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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

Seven Factors in Evaluation & Management Services

Three Key Factors:

- History
- Examination
- Medical decision-making

Four Contributing Factors:

- Counseling
- Coordination of care
- Presenting problem
- Time

All applicable factors must be considered in code assignment. When the progress note does not have levels of key factors and/or time, it is impossible to determine the code.

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 only criteria to determine code and reimbursement.

Inpatient Service Code	Time (Minutes)
99221 – Initial Care	40
99222 – Initial Care	55
99223 – Initial Care	75
99231 – Subsequent Care	25
99232 – Subsequent Care	35
99233 – Subsequent Care	50
99238 – Discharge Service	≤30
99239 – Discharge Service	>30
99252 – Consultation	35
99253 – Consultation	45
99254 – Consultation	60
99255 – Consultation	80

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