This is a basic overview and reminder of Inpatient Consultation Services Evaluation & Management (E&M) coding guidelines to help support continued improvements.

Levels for History, Physical Exam and Medical Decision-Making

When assigning an E&M code, it should be based on the different levels of history, physical exam, and medical decision-making as referenced in the below chart. First, the components are determined, and then the codes are assigned.

Possible levels for history:
1. Problem focused: Chief complaint, brief history of present illness or problem.
2. Expanded problem focused: Chief complaint, brief history of present illness and a problem pertinent system review.
3. Detailed: Chief complaint, extended history of present illness, problem pertinent system review (extended to include a review of a limited number of additional systems) and a pertinent past family and/or social history that is directly related to the member’s problem(s).
4. Comprehensive: Chief complaint, extended history of present illness, a review of systems that are directly related to the problem(s) identified in the history of present illness, plus a review of all additional body systems and a complete past, family and social history.

Possible levels for physical examination:
1. Problem focused: A limited examination of the affected body area or organ system.
2. Expanded problem focused: A limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
3. Detailed: An extended examination of the affected body area(s) and other symptomatic or related organ system(s).
4. Comprehensive: A general multisystem examination or a complete examination of a single organ system. Please note: The comprehensive examination performed as part of the preventive medicine E&M service is multisystem, but its extent is based on identified age and risk factors.

To qualify for a given type of decision-making, two of the three elements in the Complexity table must be met or exceeded. These elements are shown in the following table.

<table>
<thead>
<tr>
<th>Complexity of Medical Decision-Making</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of diagnoses or management options</td>
<td>Amount and/or complexity of data to be reviewed</td>
</tr>
<tr>
<td>Minimal</td>
<td>Minimal or none</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
</tr>
</tbody>
</table>

INITIAL HOSPITAL CARE (must meet or exceed 3 of 3 components)

<table>
<thead>
<tr>
<th>E&amp;M Code</th>
<th>History</th>
<th>Physical Examination</th>
<th>Medical Decision-Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221</td>
<td>Detailed or Comprehensive</td>
<td>Detailed or Comprehensive</td>
<td>Straightforward or Low complexity</td>
</tr>
<tr>
<td>99222</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate complexity</td>
</tr>
<tr>
<td>99223</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High complexity</td>
</tr>
</tbody>
</table>

SUBSEQUENT HOSPITAL CARE (must meet or exceed 2 of 3 components)

<table>
<thead>
<tr>
<th>E&amp;M Code</th>
<th>History</th>
<th>Physical Examination</th>
<th>Medical Decision-Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>99231</td>
<td>Problem focused</td>
<td>Problem focused</td>
<td>Straightforward or Low complexity</td>
</tr>
<tr>
<td>99232</td>
<td>Expanded Problem focused</td>
<td>Expanded Problem focused</td>
<td>Moderate complexity</td>
</tr>
<tr>
<td>99233</td>
<td>Detailed</td>
<td>Detailed</td>
<td>High complexity</td>
</tr>
</tbody>
</table>
**Code Notes**

**Initial Hospital Care (New or Established Patient) 99221-99223**

These codes are used to report the first hospital inpatient encounter with the patient by the admitting physician. For initial inpatient encounters by physicians other than the admitting physician, see initial inpatient consultation codes (99251-99255) or subsequent hospital care codes (99231-99233) as appropriate.

**Subsequent Hospital Care 99231-99233**

All levels of subsequent hospital care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient’s status, (i.e., changes in history, physical condition and response to management) since the last assessment.


**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.

**CPT® Manual**

The Current Procedural Terminology (CPT) Manual and other reference documents such as the 1995 and 1997 Documentation Guidelines provide more details about services that fulfill each of the levels within each of the three main components. In an audit, only those items documented in the 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.

**Contributing Components**

The time a physician spends providing counseling and/or coordination of care to a member is not viewed as a key component of the service levels, and not typically used as a main guide for the appropriate code. However, when counseling or coordination of care dominates the member’s visit, then that time can be used to determine the proper code, if documented correctly. In such cases, the care provider must document the exact amount of time spent and the extent of the counseling and coordination of care. For example, this would apply if more than 50 percent of the member’s visit time was spent on counseling and coordination of care. For office visits, only the time the physician spends with the member and/or the member’s family may be counted for those purposes.1

Similarly, 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 the physician deems appropriate to diagnose the problem, and the complexity of the medical decision-making involved.

**Unit/floor time (hospital observation services, inpatient hospital care, initial inpatient hospital consultations, nursing facility):**

For reporting purposes, intraservice time for these services is defined as unit/floor time, which includes the time present on the patient’s hospital unit and at the bedside rendering services for that patient. This includes the time to establish and/or review the patient’s chart, examine the patient, write notes, and communicate with other professionals and the patient’s family.

In the hospital, pre- and post-time includes time spent off the patient’s floor performing such tasks as reviewing pathology and radiology findings in another part of the hospital. This pre- and post-visit time is not included in the time component described in these codes. However, the pre- and post-work performed during the time spent off the floor or unit was included in calculating the total work of typical services in physician surveys. Thus, the unit/floor time associated with the services described by any code is a valid proxy for the total work done before, during, and after the visit.

**Prolonged E&M Services**

The CPT Manual provides guidance on the typical length of time a visit for each of the E&M CPT codes. These codes are also used with counseling or coordination of care visits.

At times, a care provider may spend more than the allotted time for the highest level CPT code in that grouping (i.e., 99310/60 minutes of face-to-face time) whether or not counseling or coordination of care is involved. When that is the case, the care provider may consider billing one of the prolonged services codes (99354 through 99357) or (99415 and 99416) in addition to the E&M code.

**Please note:** Prolonged services codes can only be billed together with an E&M code.

The information for this insert was drawn from the following sources:

1995 Documentation Guidelines for Evaluation and Management Services
1997 Documentation Guidelines for Evaluation and Management Services

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