Initial & Subsequent Hospital Care Evaluation & Management Coding

Initial (99221-99223) and subsequent (99231-99233) hospital E&M codes are reported once per day for evaluation and management (E&M) services provided to hospital inpatients.

- Initial hospital codes are used to report the first inpatient hospital encounter by the admitting physician and 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. If appropriate, consulting physician services may be reported with initial or subsequent hospital E&M codes instead of consultation codes. See the section on consultation services for details.
- Subsequent inpatient care services 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.

The level of initial or subsequent hospital E&M service may be determined by the *three key components* outlined in the Current Procedural Terminology (CPT®) code description *or by time* if counseling or coordination of care dominate the visit. 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).

Key components of hospital 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) & 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

Contributing components of hospital E&M coding:

- 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 hospital inpatient 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.

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- The nature of the health concern doesn't 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.

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.

99221-99223 –Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components (levels indicated in chart below): history; examination; and 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 are of (low/moderate/high) severity. Typically, (minutes indicated in chart below) are spent at the bedside and on the patient's hospital floor or unit.

99231-99233 – Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components (levels indicated in chart below): *interval* history (does not require PFSH), exam, MDM….Usually, the patient is (stable, recovering or improving, etc.). Typically, (minutes indicated in chart below) are spent at the bedside and on the patient's hospital floor or unit.

Initial Inpatient Hospital Care (must meet or exceed 3 of 3 key components)				
Code	**History**	**Exam**	**MDM**	**Typical Time**
99221	Detailed or Comprehensive	Detailed or Comprehensive	Straightforward or Low	30 minutes
99222	Comprehensive	Comprehensive	Moderate complexity	50 minutes
99223	Comprehensive	Comprehensive	High complexity	70 minutes
Subsequent Inpatient Hospital Care (must meet or exceed 2 of 3 key components)				
99231	Problem-focused	Problem-focused	Straightforward or Low	15 minutes
99232	Expanded problem-focused	Expanded problem-focused	Moderate complexity	25 minutes
99233	Detailed	Detailed	High complexity	35 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 Consultation Services Policy for details.
- **Modifier AI** (Principal physician of record) should be appended to the admitting physician's initial hospital E&M code to distinguish it from initial hospital E&M services reported by consulting physicians.

Prolonged E&M services may be reported if a provider spends more than the allotted time for an E&M or psychotherapy service, excluding time spent performing other separately reported services. Time spent with the patient must be documented in the medical record. The following codes for prolonged E&M services may be reported in addition to inpatient hospital E&M codes 99221-99223, 99231-99233:

99356 Prolonged service in the inpatient/observation setting, requiring unit/floor time beyond the usual service; first hour
99357 …; each additional 30 minutes (Code first 99356)
99358 Prolonged evaluation and management service before and/or after direct patient care; first hour
99359 …; each additional 30 minutes (Code first 99358)

- ➢ Prolonged services of less than 30 minutes total duration on a given date should not be report.

Resources

- **Optum Reimbursement Policies:** Consultation Services Policy
- **American Psychiatric Association (www.psychiatry.org):** Psychiatrists > Practice > Practice Management > Coding, Reimbursement, Medicare and Medicaid > Coding and Reimbursement
- **American Medical Association (www.ama-assn.org):** Practice Management > CPT® > CPT® Evaluation and Management

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(E&M) Codes and CPT Manual > Evaluation and Management Guidelines and Appendix C - E&M Extended Guidelines

- **CMS.gov:** Evaluation and Management Services Guide; 1995 Documentation Guidelines and 1997 Documentation Guidelines

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