Society for Maternal•Fetal Medicine

Coding Committee

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Physician E&M visits that last less than the lowest typical times listed

In the world of coding, time could be perplexing. Time is built into many of the Evaluation and Management (E/M) Services. Physicians are often told to select the E/M code based on the history, exam and medical decision-making elements. Times are listed for each service in the CPT manual only as guideline. 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. In MFM, time is often the controlling factor in selecting the level of service.

Uncertainty persists whether physicians and non-physicians providers (NPP) can round up or down the actual time spent face to face with patients. CPT and CMS differ when it comes to determining the time to report for encounters for which the physician spends more than half of the visit counseling or coordinating the care. CPT allows providers to round up or down to the closest typical time when choosing an E/M code for the physician's consult time but CMS does not. CPT states: "The inclusion of time as an explicit factor beginning in CPT 1992 is done to assist physicians in selecting the most appropriate level of E/M services. It should be recognized that the specific times expressed in the visit code descriptors are averages and, therefore, represent a range of times that may be higher or lower depending on actual clinical circumstances." For patients with Medicare and other insurers who follow CMS rules (e.g. Medicaid), the time chosen must meet or exceed the average time for that E/M to be chosen, i.e. time should always be rounded down for those patients.

What happens when a physician spends 8-9 minutes which is less than the typical time listed for the lowest E&M code? Example: An MFM spends less than 10 minutes discussing an abnormal finding during ultrasound. Below are a couple of options:

1) For payers who follow CMS rules, the time cannot be rounded up. For established patients, one may bill "99211". For consults and new patients, the visit may not be billed based on time if < 10 minutes so in that case the billing should be instead based on components.
2) For other payers, the physician may bill "99201" (new patients), "99212" (established patients), or "99241" (consults), which would be consistent with CPT rules. Alternatively, one may choose to bill similarly to payers who follow CMS rules as delineated above.