

Current Diagnosis Codes vs. History Diagnosis Codes

Diagnosis coding is the primary indicator for risk adjustment calculation and auditing. Under a risk adjustment model, **physicians should report all present, relevant diagnosis**. ICD guidelines instruct to choose a primary diagnosis (to describe the main reason for the visit/encounter), and to “List additional codes that describe any coexisting conditions.”

What this means is, physicians should code for all documented conditions that co-exist at the time of the encounter/visit, and require or affect patient care treatment or management.

Conditions should not be coded that were previously treated or no longer exist.

However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment. Co-existing conditions include chronic, ongoing conditions such as diabetes, congestive heart failure, atrial fibrillation, COPD, etc.

These diseases are generally managed by ongoing medication and have the potential for acute exacerbations if not treated properly, particularly if the patient is experiencing other acute conditions. It is likely that these diagnoses would be part of a general overview of the

patient’s health when treating co-existing conditions for all but the most minor of medical encounters. Co-existing conditions also include ongoing conditions such as multiple sclerosis, hemiplegia, rheumatoid arthritis and Parkinson’s disease.

Documenting complications and comorbidities is vital in risk adjustment, but guidelines largely prohibit the assumption of cause and effect relationships.

In other words, if the relationship isn’t clearly documented, there is no way to report it. Diabetes is one of the biggest challenges in this area. The basic code for diabetes, or the primary, unspecified code for diabetes is only appropriate for those diabetics who have no complications.

“History of” diagnoses are one potential problem area. The term “past medical history” (PMH) is used loosely in clinical documentation. It is easy to make an error in one of two ways with respect to these (history of) codes. One way is to code or document a past condition as active. The opposite is to code or document as “history of” a condition when that condition is still active.



If you have questions, please
contact your provider relations
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An example of coding a past condition as active is to submit an active cancer code when there is no longer any treatment for the cancer. Coding rules only allow coding of cancers as current when they are being treated by chemotherapy, radiation therapy or hormonal treatment, watchful waiting, or if the patient is too frail for, or refuses treatment. Otherwise, these would be coded under the “Personal history of primary malignant neoplasm” under Z85 codes.

There are also rules regarding **stroke codes**. After a patient has been discharged from inpatient treatment for a stroke, it’s no longer appropriate to use the stroke code. Instead, a “history of” code should be used.

As a contracting provider Blue Cross and Blue Shield of Kansas appreciates your diligence to continue good coding practices.