

Documentation and Coding: Septic Shock

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At Healthfirst, we are committed to helping providers accurately document and code their patients' health records. This tip sheet is intended to assist providers and coding staff with the documentation and ICD-10-CM selection on services submitted to Healthfirst specifically for septic shock. 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.

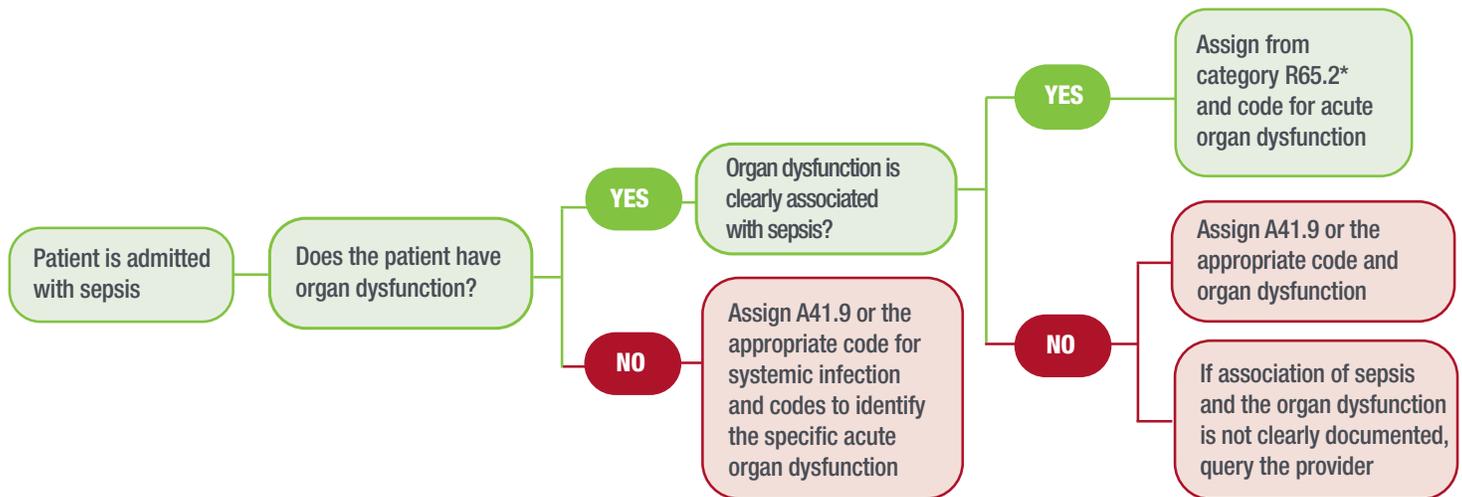
This tip sheet will offer guidance on how to submit diagnosis code with greater specificity for coding **septic shock**.

Septic Shock

Septic shock generally refers to circulatory failure associated with severe sepsis and therefore represents a type of acute organ dysfunction. For cases of septic shock, a minimum of two codes is needed to report **severe sepsis with septic shock**. Chapter-specific guidelines state, "First code for the underlying systemic infection, followed by R65.21, septic shock. 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
R65.21	Severe sepsis with septic shock (This code can never be assigned as primary diagnosis)

Documentation and Coding: Septic Shock



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

The following terms are not enough to code sepsis:

- **Septicemia** - No ICD-10-CM code for this term
- **History of sepsis** - This indicates the condition already is resolved
- **Urosepsis** - This is a non-specific term and should not be considered synonymous with sepsis
- **"Septic/Toxic"** - These are adjectives, not diagnoses; instead, use full terms such as septic shock

Sepsis, Severe Sepsis, and Septic Shock due to a postprocedural infection

- **Sepsis due to a postprocedural infection** - For infections following a procedure, code from T81.40 to T81.43 (Infection following a procedure). A code from O86.00 to O86.03 (Infection of obstetric surgical wound) that identifies the site of the infection should be coded first, if known. Assign an additional code for sepsis following a procedure (T81.44) or sepsis following an obstetrical procedure (O86.04). Use an additional code to identify the infectious agent. If the patient has severe sepsis, the appropriate code from subcategory R65.2 should also be assigned with the additional code(s) for any acute organ dysfunction.
 - For infections following infusion, transfusion, therapeutic injection, or immunization, a code from subcategory T80.2 (Infections following infusion, transfusion, and therapeutic injection), or code T88.0 (Infection following immunization), should be coded first, followed by the code for the specific infection. If the patient has severe sepsis, the appropriate code from subcategory R65.2 should also be assigned, with the additional codes(s) for any acute organ dysfunction.
- **Postprocedural infection and postprocedural septic shock** - If a postprocedural infection has resulted in septic shock, assign the codes indicated above for sepsis due to a postprocedural infection, followed by code T81.12 (Postprocedural septic shock). Do not assign code for the R65.21 (Severe sepsis with septic shock). Additional code(s) should also be assigned for any acute organ dysfunction.

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What documentation is needed to report septic shock?

- Documented diagnosis of septic shock
- Severity of illness and improvement/worsening of patient status
- Specification of causative organism if known (i.e., sepsis due to pneumonia, implant, graft, etc.)
- Sequential Organ Failure Assessment (SOFA) or quick SOFA (QSOFA) score
- Clinical findings (i.e., high fever, tachycardia, hypotension, elevated white count, altered mental status)
- Past medical history or history of any comorbidities
- Presence of risk factors and/or complications such as organ failure or dysfunction
- Treatment plan, orders, prescriptions, and referrals

Documentation Tips

- Diagnosis of sepsis cannot be made based solely on labs or blood work 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/severe sepsis was or was not present on admission, query the physician for clarification.
- **Systemic inflammatory response syndrome (SIRS) (Does not equate to sepsis)**
 - If SIRS and an infection is present, do not assume a link. 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, as there is no separate code in ICD-10-CM for SIRS due to an infectious process.

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