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Guidelines for using V-CODES (Status Codes)

This education is Part 2 of a 2-part series on
Guidelines for ICD-9 (Diagnosis Code) selection.

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Part 1: Guidelines for ICD-9 Codes

Part 2: Guidelines for V-codes (Status codes)

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Sources cited:

2005 Expert ICD-9-CM for Physicians, page 287-304

3M Coding & Reimbursement System - AMA Coding Clinic, First Quarter 2005, pages 69-
81– V codes coding guidelines 4/1/05

2005 Faye Brown's ICD-9-CM Coding Handbook

ICD-9 V-CODES

This classification of ICD-9 (Diagnosis) Codes is provided to deal with occasions when circumstances other than a disease or injury classifiable to categories 001-999 (the main part of ICD) are recorded as “diagnoses” or “problems”. This can arise in three ways:

1. **When a person who is not currently sick encounters the health services for some specific purpose**, such as to act as a donor of an organ or tissue, to receive prophylactic vaccination, or to discuss a problem which is in itself not a disease or injury.
2. **When a person with a known disease or injury, whether it is current or resolving, encounters the health care system for a specific treatment of that disease or injury** (e.g., dialysis for renal disease; chemotherapy for malignancy; cast change).
3. **When some circumstance or problem is present which influences the person’s health status, but is not in itself a current illness or injury**. In this circumstance, the V code should be used only as a supplementary code and should not be the one selected for use in primary, single cause tabulations. Examples of these circumstances are a personal history of certain diseases, or a person with an artificial heart valve in situ.

CATEGORIES OF V-CODES

Status Codes
History Codes
Aftercare Visit Codes
Follow-up Codes

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.

The status V codes/categories are:

V43	Organ or tissue replaced by other means
V45	Other postprocedural states
V49.6*	Upper limb amputation status
V49.7*	Lower limb amputation status
	<i>*These codes are for use only if there are not complications or malfunctions of the organ or tissue replaced, the amputation site, or the equipment on which the patient is dependent. These are always secondary codes.</i>
V58.6	Long-term (current) drug use
	<i>This subcategory indicates a patient’s continuous use of a prescribed drug (including such things as aspirin therapy) for the long-term treatment of a condition or for the long-term treatment of a condition of prophylactic use. It is <u>not</u> for use for patients who have addictions to drugs.</i>

History codes indicate that the patient no longer has the condition. **There are two types of history V codes, personal and family.** A history of an illness, even if no longer present, is important information that may alter the type of treatment ordered.

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.

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. **Family history** codes may be used in conjunction with screening codes to explain the need for a test or procedure.

The history V code categories are:

- V10 Personal history of malignant neoplasm
- V12 Personal history of certain other diseases
- V13 Personal history of other diseases
 - Except: V13.4 Personal history of arthritis, and
 - V13.6 Personal history of congenital malformations

These conditions are life-long, so are not true history codes
- V16 Family history of malignant neoplasm
- V17 Family history of certain chronic disabling diseases
- V19 Family history of other conditions

Aftercare visit codes cover situations when the initial treatment of a disease or injury has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease. **The aftercare V code should not be used if treatment is directed toward a current, acute disease or injury, the diagnosis code is to be used in these cases.**

The aftercare codes are generally first listed to explain the specific reason for the encounter. An aftercare code may be used as an additional code when some type of aftercare is provided in addition to the reason for admission and no diagnosis code is applicable.

The aftercare V category/codes:

- V54 Other orthopedic aftercare
- V58.3 Attention to surgical dressings and sutures

Follow-up codes are for use to explain continuing surveillance following completed treatment of a disease, condition, or injury. They imply that the condition has been fully treated and no longer exists. They should not be confused with aftercare codes that explain current treatment for a healing condition or its sequelae.

Sequencing of Follow-up Codes and History Codes: Follow-up codes may be used in conjunction with history codes to provide the full picture of the healed condition and its treatment. **The follow-up code is sequenced first, followed by the history code.**

A follow-up code may be used to explain repeated visits. Should a condition be found to have recurred on the follow-up visit, then the diagnosis code should be used in place of the follow-up code.

The follow-up V code category:

- V67 Follow-up examination

ICD-9 V-CODES

EXAMPLES OF V-CODES

Status Code

If a patient returns for a visit within the 90-day global period of aortocoronary bypass surgery, the following coding is appropriate:

CPT-4 Code	99024 (post-op visit)
Diagnosis Code	V45.81

History Code

- Personal History

The patient presents to the clinic with symptoms of severe stomach pain. Patient has a history of colon cancer which has not been treated in several years. The following coding is appropriate:

CPT-4 Code	99213 (expanded problem focused visit)
Diagnosis Code	536.8 (stomach pain)
	V10.05 (personal history of colon cancer)

- Family History

Patient gets a mammogram due to family history of breast cancer. The following coding is appropriate:

CPT-4 Code	75092
Diagnosis Code	V76.11 (screening mammogram for high-risk patient)
	V16.3 (family history of malignant neoplasm of breast)

Aftercare Visit Codes

Patient returns to the Ortho clinic for periodic follow-up visit for hip replacement surgery. Patient had surgery 3 years ago and presents today with no problems. The following coding is appropriate:

CPT-4 Code	99212 (problem focused visit)
Diagnosis Code	V54.81 (aftercare following joint replacement)
	V43.64 (joint replacement site-hip)

Follow-up Codes

Patient returns to clinic for a follow-up visit for an appendectomy done 4 months ago. The patient has had no other problems but needed to get clearance to return to work. The following coding is appropriate:

CPT-4 Code	99212 (problem focused visit)
Diagnosis Code	V67.09 (follow-up exam following other surgery)

V-Codes (Status Codes) Quiz

Name _____	Date _____
Department _____	Signature _____

1. ICD-9 V-codes is a classification of diagnosis codes provided to deal with occasions when circumstances other than a disease or injury classifiable to categories 001-999 are recorded as 'diagnoses' or 'problems'. ___ True ___ False
2. V-codes are used when patients are currently sick and seek health services for a specific purpose. ___ True ___ False
3. The four (4) categories of V-codes are _____, _____, _____ and _____.
4. Please match the following:

___ Status codes	A. The patient no longer has the condition
___ History codes	B. The patient requires continued care during the healing or recovery phase of the disease.
___ Aftercare codes	C. Explains the continuing surveillance following completed treatment of a disease, condition, or injury.
___ Follow-up codes	D. The status of a past disease or condition may affect the course of treatment and its outcome.
5. There are _____ types of history V-codes.
6. Personal history codes explain the 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. ___ True ___ False
7. The _____ V-code should not be used if treatment is directed toward a current, acute disease or injury, the diagnosis code is to be used in these cases.
8. The _____ V-code infers that the condition has been fully treated and no longer exists.
9. Circle the category of V-code for the following scenario:
 A patient returns to the clinic within the post-op period following surgery.

STATUS HISTORY AFTERCARE FOLLOW-UP
10. Circle the category of V-code for the following scenario:
 The patient has a history of colon cancer and is coming to clinic today due to severe stomach pain.

STATUS HISTORY AFTERCARE FOLLOW-UP

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 Complete quiz, be sure to print name (must be legible), the date, and your department at the top of the form.
SIGN the form (no credit will be given without a signature)
 Fax to 504-988-7777 (fax information at top of form, no cover sheet required)