Medicare allows only the medically necessary portion of a face-to-face visit. Even if a complete note is generated, only the necessary services for the condition of the patient at the time of the visit can be considered in determining the level/medical necessity of any service.

For billing Medicare, a provider may choose either version of the documentation guidelines, not a combination of the two, to document a patient encounter. However, beginning for services performed on or after September 10, 2013 physicians may use the 1997 documentation guidelines for an extended history of present illness.

**CPT Code 99223**

**Inpatient Hospital Care**

**Initial Hospital Care:**
Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:
- Comprehensive history
- Comprehensive exam
- Medical Decision making of HIGH complexity

**Comprehensive History:**
- Chief complaint/reason for admission
- Extended history of present illness (HPI)
  - Extended consists of four or more elements of the HPI
- Review of systems directly related to the problem(s) identified in the history of present illness
- Medically necessary review of ALL body systems’ history
- Medically necessary complete past, family and social history
- Four or more elements of the HPI or the status of at least three (3) chronic or inactive conditions, noting that medical necessity is ALWAYS the overarching criterion.

**HPI – History of Present Illness:**
A chronological description of the development of the patient’s present illness from the first sign and/or symptom or from the previous encounter to the present. Descriptions of present illness may include:
- Location
- Quality
- Severity
- Timing
- Context
- Modifying factors
- Associated signs/symptoms significantly related to the presenting problem(s)

**Chief Complaint:**
The Chief Complaint is a concise statement from the patient describing:
- The symptom
- Problem
- Condition
- Diagnosis
- Physician recommended return, or other factor that is the reason for the encounter

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Comprehensive physical exam:

- General, multisystem exam OR complete exam of a single organ system
- Body areas recognized:
  - Head/including face
  - Neck
  - Chest/including breasts and axilla
  - Abdomen
  - Genitalia/groin and buttocks
  - Back
  - Each extremity
- Organ systems recognized
  - Eyes, ears, nose, mouth, throat
  - Cardiovascular
  - Respiratory
  - Gastrointestinal
  - Genitourinary
  - Musculoskeletal
  - Integumentary (skin and/or breast)
  - Neurologic
  - Psychiatric
  - Endocrine
  - Hematologic/Lymphatic
  - Allergic/Immunologic

Review of Systems:
An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.

For purpose of Review of Systems the following systems are recognized:

- Constitutional (i.e., fever, weight loss)
- Eyes
- Ears, Nose, Mouth Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurologic
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

Past, Family, and/or Social History (PFSH):
Consists of a review of the following:

- Past history (patient’s past experiences with illnesses, operations, injuries, and treatments)
- Family History (a review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk)
- Social History (an age appropriate review of past and current activities)

Additional Information:

- If patient is admitted to the hospital during an encounter in another setting (i.e. physician office, nursing home, emergency room) and on the same date of service as the admission all E/M services provided by that physician in conjunction with the admission are considered part of the initial hospital care.
- Comorbidities and other underlying diseases in and of themselves are not considered when selecting the E/M codes UNLESS their presence significantly increases the complexity of the medical decision making.
- Practitioner’s choosing to use time as the determining factor:
  - MUST document time in the patient’s medical record
  - Documentation MUST support in sufficient detail the nature of the counseling
  - Code selection based on total time of the face-to-face encounter (floor time), the medical record MUST be documented in sufficient detail to justify the code selection
- Face-to-face time refers to the time with the physician ONLY. The time spent by other staff is NOT considered in selecting the appropriate level of service
- Please note that ALL services ordered or rendered to Medicare beneficiaries MUST be signed. Signatures may be handwritten or electronically signed; exceptions for stamped signatures are described in MLN Matters article MM8219. (http://www.cms.gov/Outreach-
High Complexity
Medical Decision Making
(Documentation must meet or exceed two of the following three)

• Extensive management options for diagnosis or treatment
• Extensive amount of data to be reviewed consisting of:
  - Lab results
  - Diagnostic and imaging results
  - Other practitioner’s notes/charts (i.e. PT, OT, Consultants)
  - Documentation of labs or diagnostics still needed
• High risk of complications and/or morbidity or mortality
  - Comorbidities associate with the presenting problem
  - Risk(s) of diagnostic procedure(s) performed
  - Risk(s) associated with possible management options

Guidelines regarding signature requirements are located in CMS Publication 100-08, Chapter 3, section 3.3.2.4. A sample attestation statement is available on the CGS website.

References:

• American Medical Association CPT (current procedural terminology) Codebook

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