Hospital Inpatient or Observation Care (Including Admission and Discharge Services) Evaluation & Management Coding

The information included in this guide is intended to enhance your awareness of the guidelines and policies that Optum follows to help support accurate coding and billing for behavioral health services.

Hospital inpatient or observation care codes (including admission and discharge services) 99234–99236 are used to report hospital evaluation and management (E/M) services provided to patients admitted and discharged on the same date of service (DOS) in *either* an inpatient or observation setting. A stay that includes a transition from observation to inpatient is a single stay.

Per CPT® guidelines, the level of service for codes 99234–99236 may be based on total time on the date of the encounter or on the single key component of medical decision making (MDM). A medically appropriate history and physical examination, as determined by the treating provider, is included in the code descriptors, however, the level of history and examination are no longer used when determining 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.

Medical Decision-Making (MDM) Elements			Decision	
Number & complexity of problems addressed	**Amount and/or complexity of data reviewed/analyzed**	**Risk of complications and/or morbidity/mortality**	**Level of MDM (meets or exceeds 2 of 3 elements)**	**Code** (total minutes)
Minimal	Minimal or none	Minimal	Straightforward	**99234** (45 min.)
Low	Limited	Low	Low complexity	
Moderate	Moderate	Moderate	Moderate complexity	**99235** (70 min.)
High	Extensive	High	High complexity	**99236** (85 min.)

For more details on time or MDM, including definitions and examples, refer to the CPT® Evaluation and Management (E/M) Services Guidelines appropriate for your DOS.

Code notes:

- 99234–99236 are reported for the evaluation and management of a patient including admission and discharge on the same calendar date (a minimum of 8 hours but less than 24 hours). Per CPT®, these codes require two or more encounters on the same date including an initial admission encounter and a separate discharge encounter.
  - For a patient admitted and discharged at the same encounter or admitted for less than 8 hours, see the initial hospital inpatient/observation codes (99221–99223). For patients admitted and discharged on different calendar dates, also see the hospital inpatient/observation discharge day management codes (99238 or 99239).
  - Per the Optum Same Day Same Service Reimbursement Policy, when a patient is admitted to the hospital via another site of service (e.g., hospital emergency department, physician's office, nursing facility), all services provided by the physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. A single code that represents the combined services should be reported.

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.

- 99234-99236 should not be reported on the same DOS as initial hospital care per diem codes 99221-99223, subsequent hospital care per diem codes 99231-99233, or hospital discharge day management codes 99238-99239.

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.

- 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 hospital inpatient or observation E/M service including admission and discharge (99236). Less than 15 minutes is not reported.
- CMS guidelines indicate that G0316 may be reported in addition to 99236 for time spent within the primary visit's surveyed timeframe, e.g., the date of the visit to three days after. Refer to the Internet-only Manual (IOM) 100-04 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:

- **American Psychiatric Association (APA):** CPT® Coding and Reimbursement
- **American Medical Association (AMA):** CPT® Manual > Evaluation and Management (E/M) Services Guidelines
- **Centers for Medicare & Medicaid Services (CMS):** Medicare Claims Processing Manual (IOM 100-04), Ch. 12, Sect. 30.6, and MLN006764_Evaluation_and_Management_Services_Guide_2024-09

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