1. Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99)

a. Human Immunodeficiency Virus (HIV) Infections

1) Code only confirmed cases

Code only confirmed cases of HIV infection/illness. This is an exception to the hospital inpatient guideline Section II, H.

In this context, “confirmation” does not require documentation of positive serology or culture for HIV; the provider’s diagnostic statement that the patient is HIV positive, or has an HIV-related illness is sufficient.

2) Selection and sequencing of HIV codes

(a) Patient admitted for HIV-related condition

If a patient is admitted for an HIV-related condition, the principal diagnosis should be B20, Human immunodeficiency virus [HIV] disease followed by additional diagnosis codes for all reported HIV-related conditions.

(b) Patient with HIV disease admitted for unrelated condition

If a patient with HIV disease is admitted for an unrelated condition (such as a traumatic injury), the code for the unrelated condition (e.g., the nature of injury code) should be the principal diagnosis. Other diagnoses would be B20 followed by additional diagnosis codes for all reported HIV-related conditions.

(c) Whether the patient is newly diagnosed

Whether the patient is newly diagnosed or has had previous admissions/encounters for HIV conditions is irrelevant to the sequencing decision.

(d) Asymptomatic human immunodeficiency virus

Z21, Asymptomatic human immunodeficiency virus [HIV] infection status, is to be applied when the patient without any documentation of symptoms is listed as being “HIV positive,” “known HIV,” “HIV test positive,” or similar terminology. Do not use this code if the term “AIDS” is used or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from his/her HIV positive status; use B20 in these cases.

(e) Patients with inconclusive HIV serology

Patients with inconclusive HIV serology, but no
definitive diagnosis or manifestations of the illness, may be assigned code R75, Inconclusive laboratory evidence of human immunodeficiency virus [HIV].

(f) **Previously diagnosed HIV-related illness**
Patients with any known prior diagnosis of an HIV-related illness should be coded to B20. Once a patient has developed an HIV-related illness, the patient should always be assigned code B20 on every subsequent admission/encounter. Patients previously diagnosed with any HIV illness (B20) should never be assigned to R75 or Z21, Asymptomatic human immunodeficiency virus [HIV] infection status.

(g) **HIV Infection in Pregnancy, Childbirth and the Puerperium**
During pregnancy, childbirth or the puerperium, a patient admitted (or presenting for a health care encounter) because of an HIV-related illness should receive a principal diagnosis code of O98.7-, Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium, followed by B20 and the code(s) for the HIV-related illness(es). Codes from Chapter 15 always take sequencing priority.

Patients with asymptomatic HIV infection status admitted (or presenting for a health care encounter) during pregnancy, childbirth, or the puerperium should receive codes of O98.7- and Z21.

(h) **Encounters for testing for HIV**
If a patient is being seen to determine his/her HIV status, use code Z11.4, Encounter for screening for human immunodeficiency virus [HIV]. Use additional codes for any associated high risk behavior.

If a patient with signs or symptoms is being seen for HIV testing, code the signs and symptoms. An additional counseling code Z71.7, Human immunodeficiency virus [HIV] counseling, may be used if counseling is provided during the encounter for the test.

When a patient returns to be informed of his/her HIV test results and the test result is negative, use code Z71.7, Human immunodeficiency virus [HIV] counseling.

If the results are positive, see previous guidelines and assign codes as appropriate.
b. **Infectious agents as the cause of diseases classified to other chapters**

Certain infections are classified in chapters other than Chapter 1 and no organism is identified as part of the infection code. In these instances, it is necessary to use an additional code from Chapter 1 to identify the organism. A code from category B95, Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified to other chapters, B96, Other bacterial agents as the cause of diseases classified to other chapters, or B97, Viral agents as the cause of diseases classified to other chapters, is to be used as an additional code to identify the organism. An instructional note will be found at the infection code advising that an additional organism code is required.

c. **Infections resistant to antibiotics**

Many bacterial infections are resistant to current antibiotics. It is necessary to identify all infections documented as antibiotic resistant. Assign a code from category Z16, Resistance to antimicrobial drugs, following the infection code only if the infection code does not identify drug resistance.

d. **Sepsis, Severe Sepsis, and Septic Shock**

1) **Coding of Sepsis and Severe Sepsis**

(a) **Sepsis**

For a diagnosis of sepsis, assign the appropriate code for the underlying systemic infection. If the type of infection or causal organism is not further specified, assign code A41.9, Sepsis, unspecified organism.

A code from subcategory R65.2, Severe sepsis, should not be assigned unless severe sepsis or an associated acute organ dysfunction is documented.

(i) **Negative or inconclusive blood cultures and sepsis**

Negative or inconclusive blood cultures do not preclude a diagnosis of sepsis in patients with clinical evidence of the condition, however, the provider should be queried.

(ii) **Urosepsis**

The term urosepsis is a nonspecific term. It is not to be considered synonymous with sepsis. It
has no default code in the Alphabetic Index. Should a provider use this term, he/she must be queried for clarification.

(iii) Sepsis with organ dysfunction
If a patient has sepsis and associated acute organ dysfunction or multiple organ dysfunction (MOD), follow the instructions for coding severe sepsis.

(iv) Acute organ dysfunction that is not clearly associated with the sepsis
If a patient has sepsis and an acute organ dysfunction, but the medical record documentation indicates that the acute organ dysfunction is related to a medical condition other than the sepsis, do not assign a code from subcategory R65.2, Severe sepsis. An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code. If the documentation is not clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, query the provider.

(b) Severe sepsis
The coding of severe sepsis requires a minimum of 2 codes: first a code for the underlying systemic infection, followed by a code from subcategory R65.2, 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.

Due to the complex nature of severe sepsis, some cases may require querying the provider prior to assignment of the codes.

2) Septic shock
(a) Septic shock generally refers to circulatory failure associated with severe sepsis, and therefore, it represents a type of acute organ dysfunction.

For cases of septic shock, the code for the systemic infection should be sequenced first, followed by code R65.21, Severe sepsis with septic shock or code T81.12, Postprocedural septic shock. Any additional codes for the other acute organ dysfunctions should also
be assigned. As noted in the sequencing instructions in the Tabular List, the code for septic shock cannot be assigned as a principal diagnosis.

3) Sequencing of severe sepsis
If severe sepsis is present on admission, and meets the definition of principal diagnosis, the underlying systemic infection should be assigned as principal diagnosis followed by the appropriate code from subcategory R65.2 as required by the sequencing rules in the Tabular List. A code from subcategory R65.2 can never be assigned as a principal diagnosis.

When severe sepsis develops during an encounter (it was not present on admission) the underlying systemic infection and the appropriate code from subcategory R65.2 should be assigned as secondary diagnoses.

Severe sepsis may be present on admission but the diagnosis may not be confirmed until sometime after admission. If the documentation is not clear whether severe sepsis was present on admission, the provider should be queried.

4) Sepsis and severe sepsis with a localized infection
If the reason for admission is both sepsis or severe sepsis and a localized infection, such as pneumonia or cellulitis, a code(s) for the underlying systemic infection should be assigned first and the code for the localized infection should be assigned as a secondary diagnosis. If the patient has severe sepsis, a code from subcategory R65.2 should also be assigned as a secondary diagnosis. If the patient is admitted with a localized infection, such as pneumonia, and sepsis/severe sepsis doesn’t develop until after admission, the localized infection should be assigned first, followed by the appropriate sepsis/severe sepsis codes.

5) Sepsis due to a postprocedural infection
(a) Documentation of causal relationship
As with all postprocedural complications, code assignment is based on the provider’s documentation of the relationship between the infection and the procedure.

(b) Sepsis due to a postprocedural infection
For such cases, the postprocedural infection code, such as, T80.2, Infections following infusion, transfusion, and therapeutic injection, T81.4, Infection following a procedure, T88.0, Infection following immunization, or O86.0, Infection
of obstetric surgical wound, 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 code(s) for any acute organ dysfunction.

(c) Postprocedural infection and postprocedural septic shock

In cases where a postprocedural infection has occurred and has resulted in severe sepsis and postprocedural septic shock, the code for the precipitating complication such as code T81.4, Infection following a procedure, or O86.0, Infection of obstetrical surgical wound should be coded first followed by code R65.21, Severe sepsis with septic shock and a code for the systemic infection.

6) Sepsis and severe sepsis associated with a noninfectious process (condition)

In some cases a noninfectious process (condition), such as trauma, may lead to an infection which can result in sepsis or severe sepsis. If sepsis or severe sepsis is documented as associated with a noninfectious condition, such as a burn or serious injury, and this condition meets the definition for principal diagnosis, the code for the noninfectious condition should be sequenced first, followed by the code for the resulting infection. If severe sepsis is present a code from subcategory R65.2 should also be assigned with any associated organ dysfunction(s) codes. It is not necessary to assign a code from subcategory R65.1, Systemic inflammatory response syndrome (SIRS) of non-infectious origin, for these cases.

If the infection meets the definition of principal diagnosis it should be sequenced before the non-infectious condition. When both the associated non-infectious condition and the infection meet the definition of principal diagnosis either may be assigned as principal diagnosis.

Only one code from category R65, Symptoms and signs specifically associated with systemic inflammation and infection, should be assigned. Therefore, when a non-infectious condition leads to an infection resulting in severe sepsis, assign the appropriate code from subcategory R65.2, Severe sepsis. Do not additionally assign a code from subcategory R65.1, Systemic inflammatory response syndrome (SIRS) of non-infectious origin.
See Section I.C.18. SIRS due to non-infectious process

7) Sepsis and septic shock complicating abortion, pregnancy, childbirth, and the puerperium
   See Section I.C.15. Sepsis and septic shock complicating abortion, pregnancy, childbirth and the puerperium

8) Newborn sepsis
   See Section I.C.16. f. Bacterial sepsis of Newborn

e. Methicillin Resistant *Staphylococcus aureus* (MRSA) Conditions

1) Selection and sequencing of MRSA codes
   (a) Combination codes for MRSA infection
       When a patient is diagnosed with an infection that is due to methicillin resistant *Staphylococcus aureus* (MRSA), and that infection has a combination code that includes the causal organism (e.g., sepsis, pneumonia) assign the appropriate combination code for the condition (e.g., code A41.02, Sepsis due to Methicillin resistant Staphylococcus aureus or code J15.212, Pneumonia due to Methicillin resistant Staphylococcus aureus). Do not assign code B95.62, Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere, as an additional code because the combination code includes the type of infection and the MRSA organism. Do not assign a code from subcategory Z16.11, Resistance to penicillins, as an additional diagnosis.

See Section C.1. for instructions on coding and sequencing of sepsis and severe sepsis.

(b) Other codes for MRSA infection
    When there is documentation of a current infection (e.g., wound infection, stitch abscess, urinary tract infection) due to MRSA, and that infection does not have a combination code that includes the causal organism, assign the appropriate code to identify the condition along with code B95.62, Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere for the MRSA infection. Do not assign a code from subcategory Z16.11, Resistance to penicillins.
The condition or state of being colonized or carrying MSSA or MRSA is called colonization or carriage, while an individual person is described as being colonized or being a carrier. Colonization means that MSSA or MRSA is present on or in the body without necessarily causing illness. A positive MRSA colonization test might be documented by the provider as “MRSA screen positive” or “MRSA nasal swab positive”.

Assign code Z22.322, Carrier or suspected carrier of Methicillin resistant Staphylococcus aureus, for patients documented as having MRSA colonization. Assign code Z22.321, Carrier or suspected carrier of Methicillin susceptible Staphylococcus aureus, for patients documented as having MSSA colonization. Colonization is not necessarily indicative of a disease process or as the cause of a specific condition the patient may have unless documented as such by the provider.

If a patient is documented as having both MRSA colonization and infection during a hospital admission, code Z22.322, Carrier or suspected carrier of Methicillin resistant Staphylococcus aureus, and a code for the MRSA infection may both be assigned.