Codify
BY AAPC

Primary Care Coding Alert

Reader Question: Code by Record, Not by Order

Question: The practice where I currently work has a standing order to code patients with sexually transmitted diseases such as HIV, Hepatitis C, and herpes with a code from the Z72.5 group in ICD-10. Many of these patients have history notes that say that they aren't sexually active, however, or that they have been monogamous for a long period of time. Is this a standard coding practice, or should I query the order with the practitioners?

Virginia Subscriber

Answer: Any code you assign to a patient must be substantiated by information in that patient's record. Simply put, the code choice must describe the patient's diagnosis or provide a reason for any tests or services your provider orders.

The ICD-10 common guidelines state that codes in the Z72 family should be assigned only when the documentation specifies that the patient has an associated problem. If there is no documentation in the patient's record that the patient is engaging in high-risk sexual behavior or has an associated problem, you cannot code Z72.5- (High risk sexual behavior), regardless of whether a practitioner decides you should do that.

You should question this practice with your providers and let them know that it contradicts information elsewhere in the patient record (for example, that the patient is not sexually active). And if the provider believes that adding a Z72.5- code to a patient's record is justified, you should ask the provider to clarify this in the record, so you can be sure the record supports the code and you have used it correctly.