American Academy of Pediatrics

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Using Time As the Key Factor for Evaluation and Management Visits

If you look through your Current Procedural Terminology (CPT®) book, you will notice that many of the evaluation and management (E/M) code descriptors include typical times. These typical times are averages of how long it takes a physician to complete all components of a visit at that level. As is true with averages, some times are going to be higher and some will be lower, depending on the actual clinical circumstances. Therefore, in most cases, time is only a "contributory factor" in determining which level of evaluation and management (E/M) to report for a visit. Usually, a level of E/M service is determined by the "key components" of history, examination, and medical decision making. However, if you end up spending greater than fifty percent of the total visit counseling/coordinating care, you can use time as the key factor in determining the level of E/M service that you report. Typical times are listed below for new and established office or other outpatient E/M services:

New Patient Visit	Typical Time (minutes)	Established Patient Visit	Typical Time (minutes)
99201	10	**99211**	5
99202	20	**99212**	10
99203	30	**99213**	15
99204	45	**99214**	25
99205	60	**99215**	40

Here's an example:

You see a 20-month old child with an injured leg and complete two out of the three key components (expanded problem focused history, expanded problem focused exam, or medical decision making of low complexity) necessary to code a **99213**. Upon review of the chart, you notice that the child is due for a refill on his asthma medication. You ask the mom how it has been going with the current medications and the mom starts talking about recent issues with getting the child to cooperate taking his medications. The physician spends a great deal of time counseling the mom on ways to administer the medications and how to be sure the child is getting enough. The physician also discusses the important of taking peak flow meter ratings. If you look in your CPT book, you will note that **99213** lists a typical time of 15 minutes, while a **99214** has a typical time of 25 minutes.

In order to determine whether you can code for time as the key factor, you need to answer the following questions:
A) How much time did I spend either counseling or coordinating care for the patient?
B) How much time did I spend in total for the whole visit (including time spent providing key components and time spent counseling and/or coordinating care)?
C) What percentage of B is A?

If the answer to C is equal to or less than fifty percent, then the key components should be used to determine the level of code to report. If the answer to C is greater than fifty percent, then you can use time as the key factor in determining which level of service to report; the level of key components is no longer a factor for determining the level of code to report. From our example above:
If the answer to B is 30 minutes and the answer to A is 16 minutes, then the answer to C is 53% and you could then report a **99214** (typical time for **99214** listed in CPT is 25 minutes).

+ Indicates a CPT add-on code. Code can only be reported with an appropriate primary procedure.
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To drive home the point, here are some variations with different results:
If the answer to B is 40 minutes and the answer to A is 22 minutes, then the answer to C would be 55% and you could then report a **99215** (typical time for **99215** listed in CPT is 40 minutes).
If the answer to B is 42 minutes and the answer to A is 19 minutes, then the answer to C would be 45% and you would then report a level of service based on key components (in our example above, you would report **99213**).

NOTE: In every case, it is imperative that you document the extent of the counseling/coordination of care in the medical record.

QUIZ

Q.

A 7-year-old child comes in at the end of the day with his mother and father for follow up of response to methylphenidate started 3 weeks ago for ADHD. Vital signs, including blood pressure, height and weight are obtained. You review the results of pre- and post-Connor Scale questionnaires from the parents and teachers. You question the child and family regarding appetite, tics, and other potential side effects. Everything seems to be going well and no further adjustment in medication is made. The child's mother, who was not present at the last visit, has multiple questions and concerns regarding such therapy, which you address. What would normally have been a fifteen-minute visit has lasted 40 minutes, with 22 minutes of the total visit being devoted to counseling the patient and his parents.
How would you appropriately bill for this encounter?

A.

99213 Office/outpatient visit, established patient, which requires 2 of 3 key components: an expanded problem focused history, an expanded problem focused examination, or medical decision-making of low complexity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

🚫 This is not the correct answer.

A typical 15-minute encounter for this type of visit would have likely been coded as a **99213** visit (office/outpatient visit, established patient) which requires 2 of 3 key components:

an expanded problem focused history,
expanded problem focused examination, or
medical decision making of low complexity

CPT suggests this typically takes about 15 minutes, and would have, if the mother had been there during the previous visit. As a result of the additional time spent counseling the family, which was the majority of the total visit time (22 minutes is 55% of 40 minutes), you can bill using time as the key factor.

B.

99215 Office/outpatient visit, established patient, which requires 2 of 3 key components: a comprehensive history, a comprehensive examination, or medical decision-making of high complexity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

✔ Correct!

Remember that times listed in CPT for E/M services are the typical times it takes a physician to complete all components of a visit of that level. Some times are going to be higher and some will be lower, depending on the actual clinical circumstances. Therefore, in most cases, time is only a "contributing factor" in determining which level of E/M code to report. Usually the "key components" of history, examination, and medical decision making should be used. However, if you spend greater fifty percent of the visit counseling and/or coordination care, you can use time as the key factor. In this case because 40 minutes was spent, you report the **99215** instead of the **99213.** ***Be certain to document the encounter's duration in the chart for that visit including total time spent in counseling/coordination of care.***

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When Time Spent Falls Between Two Typical Times

If the total time of a visit falls in between two reference codes (eg, a 20 minute visit, which falls just halfway between a **99213** [15 minutes] and a **99214** [25 minutes]), you need to determine if the time spent is closer to the lesser time [eg, 15 minutes] or the longer time [eg, 25 minutes]. If the time spent is closer to the lower typical time report the code with the lower time. If the time spent is closer to the higher typical time, report the code with the higher typical time.

Example**:** Physician spends 20 minutes with an established patient and parent. 15 minutes are spent in counseling/coordination of care. Since 20 minutes falls directly in between a **99213** [15 mins] and **99214** [20 mins], what do you report?

> **99213** – When the time spent is exactly the mid-point between 2 codes, you round down.

Example: Physician spends 40 minutes with a new patient. Of that time over 30 minutes is spent in counseling/coordination of care. Since 40 minutes falls in between a **99203** [30 mins] and a **99204** [45 mins], what do you report?

> **99204 –** Because the typical time mid-point was passed [ie, 38 mins] you can round-up to the higher code.

Example: Physician spends 30 minutes with an established patient and parent. The entire visit is spent in counseling/coordination of care. Since 30 minutes falls in between a **99214** [25 mins] and **99215** [40 mins], what do you report?

> **99214** – Even though you went over the typical time required for code **99214**, you did not pass the mid-point therefore you round down.

Caveat: The above guidelines for reporting when time spent falls between two typical times is a CPT guideline. Some Medicaid payers may differ.
Caveat: If you perform counseling/coordination of care for greater than 50% of a visit yet the total visit time does not meet the typical time requirement of even the lowest level code, you cannot use time as your key factor.

Prolonged Services: As a result of lengthy counseling/coordination of care encounters, time spent can go beyond even the highest typical time in the code set. When this happens, you can look to adding prolonged services. However, when using time as your key factor, prolonged services can only begin when you have reached a minimum of 30 minutes beyond the typical time listed in the highest code in the code set (eg, **99205**, **99215**).

+99354 Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)

+99355 Each additional 30 minutes (Use in conjunction with **99354**)

Example: Physician spends 80 minutes with a new patient. Of that time over 60 minutes is spent in counseling/coordination of care. What do you report?

> **99205** (60 minutes)
> Can you add-on prolonged services? No. Because the time spent was only 20 minutes above the typical time listed in the highest code (**99205** = 60 minutes). You need a minimum of 90 minutes to add on prolonged services.

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Example: Physician spends 80 minutes with an established patient. Of that time over 60 minutes is spent in counseling/coordination of care. What do you report?

99215 (40 minutes)

Can you add-on prolonged services? Yes. Because the time spent was greater than 30 minutes beyond the typical time listed in the highest code (**99215** = 40 minutes). You would then also report **99354** in addition to the **99215** (no modifier is needed).

Prolonged Clinical Staff Services with Physician or Other Qualified Health Care Professional Supervision

Codes **99415, 99416** are used when a prolonged E/M service is provided in the office or outpatient setting that involves prolonged clinical staff face-to-face time beyond the typical face-to-face time of the E/M service, as stated in the code description.

+ **99415** Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour
+ **99416** each additional 30 minutes

Refer to the prolonged services resource for more details.

Be certain to document the encounter's duration in the chart for that visit including time spent in counseling/coordination of care.

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