Initial & Subsequent Hospital Inpatient or Observation Care Evaluation & Management (E/M) Coding

Effective 01/01/2023: Hospital observation care codes (99217-99220, 99224-99226) are deleted, and code descriptors for hospital inpatient initial, subsequent and discharge codes (99221-99223, 99231-99233, 99238-99239) are revised to include inpatient or observation E/M services. The level of observation or inpatient E/M service may be based on *total time* for E/M services performed on the date of the encounter or on the *level of medical decision making (MDM).* A medically appropriate history and physical examination, as determined by the treating provider, are included in the code descriptors, however, these elements are not used to determine the level of E/M service. Note: E/M services that are billed with a psychotherapy add-on code (90833, 90836, 90838) cannot be billed by time and must be billed based on MDM components.

- **Total time** for reporting these services includes *face-to-face and non-face-to-face time* personally spent by the physician or other QHP on the date of the encounter. Code descriptions specify the time that must be met or exceeded
  - Includes time for activities such as preparing to see the patient, obtaining a history, performing an exam, providing counseling or education, preparing orders, independently interpreting tests or coordinating care (if not separately reported) and documenting the health record
  - Excludes time for activities performed by clinical staff, time spent performing separately reportable procedures, travel time or general teaching time
- **MDM elements:** To qualify for a given level of decision-making, 2 of 3 MDM elements must be met or exceeded

  1. Number and complexity of problem(s) that are addressed during the encounter
  - A problem is considered to be addressed or managed when it is evaluated or treated at the encounter by the physician reporting the service

  2. Amount and/or complexity of data to be reviewed and analyzed
  - Data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter (excluding interpretations that are separately reported)

  3. Risk of complications and/or morbidity or mortality of patient management
  - Risk is described as the probability and/or consequences of an event. For the purposes of MDM, the level of risk is based on consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization.

  For more details on time or MDM, including definitions and examples, refer to the CPT 2023 E/M Services Guidelines.

Medical decision making (MDM) elements			Level of MDM	Code
Number & complexity of problems addressed	**Amount and/or complexity of data reviewed/analyzed**	**Risk of complications and/or morbidity/mortality**	**Meets or exceeds 2 of 3 MDM elements**	**(Time in minutes)**
Minimal Low	Minimal or none Limited	Minimal Low	**Straightforward** **Low complexity**	**99221** (40) **99231** (25)
Moderate	Moderate	Moderate	**Moderate complexity**	**99222** (55) **99232** (35)
High	Extensive	High	**High complexity**	**99223** (75) **99233** (50)

Prior to 1/1/2023, the level of service for codes 99221-99223 and 99231-99233 is based on the three key components of history, examination and MDM with time *only* used as the determining factor if counseling and/or coordination of care dominate the visit. Refer to the CPT® E/M Guidelines appropriate for your date of service for details.

Code notes: Initial and subsequent hospital inpatient or observation care codes are "per diem" services and may be reported only once per day by the same physician or physicians of the same specialty from the same group practice. Note: A stay that includes a transition from observation to inpatient status is a single stay.

- **Initial hospital inpatient or observation care codes (99221-99223)** are used to report the first hospital inpatient or observation encounter by the admitting physician. In alignment with CMS, these codes include *all* E/M services provided by the admitting physician or other QHP on the same date, even when initiated in another setting (e.g., emergency department, nursing facility, office, etc.). The level of initial hospital E/M code reported should reflect the combined services. **Modifier AI** (Principal Physician of Record) is used to identify the admitting physician's initial

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encounter. See details for reporting consultations on the next page.

- **Subsequent hospital inpatient or observation care codes (99231-99233)** represent E/M services that occur after the first encounter of the patient's hospital admission and include review of the medical record, including all diagnostic studies, as well as changes noted in the patient's condition and response to treatment since the last evaluation.
  - Per CMS, if an initial encounter does not meet the initial code criteria, a subsequent hospital care code may be reported

Consultation services:

- **Effective 1/1/2010,** the CPT® consultation codes (99241-99245 and 99251-99255) are no longer recognized for Medicare Part B payment. Effective for services furnished on or after 1/1/2010, providers should code a patient E/M visit with an E/M code that represents where the visit occurs and that identifies the complexity of the visit performed.
- **Effective for claims with dates of service on or after 3/1/2020,** Optum aligns with CMS and does not reimburse consultation services procedure codes 99241-99245, 99251-99255, including when performed via telehealth. See the Optum Consultation Services Reimbursement Policy for details.

Prolonged E/M services:

Prolonged services are reimbursed when the primary E/M service is selected based on time. Optum requires providers to list the appropriate start and stop time for prolonged services codes in the medical record in order to determine the appropriate type of prolonged services.

Effective 1/1/2023:

- New prolonged service codes 99418 and G0317 are available to report 15-minute increments of prolonged services with or without direct patient contact on the date of a hospital inpatient/observation E/M service (less than 15 minutes is not reported)
- Prolonged service codes 99354-99357 are deleted, and codes 99358-99359 are revised to represent prolonged services without direct patient contact that occurs on a date *other* than the related face-to-face E/M service with the patient and/or family or caregiver. For prior dates of service, these codes may also be reported for non-face-to-face services provided on the same date as a related E/M service (except office E/M visits 99202-99205 or 99212-99215).
  - Report 99358 only once per date for the first hour of prolonged service (less than 30 minutes is not reported).
  - Report 99359 for each additional 30 minutes beyond the first hour or for the final 15 to 30 minutes of prolonged service on a given date (less than 15 minutes beyond the first hour/final 30 minutes is not reported separately).

To report 15-minute increments of prolonged E/M services with or without direct patient contact provided on the same date as an outpatient E/M service (99205, 99215), see codes 99417 or G2212. To report prolonged face-to-face clinical staff services provided in an office/outpatient setting with physician supervision, see codes 99415-99416. Refer to the Optum Prolonged Services Reimbursement Policy for details.

Resources:

This overview and reminder of E/M coding guidelines is provided to help support continued improvements. Please review these additional resources for more details:

- **Optum Reimbursement Policies:** Consultation Services Reimbursement Policy, Prolonged Services Reimbursement Policy and Same Day Same Service Reimbursement Policy
- **American Psychiatric Association (APA):** CPT Coding and Reimbursement
- **American Medical Association (AMA):** CPT® Evaluation and Management and CPT Manual > Evaluation and Management (E/M) Guidelines
- **CMS Medicare Claims Processing Manual:** Internet-Only Manual (IOM) 100-04, Ch. 12, Sect. 30.6, Evaluation and Management Services Guide; 1995 Documentation Guidelines and 1997 Documentation Guidelines

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