County of San Diego Medi-Cal Fee for Service Provider Inpatient Professional Services Documentation Guide

Inpatient Professional Service Review Criteria:
- Client name or identifier is present on the progress note
- Provider identifier is present on the progress note
- The progress note is legible
- The diagnosis or diagnosis code is indicated
- The progress note supports the code billed

General Documentation Principles
- The medical record should be complete and legible
- Documentation of each patient encounter should include:
    - Reason for the encounter & relevant history
    - Physical examination findings & interpretation of diagnostic test results
    - Assessment, clinical impression, or diagnosis
    - Plan for care
    - Date and legible identity of the examiner and patient

Factors of Medical Decision Making:
- Number and complexity of problems addressed at the encounter
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complications and/or morbidity or mortality of patient management

Procedural code selection is based on total time (face-to-face and not face-to-face) or medical decision making. All applicable factors must be considered, otherwise it is impossible to determine an appropriate code.

Medical Decision-Making (MDM) Elements			Decision
Number of diagnosis or management options	**Amount and/or complexity of data to be reviewed**	**Risk of complications and/or morbidity/mortality**	**Level of MDM (meets or exceeds 2 of 3 elements)**
Minimal	Minimal or none	Minimal	Straightforward
Limited	Limited	Low	Low
Multiple	Moderate	Moderate	Moderate
Extensive	Extensive	High	High

Code	Medical Decision-Making	Time (minutes)
99221 – Initial Inpatient Hospital Care	Low	40
99222 – Initial Inpatient Hospital Care	Moderate	55
99223 – Initial Inpatient Hospital Care	High	75
99231 – Subsequent Inpatient Hospital Care	Low	25
99232 – Subsequent Inpatient Hospital Care	Moderate	35
99233 – Subsequent Inpatient Hospital Care	High	50
99238 – Discharge Service	Discharge appropriate	≤30
99239 – Discharge Service	Discharge appropriate	>30

When Counseling or Coordination of Care dominates (>50%) the encounter with the patient and/or family then time shall be considered the key or controlling factor for determining the correct code. For Discharge Services, time is the key criteria to determine code and reimbursement.