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

Effective 1/1/2023: Hospital observation codes (99217-99220, 99224-99226) are deleted, and hospital inpatient codes (99221-99223, 99231-99233, 99238-99239) are revised to include observation or inpatient E/M services. Refer to the CPT® guidelines for more details. For prior dates of service, the following guidelines apply.

Initial observation E/M codes (99218-99220) describe the *first visit* of the patient's admission for hospital outpatient observation care by the supervising physician or other qualified health care professional (QHP). Hospital outpatient observation status includes the supervision of the care plan for observation as well as the periodic reassessments. The patient is not required to be physically located in a designated observation area within a hospital; however, if such an area is utilized, these codes should be reported.

These codes include *all* E/M services associated with the observation status admission 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 observation hospital E/M code reported should reflect the combined services. For more details on reporting multiple E/M services, see the Optum Same Day Same Service Reimbursement Policy.

The level of initial observation E/M service may be determined by the *three key components* outlined in the CPT® code description *or by time* if counseling or coordination of care dominate the visit. The nature of the health concern does not determine the code to be assigned, however, it may affect the level of history and/or physical exam appropriate to diagnose the problem and the complexity of the MDM involved.

Key components for initial observation E/M coding include history, examination, and medical decision making (MDM). Each key component can be assigned a level based on the amount of work a provider needs to perform given the member's specific health issue. Documentation should reflect the work performed.

- **History:** Chief complaint (CC), history of present illness (HPI), review of systems (ROS) and past, family, and/or social history (PFSH)

  Possible levels for history:
  - **Problem focused -** CC, brief HPI
  - **Expanded problem focused -** CC, brief HPI, problem pertinent ROS
  - **Detailed -** CC, extended HPI, extended ROS, pertinent PFSH
  - **Comprehensive -** CC, extended HPI, complete ROS, complete PFSH

- **Examination:** Body area(s) or organ system(s)

  Possible levels of examination:
  - **Problem focused -** limited exam of the affected body area/organ system.
  - **Expanded problem focused -** limited exam of the affected body area/organ system & other symptomatic or related organ system(s).
  - **Detailed -** extended exam of the affected body area(s) and other symptomatic or related organ system(s).
  - **Comprehensive -** general multi-system exam/complete exam of a single organ system

- **MDM:** The number of diagnoses or management options, the amount and/or complexity of data to be reviewed, and the risk of complications and/or morbidity or mortality. To qualify for a given type of decision-making, 2 of 3 MDM elements must be met or exceeded. See the chart below for details on the four possible levels of MDM:

Medical Decision-Making (MDM) Elements			Decision
Number of diagnoses or management options	**Amount and/or complexity of data to be reviewed**	**Risk of complications and/or morbidity/mortality**	**Level of MDM (meets or exceeds 2 of 3 elements)**
Minimal	Minimal or none	Minimal	Straightforward
Limited	Limited	Low	Low complexity
Multiple	Moderate	Moderate	Moderate complexity
Extensive	Extensive	High	High complexity

Using time to determine observation code selection:

- The time a physician spends providing counseling and/or coordination of care to a member is *only* used in code selection if counseling and/or coordination of care dominates the member's visit (more than 50%). The exact amount of time spent and the extent of the counseling and/or coordination of care must be documented in the medical record.

BH4651a_02/2023 United Behavioral Health and United Behavioral Health of New York, I.P.A., Inc. operating under the brand Optum U.S. Behavioral Health Plan, California doing business as OptumHealth Behavioral Solutions of California

- **Unit/floor time:** For coding observation care services, *only* unit/floor time is to be included in the time calculation. This includes the time present on the patient's hospital unit and at the bedside rendering services for that patient such as establishing and/or reviewing the patient's chart, examining the patient, writing notes, and communicating with other professionals and the patient's family.
- **Note:** Time may *not* be used to determine the level of E/M service if reported with add-on codes for psychotherapy (90833, 90836, 90838).

Code notes: Refer to the CPT® Manual and reference documents (e.g., 1995 and 1997 Documentation Guidelines) for more details on services that fulfill the levels within the three key components. In an audit, only those items documented in a member's medical record may be used to support the levels of the three key components. It is important to thoroughly document *only* the services performed.

99218-99220 - Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components (levels indicated in chart below): history; examination; medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of (low, moderate or high) severity. Typically, (minutes indicated in chart below) are spent at the bedside and on the patient's hospital floor or unit.

Initial Observation Care (must meet or exceed 3 of 3 key components)				
Code	**History**	**Exam**	**MDM**	**Typical Time**
99218	Detailed or Comprehensive	Detailed or Comprehensive	Straightforward or Low	30 minutes
99219	Comprehensive	Comprehensive	Moderate complexity	50 minutes
99220	Comprehensive	Comprehensive	High complexity	70 minutes

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 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.

BH4651a_02/2023 United Behavioral Health and United Behavioral Health of New York, I.P.A., Inc. operating under the brand Optum U.S. Behavioral Health Plan, California doing business as OptumHealth Behavioral Solutions of California

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

BH4651a_02/2023 United Behavioral Health and United Behavioral Health of New York, I.P.A., Inc. operating under the brand Optum U.S. Behavioral Health Plan, California doing business as OptumHealth Behavioral Solutions of California