E/M coding can be so complex that you forget those visits where it's just a matter of time.

TIME IS ON YOUR SIDE

Coding on the Basis of Time

Emily Hill, PA

In our fast-paced world, it seems there simply isn't enough time in a day to get everything done. For a family physician, getting everything done may require extended office hours or long nights spent catching up on documentation. Time seems like an enemy. There is, however, a way to make time work to your advantage – by using time-based coding for some of your patient encounters.

Time and E/M services

Prior to 1992, time was an implicit component of evaluation and management (E/M) coding. Code descriptors included language such as "brief," "limited" and "extended," but these terms were not defined. Beginning in 1992, time was included as an explicit factor for many categories of E/M services, including office visits, inpatient services and consultations. The times associated with these codes in CPT are considered the "average" time spent providing a given level of care to a patient (e.g., 25 minutes for a 99214).

When selecting a level of service based on the extent of the history, examination or medical decision making necessary to evaluate or treat the patient, it is not necessary to meet these time requirements. However, when counseling or coordination of care is the predominant activity during a patient visit, the level of care can be selected based on the time spent with the patient.

CPT states, "When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital

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Only the time spent by the primary provider can be considered.

Time alone can be used to select the level of care for a patient visit if counseling or coordination of care is the predominant activity.

In the outpatient setting, physicians can include only their face-to-face time with the patient or family.

In inpatient and nursing home settings, physicians can also include any time spent on the unit or floor related to the patient's care.

or nursing facility), then time may be considered the key or controlling factor to qualify for a particular level of E/M services." This means that time alone can be used to select a level of care, regardless of the extent of the history, exam or the medical decision making, if the majority of the encounter involves counseling or coordination of care. For E/M services, counseling may include a discussion of test results, diagnostic or treatment recommendations, prognosis, risks and benefits of management options, instructions, education, compliance or risk-factor reduction.

What counts

When coding on the basis of time in the outpatient setting, you can count only your face-to-face time with the patient or family. This face-to-face time includes not only the time spent counseling but also the time associated with any history, exam or medical decision making that you perform. The time you spend reviewing records, talking with other providers and documenting the encounter without the patient or family present cannot be considered. (See the tables at the right for a comparison of the times for outpatient services.)

In inpatient and nursing home settings, time is now measured using the face-to-face time with the patient as well as other time spent on the unit or floor related to the care of the patient. This unit/floor time might include discussions with nursing staff or therapists, calls to other physicians or providers, and tasks such as reviewing or documenting in the medical record. (See the tables at the right for a comparison of the times for inpatient and nursing home services.) Initial and subsequent hospital care codes (99221-99233) include all services provided on a calendar date. Therefore, any face-to-face and other unit/floor time devoted to the patient between one midnight and the next should be included when determining the total time spent with the patient.

Sometimes, even though the encounter took more time than is usually required, it is not appropriate to report the service according to time. For example, the visit might have taken longer because the history was extensive, the patient was a poor historian or the patient's physical restrictions extended the exam time. In these instances, the level of service should be based on the key components (history, exam or medical decision making) since counseling was not the predominant activity.

Who counts

Only the time spent by the primary provider (physician, physician assistant, nurse practitioner, etc.) can be considered in determining the level of service. Time spent with the patient by other members of your staff such as nurses and medical assistants cannot be factored into the face-to-face time.

CPT states that counseling involves a discussion with the patient or family. It goes on to say that encounters with parties who have assumed responsibility for the patient can be used to calculate the face-to-face time. This might include not just family members but foster parents, legal guardians and the like.

Third-party payers, including Medicare, may have different guidelines than CPT suggests. For example, Medicare guidelines require that the patient be present for any E/M service that is reported for payment. Thus, when time-based coding is applied in the outpatient setting for Medicare-covered visits, the patient must be present for any counseling activities. In the inpatient setting, Medicare does cover time spent on the unit or floor in discussion with family members as long as the physician has provided a face-to-face service to the patient on that day.

About the Author

Emily Hill is president of Hill & Associates, a Wilmington, N.C., consulting firm specializing in coding and compliance. Author disclosure: nothing to disclose.

Which services are eligible

CPT descriptors do not include a time component for all E/M services. For example, average times have not been established for preventive medicine services, emergency department services or observation care services.

On the other hand, time is the primary basis for selecting codes for certain categories of service such as adult critical care services, care plan oversight services, hospital discharge services and prolonged services. For these services, the time requirements are listed in the CPT code descriptor, and in some cases CPT provides tables to illustrate the proper reporting of the service.

The table on page 20 lists the categories of service that may be reported based on either time or key components, those that may not be reported using time, and those that are always reported using time. This article is primarily concerned with the first group.

When to use time

The following examples help illustrate when to code on the basis of time versus when to code based on the work associated with the key components of the visit.

Example 1: A patient returns to discuss the findings of a bone-density study ordered at her recent wellness visit. A comprehensive history and examination were recorded at that visit, so there is no need to repeat these components at the current visit. However, it is necessary to discuss with her the test results, the medical implications and possible management options. This visit involves counseling almost exclusively. If the physician spends at least 15 minutes of face-to-face time with the patient and the majority of that time involves counseling, then code 99213 could be reported (since 15 minutes is the typical time associated with that code). In contrast, using the key components to determine the level of care, the proper code would likely be 99212.

Example 2: A patient comes in for follow-up of her insulin-dependent diabetes, hypertension and obesity. At the visit, she complains of vision difficulties and occasional shortness of breath. Her blood sugar and blood pressure recordings from home indicate less than adequate control. A detailed exam is performed and adjustments are made to her medications. She is counseled concerning diet, medication changes and compliance with the established plan of care.

In this example, even though counseling was an important part of the encounter, code 99214 can be selected based on the extent of

TYPICAL TIMES FOR CPT CODES

The tables below show the average times associated with common codes, per CPT. For example, a 99214 typically requires 25 minutes of face-to-face time with the patient. Under time-based coding, more than half of the face-to-face time (in the office or other outpatient setting) or more than half of the floor/unit time (in the hospital or nursing facility) must be spent on counseling or coordinating care. The time spent with the patient must meet or exceed the typical time for the code selected, according to Medicare. Other payers may allow the physician to select the code whose typical time is closest to the time spent with the patient.

TYPICAL TIMES FOR OUTPATIENT E/M SERVICES

Outpatient – New					
Codes	99201	99202	99203	99204	99205
Times	10 min.	20 min.	30 min.	45 min.	60 min.
Outpatient – Established					
Codes	99211	99212	99213	99214	99215
Times	5 min.	10 min.	15 min.	25 min.	40 min.
Outpatient – Consultation					
Codes	99241	99242	99243	99244	99245
Times	15 min.	30 min.	40 min.	60 min.	80 min.

TYPICAL TIMES FOR INPATIENT E/M SERVICES

Initial Inpatient Care					
Codes	99221	99222	99223		
Times	30 min.	50 min.	70 min.		
Subsequent Inpatient Care					
Codes	99231	99232	99233		
Times	15 min.	25 min.	35 min.		
Inpatient Consultation					
Codes	99251	99252	99253	99254	99255
Times	20 min.	40 min.	55 min.	80 min.	110 min.

TYPICAL TIMES FOR NURSING FACILITY CARE

Initial Nursing Facility Care				
Codes	99304	99305	99306	
Times	25 min.	35 min.	45 min.	
Subsequent Nursing Facility Care				
Codes	99307	99308	99309	99310
Times	10 min.	15 min.	25 min.	35 min.

Not all CPT codes may be selected on the basis of time; others *must* be coded on the basis of time.

When time-based coding is an option, physicians should consider whether it is more advantageous than coding based on key components.

Some payers view the typical times listed in CPT as thresholds that must be met for time-based coding.

TIME-BASED CODING FOR PRIMARY CATEGORIES OF E/M SERVICES

The following table outlines common categories of E/M services that may be coded on the basis of either time or key components, those that may not be coded on the basis of time and those that must always be coded on the basis of time.

E/M services that may be coded on the basis of time *or* key components	**Codes**
Office or other outpatient services	
• New patient	99201-99205
• Established patient	99211-99215
Hospital inpatient services	
• Initial hospital care	99221-99223
• Subsequent hospital care	99231-99233
Consultations	
• Office consultations	99241-99245
• Inpatient consultations	99251-99255
Nursing facility services	
• Initial nursing facility care	99304-99306
• Subsequent nursing facility care	99307-99310
Domiciliary, rest home or custodial care services	
• New patient	99324-99328
• Established patient	99334-99337
Home services	
• New patient	99341-99345
• Established patient	99347-99350
E/M services that may *not* be coded on the basis of time	**Codes**
Hospital observation services	
• Hospital observation discharge services	99217
• Initial hospital observation services	99218-99220
• Hospital observation or inpatient care services	99234-99236
Emergency department services	99281-99288
Critical care services	
• Pediatric	99293-99294
• Neonatal	99295-99296
Preventive medicine services	
• New patient	99381-99387
• Established patient	99391-99397
Newborn care	99431-99440
Non-face-to-face physician services	
• Online medical evaluation	99444
E/M services that are *always* based on time *(Note: not an exhaustive list.)*	**Codes**
Hospital discharge services	99238-99239
Pediatric patient transport	99289-99290
Critical care services	
• Adult	99291-99292
Nursing facility discharge	99315-99316
Care plan oversight services	
• Assisted living facility or home	99339-99340
• Home health, hospice and nursing facility	99374-99380
Prolonged services	
• With direct patient contact	99354-99357
• Without direct patient contact	99358-99359
Non-face-to-face physician services	
• Telephone services	99441-99443

the work associated with the key components. Remember, it is not necessary to meet the typical time of 25 minutes for a 99214 when the history, exam or medical decision making are the basis for the code selection. In order for time-based coding to increase the level of service to a 99215 in this example, the total encounter time would have to be at least 40 minutes with more than 50 percent of the visit involved in counseling. This assumes that the patient has Medicare or another plan which requires that the typical time for a given code be met or exceeded. Some payers may allow the physician to select the code that has a typical time closest to the time spent with the patient.

Example 3: A patient comes in for follow-up of his hypertension, which is well-controlled on a single antihypertensive medication. He indicates he is doing well, and his relevant review of systems is negative. However, he has had a 15-pound weight gain over the last year and expresses frustration with his attempts to lose weight. A discussion ensues regarding his daily food intake, exercise habits and his previous attempts to diet. He is counseled regarding his current habits, goal setting and planned follow-up. The total encounter time was 30 minutes, of which 20 minutes were spent in counseling activities.

In this example, counseling was the primary focus of the visit and time-based coding is the more advantageous way to select the level of care. Since the total time of the encounter was 30 minutes and greater than 50 percent involved in counseling, code 99214 (typical time 25 minutes) can be reported. The total time of the encounter, rather than just the time spent counseling, is used to select the level of service. Using the key components, this visit might have been reported as 99213.

How to document

It is important that the documentation specifically state the amount of time involved in the service. Statements such as "discussed at length" or "extensive discussion" do not match to a specific CPT code and are open to interpretation. Instead, document the actual time spent with the patient (e.g., 15 minutes). If the encounter involved counseling as well as time spent performing the key components of an E/M service, the best practice is to indicate the total time spent with the patient and specify that more than half of the encounter involved counseling. This verifies that the requirements for using time to select an E/M code have been met and makes it clear that time was the determining factor for the code selected.

The documentation should also reflect the nature of the counseling or coordination of care activities. Simply listing your clinical impressions and stating that more than 50 percent of the encounter was spent in discussion is not sufficient documentation for time-based coding. While it is not necessary to document a detailed account of the discussion, you should identify the major areas of discussion (e.g., "counseled patient regarding weight gain, daily food intake and goal setting") and make sure your note is thorough enough to justify the amount of time reported.

When selecting a code that is always based on time, you must also document the time associated with the visit. For example, the two codes for hospital discharge services are distinguished based on the time the physician spent providing services to a patient on the day of discharge. Code 99238 is for 30 minutes or less and 99239 is for more than 30 minutes. Note that code 99239 pays almost $30 more than code 99238, so be sure to code correctly.

Putting time to work

Time-based coding may not be the primary way of selecting E/M codes, but for encounters that involve extensive counseling it offers the best opportunity to get paid for your work. You will often know in advance that certain visits should be reported based on time, using clues from the schedule or the nurse's notes. For example, time-based coding is likely if the visit is primarily to discuss lab results or follow up on a new medication, or if family members have accompanied the patient.

Get in the habit of glancing at your watch before you enter an exam room, or place a clock in your exam room on the wall behind the patient, and note your start and end time. You can casually glance at the time without the patient being aware of it. Understanding the rules related to time-based coding will not only help you obtain proper payment but also allow you to spend the time necessary to help your patients meet their treatment goals. FPM

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Other payers allow the physician to select the code whose typical time is closest to the actual time spent with the patient.

Physicians should document the actual time spent with the patient and the nature of any counseling or coordination of care activities.

A physician's schedule or nurse's notes can give advance warning of visits that should be coded on the basis of time.