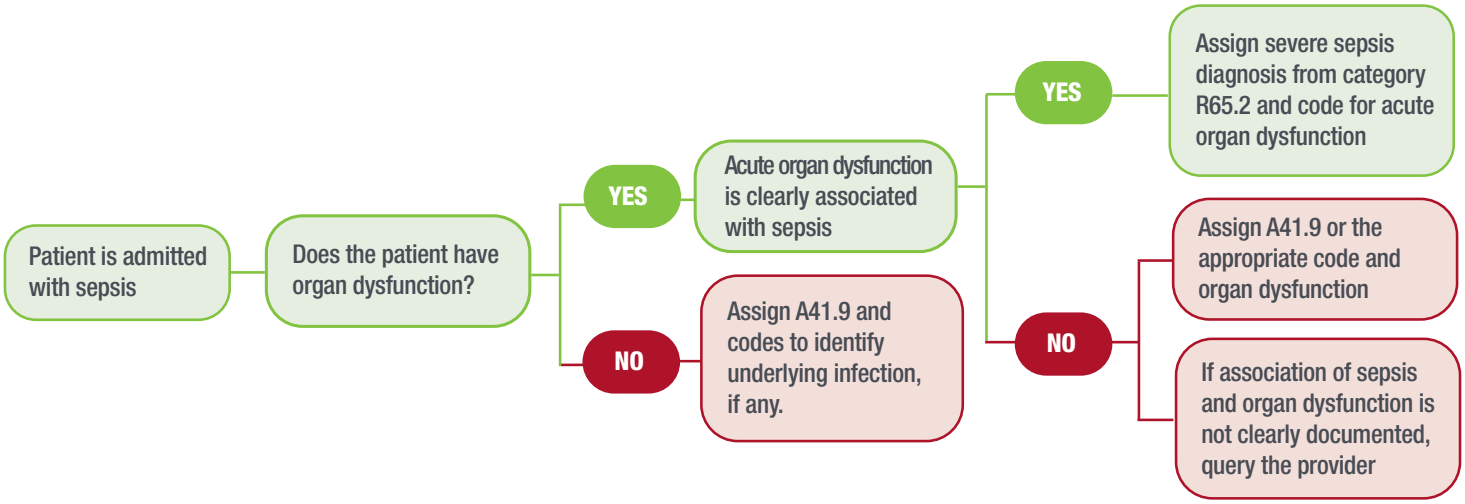
Patient presents with altered mental status, high fever, tachycardia, and hypotension. Labs indicated WCB of 26,000 and chest X-ray showed pneumonia. On the discharge summary, patient had sepsis due to pneumonia, pneumonia, encephalopathy due to sepsis and pneumonia, and fever due to sepsis.

The reported diagnoses are sequenced as follows:

1st Code	**A40.3** - Sepsis due to pneumonia
2nd Code	**J18.9** - Pneumonia
3rd Code	**G93.41** (listed as one of the organ dysfunctions in the instructional notes within ICD-10-CM at R65) - Encephalopathy (metabolic) (septic)
4th Code	**R65.20** - Severe sepsis **without** septic shock

Documentation and Coding:

Severe Sepsis



What documentation is needed to report severe sepsis?

- Documented diagnosis of severe sepsis
- Severity of illness and improvement/worsening of patient status
- 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 any comorbidities
- Presence of risk factors and/or complications such as organ failure or dysfunction
- Treatment plan, orders, and referrals
- Specification if organ dysfunction is linkage

Documentation Tips

- Diagnosis of severe sepsis cannot be made based solely on labs or bloodwork findings.
- It is best practice for the documentation of severe sepsis to be specific 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.

Documentation Tips (continued)

- **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.
- **Sequencing of severe sepsis**
  - If severe sepsis is present on admission, and it meets the definition of principal diagnosis, the underlying systemic infection should be assigned as principal diagnosis; the underlying systemic condition should be documented and coded as principal diagnosis followed by the appropriate code from subcategory **R65.2**, as required by the sequencing rules as a principal diagnosis on the facility setting.
  - When severe sepsis is present during an encounter (not present on admission), the underlying systemic infection and the appropriate code from subcategory **R65.2** should be assigned as secondary diagnoses.
  - While severe sepsis may be present on admission, the diagnosis may not be confirmed until a later time after admission. If the documentation is not clear whether severe sepsis was present on admission, the provider must be queried.

Questions?

Contact us at **#Risk_Adjustments_and_clinical_Documentation@healthfirst.org**.

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

References: **EncoderPro.com**; **AHIMA.org**; **ICD-10-CM Official Guidelines for Coding and Reporting FY 2021**; **Mayo Clinic Q and A: Understanding sepsis and septic shock**