Physician Hospital Coding Reference Packet

Updated 9/23/2024

INPATIENT/OBSERVATION E&M CODES

Option 1: Medical Decision-Making

Must meet **TWO** of the three elements (PROBLEMS/DATA/RISK) to meet MDM level

Code	MDM Level	Number and complexity of PROBLEMS addressed	Amount and/or complexity of DATA reviewed	RISK of complications, morbidity and/or mortality of patient management decisions made
99221 **99231**	**Low**	**Low** 2 or more self-limited/minor **or** 1 stable chronic illness **or** 1 acute uncomplicated illness	**Limited** (Must meet **1 of 2** categories) Cat 1: Tests & documents (quantity of 2) Cat 2: Assessment with independent historian	**Low** risk of morbidity from additional diagnostic testing or treatment
99222 **99232**	**Moderate**	**Moderate** 1 or more chronic illnesses with exacerbation **or** 2 or more stable chronic illness **or** 1 undiagnosed new problem **or** 1 acute complicated illness	**Moderate** (Must meet **1 of 3** categories) Cat 1: Tests, documents or independent historians (quantity of 3) Cat 2: Independent interpretation of tests Cat 3: Discussion of mgmt. or test interpretation with external provider	**Moderate** risk of morbidity Examples: • Prescription drug mgmt • Decision regarding minor surgery • Decision regarding elective major surgery • Diagnosis or treatment limited by social determinants of health
99223 **99233**	**High**	**High** 1 or more chronic illnesses with severe exacerbation **or** 1 acute or chronic illness with threat to life or bodily function	**Extensive** (Must meet **2 of 3** categories) Cat 1: Tests, documents or independent historians (quantity of 3) Cat 2: Independent interpretation of tests Cat 3: Discussion of mgmt. or test interpretation with external provider	**High** risk of morbidity Examples: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care

NOTE: Observation care codes (99217, 99218, 99219, 99220, 99224, 99225, 99226) have been deleted. Use IP codes to report Observation care.

INPATIENT/OBSERVATION E&M CODES

Option 2: Time

Includes face-to-face and non-face-to-face time **personally spent by clinician on day of encounter**. Includes time spent:

- Preparing to see patient (e.g. review of tests)
- Obtaining/reviewing separately obtained history
- Performing medically appropriate history/exam
- Counseling and educating patient/family/caregiver
- Ordering meds, tests or procedures
- Referring/communicating with other health care professionals
- Documenting clinical info in EMR
- Independently interpreting results
- Communicating results to patient/family/caregiver
- Care coordination

INITIAL Inpatient/Observation Care	
Code	**Time (minutes)**
99221	40 - 54
99222	55 - 74
99223	75 +

SUBSEQUENT Inpatient/Obsservation Care	
Code	**Time (minutes)**
99231	25 - 34
99232	35 - 49
99233	50 +

NOTE: Observation care codes (99217, 99218, 99219, 99220, 99224, 99225, 99226) have been deleted. Use IP codes to report Observation care

ADMISSION & DISCHARGE CODING		
Hospital Length of Stay	**Discharged On:**	**Code(s) to Use:**
< 8 hours	Same calendar date as admission or start of observation	Initial IP hospital services only 99221 - 99223
8 or more hours	Same calendar date as admission or start of observation	Admit/Discharge codes: 99234 - 99236
< 8 hours	Different calendar date than admission or start of observation	Initial IP hospital services only 99221 - 99223
8 or more hours	Different calendar date than admission or start of observation	Admit/Discharge codes: 99234 - 99236

*Use the "**HELPME**" code if you aren't sure what code to add. A coder will review and add the correct code.

OUTPATIENT / OFFICE VISIT E&M CODES

Option 1: Time

Includes face-to-face and non-face-to-face time **personally spent by clinician on day of encounter**, whether or not counseling and/or coordination of care dominate the service. Includes time spent:

- Preparing to see patient (e.g. review of tests)
- Obtaining/reviewing separately obtained history
- Performing medically appropriate exam/evaluation
- Counseling and educating
- Ordering meds, tests or procedures
- Referring/communicating with other health care professionals
- Documenting clinical info
- Interpreting results
- Care coordination
- NOTE: Cannot consider any time billed under a separate CPT code in the time calculation

Office or Other Outpatient Visits NEW Patients

Code	Time (minutes)
99202	15 - 29
99203	30 - 44
99204	45 - 49
99205	60 - 74

Office or Other Outpatient Visits ESTABLISHED Patients

Code	Time (minutes)
99211	N/A
99212	10 - 19
99213	20 - 29
99214	30 - 39
99215	40 - 54

OUTPATIENT / OFFICE VISIT E&M CODES

Option 2: Medical Decision-Making:

Includes establishing diagnoses, assessing status of condition, and/or selecting management option.

Must meet **TWO** of the three elements for a particular level of MDM

Code	MDM Level	Number and complexity of PROBLEMS addressed	Amount and/or complexity of DATA reviewed	RISK of complications, morbidity and/or mortality of patient management decisions made
99202 **99212**	**Straight-forward**	**Minimal** 1 self-limited or minor	**Minimal or none**	**Minimal** risk of morbidity from additional diagnostic testing or treatment
99203 **99213**	**Low**	**Low** 2 or more self-limited **or** 1 stable chronic illness **or** 1 acute	**Limited** (1 of 2 categories) Cat 1: Tests & documents (2) Cat 2: Assessment with independent historian	**Low** risk of morbidity from additional diagnostic testing or treatment
99204 **99214**	**Moderate**	**Moderate** 1 or more chronic illnesses with exacerbation **or** 2 or more stable chronic **or** 1 undiagnosed new problem **or** 1 acute complicated	**Moderate** (1 of 3 categories) Cat 1: Tests, documents or independent historians (3) Cat 2: Independent interpretation of tests Cat 3: Discussion or mgmt. or test interpretation with external provider	**Moderate** risk of morbidity Examples: • Prescription drug mgmt • Decision regarding minor surgery with risk factors • Decision regarding elective major surgery without risk factors • Dx or treatment limited by social determinants of health
99205 **99215**	**High**	**High** 1 or more chronic illnesses with severe exacerbation **or** 1 acute or chronic with threat to life/bodily function in the near term without treatment	**Extensive** (2 of 3 categories) Cat 1: Tests, documents or independent historians (3) Cat 2: Independent interpretation of tests Cat 3: Discussion of mgmt. or test interpretation with external provider	**High** risk of morbidity Examples: • Drug therapy requiring monitoring for toxicity • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care due to poor prognosis

*Use the "**HELPME**" code if you aren't sure what code to add. A coder will review and add the correct code.

Interfacility Transfers

For interfacility transfers between **MUH, MHG, MHN and MHS**:

- Can only bill one **Subsequent** visit (99231, 99232, 99233) on the date of transfer. Must decide which provider bills for visit (sending or receiving).
- Do not bill a discharge code for the transferring facility or an Initial visit code for the receiving facility.

For interfacility transfers between **MOBH** and **MUH/MHG/MHN/MHS**:

- The sending provider can bill a **Discharge** on date of transfer.
- If the receiving provider sees the transferred patient on the same date of service as the Discharge, the receiving provider should bill a **Subsequent** visit.
- If the receiving provider sees the transferred patient on the next date of service after Discharge, the receiving provider could bill an **Initial** visit.

Critical Care Services

- **99291** — the first 30 to 74 minutes of critical care time
  - If providing less than 30 minutes, do not use a critical care procedure code
- **99292** — 30-minute increments of time when more than 30 minutes past the first 74 minutes
  - Must document at least 104 minutes to submit
  - Must provide a full 30 minutes for each unit of 99292

Total Duration of Critical Care	Appropriate CPT Codes
Less than 30 minutes	Other appropriate E&M code
30 – 74 minutes	99291 x 1
75 – 104 minutes	99291 x 1 and 99292 x 1
105 – 134 minutes	99291 x 1 and 99292 x 2
135 – 164 minutes	99291 x 1 and 99292 x 3
165 – 194 minutes	99291 x 1 and 99292 x 4
195 minutes or longer	99291/99292 following above

Key Points:

- To submit critical care, documentation must support:
  - The patient was critically ill or injured, with
  - Acute impairment of one or more vital organ systems and
  - Probability of imminent life-threatening deterioration of the patient condition
  - Time spent on the patient
- Full Attention of Rendering Provider:
  - Services require the full attention of the provider rendering the service
  - Time must be spent at the patient's immediate bedside or elsewhere on the floor/unit so long as the provider is immediately available to the patient
  - Cannot provide services to any other patient during critical care time period
  - Only one provider may bill for critical care services during any single time period even if more than one physician is providing care to the critically ill patient
- Time-Based Service:
  - Time may be continuous or an aggregate of intermittent time spent by members of the same group and same specialty
- Concurrent Critical Care:
  - Initial Critical Care 99291 – to be reported only once per day within same specialty
  - Subsequent Critical Care 99292 – may be performed and billed separately by other group members including NPPs
  - Aggregate Critical Care – time spent by providers in the same specialty may be added to meet the time required to report 99291 or 99292, and billed under one provider's claim. When 99292 is based on aggregate time, a minimum of 104 minutes must be reached, and documentation should reflect aggregate time.

Critical Care Services (cont.)

- Split-Shared Services:
  - Critical care may be split-shared by physician and NPP in same group.
  - The provider who provided more than half of the cumulative critical care time may bill for total units of critical care
- Global Surgery Unrelated to Critical Care:
  - Critical Care is not payable on the same calendar date as a procedure with a global surgical period (0/10/90 day), unless the Critical Care meets the below criteria:
    - Service provided meets the definition of Critical Care and require the full attention of the provider.
    - Critical Care is unrelated to the specific anatomic injury or general surgical procedure performed.
    - Critical Care is above and beyond the procedure performed (beyond usual pre- and post-op care)
    - Modifier FT is used to report Critical Care unrelated to the procedure
- Teaching Physician Services and Critical Care:
  - Time teaching cannot be counted towards Critical Care
  - Time spent by the resident in the absence of the teaching physician cannot be billed as Critical Care; only time spent by resident and teaching physician together with the patient can be counted towards critical time.
  - A combination of the teaching physician and resident's documentation may support Critical Care services.
  - The teaching physician may refer to the resident's documentation; however, the teaching physician's note must provide substantive documentation.
- Services Included in Critical Care, **<u>not</u> separately payable when furnished with Critical Care:**
  - Interpretation of cardiac output measurements (93561, 93562)
  - Chest x-rays (71045, 71046)
  - Pulse oximetry (94760-94762)
  - Blood gases and collection and interpretation of physiologic data (e.g. ECGs, blood pressures, hematologic data)
  - Gastric intubation (43752, 43753)
  - Temporary transcutaneous pacing (92953)
  - Ventilator management (94002-94004, 94660, 94662)
  - Vascular access procedures
- Services Not Included in Critical Care, **separately payable when furnished with Critical Care (time spent performing these services cannot be included in critical care time):**
  - Endotracheal intubation (31500)
  - Insertion and placement of flow-directed catheter (Swan-Ganz) (93503)
  - CPR (92950)

*Use the "**HELPME**" code if you aren't sure what code to add. A coder will review and add the correct code.

Prolonged Services

- Prolonged Service codes are add-on codes to E&M services
- In order to use Prolonged Service codes, the primary code must be selected based on time.
- Prolonged Service codes may only be added to the highest level code in the category.
- May include both face-to-face and non-face-to-face time.

Outpatient/Office Prolonged Service Codes (99417 or G2212):

Primary E&M Code	Time	Time threshold to add 99417 (private payer)	Time threshold to add G2212 (Medicare/Medicaid)
99205 (New)	60 minutes	75 minutes	89 minutes
99215 (Estab)	40 minutes	55 minutes	69 minutes

Examples of Codes for Billing Prolonged Outpatient/Office Services:

Codes	Total Time Required for Reporting
99205 (no prolonged code)	60-74 minutes
99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and G2212 x 2	104-118 minutes
99205 x 1 and G2212 x 3 or more for each additional 15 minutes	119 minutes or more
99215 (no prolonged code)	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84-98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes	99 minutes or more

Codes	Total Time Required for Reporting
99205 (no prolonged code)	60-74 minutes
99205 x 1 and 99417 x 1	75-89 minutes
99205 x 1 and 99417 x 2	90-104 minutes
99205 x 1 and 99417 x 3 or more for each additional 15 minutes	105 minutes or more
99215 (no prolonged code)	40-54 minutes
99215 x 1 and 99417 x 1	55-69 minutes
99215 x 1 and 99417 x 2	70-84 minutes
99215 x 1 and 99417 x 3 or more for each additional 15 minutes	85 minutes or more

Prolonged Services (cont.)

Inpatient/Observation Prolonged Service Codes (99418 or G0316):

Primary E&M Code	Prolonged Code	Time Threshold to Report Prolonged Code	Can Count Physician/NPP time spent within this time period
99223 (Initial IP/Obs)	G0316 (MCR/MCD) 99418 (Private)	90 minutes	Date of visit
99233 (Subs IP/Obs)	G0316 (MCR/MCD) 99418 (Private)	65 minutes	Date of visit
99236 (IP/Obs Same Day Adm/Disch)	G0316 (MCR/MCD) 99418 (Private)	110 minutes	Date of visit to 3 days after

Examples of Codes for Billing Prolonged Inpatient/Observation Services:

Codes	Total Time Required for Reporting
99223 (no prolonged code)	75-89 minutes
99223 x 1 and 99418/G0316 x 1	90-105 minutes
99223 x 1 and 99418/G0316 x 2	106-121 minutes
99223 x 1 and 99418/G0316 x 3 or more for each additional 15 minutes	122 minutes or more
99233 (no prolonged code)	50-64 minutes
99233 x 1 and 99418/G0316 x 1	65-80 minutes
99233 x 1 and 99418/G0316 x 2	81-96 minutes
99233 x 1 and 99418/G0316 x 3 or more for each additional 15 minutes	97 minutes or more

*Use the "**HELPME**" code if you aren't sure what code to add. A coder will review and add the correct code.

Global Surgery Package Concept

The global surgical package includes all necessary services normally provided by a physician (or members of the same group/same specialty) before, during, and after a procedure.

Global Surgery Classifications:

0-Day Post-operative period (endoscopies and some minor procedures)

- No preop or postop days
- Generally, an E&M on procedure day isn't payable (without modifier25)

10-Day Post-operative period (other minor procedures)

- No preop period
- Generally, an E&M on procedure day isn't payable (without modifier25)
- Total global period is 11 days; count surgery day plus 10 days immediately following

90-Day Post-operative period (major procedures)

- 1 day preop included
- Generally, an E&M on procedure day isn't payable (without modifier 25)
- Total global period is 92 days; count 1 day before surgery, day of surgery, and 90 days immediately following

Global Surgery Payment Includes:

- Pre-operative visits after decision to operate. For major procedures, this includes preop visit the day before surgery. For minor procedures, this includes preop visits on the day of surgery.
- Intra-operative services normally a necessary part of the surgical procedure
- All additional medical or surgical services the surgeon provides during the post-operative period when complications don't require additional trip to operating room
- Follow-up post-operative recovery period visits
- Post-surgical patient pain management
- Supplies
- Miscellaneous services, such as dressing changes, local incision care, operative pack removal, cutaneous sutures and staple removal, lines, wires, tubes, drains, casts, splints; insertion, irrigation and urinary catheter removal, routine peripheral intravenous lines, nasogastric and rectal tubes; tracheostomy tube changes and removals

Global Modifiers

24: Unrelated E&M Service by the Same Physician During Postoperative Period

Appropriate Use: Medicare defines "same physician" as physicians in the same group/specialty

Append Modifier 24 to the E&M code when:

- An unrelated E&M service is performed beginning the day after the procedure, by the same physician, during the 10 or 90-day post-operative period
- Documentation indicates the service was exclusively for treatment of the underlying condition and not for postop care
- Same physician is managing immunosuppressant therapy during postop period of transplant
- Same physician is managing chemotherapy during postop period of procedure

25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

Appropriate Use: Modifier 25 is used to indicate that a patient's condition required a significant, separately identifiable evaluation and management (E/M) service above and beyond that associated with another procedure or service being reported by the same physician or other qualified health care professional (QHP) on the same date. This service must be above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure or service that was performed on that same date, and it must be substantiated by documentation in the patient's record that satisfies the relevant criteria for the respective E/M service to be reported.

- **Append only to E/M services.** Modifier 25 should only be appended to E/M services codes
- **Requires awareness of usual preoperative and postoperative services.** When an E/M service is reported in conjunction with another procedure, the E/M service should include work performed above and beyond the usual preoperative and postoperative services associated with the procedure performed on the same date of service.
- **Pre- and post-operative services typically associated with a procedure include the following and cannot be reported with a separate E/M services code:**
    - Review of patient's relevant past medical history,
    - Assessment of the problem area to be treated by surgical or other service,
    - Formulation and explanation of the clinical diagnosis,
    - Review and explanation of the procedure to the patient, family, or caregiver,
    - Discussion of alternative treatments or diagnostic options,
    - Obtaining informed consent,
    - Providing postoperative care instructions,
    - Discussion of any further treatment and follow up after the procedure

57: Decision for Surgery

Appropriate Use: Append to an E&M service where the decision to perform surgery is made either the day before a major surgery (90-day global) or the day of a major surgery.

Global Modifiers (cont.)

FT: Unrelated critical care during postoperative period or on same day as a procedure or another E&M visit

Appropriate Use: For critical care visits that are unrelated to the surgical procedure but performed on the same day; or when critical care services provided during a global surgical period are unrelated to a surgical procedure.

Additional Modifiers

AI: Admitting/Attending Physician

Appropriate Use: Admitting Physician appends to the initial Inpatient E&M service (99221-99223)

GC: Resident under the direction of a Teaching Physician

Appropriate Use: Appended by Teaching Physician to indicate service has been performed in part by a resident under the direction of the Teaching Physician

Consultations

- Medicare and certain other private payers don't recognize consult codes.
- Providers should enter the Consult code, and the Business Office will cross-walk to the appropriate E&M code, if required.

Outpatient/Office Consultations (New or Established)

Based on MDM	Based on TIME	Outpatient Consult Codes
Straightforward MDM [1 minor problem; No data review; Minimal Risk of morbidity]	20 minutes	99242
Low Level MDM [2 or more minor, 1 stable chronic or 1 acute problem; Limited data review; Low risk of morbidity]	30 minutes	99243
Moderate Level MDM [1 or more chronic with exacerbation, 2 or more stable chronic, 1 new or 1 acute complicated problem; Moderate data review; Moderate risk i.e. Prescription drug management, decision for minor surgery]	40 minutes	99244
High Level MDM [1 or more chronic or acute with severe exacerbation problem; Extensive data review; High risk of morbidity]	55 minutes	99245

Inpatient/Observation Consultations (New or Established)

Based on MDM	Based on TIME	Inpatient Consult Codes
Straightforward MDM [1 minor problem; No data review; Minimal Risk of morbidity]	35 minutes	99252
Low Level MDM [2 or more minor, 1 stable chronic or 1 acute problem; Limited data review; Low risk of morbidity]	45 minutes	99253
Moderate Level MDM [1 or more chronic with exacerbation, 2 or more stable chronic, 1 new or 1 acute complicated problem; Moderate data review; Moderate risk i.e. Prescription drug management, decision for minor surgery]	60 minutes	99254
High Level MDM [1 or more chronic or acute with severe exacerbation problem; Extensive data review; High risk of morbidity]	80 minutes	99255

Miscellaneous Codes – Common Bedside Procedures

Chest tube (open approach): 32551
Chest tube (percutaneous without guidance): 32556
Chest tube (percutaneous with guidance): 32557
Central Line placement (age 5 +, non-tunneled): 36556
Central Line placement (less than age 5, tunneled): 36557
Central Line placement (age 5 +, tunneled): 36557
CPR: 92950
Cardioversion: 92960

HELPME Code

In Epic, the "HELPME" code is a place-holder code, to be used when the provider does not know what code to add. A coder will review and add the correct code.

This is intended as a help tool only. All providers are expected to use this guide to determine the correct code to use for hospital rounding charges.

NOBILL Code

Choose the "NOBILL" code to indicate that a service or procedure was performed but is not appropriate to be billed. Examples of when to use the "NOBILL" place-holder code:

- Conditional discharge and patient leaves AMA prior to discharge
- H&P performed by resident on patient transferred to different service before attending examination
- Service performed by non-credentialled provider