Historical malignant neoplasms and acute conditions in non-acute settings

Documentation and coding best practices

Santa Clara Family Health Plan™

Good medical record documentation includes adhering to coding guidelines for each diagnosis code submitted on the claim. This newsletter reinforces the coding guidelines for "history of" or "PMH" malignant neoplasms and acute conditions in non-acute settings.

Coding for historical malignant neoplasms

According to ICD-10-CM Official Guidelines for Coding and Reporting (https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2020_final.pdf), the phrase "history of" refers to a past medical condition that no longer exists and the patient is not receiving active treatment for it but the condition has the potential for recurrence. A primary malignancy is not active when it has been excised or eradicated from its site and there is no further treatment directed to that site. When the neoplasm is non-active, use category **Z codes such as ICD-10-CM category Z85.-, Personal history of malignant neoplasm**.

Tips

Use explicit documentation to report the status of active cancer and anti-neoplastic treatment.

Do not use "history of" or "PMH" for patients with active cancer. To document the history of cancer, use time. For example: Patient diagnosed with cancer in 2014.

If the patient has (active) cancer and opts for no medical treatment, explicitly document such preference and code for active cancer diagnosis.

Neoplasms (C00-D49) of the ICD-10-CM for the codes for active malignant neoplasms.

Acute conditions in non-acute settings

Diagnoses such as stroke, acute myocardial infractions (MIs), and deep vein thrombosis are typically not diagnosed in an outpatient setting. These diagnoses are designated for the acute phase of the illness. Once the acute phase of the condition has subsided, the same diagnosis code may not apply. For example, a transient ischemic attack (TIA) is a transient version of the cerebrovascular accident (CVA) where symptoms resolve quickly and without residual deficits. The TIA is coded to **G45.9** for the initial care during the acute phase of the illness. Subsequent care visits, care after the acute phase, is coded to **Z86.73, Personal history of TIA**.

- Robust documentation is vital for code selection. Depending on the acute condition's phase, the official coding guidelines can have multiple codes.
  - For example, the official coding guidelines instructs MIs to be coded as acute while the MI is equal to or less than four weeks old. If the patient is still receiving care related to the MI after the four-week timeframe, assign code **I25.2, Old or healed myocardial infarction not requiring further care**.
- If a condition is no longer active or receiving care during its acute phase but is still relevant to the encounter, check to see if another code accurately reflects the condition's status. If no diagnosis code exists, use category **Z codes, Personal history of**.

For questions about documentation and coding or to schedule a training session, please contact Monday Reynolds, Certified Coder.

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