CME

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WHEN THE CHIEF COMPLAINT IS "MEDICATION REFILL"

Q Our electronic health record (EHR) automatically inserts the chief complaint noted by our scheduler into the office visit note. How do we provide sufficient documentation if the chief complaint is "medication refill"?

A You should receive credit for documenting the chief complaint even though the documentation is found elsewhere in the note as long as you describe your assessment (e.g., diabetes — stable) and plan (e.g., medication refilled, continue current dose, increase activity, and reduce calories as discussed) for each condition you address.

Preferably, the history of present illness documentation would include any complaints the patient presents with (e.g., follow-up of hypertension, hypercholesterolemia, and a complaint of left shoulder pain) and the status of any chronic conditions (e.g., patient taking medication as prescribed with no side effects).

It may also be possible to work with the EHR vendor to allow physicians and other qualified health care professionals to complete a chief complaint field rather than just carrying forward a reason for the visit stated during scheduling.

99221 FOR SECOND HOSPITAL ENCOUNTER?

Q I admitted a patient to the hospital one night after a brief encounter that did not meet the requirements for CPT code 99221, "New or established patient initial hospital inpatient care services." If I completed a more comprehensive E/M service the next morning, can I report code 99221 for that service?

A No. Report code 99221 only for the date of service of your initial hospital encounter with the patient. Check with individual payers for guidance on what to report for the initial encounter that does not meet the requirements for 99221.

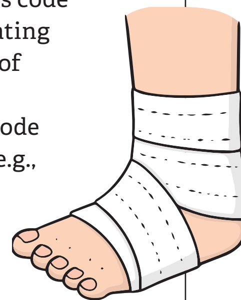
Some payers may require code 99499, "Other evaluation and management services." For Medicare patients, you may report a subsequent hospital visit code (99231-99233) for an initial hospital care encounter that does not meet the reporting requirements for 99221. In the scenario you describe, you would also report subsequent hospital care for your visit the next morning.

Report code 99221 only for the date of service of your initial hospital encounter with the patient.

STAPH INFECTION OF A WOUND

Q Which ICD-10 diagnosis code should I report for treating a staph infection of a wound of the foot?

A Report first an ICD-10 code describing the wound (e.g., puncture or laceration) followed by B95.8, "Unspecified staphylococcus as the cause of diseases classified elsewhere."



ICD-10 describes codes in categories B95-B97 as "provided for use as supplementary or additional codes to identify the infectious agent(s) in diseases classified elsewhere." Many codes describing manifestations of disease include the descriptor "of diseases classified elsewhere." These are always reported secondary to codes for the underlying etiology. The ICD-10 tabular list includes "code first" and "use additional code" instructions to guide correct reporting. FPM

Send comments to **fpmedit@aafp.org,** or add your comments to the article online.

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Cindy Hughes is an independent consulting editor based in El Dorado, Kan., and a contributing editor to *FPM*. Author disclosure: no relevant financial affiliations disclosed.

EDITOR'S NOTE:

Reviewed by the *FPM* Coding & Documentation Review Panel. Some payers may not agree with the advice given. Refer to current coding manuals and payer policies.

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