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"History Of"

Coders, by rule, **cannot code** anything that follows the phrase "history of", because of the ambiguity of the term.

Consider these examples:

- "The patient has a history of strep throat."
  - We understand strep throat is a past diagnosis.
- "The patient has a history of COPD."
  - We understand the patient still has COPD, because it is chronic.
- "The patient has a history of breast cancer."
  - Is it active or in remission?

The coding system cannot make the interpretation, thus, the rule.

The phrase "history of" in the coding system indicates a condition that the patient had, but no longer has, and is **no longer receiving treatment**. The phrase is used to communicate resolved conditions, such as recent acute respiratory failure or remote breast cancer, so subsequent caregivers can remain alert for recurrence.

Consider documenting existing and currently active conditions as "chronic", "established", "baseline" or "the patient has …" in order to clarify as active and treated, and to distinguish from old, resolved conditions.

Source: ICD-10-CM Official Guidelines for Coding and Reporting, 2018, page 92