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

Effective Jan. 1, 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.

- **Total time** for reporting these services includes *face-to-face and non-face-to-face time* personally spent by the physician or other qualified health care professional (QHP) on the date of the encounter. Code descriptions specify the time that must be met or exceeded. **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.
  - 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 prior dates of service (DOS), code selection is based on the three key components (history, exam and MDM) with time *only* used as the determining factor if counseling and/or coordination of care dominate the visit. For more details on time or MDM, including definitions and examples, refer to the CPT® E/M Services Guidelines appropriate for your DOS.

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**	**(Total time in minutes)**
Minimal Low	Minimal or none Limited	Minimal Low	**Straightforward** **Low complexity**	**99221** (40 min.) **99231** (25 min.)
Moderate	Moderate	Moderate	**Moderate complexity**	**99222** (55 min.) **99232** (35 min.)
High	Extensive	High	**High complexity**	**99223** (75 min.) **99233** (50 min.)

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. See the Optum Same Day Same Service policy for details on reporting multiple E/M services.

- **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 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.

Professional services provided during active facility-based programs: Per the Optum Facility-Based Behavioral Health Program Professional Fees Reimbursement Policy, unless specified within a provider contract, the single rate for a facility-based treatment program does not include attending physician charges for supervision and evaluation during active facility-based programs. These charges may be billed by a single daily E/M code as clinically appropriate.

Consultation services: Per the Optum Consultation Services Reimbursement Policy, effective for claims with DOS on or after Mar. 1, 2020, Optum aligns with CMS and does not reimburse consultation codes 99242-99245 or 99252-99255, including when performed via telehealth. An appropriate E/M code should be reported to represent the service provided to the patient. Per CMS, if an initial encounter does not meet the initial code criteria, a subsequent hospital care code may be reported. For prior DOS, consultation codes are reimbursed in alignment with CPT guidelines. See the policy for details.

Prolonged E/M services: Per the Optum Prolonged Services Reimbursement Policy, 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. Refer to the policy for more details, including a list of prolonged services codes with appropriate primary E/M codes for various settings applicable to commercial and Medicare plans.

Effective Jan. 1, 2023:

- Prolonged service codes 99418 (commercial) and G0316 (Medicare) are available to report 15-minute increments of prolonged services with or without direct patient contact on the date of a high-level initial or subsequent hospital inpatient or observation E/M service (99223 or 99233). Less than 15 minutes is not reported.
- Codes 99358 and 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. These codes should not be reported on the same DOS as another E/M code. For prior DOS, 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).

NOTE: These codes are invalid for Medicare (e.g., Physician Fee Schedule status = I – Not valid for Medicare services).

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, Facility-Based Behavioral Health Program Professional Fees 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
- **Centers for Medicare & Medicaid Services (CMS):** Internet-Only Manual (IOM) 100-04, Ch. 12, Sect. 30.6, Evaluation and Management Services Guide; 1995 Documentation Guidelines and 1997 Documentation Guidelines