Inpatient Consultation Evaluation & Management Coding

Inpatient consultation E&M codes (99251-99255) may be used to report consultations performed in an inpatient setting. A consultation is provided at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem.

- **Effective for services furnished on or after January 1, 2010,** providers should code a patient evaluation and management visit with E/M codes that represents **where** the visit occurs and that identify the **complexity** of the visit performed
- **Effective March 1, 2020,** the Current Procedural Terminology (CPT®) consultation codes (ranges 99241-99245 and 99251-99255) **Optum aligns with the Centers for Medicare and Medicaid Services (CMS) and does not reimburse consultation services.** See the Consultation Services Policy for details. For Medicaid services, please see state specific guidelines.

The level of inpatient consultation 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. 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 inpatient consultation 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 inpatient consultation 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 inpatient consultation 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

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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.

99251-99255 – Inpatient consultation for a new or established 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 presenting problem(s) are (self limited or minor/low/ moderate/moderate to high). 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**
99251	Problem-focused	Problem-focused	Straightforward	20 minutes
99252	Expanded problem-focused	Expanded problem-focused	Straightforward	40 minutes
99253	Detailed	Detailed	Low complexity	55 minutes
99254	Comprehensive	Comprehensive	Moderate complexity	80 minutes
99255	Comprehensive	Comprehensive	High complexity	110 minutes

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 consultation E&M codes 99251-99255:

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.

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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