Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Reader Question

Question: We treated a patient for leukemia several years ago and now we see her annually for a yearly visit. Should we continue to report the leukemia diagnosis or switch to a "history of" cancer code?

Answer: If the patient's treatment is completed, the medical record reflects no instances of recurrence, and the physician documents no sign of reoccurrence, using a "history of" diagnosis would be appropriate if it bears on and is relevant to the patient's treatment.

ICD-9 coding guidelines specify that the personal "history of" 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." For example, use V10.6x (Personal history of malignant neoplasm; leukemia) for patients with prior history of leukemia.

Tip: Code the condition as "current" if the patient is still receiving active treatment or the patient is still in that grace period after treatment and the physician is not sure whether the cancer has been eradicated or not. Once the patient is past that point, you can report the appropriate "history of" diagnosis code.