Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Reader Questions: If Cancer's Still Present, Ignore 'History of' Codes

Question: At what point should I report a "history of" code instead of the actual cancer diagnosis?

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.