The Transformation of Documenting and Coding for Neurologic Hospital Inpatient and Observation Services

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ABSTRACT

Landmark changes to documenting and coding for office or other outpatient evaluation and management (E/M) codes were implemented on January 1, 2021. To decrease clinicians' administrative burden, many documentation requirements were eliminated. In addition, major changes were made in how medical decision making and time spent on the date of the encounter are used to determine the level of service. On January 1, 2023, these changes were extended to inpatient and observation E/M services. The level of service in both inpatient and outpatient settings can now be selected based on the total time dedicated to the patient's care on the day of the encounter or the new method of medical decision making. This article discusses the optimal ways to document and code for inpatient hospital and observation encounters after January 1, 2023.

INTRODUCTION

In January 2021, major revisions to evaluation and management (E/M) codes were implemented in *Current Procedural Terminology* (*CPT*) codes in response to requests by the Centers for Medicare & Medicaid Services (CMS) and others to simplify documentation, decrease administrative burden on clinicians when documenting office or other outpatient clinical encounters, and make clinical notes more reflective of what clinicians do during these visits.[1] These changes required documentation of only a medically appropriate history and examination. The calculation of level of service could use two different methods: either what was done or the time spent on the date of the encounter. Both methods were changed significantly from previous rules established in 1995[2] and 1997.[3]

The first change was to make medical decision making the sole determinant of what was done, eliminating mandated elements of history and physical examination. Medical decision making includes three domains, each with four different levels of complexity: (1) number of problems addressed, (2) amount of data reviewed or analyzed, and (3) risk of morbidity and mortality of patient

management. The level of complexity of the highest two of the three domains is used to determine the level of service when billing based on medical decision making.[1]

The second change redefines time as the total time spent on the date of the encounter rather than what was considered "typical time" with the requirement that at least 50% of the typical time be spent performing counseling and coordination of care. For the outpatient setting, time is defined by a range of minutes for each level of service. It includes time spent before, during, and after the encounter on the calendar day of the encounter. The new definition of time includes all relevant face-to-face and non–face-to-face activities.

Beginning January 2023, similar changes were applied to E/M services in all settings.[4-6] All E/M services neurologists perform, including hospital inpatient and observation, can now be billed based on medical decision making or total time. Hospital inpatient and observation services have been combined into a single family of codes that are applicable to all initial and subsequent encounters in the hospital setting. Although consultation codes were also revised, Medicare, many Medicaid programs, and most commercial payers do not currently cover them.[7] Services that exceed the maximum time assigned to the longest inpatient initial or subsequent encounters are reported by adding prolonged services code 99418 to the base code. This is analogous to code 99417 used for outpatient services. Medicare does not cover either 99417 or 99418. Instead, CMS established longer time thresholds for prolonged E/M services in outpatient and inpatient settings and uses their own G codes to document these encounters.[7]

HISTORY AND EXAMINATION

Best medical practice for any encounter should always include a medically appropriate history, physical examination, or both, as determined by the physician or other qualified health care professional. The elements previously referred to as "bullets" within the history of present illness and the details of the past medical, social, and family history, and review of systems are no longer required for code selection. Similarly, elements of the physical examination listed in the neurology single system examination in 1997[3] and the general medical examination in 1995[2] are no longer mandated for selecting a level of service.

Other Tests or Services on the Date of an E/M Encounter

Ordering, performing, and interpreting diagnostic tests or studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation of those tests or studies is reported and billed separately by the same physician or other qualified health care professional reporting the E/M service. For example, if an EEG was obtained and interpreted by the same physician who is providing the E/M service on the same date, a professional fee can be submitted for interpreting the EEG, but that study cannot be counted as an element of data reviewed by that physician to determine the level of service for the E/M code. Another clinician caring for that patient may review the EEG report and count their review as an element of data review. The data elements reviewed for a specific test (such as a lipid profile performed on a specific date) can only be counted once by the ordering provider—on the date of the encounter that the test is ordered.

HOSPITAL INPATIENT AND OBSERVATION CARE SERVICES

For inpatient hospital and observation services, there are three levels of service for each of the two subcategories of hospital encounters: initial and subsequent encounters. Initial service is selected when the patient has not received any professional services from a physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice during the current inpatient stay.[6] Subsequent service codes are selected when the patient has already received care from someone in the same group practice during the current inpatient stay.[6] When a hospital stay transitions from observation status to inpatient or vice versa, it is considered a single stay.[6]

The levels of service of the initial and subsequent E/M codes are differentiated by medical decision making or total time that must be met or exceeded (CODING TABLE 1). Either level of medical decision making or total time can be chosen to determine the level of the service for an E/M encounter.

MEDICAL DECISION MAKING

Medical decision making is categorized as straightforward, low, moderate, or high. The three domains of medical decision making defined for the new inpatient E/M codes parallel the outpatient code rules established in 2021[1]:

- **Number and complexity of problems addressed**
- **Amount or complexity of data reviewed or analyzed**
- **Risk of complications or morbidity and mortality of patient management**

To qualify for a given level of medical decision making, one must meet the highest level in two of the three domains. Level 1 is straightforward or low

CODING TABLE 1 **Medical Decision Making and Time for Inpatient or Observation Encounters**[a]

Medical decision making	*CPT* code	History	Exam	Time (minutes)
Initial encounter				
Straightforward or low	99221	Medically appropriate	Medically appropriate	40 or more
Moderate	99222	Medically appropriate	Medically appropriate	55 or more
High[b]	99223	Medically appropriate	Medically appropriate	75 or more
Subsequent encounters				
Straightforward or low	99231	Medically appropriate	Medically appropriate	25 or more
Moderate	99232	Medically appropriate	Medically appropriate	35 or more
High[c]	99233	Medically appropriate	Medically appropriate	50 or more

CPT = Current Procedural Terminology.

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[b] For services of 90 minutes or longer, use prolonged services code 99418. For Medicare, for services of 105 minutes or longer, use prolonged services code G0316.

[c] For services of 65 minutes or longer, use prolonged services code 99418. For Medicare, for services of 80 minutes or longer, use prolonged services code G0316.

medical decision making, level 2 is moderate, and level 3 is high. Only a few additional elements in the problem and risk domains were added in 2023 to reflect inpatient and observation services.

Problems

This domain includes any problems addressed during the inpatient hospital encounter. Comorbidities not addressed during the encounter cannot be used for determining the level of this domain. For example, hypertension and hyperlipidemia are often relevant problems in a patient with stroke during a hospital encounter as part of the discussion of secondary stroke prevention, and medications to address these issues may be prescribed. However, if discussion and management of these issues are delegated to another physician or other qualified health care professional they cannot be used to determine the number and complexity of problems addressed. *CPT* defines a problem as "a disease condition, illness, injury, symptom, sign, finding, complaint or other matter addressed at the encounter with or without a diagnosis being established at the time of the encounter."[6] The 2023 problem domain differs from the 2021-2022 outpatient medical decision making in only two components: 1 stable, acute illness; or 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care.[1,4-6] Because testing and evaluations may occur during a hospital stay, the final diagnosis may be different from the presenting symptoms. The highest risk problem in the differential diagnosis (eg, one acute or chronic illness or injury that poses a threat to life or bodily function[6]) that is considered can be used to determine the level of the encounter. For example, if the risk of stroke is high in a patient's presentation, that patient will meet the high-risk category for problems addressed, regardless of whether a stroke is eventually diagnosed.

Problems addressed during the initial encounter may differ from problems addressed in subsequent encounters. If a problem is not at treatment goal, such as elevated blood pressure despite antihypertensive medications, then that problem is not considered "stable" as stated in the CPT manual.[6]

Number and Complexity of Problems Addressed

- **Low**
  - 2 or more self-limited or minor problems; OR
  - 1 stable chronic illness; OR
  - 1 acute uncomplicated illness or injury; OR
  - 1 stable acute illness (new for 2023); OR
  - acute uncomplicated illness or injury requiring hospital inpatient or observation level of care (new for 2023)
- **Moderate**
  - 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; OR
  - 2 or more stable chronic illnesses; OR
  - 1 undiagnosed new problem with uncertain prognosis; OR
  - 1 acute illness with systemic symptoms; OR
  - 1 acute complicated injury

- **High**
  - 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; OR
  - 1 acute or chronic illness or injury that poses a threat to life or bodily function

Data

This category parallels the outpatient E/M medical decision making table without any changes from 2021-2022 outpatient rules. There are 3 different categories of data to be analyzed or reviewed: limited, moderate, and extensive. For the limited data category, either category 1 or an assessment requiring an independent historian is met. For the moderate category, 1 of the 3 categories of data must be met, and for the extensive category, 2 of the 3 categories must be met. Please refer to the complete Levels of Medical Decision Making (MDM) table from the American Medical Association for more information.[6]

Data Categories

Limited Data

(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

OR

Category 2: Assessment requiring an independent historian(s)

Moderate Data

(Must meet the requirements of at least 1 out of 3 categories)

OR

Extensive Data

(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)

OR

Category 2: Independent interpretation of tests

- Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);

OR

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)

ANALYZED. When tests are ordered by another physician or other qualified health care professional, such as the emergency department physician ordering a complete blood cell count (CBC) and complete metabolic profile (CMP), but the laboratory results are interpreted by the neurologist, they are counted as reviewing results of two tests.

INDEPENDENT INTERPRETATION OF TEST. Although the report from the radiologist is typically available in the medical record, neurologists will often perform and document their personal review of imaging. If this was done, the neurologist should document that neuroimaging was personally reviewed and state a brief impression of the imaging findings.

For category 3, an interactive exchange must take place between clinicians that results in a decision, not necessarily an action, about patient care. Routing a chart note would not count as an interactive exchange. The exchange does not have to be synchronous but must be initiated and completed within a short time so that an intervention can occur, if necessary.

Risk

Risks associated with management decisions regarding a condition are distinct from the risks of those problems. There are three levels of risk for this domain: low, moderate, and high. Two additional examples were added for 2023 as noted below.

Risk of Complications or Morbidity or Mortality of Patient Management

- **Low risk**
  - Low risk of morbidity from additional diagnostic testing or treatment
- **Moderate risk**
  - Examples only:
    - Any 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 risk**
  - 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 care (new for 2023)

- → Decision not to resuscitate or to de-escalate care because of poor prognosis
- → Parenteral controlled substances (new for 2023)

TIME

When time is the determinant of the level of service for an encounter, total time on the calendar date, from midnight to midnight, of the encounter is used. This includes face-to-face time and non–face-to-face time personally spent by the physician or qualified health care professional on that day. When the service is continuous before and through midnight, all the time may be applied to the reported date of the service. Activities that can be counted are unchanged from 2021-2022 outpatient time rules. Counseling and coordination of care can be included in total time, but the requirement that more than 50% of the time was spent in these activities to bill based on time is no longer required.[6]

- **The following activities can be included when summing total time on the calendar day:**
  - Preparing to see the patient
  - Obtaining or reviewing a separately obtained history
  - Performing a medically appropriate examination, evaluation, or both
  - Counseling and educating the patient, family, or caregiver
  - Ordering medications, tests, or procedures
  - Referring to and communicating with other health care professionals
  - Documenting clinical information in the electronic or other health record
  - Independently interpreting results and communicating to the patient, family, or caregiver
  - Care coordination not separately reported
- **Time does not count for:**
  - Any services reported separately
  - Travel
  - General teaching that is not specific to a patient's management

To prevent confusion, the number of minutes should be clearly documented in the note for that encounter only when time is used to choose the level of service. The attending physician is the billing provider for patients seen in teaching hospitals with trainees. The time spent by residents taking the history and performing the physical examination does not count if the attending physician is not present. Time spent teaching by the attending neurologist that is specific to the patient's case does count when doing time-based billing.

Same Day Admission and Discharge Hospital Inpatient or Observation Care Services

When patients are admitted and discharged on the same date of service, codes 99234-99236 should be used. These codes require two or more encounters on the same date (CODING TABLE 2). If the admission and discharge are done during a

single encounter, then the initial hospital service codes 99221, 99222, or 99223 can be used.

Prolonged Services When Billing Based on Time

There are two different methods to code for services that exceed the maximum time of the highest level of initial or subsequent inpatient or observation E/M encounters. For initial services of 90 minutes or longer in patients not billing through Medicare, use prolonged initial services code 99418.[6] For patients using Medicare, use prolonged services code G0316 for initial services of 105 minutes or longer.[7] For subsequent services of 65 minutes or longer in patients not billing through Medicare, use prolonged services code 99418.[6] For patients using Medicare, use prolonged services code G0316 for subsequent services of 80 minutes or longer.[7] Multiple units of prolonged services codes can be used. It is important to review your payers' policies prior to submission of a prolonged services encounter to ensure coverage.

> **99418:** Prolonged inpatient or observation evaluation and management services time with or without direct patient contact **beyond the required time of the primary service** when the primary service level has been selected using total time, each 15 minutes of total time[6]
>
> **G0316:** Prolonged **hospital inpatient or observation care** evaluation and management services **beyond the total time for the primary service** (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact[7]

Non–Face-to-Face Work Outside Day of Encounter

For non–face-to-face work that includes a minimum of 60 minutes or more of total time on a date outside the calendar day of the encounter, 99358 can be used. For every 30 minutes or more above the 60-minute time, the add-on code 99359 can be used.

Consultation E/M Codes 99252-99255

Effective January 1, 2023, both the level 1 office consultation code, 99241, and the corresponding inpatient consultation code, 99251, have been deleted and are no longer valid codes. Consultation codes are not currently reimbursed by Medicare. Reimbursement by commercial payers for consultation codes varies by payer. If payers will not cover consultation codes then inpatient or observation codes (initial

Admission and Discharge on Same Day for Hospital Inpatient or Observation Care[a] CODING TABLE 2

Medical decision Making	*CPT* code	History	Exam	Time (minutes)
Straightforward or low	99234	Medically appropriate	Medically appropriate	45 or more
Moderate	99235	Medically appropriate	Medically appropriate	70 or more
High	99236	Medically appropriate	Medically appropriate	85 or more

CPT = Current Procedural Terminology.

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and subsequent encounters) should be reported instead. Consultations are provided at the request of another physician or other qualified health care professional to recommend care for a specific problem. When consulting, a written report must be completed and sent to the requesting physician. Because only one consultation may be reported by a consultant per admission, any subsequent encounters by the consultant should be reported as subsequent inpatient codes 99231-99233.

CASE 1

A 68-year-old woman with hypertension and diabetes was evaluated by a neurologist in the emergency department (ED). The neurologist decided to admit the patient to the neurology service for a probable stroke. Upon talking to the patient and corroborating her history with her husband moments after she arrived at the hospital, the neurologist confirmed that the patient was last known well when she went to sleep but awoke the next morning with mild weakness of her left side and slight slurring of her speech. On examination, the patient had slight flattening of the left nasolabial fold with some associated dysarthria, mild left pronator drift, and 4+/5 power in the proximal left leg. Her National Institutes of Health Stroke Scale (NIHSS) score was 4. The neurologist reviewed some basic laboratory tests that were drawn in the ED, which included a CBC, CMP, and prothrombin time and international normalized ratio (INR). A CT of the head and CT angiogram (CTA) of the head and neck were ordered by the ED and independently interpreted by the neurologist. In addition to the history, examination, and review of imaging, the patient was counseled on the diagnosis of ischemic stroke and anticipated diagnostic testing. The total time spent on this encounter was 58 minutes.

DISCUSSION

For this patient, the level of service is an initial encounter in the inpatient hospital setting since she was admitted from the ED for a possible stroke. Therefore, *CPT* 99221-99223 are the code options available.

If the patient is in designated observation status, now no differentiation exists between an initial inpatient hospital encounter or an initial observation encounter; they both use the same codes 99221-99223. The next step is to determine if the level of the new patient admission or observation should be chosen based on medical decision making or total time. The components of medical decision making include problems addressed, data reviewed and analyzed, and risk of patient management.

Problem Addressed

This acute stroke meets the criteria of "1 acute or chronic illness or injury that poses a threat to life or bodily function,"[6] and therefore meets the criteria of a "high" level in this category.

Data Reviewed and Analyzed

During this initial hospital encounter, a CBC and CMP were reviewed, as well as prothrombin time and INR. These three test panels, along with the history

obtained from the patient's husband, meet category 1, which is any combination of three pieces of data. The neurologist then independently interprets the head CT and CTA of the head and neck separately from the radiologist, which meets category 2 in data reviewed. Given that criterion for category 1, review of three elements of data, and category 2, independent interpretation of diagnostic testing are met, the data analysis and review is "extensive" since it meets the requirements of at least 2 of 3 categories in this domain.

Risk of Patient Management

Given the likely diagnosis of right hemispheric stroke based on her symptoms, the decision to hospitalize and admit the patient from the ED is considered a high level of risk of patient management.

If one selected the level of service based on medical decision making, because all three medical decision making domains are at high levels, the code should be 99223.

If this initial hospital encounter is billed based on time, a minimum of 55 minutes was met, supporting 99222. Code 99223 could not be chosen because less than 75 minutes of total time was spent.

If the level of service by medical decision making and time do not agree, the neurologist can choose either method to determine the E/M code. If time is used, the total time on the date of service must be documented in the note. To prevent confusion, it is better to omit time if medical decision making is used to determine the level of service.

CASE 2

A 59-year-old man was admitted 5 days previously with right-sided weakness and loss of sensation. His initial neurologic evaluation at admission included a blood pressure of 190/105 mm Hg and a head CT showed an acute hemorrhage in the left thalamus. Repeat brain imaging two days later showed a stable hemorrhage size without resolution of the edema noted initially, and his systolic blood pressure improved to 140 mm Hg with a nicardipine infusion. On day 5 of his inpatient hospital stay, a subsequent neurologic examination is notable for decreased sensation to all modalities in the right face, arm, and leg, and the patient has an NIHSS score of 1. As part of the subsequent inpatient hospital encounter, the neurologist counseled the patient extensively on his pertinent risk factors for brain hemorrhage, including hypertension and tobacco use. The total time spent face-to-face and non–face-to-face on the calendar day of the encounter was 38 minutes.

DISCUSSION

This patient is being seen for a follow-up (subsequent) inpatient hospital encounter on day 5 of his hospital stay, so the level of service options to use are codes 99231-99233.

Problems Addressed

During the first several days, the acute hemorrhage can be considered as "one acute or chronic illness or injury that poses a threat to life or bodily function"[6]

because it meets the high-risk category even several days after the hemorrhage if documented as such. At some point in time, typically days after the acute phase of a thalamic hemorrhage, the hemorrhage is no longer acute and fails to meet a high-risk level.

Data Reviewed and Analyzed

The repeat head CT that was individually reviewed by the neurologist meets category 2 of independent interpretation of tests even if it was ordered by that neurologist if the neurologist enters their own findings in the note. Copy and paste of the official report does not count. The data reviewed or analyzed meet the moderate category if laboratory tests were reviewed including CBC, prothrombin time or INR, and a CMP, and a third repeat head CT was ordered. If the repeat head CT was ordered by the neurologist, it would only count toward one part of category 1 in data reviewed; therefore, this would meet a moderate category for data reviewed.

Risk of Patient Management

This encounter meets the high-risk inpatient management element if the area of edema worsens and a higher level of care is required, for example, if the patient needs more intensive monitoring in the intensive care unit. Without the need to escalate the level of care to an intensive care unit setting, documenting the continued cerebral edema, and lack of improvement in the neurologic examination, this patient is still in the moderate risk category for patient management.

Given that at least two of the three elements meet the moderate category of risk, this encounter would meet the moderate level of 99232 if billed based on medical decision making.

If this subsequent hospital encounter is billed based on time, 38 minutes were spent supporting 99232. Code 99233 could not be chosen because less than 50 minutes of total time was spent.

If the level of service by medical decision making and time do not agree, the neurologist can choose either method to determine the E/M code. If time is used, the total time on the date of service must be documented in the note. To prevent confusion, it is better to omit time if medical decision making is used to determine the level of service.

CASE 3

A 57-year-old woman is seen by a neurologist in a subsequent inpatient hospital encounter on day 4 during hospitalization for left hemispheric stroke. She was initially seen on admission when she presented with expressive aphasia and was treated with intravenous thrombolysis. Her language had slowly improved during her hospital stay, and no symptoms suggested recurrent cerebral ischemia. Testing during her hospitalization included an MRI that showed a small stroke in the left frontal lobe, an MR angiogram that showed no significant extracranial carotid or intracranial stenosis, and an echocardiogram that revealed no obvious source of cardioembolism. The results of her diagnostic testing, the cryptogenic nature of her stroke, and the role of additional cardiac monitoring to evaluate for occult atrial fibrillation are reviewed with the patient. The total time spent face-to-face with the patient, husband, and family

members in addition to non–face-to-face time reviewing all the testing completed to date is 80 minutes.

DISCUSSION

Given the lengthy discussion with the patient and her family members during this inpatient hospital encounter, use of a prolonged services code in addition to code 99233 is appropriate. Because the total time on the calendar day of the encounter was 80 minutes the billing physician would report codes 99233 and 99418. Code 99233 accounts for the initial 65 minutes and the additional 15 minutes are reported using the prolonged service code 99418.

CONCLUSION

For 2023, changes similar to those instituted previously for outpatient E/M codes to determine level of service based on time or medical decision making have now been implemented for hospital inpatient services codes.[4-6] Observation services are combined with hospital inpatient initial (99221-99223) and subsequent encounter codes (99231-99233). A few updates to the *CPT* medical decision making table were included to reflect changes pertinent to inpatient services.[6] Administrative burden on clinicians should be lessened. Neurologists should revise existing note templates to optimize use of these new codes or risk coding incorrectly and spending unnecessary time and effort to meet documentation requirements that no longer exist.

Experience with the new codes is limited because they were implemented so recently. Payers may differ in how they interpret the proper use of these new codes. The best current example is how CMS codes for prolonged services using different threshold times and codes.[7] Additional nuances in the proper use of the 2023 E/M codes may become evident as stakeholders gain more experience with these new rules. As was the case with the 2021 outpatient E/M changes, clarifications and editorial revisions from CPT may be promulgated in the future.

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DISCLOSURE

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