



Initial Observation Care Evaluation & Management Coding

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.

The level of initial observation 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 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) & 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 initial hospital observation 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 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.

- 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.

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 Consultation Services Policy for details.

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 with direct patient contact may be reported in addition to Initial Observation Care E&M codes 99218-99220:

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)

- 99358-99359 may *not* be reported on the *same date* as office or other outpatient E&M codes (99202-99205, 99212-99215) but may be reported on a *different* date than the primary service to which it is related, including office or other outpatient services.
- For prolonged service codes based on 1 hour (or each additional 30 minutes), less than 30 minutes total duration on a given date should not be reported.

This overview and reminder of Evaluation & Management (E&M) coding guidelines is provided to help support continued improvements. Please review these additional resources for more details.

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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 \(E&M\) 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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