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DIAGNOSIS. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as \" that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.\" …

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99202-99205: In 2021, new patient codes 99202-99205 will no longer require the 3 key components or reference typical face-to-face time. Instead, each service includes " a medically appropriate history and/or examination," and code selection will be based on the MDM level or total time spent on that date.

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The inpatient coding system is solely based on the assignment of ICD-9/10-CM diagnostic and procedural codes for billing and appropriate reimbursement. It's the standard coding system used by physicians and other healthcare providers for classification and coding of all diagnoses. It uses ICD-10-PCS to report procedures.

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Initial Hospital Care (99221-99223) These codes are used to bill for initial hospital services otherwise known to physicians as H&Ps. When you

admit a patient to the hospital as in inpatient, these are the codes you will use. There are several common documentation blunders that many physicians repeat over and over again for these visits.

E&M Coding Guidelines - Coding Info
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Guidelines for Evaluation and Management Services and the 1997 Documentation Guidelines for Evaluation and Management Services. These

publications are also available in the Reference Section. NOTE: For billing Medicare, you may use either version of the documentation guidelines for a patient encounter, not a combination of the two.

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