Coding Tip: Time Based E/M Coding

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In our fast-paced world, it sometimes seems there is simply not enough time in a day to get everything done. For the Maternal Fetal Medicine specialist encountering a patient whose care requires longer than the usual visit, time can seem like a "no-win" situation. There is a way to make time work to your advantage by using time-based coding for some of your patient encounters. Time-based coding may not be the primary way of selecting E/M codes, but for encounters that involve extensive counseling or pre/ post visit activities, it offers the best opportunity to get paid for your work.

The 2021 and the 2023 CPT revisions to E/M coding and documentation guidelines for time-based coding allows for an expanded use of time to determine the level of care. If time is used to select the level of service, the E/M code is based on the *total amount of time on the date of service.* In addition to face-to-face time, prep time and follow-up work on the same day provided personally by the MFM (or QHP) can be counted towards the selection of the E/M code. Time can be used to select codes for both outpatient and hospital-based encounters.

The physician/QHP time includes the following activities:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically necessary and appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests or procedures
- Referring and communicating with other health care professionals (when not reported separately)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not reported separately) and communicating results to the patient/family/caregiver
- Care coordination (not reported separately)

It does not include:

- Performance of other services that are reported separately
- Travel
- Teaching that is general and not limited to discussion that is required for the management of a specific patient
- Activities provided by clinical or administrative staff
- Time spent on days other than the date of service

Documentation

It is important that the documentation specifically state the amount of time involved in the service. Statements such as "discussed at length" or "extensive record review" do not match to a specific CPT code. Instead, you should document the actual time spent on the date of service.
The threshold time for the selected code must be met or exceeded. For example, at least 30 minutes must be documented to meet the time requirements for CPT 99214 which is associated with 30-39 minutes. (See tables below for times associated with outpatient E/M codes.)

There is not a requirement to specify the amount of time spent on each specific task. However, the clinical record should reflect the activities that count towards the time threshold. Since total time is used to select the E/M code, it is no longer necessary to document face-to-face time or to indicate that counseling or coordination of care dominated the encounter.

Many practices have developed macros to assist with the documentation of time. Some are simple and simply indicate the total time on the date of service. Others include additional statements that list some of the activities or explicitly state that the performance of procedures and ultrasound studies are not included in the total time. Although there is not a specific prohibition against always recording threshold times, it is best practice to vary the times to reflect a more accurate calculation of the time spent on patient care activities.

Tips for Tracking Time

Keeping track of the total time spent on the date of service can be challenging, particularly when non-face-to-face activities are contributing to the calculation of total time. Although some activities may only take a couple of minutes; minutes add up! It may be helpful to calculate the average time for some recurring tasks such as calls to the pharmacy, making certain referrals, or completion of commonly used forms. Remember these are calculated only when they are personally performed by the MFM/QHP.

Although best practice is to close your EMR record in a timely fashion, there may be situations when it is best to delay signing off on a note. If you anticipate a lengthy clinical note or a call later in the day with another provider, you might want to wait until the end of the day to close the note to allow that time to be included in selecting the E/M code.

Some EMRs have a function that automatically tracks time when the note is open. This may not always be an accurate account of the actual time spent on patient care activities, but it may still be helpful. You may want to have the encounter open while reviewing the medical record and during the face-to-face visit with the patient. Likewise, if you are reviewing test results following the visit or speaking with another provider later in the day, having the record open may be helpful in tracking time.

Often, it will be a good faith effort to estimate the total time on the day of the encounter. If you estimate being close to the threshold for the next level, it might be best to be conservative and select the lower level code.

Prolonged Services

CPT codes 99417 and 99418 describe prolonged services for outpatient and inpatient/observation care, respectively. Prolonged total time is time that is 15-minutes beyond the time required to report the highest-level

primary service (i.e. 99205, 99215, 99223, 99233, 99245, 99255.) The codes are reported for each 15-minute increment beyond the *threshold* time of the primary code. You may no longer use previous prolonged services codes 99354-99357.

CMS has created its own codes for reporting prolonged services also based on 15-minute increments. G2212 is for outpatient services when the *maximum* time associated with the highest-level primary service has been reached. Code G0316 is reported for inpatient/observation services that are beyond the total time for the highest level primary service.

TIMES FOR OUTPATIENT E/M SERVICES

New Outpatient E/M Codes					
Code	99201-Deleted	99202	99203	99204	99205
Time	N/A	15-29 min.	30-44 min.	45-59 min.	60-74 min.
MDM	N/A	Straightforward	Low	Moderate	High
Established Outpatient E/M Codes					
Code	99211	99212	99213	99214	99215
Time	N/A	10-19 min.	20-29 min.	30-39 min.	40-54 min.
MDM	N/A	Straightforward	Low	Moderate	High

Example

MFM sees an establish patient for an office visit and detailed fetal anatomy survey. She is 22 weeks GA, AMA and has diabetes and cardiac disease. The MFM spends total time of 65 minutes on the date of service encounter addressing the patient's medical conditions, separate from the ultrasound procedure. A 76811 is performed with normal findings, interpreted and report generated and separately billed for.

Proper coding, Total-Time Based: 76811, 99215 (40-54 minutes) + modifier 25, 99417 (first 15 minutes of time exceeding the highest level of E/M service threshold).

Sample Documentation:
The following are sample macros. The amount of documentation detail can be variable depending on your practice or institution preference. Remember that there is NOT a requirement to specify the amount of time spent on each specific task as per AMA guidance (https://www.ama-assn.org/system/files/regulatory-myths-doc-coding-em.pdf). Some of the driving force behind the updated E/M codes was to reduce provider burden for documentation; others argue that more detailed macros help reduce denials during records review. Here we provide different examples for documentation that you are welcome to adapt to your practice if you find helpful.

Sample 1:

Total time spent for E/M office visit encounter today: 65 minutes.

Sample 2:

Total time spent for E/M office visit encounter today (excluding/separate from time spent on ultrasound): 65 minutes.

Sample 3:

Total time spent on patient care was 65 minutes.
This included the following tasks: preparing to see the patient; history and exam; counseling and educating the patient/family/caregiver; ordering medications, tests or procedures; referral or communication with other healthcare professionals; record documentation; interpretation of tests and communication of results; and care coordination. Total time excludes/is separate from time spent on ultrasound.

Sample 4:

The patient had all her questions answered. She voiced understanding of the plan of care and her satisfaction with our care today. Thank you for the opportunity to participate in the care of Ms. XX YY. Please do not hesitate to contact us if you may have any questions or concerns.

- *I spent 15 minutes prior to the visit preparing to see the patient (reviewing medical records and tests).*
- *I spent 30 minutes face-face-to-face with the patient and/or family members for counseling and coordination of care.*
- *I spent 20 minutes after the visit with the patient documenting the visit in the electronic health record and/or communicating with other health care professionals and/or care coordination.*
- *(These times were separate from the time spent on ultrasound procedure on the same date)*
- *Total time spent on today's date of service for E/M: 65 minutes.*

Please submit any questions you may have to the SMFM Coding Committee Ask a Coding Question website (https://www.smfm.org/coding/questions/new). Additional information and resources are also available on our coding website. Thank you very much.