Home Health ICD-9/ICD-10 Alert

READER QUESTIONS: Know When Diagnoses Make History

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

-- Pennsylvania Subscriber

Answer: If the patient's treatment is completed and the physician states there is no sign of reoccurrence, using a "history of" diagnosis would be appropriate. The ICD-9-CM 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 V10.3 (Personal history of malignant neoplasm; Breast) for patients with prior history of breast cancer.

You should 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. Active treatment can be long-term medication such as Tamoxifen. If a patient had breast cancer (CA) five years ago but is still taking Tamoxifen, you could code breast CA as current such as 174.x (Malignant neoplasm of female breast) if that is indicated.

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