



Initial Hospital Observation Care Evaluation & Management (E/M) Coding (Prior to Jan. 1, 2023)

Effective Jan. 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 relevant to your date of service (DOS) for more details. For prior dates of service (DOS), 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 medical decision making (MDM) involved.

Key components for initial observation E/M coding include history, examination, and 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.

- **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: 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. 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 records 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.

- Prior to Jan. 1, 2023, prolonged services with direct patient contact requiring unit/floor time beyond the usual service in an inpatient/observation setting were reported with 99356 (first hour) and 99357 (additional 30 minutes). Less than 30 total minutes and less than 15 minutes beyond the first hour or beyond the final 30 minutes are not separately reported.
- Effective Jan. 1, 2023, codes 99356-99357 are deleted, and 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 hospital inpatient or observation E/M service. Less than 15 minutes is not reported.

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
- **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](#)

Insurance coverage provided by or through UnitedHealthcare Insurance Company, All Savers Insurance Company, or its affiliates. Health plan coverage provided by UnitedHealthcare of Arizona, Inc., UHC of California DBA UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Colorado, Inc., UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare of Texas, LLC, UnitedHealthcare Benefits of Texas, Inc., UnitedHealthcare of Utah, Inc. and UnitedHealthcare of Washington, Inc. or other affiliates. Administrative services provided by United HealthCare Services, Inc., OptumRx, OptumHealth Care Solutions, Inc., or its affiliates. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC), United Behavioral Health (UBH) or its affiliates.