MOUNTAIN HEALTH CO-OP

Correct Coding and Documentation Resource Sheet

Policy	Article-003
Effective Date	**01/01/2026**
Reviewed/Revised Date	03/23/2026
Next Review Date	03/23/2027
Origination Date	01/01/2026
Originated Department	Correct Coding Integrity

Hospital & Observation E/M Services Educational Guide

Audience

Applies to all individuals involved in hospital or observation E/M services:

Clinical Providers

- Physicians
- Nurse Practitioners (NPs)
- Physician Assistants (PAs)
- Hospitalists and in-hospital clinical specialists

Coding & Billing Professionals

- Medical Coders
- CDI Specialists
- Revenue Cycle staff
- Compliance and audit personnel

E/M Coding Overview: Hospital & Observation

Service Type	CPT Codes	Notes
Initial Hospital Care (New Admit)	99221–99223	First hospital encounter for current admission
Initial Observation Care	99218–99220	First observation patient evaluation
Subsequent Hospital Care	99231–99233	Follow-up during hospitalization
Subsequent Observation Care	99224–99226	Follow-up during observation stay
Discharge Services	99238–99239	Hospital discharge; time-based
Observation Discharge	99217	Typically billed by the admitting provider

Notes:
1. New vs Established Patient: For hospital/obs, “new” = first encounter for this admission. 2. Time vs MDM: Hospital/observation visits can be coded using MDM or total time for discharge or complex cases (per CMS guidance).

MDM-Based Decision-Making Table		
Step 1 – Number & Complexity of Problems Addresses		
Problem Type	**Characteristics/Examples**	**Points**
Minimal	Minor problem, self-limited	1
Low	Stable chronic or uncomplicated acute	2
Moderate	Exacerbation of chronic disease, acute new problem	3
High	Threat to life or organ system, new acute condition requiring intervention	4

Step 2 – Data Reviewed/Ordered	
Data Type	**Complexity/Points**
Review labs, imaging (single test)	1
Multiple lab or imaging studies	2
Independent test interpretation (ECG, imaging)	2–3
Consultation with other providers	1–2
Complex data requiring independent analysis	3

Step 3 – Risk of Morbidity/Mortality		
Risk level	**Examples**	**Points**
Minimal	Minor procedures, no significant intervention	1
Low	Prescription adjustment, minor interventions	2
Moderate	Hospital-level care, IV medications, close monitoring	3
High	Life-threatening condition, ICU care required	4

Step 4 – MDM Level Assignment			
MDM Level	**Points/Complexity**	**Hospital CPT Codes**	**Observation CPT Codes**
Minimal	Problems 1, Data 1, Risk 1	Rare	Rare

Low	Problems 2–3, Data 2, Risk 2	99221 / 99231	99218 / 99224
Moderate	Problems 3–4, Data 3, Risk 3	99222 / 99232	99219 / 99225
High	Problems ≥4, Data 4, Risk 4	99223 / 99233	99220 / 99226

Note:
Points are illustrative; always cross-check with 2026 AMA MDM tables.

Time-Based E/M Leveling (Hospital/Observation)		
CPT Code	**Total Time (minutes)**	**Notes**
99221	30–44	Initial hospital care
99222	45–59	Initial hospital care
99223	60–74	Initial hospital care
99231	15–19	Subsequent hospital care
99232	20–29	Subsequent hospital care
99233	30–39	Subsequent hospital care
99218	30–44	Initial observation care
99219	45–59	Initial observation care
99220	60–74	Initial observation care
99224	20–29	Subsequent observation
99225	30–39	Subsequent observation
99226	40–54	Subsequent observation
99238	30	Hospital discharge
99239	45+	Hospital discharge (multiple days)
99217	30	Observation discharge
Tip: Hospital discharge can be coded by time only if multiple complex problems are addressed on discharge day.		

Hospital/Observation Quick Decision Flow

1. **Determine Encounter Type:**
   - **1.1** Initial vs Subsequent vs Discharge
   - **1.2** Hospital vs Observation
2. **Select Leveling Method:**
   - **2.1 MDM** → use MDM tables above
   - **2.2 Time** → use total provider time
3. **Assign CPT Code:**
   - **3.1** Initial, subsequent, or discharge codes per tables
   - **3.2** Document total time if coding by time
4. **Ensure Documentation:**
   - **4.1** History, exam, MDM, orders, labs, imaging

4.2 Interventions performed
4.3 Patient status and risk
4.4 Discharge instructions for discharge visits

CDI & Audit Focus Areas	
Audit Trigger	**Recommended Action**
Missing HPI, exam, or MDM	Complete detailed documentation for hospital/observation visit
Unsupported level of service	Ensure MDM or time documentation supports billed code
Incomplete discharge notes	Document medications, follow-up, patient education
Inconsistent data	Verify labs, imaging, consults align with notes
Multiple comorbidities	Ensure risk is documented for complex cases

References

AMA CPT® Evaluation and Management Guidelines
CMS E/M Documentation Requirements

Review/Revision/Approval History	
Date	Description
01/01/2026	**Correct Coding Integrity**
03/23/2026	**Revised by Mountain Health CO-OP Committee**

Disclaimer

This document is for informational purposes only. It should not replace clinical judgment or provide medical advice. Coverage, benefits, and eligibility are determined by the member's benefit plan. CPT codes and procedures included are for informational purposes only and do not guarantee reimbursement.