Evaluating and managing hospital E/M services

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The documentation required by Current Procedural Terminology (CPT©) for correct coding and billing of hospital evaluation and management (E/M) services is very complicated and fills the pages of many books. The associated contractual and regulatory requirements could fill many rooms. Still, a basic understanding of the rules, regulations and concepts governing these services can help guide hospitalists on this documentation journey.

The key components of E/M that determine the level of services provided and billable include history, physical exam and medical decision making (MDM), all of which must be documented for every encounter. While in some situations such components as time or coordination of care are the determinative factors, the three key components must still be documented. All documentation and signatures must be legible. Illegible notes are detrimental to patient care and safety; do not meet

E/M codes for hospitalists

Hospital inpatient		
Initial (3 of 3 key components)	Subsequent (2 of 3 key components)	Discharge day (all services based on time)
99221	99231	99238 (up to 30 minutes)
99222	99232	99239 (more than 30 minutes)
99223	99233	-
Hospital observation		
Initial (3 of 3 key components)	Subsequent (2 of 3 key components)	Discharge day (all services)
99218	99224	99217
99219	99225	-
99220	99226	-
Add-on E/M codes*		
Critical care	Prolonged service	
99291 (60 minutes)	99356 (60 minutes)	
99292 (each additional 30 minutes)	99357 (each additional 30 minutes)	

** Subject to time calculation rules*

Note: If admission and discharge occur on the same date, other E/M codes (99234-99236) are used for either observation or inpatient services.

Source: 2011 Current Procedural Terminology©, American Medical Association.