

TIME IS OF THE ESSENCE:

Coding on the Basis of Time for Physician Services

Sometimes, coding is almost as simple as looking at the clock.

Aris Sophocles, MD, JD



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In the world of coding, time is perplexing. On the one hand, time is built into the evaluation and management (E/M) codes, so physicians are told to base their E/M code selection on the history, exam and medical decision-making elements, not on time spent. Times are listed for each service in the CPT manual only as a guideline. On the other hand, CPT lists a variety of codes that are strictly time dependent and even has codes for prolonged services. As a result, there is much confusion around the importance of time, especially when coding unusually long office and inpatient visits.

With a correct understanding of time and how it relates to coding, physicians can know when a higher code may be justified even though the history, exam and medical decision-making elements are lacking. They can also know how to code the following vexing situations:

1. The asthma flare-up that requires two hours of office time;
2. The patient who requires 25 minutes of your time reviewing problems, adjusting medications, counseling and coordinating care, but who does not require an extensive exam or complex medical decision making;
3. The visit devoted to counseling on



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Dr. Sophocles is a family physician practicing in Denver and a clinical professor at the University of Colorado Medical School, Department of Family Medicine. Conflicts of interest: Dr. Sophocles discloses he is founder of FCMC Professional Software. Copyright © 2003 Aris Sophocles, MD. Published with permission.



There is much confusion around the importance of time in coding, especially when physicians provide unusually long office and inpatient visits.



CPT describes three kinds of time: face-to-face, floor/unit and non-face-to-face.



To help physicians understand how much time is typically involved in the services they provide, CPT publishes average time guidelines for all of the E/M codes.



A 99213 office visit requires 15 minutes of a physician's time on average, according to CPT.

risk factors and newly discovered problems following an annual physical;

4. The hospital visit that takes hours because of maternal fetal or other physiologic monitoring;

5. The hospital standby as you wait to see whether your services are needed to perform surgery or resuscitate a newborn.

None of the above fit neatly within the E/M coding categories, but all are codable and reimbursable if you understand time and how to code for it.

What is time?

The powers that be (that is, the CPT Editorial Panel of the AMA) describe three kinds of time:

1. **Face-to-face time** occurs when the physician meets directly, face-to-face with the patient or family. It applies to office and other outpatient visits.

2. **Floor/unit time** occurs when the physician is physically present on the patient's hospital floor or unit delivering bedside services to the patient. It includes both time spent with the patient and time spent working on the patient's chart or discussing his or her care with nurses and others. It applies to hospital observation services, inpatient hospital care, initial and follow-up hospital consultations, and nursing facility services.

3. **Non-face-to-face time** (or pre- and post-encounter time) occurs when the physician performs work related to the patient before or after the face-to-face time or floor/unit time with that patient. It includes tasks such as retrieving records and

You must first understand how much time is typically involved in the services you are providing.

test results, arranging for further services and communicating with other health care providers and the patient outside of the face-to-face encounter or on the floor/unit. In the hospital, pre- and post-encounter time also includes such tasks as reviewing pathology and radiology findings in another part of the hospital. This is "not included in the time component described in the E/M codes. However, the pre- and post-face-to-

KEY POINTS

- CPT details the average amount of time physicians spend on various levels of office visits, inpatient consultations, home services, etc.
- If a physician spends more than 50 percent of a face-to-face visit counseling or coordinating a patient's care, the physician can code the visit on the basis of time, even if the history, exam or medical decision-making elements are lacking.
- Prolonged service codes can be reported in addition to an E/M code when the length of time a physician spends with a patient goes beyond what is typical for that service.

face work associated with an encounter was included in calculating the total work of typical services in physician surveys," according to CPT 2003.¹

If this seems confusing, consider that the theoretical physicist Stephen Hawking also described three kinds of time: thermodynamic time, psychological time and cosmological time.² Time-based coding, with all its complexity, is considerably easier to understand than Hawking's theories.

E/M time guidelines

Before you can accurately code on the basis of time, you must first understand how much time is typically involved in the services you are providing. CPT furnishes this information for office visits, inpatient consultations, home services, etc., and the average time guidelines are summarized on page 30. For example, according to CPT, a 99203 office visit typically requires 30 minutes of a physician's time, while a 99213 office visit requires 15 minutes on average.

When time can be used as the basis for selecting the right code, there is some debate as to whether physicians can round their actual time spent either up or down to the nearest average or whether they must always select the lower code. Neither CPT nor Medicare's "Documentation Guidelines for E/M Services" address this issue specifically; therefore, many physicians take the conservative approach and use the lower code. However, I believe it is reasonable to think of the time guidelines listed in CPT not as thresholds but simply as averages to help you select the most appropriate code for the time spent. Under this interpreta-

tion, physicians' actual time spent (either face-to-face or floor/unit) should be rounded either up or down to the nearest average. For example, if a physician spent 18 minutes with a new patient in the office (and if the visit met the conditions for time-based coding, discussed below), the physician could automatically code the visit as a 99202.

The "greater than 50 percent" rule

It is not unusual to spend a considerable amount of time face-to-face with a patient reviewing problems, adjusting medication dosages, and counseling or coordinating care only to find that you do not have enough history, exam or medical decision-making elements to support a code that would otherwise be appropriate for a visit of that duration. In other words, you've spent the time, but the points don't add up. This is when the "greater than 50 percent rule" applies.

When you devote more than 50 percent of your face-to-face time with the patient to counseling or coordinating care, "time may be considered the key or controlling factor to qualify for a particular level of E/M service," per CPT. To code these encounters, use the code from the appropriate table on page 30 that relates to the total time spent with the patient. For example, if you spent 25 minutes face-to-face with an established patient in the office, and more than half of that time was spent counseling the patient or coordinating his or her care, you could use the 99214 code even if you lack the history, exam or medical decision-making elements.

Prolonged times

The prolonged service codes in CPT are meant to be reported in addition to E/M codes when the length of time a physician spends with a patient goes at least 30 minutes beyond what is typical for that service. (See the prolonged service guidelines on page 30.) Use 99354 for the first 30 to 74 minutes beyond the typical time required for that service and 99355 for each additional half-hour. According to CPT, an example of a prolonged outpatient visit would be the care of an office patient with an acute asthma attack who warrants prolonged face-to-face care by a physician.

For inpatients, prolonged care is reported using 99356 for the first hour beyond the typical time required for that service and 99357 for each additional half-hour. An example per CPT would be maternal fetal monitoring for high-risk delivery.

CPT also contains two codes for prolonged physician services that are not face-to-face: 99358 and 99359. These are for pre- and post-care services provided in either the outpatient or inpatient setting. Code 99358 is used for the first 30 minutes to an hour of service, and code 99359 is used for each additional 30 minutes or for

You've spent the time, but the points don't add up. This is when the "greater than 50 percent rule" applies.

the final 15 to 30 minutes on a given day.

Finally, prolonged physician services can be reported by attaching the -21 modifier to the E/M code. When this is done, a written report may be appropriate. Typically, this approach is used when the physician provides face-to-face services or floor/unit services that are greater than what is normally required for the highest level of E/M service within that category.

Time-dependent codes

Physicians provide a number of services that are strictly time dependent. These include the following:

1. Physician standby services: Use code 99360 for each 30 minutes. Examples per CPT include operative standby or standby for frozen section, cesarean/high-risk delivery or monitoring EEG.
2. Critical care transport for pediatric patients 24 months and younger: Use code 99289 for 30 to 74 minutes and 99290 for each additional 30 minutes.
3. Critical care transport for patients over the age of 24 months: Use code 99291 for 30 to 74 minutes and 99292 for each additional 30 minutes.
4. Case management services: For team conferences lasting approximately 30 minutes, use 99361; for conferences lasting approximately 60 minutes, use 99362.
5. Care plan oversight: For services relating to home care, use 99374 for 15 to 29

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When a physician spends more than 50 percent of face-to-face visit time either counseling the patient or coordinating the patient's care, time may be considered the key factor in qualifying for a particular level of E/M service.



When the "greater than 50 percent" rule applies, the physician does not have to satisfy the code's history, exam or medical decision-making requirements.



Prolonged service codes can be reported in addition to E/M codes for a visit if the physicians' time spent is at least 30 minutes beyond what is typical for that service.



Physicians provide a number of services that are strictly time dependent, such as physician standby services (e.g., 99360) and case management services (e.g., 99361).

TIME-BASED CODING GUIDELINES

CPT 2003 offers a number of guidelines for time-based coding. The average time and prolonged service guidelines are summarized here.



Average time guidelines

CPT lists average time guidelines for a variety of services, shown below. While time spent does not determine the level of coding in most cases, the averages can assist physicians in recognizing prolonged services and coding appropriately.

For visits that involve more than 50 percent counseling or coordination of care, time can determine the level of coding. For example, if a 30-minute office visit with an established patient involved more than 15 minutes of counseling and coordination of care, you could automatically code the visit as a 99214.

OFFICE VISITS

Avg. minutes spent (face-to-face)	New patient code	Established patient code
5		99211
10	99201	99212
15		99213
20	99202	
25		99214
30	99203	
40		99215
45	99204	
60	99205	

INPATIENT CARE

Avg. minutes spent (floor/unit)	Initial care code	Subsequent care code
15		99231
25		99232
30	99221	
35		99233
50	99222	
70	99223	

OUTPATIENT CONSULTATIONS, NEW OR ESTABLISHED PATIENTS

Avg. minutes spent (face-to-face)	Consultation code
15	99241
30	99242
40	99243
60	99244
80	99245

INPATIENT CONSULTATIONS, NEW OR ESTABLISHED PATIENTS

Avg. minutes spent (floor/unit)	Initial consultation code	Follow-up consultation code
10		99261
20	99251	99262
30		99263
40	99252	
55	99253	
80	99254	

NURSING FACILITY VISITS, NEW OR ESTABLISHED PATIENTS

Avg. minutes spent (floor/unit)	Annual assessment code	Subsequent visit code
15		99311
25		99312
30	99301	
35		99313
40	99302	
50	99303	

HOME SERVICES

Avg. minutes spent (face-to-face)	New patient code	Established patient code
15		99347
20	99341	
25		99348
30	99342	
40		99349
45	99343	
60	99344	99350
75	99345	

Prolonged service guidelines

When physicians provide services that require more time than what is typical, they can submit prolonged service codes in addition to the appropriate evaluation and management (E/M) code. When calculating the number of minutes spent in prolonged service, do not include the average time allotted by CPT for that E/M code; count only the minutes spent beyond the typical service.

OUTPATIENT CARE

Minutes of prolonged service (face-to-face)	Code
Less than 30 minutes	Not reported separately
30-74	99354
75-104	99354 plus 99355
105-134	99354 plus 99355 x 2
135-164	99354 plus 99355 x 3
165-194	99354 plus 99355 x 4

INPATIENT CARE

Minutes of prolonged service (floor/unit)	Code
Less than 60 minutes	Not reported separately
60	99356
61-90	99356 plus 99357
91-120	99356 plus 99357 x 2
121-150	99356 plus 99357 x 3
151-180	99356 plus 99357 x 4

minutes and 99375 for 30 minutes or greater. For services relating to hospice care, use 99377 for 15 to 29 minutes and 99378 for 30 minutes or more. For services relating to nursing facility care, use 99379 for 15 to 29 minutes and 99380 for 30 minutes or more.

6. Physical, speech and occupational therapy modalities: Report in 15-minute increments.

7. Counseling and risk-factor reduction: According to CPT, the following codes are to be used for separate encounters devoted to preventive medicine counseling and risk-factor reduction interventions for individual patients without symptoms or established illness:

- 99401 for 15 minutes,
- 99402 for 30 minutes,
- 99403 for 45 minutes,
- 99404 for 60 minutes.

For group counseling, use 99411 for 30 minutes and 99412 for 60 minutes.

Documenting time

The rules for documenting how much time is spent in patient care are not very detailed. CPT 2003 provides the following instruction: "The extent of counseling and/or coordination of care must be documented in the medical record." The only other guideline CPT offers refers to critical care services. It reads, "Time spent with the individual patient should be recorded in the patient's record."

Medicare's "Documentation Guidelines for E/M Services" go a bit further by directing physicians to note the total length of the encounter (face-to-face or floor/unit time, as appropriate) and describe the counseling or activities to coordinate care. For example, you might document "20 minutes face-to-face; counseling/coordination of care > 50 percent of visit." Your progress note should reflect the nature of the counseling or coordination of care you provided.

While physicians typically state on the encounter note how much time they spent for that day's service, they rarely record the exact start and stop times, especially in inpatient settings because the total time there is often not continuous. Since it is not practical to record start and stop times in the inpatient setting, excluding start and stop times makes sense. Whether it is wise to exclude start and stop times in the outpa-

tient setting as well is debatable. If challenged by an auditor or a patient with a vague memory of how much time was spent, it would be useful to have documented start and stop times.

Charging and collecting for time

The 2003 fee schedule for Medicare services includes fees for prolonged face-to-face and floor/unit services and critical care transport services. It does not include fees for non-face-to-face, standby, case management, care plan oversight or counseling services.

For those services that are not assigned relative values by Medicare, you will need to assign charges based on what your time is worth. I have created fee-schedule software to manage this task. It includes relative values for services such as care plan oversight and counseling, which can be readily converted to both Medicare and non-Medicare fees. (See www.practicetools.biz; similar products may be on the market. For additional information on creating your own fee schedule, see page 54 of this issue.) When contracting with commercial payers, be sure to include language to the effect that services not assigned fees by Medicare will be paid as billed or according to some pre-arranged discount.

The importance of time

Despite warnings and disclaimers to the contrary, time is central to the E/M coding system. Though it may not always determine what code is selected for the primary E/M service, it does play an important role in selecting the appropriate code for prolonged services, for services that involve extensive counseling or coordination of care, and for time-dependent codes. A better understanding of the rules of coding on the basis of time will help physicians secure fair compensation for all the services they provide. **F M**

Send comments to fpmedit@aafp.org.

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1. *Current Procedural Terminology*. Chicago: American Medical Association; 2003.
2. Hawking S. *A Brief History of Time*. New York: Bantam Doubleday Dell Pub; 1988:145.

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When physicians provide individual counseling and risk-factor reduction interventions at a separate encounter devoted solely to that purpose, they can use counseling codes 99401-99404.



For all encounters, physicians should note the total length of the encounter (face-to-face or floor time, as appropriate) and describe the counseling or coordination of care activities, if any.



The 2003 fee schedule for Medicare services includes some fees for time-dependent codes; for those services that are not assigned relative values by Medicare, physicians should assign charges based on what their time is worth.



A better understanding of the rules of coding on the basis of time will help physicians secure fair compensation for the services they provide.