Tips & Tricks

Find & assign your Attention to/Status/History codes properly

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.

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)

History Code Guidelines

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.

Family history codes are for use when a patient has a family member(s) who has had a particular disease that causes the patient to be at higher risk of also contracting the disease.

Section I.C.21.c.4)

History Code Guidelines

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)