Sepsis

Sepsis is a life-threatening condition. It is the reaction to an infection in which the body attacks its own organs and tissues: it is time-critical, requiring immediate treatment. Sepsis is not an infection itself. **When documented in the medical record it must always be recorded with a code specifically stating ‘sepsis’**. Both the associated clinical terminology and the available ICD-10 index trails and codes are complicated. This guidance is intended to clarify problems associated with coding sepsis in SMR records.

The Main Condition definition must be followed. Sepsis will often be the Main Condition, but if it is not, it must be regarded as an ‘active comorbidity’ in terms of the comorbidities guidance (see ICD-10 Consolidation June 2017 ‘Other conditions coding on SMR01’) and must be fully and specifically recorded before any ‘background comorbidities’ are recorded.

The code **A41.9 Sepsis, unspecified** is used in many of the examples below. If the organism causing the sepsis is known, a more specific code from A40.- or A41.- must be recorded instead of A41.9 (see also F below).

A) The terms **sepsis, severe sepsis** (coded to **R65.1 Systemic inflammatory response syndrome of infectious origin with organ failure**) and **septic shock** (**R57.2 Septic shock**) must always be coded if stated by the clinician. However, if the patient is described as having both severe sepsis and septic shock, only the septic shock need be recorded:

- Sepsis NOS = A41.9
- Severe sepsis NOS = A41.9 followed by R65.1
- Septic shock NOS = A41.9 followed by R57.2
- Severe sepsis and septic shock NOS = A41.9 followed by R57.2

B) When stated by the clinician, organ failure in sepsis must be recorded.

‘Multi-organ failure’ NOS is coded **R68.8 Other specified general symptoms and signs**.

- Sepsis with multiple organ failure NOS = A41.9 followed by R68.8
- Sepsis with septic shock and multiple organ failure NOS = A41.9 followed by R57.2 and R68.8
Example:
*Streptococcus B meningitis with sepsis and multi-organ failure*

**G00.2 Streptococcal meningitis**

**A40.1 Sepsis due to Streptococcus, group B**

**R68.8 Other specified general symptoms and signs**

If the specific organs in failure are known, the specific failure codes should be recorded:

Example:
*Urinary sepsis due to streptococcus group A, with septic shock and kidney and liver failure:*

**A40.0 Sepsis due to Streptococcus, group A**

**N39.0 Urinary tract infection, site not specified**

**R57.2 Septic shock**

**N19.X Unspecified kidney failure**

**K72.9 Hepatic failure, unspecified**

There is no need to add B95.0 to the infection code in this example, as the infecting organism is specified by the sepsis code.

C) Some index trails from the lead term ‘Sepsis’ lead to codes which are not specific to sepsis. For example:

**Sepsis**

– urinary.............................................. leads to **N39.0 Urinary tract infection, site not specified**

... 

– due to device, implant or graft

- - catheter

- - urinary (indwelling).......... leads to **T83.5 Infection and inflammatory reaction due to prosthetic device, implant and graft in urinary system**

In such cases a specific sepsis code must be assigned in addition to the code from the index trail. Examples:

*Urinary sepsis due to streptococcus group A infection:*

**A40.0 Sepsis due to Streptococcus, group A**

**N39.0 Urinary tract infection, site not specified**
Coagulase-negative staphylococcal sepsis due to central line infection:

**A41.1 Sepsis due to other specified *Staphylococcus***

**T82.7 Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts**

**Y84.8 Other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure**

There is no need to add a code from B95 to the infection code in these examples, as the infecting organism is specified by the sepsis code.

D) Local infections leading to sepsis must be coded as well as the sepsis. For example:

- **Biliary sepsis NOS**  
  A41.9 followed by K83.9 *Disease of biliary tract, unspecified*

- **Biliary sepsis with cholangitis**  
  A41.9 followed by K83.0 *Cholangitis*

- **Biliary sepsis with cholecystitis**  
  A41.9 followed by K81.- *Cholecystitis*

- **Biliary sepsis with gallstones**  
  A41.9 followed by K80.- *Cholelithiasis*

- **Chest sepsis NOS**  
  A41.9 followed by J22.X *Unspecified acute lower respiratory infection*

- **Urosepsis/urinary sepsis NOS**  
  A41.9 followed by N39.0 *Urinary tract infection, site not specified*

**E. coli sepsis due to post-operative *E.coli* infection of surgical wound following anterior cruciate ligament reconstruction:**

**A41.5 Sepsis due to other Gram-negative organisms**

**T81.4 Infection following a procedure, not elsewhere classified**

**Y83.4 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, other reconstructive surgery**

**B96.2 *Escherichia coli* ([E. coli]) as the cause of diseases classified to other chapters**

In this case B96.2 is recorded because it adds specificity for *E.coli* (a Gram-negative organism), whereas A41.5 does not.

**Septic shock and necrotising fasciitis of leg arising from *Vibrio vulnificus* infection of minor wound. Patient under care of orthopaedic surgeons for repeated debridement of leg lesions:**

**M72.66 Necrotizing fasciitis - lower leg**

**A41.8 Other specified sepsis**

**R57.2 Septic shock**

**T79.3 Post-traumatic wound infection, NEC**
X59.9 Exposure to unspecified factor, unspecified place

B98.1 *Vibrio vulnificus* as the cause of diseases classified to other chapters

In this case the main condition is necrotising fasciitis, but the sepsis must still be coded fully. B98.1 is recorded because it adds specificity for *V. vulnificus*, whereas A41.8 does not.

E) *Neutropenic sepsis NOS is coded*

A41.9 Sepsis unspecified
D70.X Agranulocytosis

If it is known that the neutropenia was due to a drug, an adverse effects code from Chapter XX must be assigned after D70.X. If the neutropenia was a consequence of radiotherapy, Y84.2 Radiological procedure and radiotherapy would be assigned.

F) A number of other ICD-10 codes also specify sepsis. These are:

P36.- Bacterial Sepsis Of Newborn
A02.1 *Salmonella* sepsis
A22.7 Anthrax sepsis
A26.7 *Erysipelothrix* sepsis
A32.7 Listerial sepsis
A42.7 Actinomycotic sepsis
B37.7 Candidal sepsis
O85 Puerperal sepsis

The principles outlined above using A40.- / A41.- codes also apply to these codes.

It is not necessary to add a code from A40.- or A41.- to those in the above list. However R65.1, R57.2, R68.8 or specific organ failure codes should be recorded with codes in this list *if appropriate*, according to the principles described in A) and B) above.

Since ICD-10 V5 was finalized, a new clinical definition of sepsis has been issued [The third international consensus definitions of sepsis and septic shock (Sepsis-3)]. As it is gradually implemented, the new definition may see a slight change in the sepsis-related terminology used by clinicians. However this standard should continue to be applied.

This standard supersedes the intermediate standard on sepsis coding published in SCCS 16, October 2017.
Use of “Z” codes
Update to SCCS15 Sep 17 (Z90.1, Z92.2, Z95.- and Z96.6 now included)

This document is for guidance of when to use codes from the ICD-10 chapter – “Factors influencing health status and contact with health services”. It is not meant to be exhaustive, but concentrates on the codes that have been identified as being poorly recorded in the past. As a general rule, where any of the factors are mentioned on the Discharge Summary, then they should be coded against the episode. Whilst primarily concentrating on the use of these codes on SMR01s, where space allows and information is available, coders should also consider the use of these codes on other SMRs.

Persons encountering health services for examination and investigation Z00 – Z13

Z03.- Medical observation and evaluation for suspected diseases and conditions

Z04.- Examination and observation for other reasons

Every patient in hospital is observed and examined so it is not normally necessary to code these. However, Z03.- and Z04.- should be used when there is a reason e.g. symptoms, history, for suspecting that the patient may have a condition but after a period of observation there is found to be no condition present.

Examples:
1) Child found with empty medicine bottle
   Z03.6 Observation for suspected toxic effect from ingested substance

2) A patient was kept in hospital overnight with a minor condition e.g. superficial head injury which would not normally warrant an overnight stay
   S00.9 Superficial injury of head, part unspecified
   X59.9 Accident NOS
   Z04.3 Examination and observation following other accident

Z08.- Follow-up examination after treatment for malignant neoplasms
Z09.- Follow-up examination after treatment for conditions other than malignant neoplasms

The above codes have specific rules regarding sequencing, dependant upon other findings during the episode.

Z11.- Special screening examination for infectious and parasitic diseases
Z12.- Special screening examination for neoplasms
Z13.- Special screening examination for other diseases and disorders

Screening examination codes should be used for elective admissions in main position where the patient currently has no symptoms of a disease but there is reason to suspect they may develop it e.g. strong family history of the disease. This code should be omitted if evidence of the disease is found.

Persons with potential health hazards related to communicable diseases Z20 – Z29

Z22.- **Carrier of infectious disease.** Where the patient has been identified as a carrier or ‘positive’ in this episode.

Z29.0 **Isolation.** This code should always be recorded if it has been necessary to isolate the patient.

**Persons encountering health services in circumstances related to reproduction**

Z30 – Z39

Z36.- **Antenatal screening.**

For use on SMR02s to highlight reason for admission.

**Persons encountering health services for specific procedures and health care Z40 – Z54**

This block contains many ‘Z’ codes that may be used in the primary position, reflecting the main reason for admission.

**Example:** Patient admitted for change of colostomy

Z43.3 **Attention to colostomy**

Z54.- **Convalescence.** These codes are normally in a secondary or subsequent position to indicate continuing care for a condition but may be valid as Main Condition. Please refer to CQ2 Feb97 for further information.

**Persons with potential health hazards related to socioeconomic and psychosocial circumstances Z55 – Z65**

Codes from this block are considered “additional information” and should never appear as “Main Condition”. Only use where the clinician has clearly stated the circumstances within this episode in the patient’s record.

Z60.2 **Living alone** Record where this factor has affected the patient’s length of stay.

**Persons encountering health services in other circumstances Z70 – Z76**

Codes from this block are considered “additional information” and should rarely appear as “Main Condition”. Only use where the clinician has clearly stated the circumstances within this episode of the patient’s record.

Z74.- **Problems related to care-provider dependency**

Z75.- **Problems related to medical facilities and other health care**

Record where the factor has affected the patient’s length of stay.

Particularly important is **Z75.1 Person awaiting admission to adequate facility elsewhere.**

Z75.5 – **Holiday relief care.**

This code has its own rules. For further information please refer to standards:

Holiday Relief Care (Respite care) Coding on SMR01 SCCS6 July 14

Holiday Relief Care (Respite care) Coding on SMR04 SCCS2 July 13
Persons with potential health hazards related to family and personal history and certain conditions influencing health status Z80 – Z99

Codes from this block are considered “additional information” and should never appear as “Main Condition”, with the exception of Z85.6 Personal history of leukaemia and Z85.7 Personal history of other malignant neoplasms of lymphoid, haematopoietic and related tissues where the condition is in remission.

Z80 – Z84 Family history of diseases
These should be coded if patients are being investigated/treated for suspected cancers, IHD, mental illness etc. Follow the notes against each category to select the appropriate code.

Z85.- Personal history of malignant neoplasm
Only code if relevant to the patient’s current condition:
- if the patient is suspected of having or has been diagnosed with cancer in another part of the body.
- if the patient is admitted with a problem in the part of the body previously affected by cancer.

Z86 - Z87 Personal history of other diseases and conditions
Only assign if relevant to the patient’s current condition e.g. patient has right-sided weakness and had a previous TIA. PH codes should not be added when the patient is treated for a recurrence of the same disease.

Z90.1 Acquired absence of breast(s)
Record if the patient is admitted with a problem in the remaining breast.

Z92.2 Personal History of long-term (current) use of other medicaments
It is NOT necessary to use this code where a corresponding condition has been recorded e.g. where asthma has been recorded, no need to add long term use of Ventolin.

Z95.- Presence of cardiac and vascular implants and grafts
Record where the patient is in for any investigation or treatment of heart or vascular problems and has had previous cardiac surgery.

Z96.6 Presence of orthopaedic joint implants
It is NOT necessary to record this where the patient is in for revision surgery on the same joint or for treatment of a complication of the implant but should be used for continuing care after joint implant surgery or if having an implant on any other joint.

Many of the ‘Z’ codes have their own particular rules for recording e.g. Personal History codes with codes for Follow-up Examinations, Procedures Not Carried Out, Continuing Care, etc. Rules should be followed for all.

When adding ‘Z’ codes to reflect additional information, true comorbidities should take priority with the exception of ‘Z’ codes which indicate the length of stay has been affected e.g. Z75.1 Person awaiting admission to adequate facility elsewhere.
Scottish Clinical Coding Standards OPCS4

Colonoscopies/Sigmoidoscopies
Update to CG15 Nov 2004 (Addition of category H37)

Because the titles of categories H23.- to H28.- and category H37, include reference to sigmoidoscopes, when coding colonoscopies or sigmoidoscopies, the coder should use the code applicable to the instrument rather than the part of the intestine examined. Any colonoscopy/sigmoidoscopy which fails to progress to the intended area, and where nothing but examination was carried out, should have a Z code added to indicate how far it reached.

For example: patient comes in for a colonoscopy, but because of poor bowel preparation the scope cannot proceed beyond the rectum.

Code to
H22.9 Colonoscopy NEC with
Z29.1 Rectum

N.B. Change as follows: category H37 added

This standard supersedes the standard “Colonoscopies/Sigmoidoscopies” CG15 Nov 04

PLEASE NOTE THAT ALL CODING STANDARDS IN THIS EDITION APPLY TO ALL DISCHARGES ON AND AFTER 1ST APRIL 2018.

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