BlueCross BlueShield of North Carolina

Documentation and Coding

Historical Condition Coding Tips

A quick reference guide to assist with accurate, complete documentation and coding that reflects the true nature of a patient's current health status at the highest level of specificity. Per ICD-10 official guidelines for reporting and coding,

The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation, accurate coding cannot be achieved.

Additional coding resources may be found on our *Provider Risk Coding Education website*

This is to be used as coding guidance and is not a guarantee of payment or direct instructions on how to code Member conditions.

What is a historical condition?

- A condition that is no longer receiving treatment and/or no longer exists.
- A condition that is not receiving treatment but impacts current care and/or treatment for active conditions.

When should I code a condition as historical?

When a condition is no longer receiving treatment and/or no longer exists.
Example: Patient with dx of Breast Cancer, has completed all treatments and had a mastectomy.

How do I code a condition that isn't active but is considered when planning treatment for a current condition?

If the historical condition or family history impacts current care or influences treatment, you will utilize a "history of" ICD-10 - Z-Code (Z80-Z87).

Example: 38 yo woman with family history of breast cancer. Code Z80.3 to reflect the family history, it may impact the frequency of her screenings for breast cancer.

Frequently mis-coded historical conditions:

- **Cancer**
- **Acute MI**
- **Acute Stroke**

Additional education related to coding Historical Conditions can be tailored to the needs of your group.
Please send your inquiry to our Provider Engagement Risk Adjustment Team at ***BCBSNCRiskAdj@bcbsnc.com***