Tips & Tricks: Status/History

By: Rachel McKenty, CPC, COC, CPB, AAPC Approved Instructor

LEGACY

www.medicalbillco.com

Status Code Guidelines

Status codes indicate that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition. …

A status code is informative, because the status may affect the course of treatment and its outcome. A status code is distinct from a history code. The history code indicates that the patient no longer has the condition.

Section I.C.21.c.3

Status Code Guidelines

A status code should not be used with a diagnosis code from one of the body system chapters, if the diagnosis code includes the information provided by the status code.

For example, code Z94.1, Heart transplant status, should not be used with a code from subcategory T86.2, Complications of heart transplant. The status code does not provide additional information. The complication code indicates the heart transplant status and added a status code is duplicative.

Section I.C.21.c.3

Status Code Guidelines

Status Z codes may be used with aftercare Z codes to indicate the nature of the aftercare.

For example, code Z95.1, Presence of aortocoronary bypass graft, may be used with code Z48.812, Encounter for surgical aftercare following surgery on the circulatory system, to indicate the surgery for which the aftercare is being performed.

A status code should not be used when the aftercare code indicates the type of status, such as using Z43.0, Encounter for attention to tracheostomy, with Z93.0, Tracheostomy status

Section I.C.21.c.7

Examples of Status Codes

Refer to ICD-10-CM Chapter 21: Factors influencing health status and contact with health services.

Amputation

Category Z44 - Encounter for fitting and adjustment of artificial limb
Category Z97 - Presence of artificial limb
• Arm (partial/complete) • Leg (partial/complete)
Category Z89 - Acquired absence of limb
• Hand • Wrist • Arm (Above/below elbow) • Toe
• Foot • Ankle • Leg (Above/below knee)

Intervention

Use of:
• Z79.4 Insulin
Presence of:
• Z95.811 Heart assist device
• Z95.812 fully implantable artificial heart
Dependence on:
• Category Z99- respirator/ventilator

Condition/Disease

• Z21 Asymptomatic HIV/AIDS
• Category Z32-Z39- Pregnancy Encounters, Screenings, & Outcomes

Artificial Opening

Category Z43- Encounter for attention to artificial opening
Category Z93- Ostomy status
• Tracheostomy • Ileostomy • Cystostomy

Transplant

Category Z48- Encounter for aftercare following transplant
Category Z94- Transplant status
• Heart • Liver • Stem cell • Intestine

History Code Guidelines: Personal

Personal history codes explain a patient's past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring.

Personal history codes may be used in conjunction with follow-up codes and family history codes may be used in conjunction with screening codes to explain the need for a test or procedure. History codes are also acceptable on any medical record regardless of the reason for visit. A history of an illness, even if no longer present, is important information that may alter the type of treatment ordered.

Section I.C.21.c.4

Personal History: Example

A *screening* colonoscopy is a procedure that is recommended to be done every 10 years for *asymptomatic* adults at age 50 years.

The guidelines do not apply to adults with a long-standing history of inflammatory bowel disease, genetic syndromes such as familial polyps, a personal history of previous colorectal cancer or benign polyps, a family history of colorectal cancer, or other risk factors.

In these cases where a patient has a personal or family history of the above conditions a patient may be recommended to have a screening colonoscopy more frequently than the 10 years and these history codes explain the reason for the more frequent screening test and provide the medical necessity needed.

Z85.038: Personal History of other malignant neoplasm of the large intestines

History Code Guidelines: Family

Family history codes are for use when a patient has a family member(s) who has a particular disease that causes the patient to be at higher risk of also contracting the disease. A family history can help a physician recommend treatment to reduce the patient's risk of disease, provide early warning signs of disease, and help plan lifestyle changes to keep the patient well. The family history codes can help explain the need for a test or procedure and provide the medical necessity for it to be done.

Section I.C.21.c.4

Family History: Example

A 25-year-old patient has had a *screening* mammogram done and it was found that the patient has dense breasts, which can cause problems for the physician in being able to read the mammogram and find any abnormalities that may be present. The patient also has a family history of breast cancer in her mother. She has been sent to have a breast ultrasound to look for any possible abnormalities. You would report the breast density and that would provide the medical necessity for a more extensive test to be done such as the ultrasound. Since this is a screening exam in a young patient, the family history of breast cancer may provide the needed medical necessity for this exam to be done at a younger age than normally recommended, as the American Cancer Society recommends women begin screening at age 45.

Z80.3: Family History of other malignant neoplasm of breast

Contact Us

Phone

253-212-0354

Website

www.medicalbillco.com

E-mail

Legacy@medicalbillco.com