Office of Integrity & Compliance

2023 Inpatient/Observation E&M Guidelines

Initial & Subsequent Inpatient/Observation Care

Inpatient/Observation level of service is based on either: **Time** or **Complexity of Medical Decision Making**

Initial Hospital Inpatient/Observation Care

Codes	Time (minutes)
99221	40-54
99222	55-74
99223	75-89

Subsequent Hospital Inpatient/Observation Care

Codes	Time (minutes)
99231	25-34
99232	35-49
99233	50-64

Inpatient/Observation Care Same Day Admission and Discharge

(requires 2 notes, use 1 code)

Codes	Time (minutes)
99234	45-69
99235	70-84
99236	85

Time personally spent on the calendar date of the encounter: *"I personally spent ____ minutes on the calendar day of the encounter, including pre and post visit work."* Activities include:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Documenting clinical information in the electronic or other health record
- Care coordination (not separately reported)

Discharge Day Management

Codes	Time (minutes)
99238	<30 minutes
99239	> 30 minutes

- Bill discharge code 99238 when documentation does not support **> than 30 minutes**.
- Discharge level **99239 requires** the documentation of **greater than 30 minutes** was spent on discharge planning.
- Hospital Discharge codes include as appropriate:
    - Documentation of a final examination
    - Discussion of the hospital stay (briefly describe why the patient was placed in OBS, the services provided and the outcome).
    - Preparation of discharge records, discharge instructions, prescriptions and referrals.
- A discharge order on each patient must be written, dated, timed and signed by the practitioner.
- A final progress note may be substituted for the discharge summary for Observation Cases and Inpatient admissions for problem of a minor nature requiring less than 48-hours hospitalization.
- A Discharge summary is required for Inpatient stays lasting more than 48-hours. (A discharge summary is recommended for all Inpatient admissions).

Prolonged Services Time Table

Inpatient/Observation E&M prolonged service code 99418 is only used when the primary service highest-level has been exceeded by 15 minutes.

Initial Hospital Inpatient/Observation Care + Prolonged Services			
Code	**99223**	**99223 + 99418 x1**	**99223 + 99418 x2**
Time (minutes)	76-89 No Prolonged code < 90 min	90-105	106-121

Subsequent Hospital Inpatient/Observation Care + Prolonged Services			
Code	**99233**	**99233 + 99418 x1**	**99233 + 99418 x2**
Time (minutes)	51-64 No Prolonged code < 65 min	65-80	81-96

Precepting Residents and Fellows: Time-Based Considerations

- Time spent by a Resident or Fellow cannot be counted towards the billable level of service
- Teaching physician's personal time on day of encounter counts towards the billable level of service

2023 CPT E&M Inpatient & Outpatient Level of Medical Decision Making (MDM)

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

Low	**Low**
	• 2 or more self-limited or minor problems
	• 1 stable chronic illness
	• 1 acute, uncomplicated illness or injury
	• 1 stable, acute illness
	• 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
		Limited
		(Must meet the requirements of at least 1 of the 2 categories)
		Category 1: Tests and documents
		• **Any combination of 2 from the following:**
		  • Review of prior external note(s) from each unique source*
		  • Review of the result(s) of each unique test*
		  • Ordering of each unique test*
		Category 2: Assessment requiring an independent historian(s)
		(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high).
			Low risk of morbidity from additional diagnostic testing or treatment

Moderate	**Moderate**
	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment
	• 2 or more stable chronic illnesses
	• 1 undiagnosed new problem with uncertain prognosis
	• 1 acute illness with systemic symptoms
	• 1 acute complicated injury
		Moderate
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• **Any combination of 3 from the following:**
		  • Review of prior external note(s) from each unique source*
		  • Review of the result(s) of each unique test*
		  • Ordering of each unique test*
		  • Assessment requiring an independent historian(s)
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported).
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported).
			Moderate risk of morbidity from additional diagnostic testing or treatment
			Examples only:
			• Prescription drug management
			• Decision regarding minor surgery with identified patient or procedure risk factors
			• Decision regarding elective major surgery without identified patient or procedure risk factors
			• Diagnosis or treatment significantly limited by social determinants of health

High	**High**
	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment
	• 1 acute or chronic illness or injury that poses a threat to life or bodily function
		Extensive
		(Must meet the requirements of at least 2 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• **Any combination of 3 from the following:**
		  • Review of prior external note(s) from each unique source*
		  • Review of the result(s) of each unique test*
		  • Ordering of each unique test*
		  • Assessment requiring an independent historian(s)
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported).
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported).
			High risk of morbidity from additional diagnostic testing or treatment
			Examples only:
			• Drug therapy requiring intensive monitoring for toxicity
			• Decision regarding elective major surgery with identified patient or procedure risk factors
			• Decision regarding emergency major surgery
			• Decision regarding hospitalization or escalation of hospital-level of care
			• Decision not to resuscitate or to de-escalate care because of poor prognosis
			• Parenteral controlled substances