Coding for Time

In the world of coding, time is perplexing. On the one hand time is built into the evaluation and management codes, and so we are told to base E/M code selection on history, physical, and decision-making elements, not on time spent. Times are listed for each service only as a guideline. On the other hand, there are lots of codes that are strictly time dependent, and there are E/M codes for prolonged services.

As a result there is lots of confusion around the importance of time, especially for those office and in-patient E/M codes that are selected for unusually long visits. A higher code can be used for longer visits even though there may not be enough history, physical, and decision-making elements, if there is sufficient time spent to justify the selection.

Understanding time can help you code all of the following vexing situations:

1. The asthma flare-up that requires 2 hours of office time;
2. The patient who requires 25 minutes to review problems, adjust medications, counsel, and coordinate care, but who does not require an extensive history or physical or complex decision making;
3. The visit that follows an annual physical which is devoted to counseling on risk factors and newly discovered problems;
4. The hospital visit that takes hours because of maternal/fetal monitoring or other physiologic monitoring;
5. Standing by in the hospital in case 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 one understands time and how to code for it.

What is Time? The powers that be (CMS and the AMA) describe 3 kinds of time: "face-to-face" time, "floor/unit" time, and "non-face-to-face" time, also known as "pre- and post-encounter" time. Face-to-face time is "only that time that the physician spends face-to-face with the patient and/or family."[i] It applies to office and other out-patient visits.

Floor/unit time is "the time that the physician is present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time in which the physician establishes and/or reviews the patient's chart, examines the patient, writes notes and communicates with other professionals and the patient's family."[ii] It applies to hospital observation services, in-patient hospital care, initial and follow-up hospital consultations, and nursing facility services.

Non-face-to-face or pre- and post-encounter time is "time doing work before or after the face-to-face time with the patient, performing such tasks as retrieving records and tests, arranging for further services, and communicating further with other professionals and the patient through written reports and telephone contact. In the hospital, pre- and post-time 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-face work associated with an encounter was included in calculating the total work of typical services in physician surveys."[iii]

If this seems confusing, consider that the theoretical physicist Stephen Hawking also described three kinds of time: thermodynamic time, psychological time, and cosmological time.[iv] Coding time, for all its complexity, is considerably easier to understand.

Before one can accurately select prolonged service codes, he or she must understand what is meant by regular length services, i.e., not prolonged services. Table 46 lists the average time guidelines for office visits. Time refers to face-to-face contact.

Table 46: Time Guidelines for Office Visits[v]

	New	Established
Minutes		
5		99211
10	99201	99212
15		99213
20	99202	
25		99214
30	99203	
40		99215
45	99204	
60	99205	

Table 47 lists the time guidelines for hospital visits. This kind of service is floor/unit time.

Table 47: Time Guidelines for Hospital Care[vi]

	Initial	Subsequent
Minutes		
15		99231
25		99232
30	99221	
35		99233
50	99222	
70	99223	

Time spent doing discharge planning is reported using codes 99238 for 30 minutes or less and 99239 for more than 30 minutes.

Table 48 describes the time guidelines for consultations performed in the office or other out-patient site. Time is based on face-to-face contact between the physician and

the patient and/or his family. These codes apply to both new and established patients seen in the out-patient setting.

Table 48: Time Guidelines for Office Consultations[vii]

Minutes	Code
15	99241
30	99242
40	99243
60	99244
80	99245

Incidentally, the diagnostic codes to use for presurgical physicals/consults are V72.8 (pre-op cardiovascular exam), V72.82 (pre-op respiratory exam), V72.83 (other pre-op exam), and V72.84 (pre-op exam, unspecified). Again, the “4 R’s” of consultations are: document that the consultation was **r**equested by another physician or healthcare provider (not by a patient), document the **r**eason for the request, document the services **r**endered, and write a written **r**eport.

Table 49 describes the time guidelines for consultations performed in the hospital, nursing home, or partial hospital settings with either new or established patients. As for other in-patient services, time relates to floor/unit time.

Table 49: Time Guidelines for In-patient Consultations[viii]

	Initial	Follow-up
Minutes		
10		99261
20	99251	99262
30		99263
40	99252	
55	99253	
80	99254	

In 2007 new nursing home visit codes were published, and in 2008 new time guidelines for those visits were released.

Table 50: Time Guidelines for Nursing Home Visits[ix]

	Initial	Subsequent	Annual Assessment
Minutes			
10		99307	
15		99308	
25	99304	99309	
35	99305	99310	99318
45	99306		

	Direct	Not direct
Minutes		
30 or more	9936 6	99367 (physician)
		99368 (non-physician)

For nursing home discharge planning use 99315 for 30 minutes or less, and 99316 for more than 30 minutes.[x]

For supervision of domiciliary, rest home (eg, assisted living facility), or home care plan oversight services use 99339 for 15 to 29 minutes and 99340 for 30 minutes or more.[xi]

Table 51 describes time guidelines for home services. Time refers to face-to-face contact with the patient and/or family.

Table 51: Time Guidelines for Home Services[xii]

	New	Established
Minutes		
15		99347
20	9934 1	
25		99348
30	9934 2	
40		99349
45	9934 3	
60	9934 4	99350
75	9934 5	

Table 52 describes time guidelines for both direct (face-to-face with patient or patient's guardian) and non-face-to-face conferences for qualified non-physician health care professionals. Physicians should use E & M codes for the former, and should use 99367 to report the latter.

Table 52: Time Guidelines for Medical Team Conferences[xiii]

Average time means that the number of minutes is not a threshold for choosing a code. Instead they are averages, and the actual amount of time spent, either face-to-face or floor/unit, should be rounded up or down to the nearest average.[xiv] For example, if 16 minutes is spent with a new patient, round up to 20 minutes, the average time for a 99202. Conversely, if one spends 30 minutes with an established patient, she should round down to 25 minutes, the average time for a 99214.

When time is spent, but the points don't add up use the "Greater than 50 Percent" rule. It is not unusual to spend a lot of time face-to-face with a patient reviewing problems, adjusting medication doses, and counseling and/or coordinating care, only to find that there are not enough history, physical, or decision-making elements to support using a code that would otherwise be appropriate for a visit of that duration. This is when the "greater than 50 percent rule" applies

When greater than 50 percent of the time spent face-to-face with the patient is spent counseling and/or coordinating care, use the code from the above tables that is closest to the total time spent with the patient. For example, when 25 minutes is spent with an established patient, and more than half of that time is counseling and/or coordinating care, use the 99214 code.

When providing psychotherapy, "counseling" means "professional guidance of the individual by utilizing psychological methods especially in collecting case history data, using various techniques of the personal interview, and testing interests and aptitudes."[xv] In the context of medical and surgical care, counseling includes discussing the prognosis, risks and benefits of management (treatment) options, instructions for management and/or follow-up, and the importance of compliance with chosen management options. It can also include discussions of diagnostic and laboratory test results, impressions, and recommended studies, as well as risk factor reduction, patient and family education.[xvi] When attempting to reduce risk factors, counseling includes discussions of family problems, diet and exercise, substance abuse, sexual practices, injury prevention, and dental health.[xvii]

Counseling can be provided to individuals and parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members.[xviii]

Coordination of care includes discussions with other care providers such as physicians and agencies involved in the care of the patient.[xix]

The prolonged service codes are meant to be separately reported in addition to E/M codes. The first set relate to "face-to-face" or "floor/unit" times. In the office setting this means time spent with the patient and/or patient's family. In the hospital, it means time spent on the floor working on a particular patient's care. It includes both time spent with the patient, and time spent working on his chart or discussing his care with nurses and others. For both settings, less than 30 minutes of prolonged service is not separately reportable. Additionally, less than 15 minutes beyond the first hour of prolonged service or beyond the final 30 minutes is not reported separately. An example of a prolonged out-patient visit would be the care of an office patient with an acute asthma attack who warrants prolonged face-to-face care by a physician.[xx]

Table 53: Prolonged Service Codes for Office Visits[xxi]

Minutes	Code
30-74	99354
75-104	99354 x 1 plus 99355 x 1
105-134	99354 x 1 plus 99355 x 2
135-164	99354 x 1 plus 99355 x 3
165-194	99354 x 1 plus 99355 x 4

For in-patients prolonged care is reported using 99356 for the first hour, and 99357 for each additional half hour. An example would be maternal-fetal monitoring for high-risk delivery or other physiologic monitoring, or prolonged care of an acutely ill in-patient.

Table 54: Prolonged Service Codes for Hospital Visits [xxii]

Minutes	Code
60	99356
61-90	99356 x 1 plus 99357 x 1
91-120	99356 x 1 plus 99357 x 2
121-150	99356 x 1 plus 99357 x 3
151-180	99356 x 1 plus 99357 x 4

There are also codes for prolonged physician services that are not face-to-face. These are for pre- and post-care services provided in either the out-patient or in-patient setting. No matter where the service is delivered, 99358 and 99359 are used to report prolonged physician services without direct patient contact. 99358 is used for the first 30 minutes to an hour of service, and 99359 is used for each additional 30 minutes or for the final 15 to 30 minutes on a given day.[xxiii]

There are a number of services that are strictly time dependent. These include:

1. Physician standby services: 99360 for each 30 minutes. Examples include operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG.[xxiv]

2. Pediatric (24 months or less) patient transport: 99466 for 30 to 74 minutes and 99467 for each additional 30 minutes.[xxv]
3. Pediatric (over 24 months of age) patient critical care transport: 99291 for 30 to 74 minutes, and 99292 for each additional 30 minutes.[xxvi]
4. For care plan oversight services relating to home care, use 99374 for 15 to 29 minutes and 99375 for 30 minutes or greater.[xxvii]
5. For care plan oversight services relating to hospice care, use 99377 for 15 to 29 minutes and 99378 for greater than 30 minutes.[xxviii]
6. Intravenous infusions for hydration are coded by time: 96360 for initial, 31 minutes to 1 hour, and 96361 for each additional hour. When infusions are administered for therapeutic or diagnostic purposes, not for hydration, use 96365 for up to 1 hour and 96366 for each additional hour. For an additional infusion use 96367, and for a concurrent infusion use 96368.[xxix]
7. For counseling and risk factor reduction performed during a separate visit **(not as part of an office visit or a preventive medicine service)** use the following codes for individual counseling:

Table 55: Counseling Code Time Guidelines[xxx]

Minutes	Code for Counseling Services
15	99401
30	99402
45	99403
60	99404

Counseling codes are not supposed to be used for discussion of preexisting problems for established patients or for patients with symptoms.[xxxi] They apply to counseling for problems discovered during or relating to preventive service visits. Use 99411 for group counseling lasting 30 minutes, and 99412 for group counseling lasting 60 minutes. [xxxii]

For counseling related to smoking or alcohol, use the following codes. These may be reported in addition to an office visit or preventive medicine service.

Table 56: Behavioral Change Intervention Time Guidelines[xxxiii]

	Tobacco	Alcohol
Minutes		
3-10	99406	
11+	99407	
15-30		99408
31+		99409

Behavior change interventions for alcohol and/or substance (other than alcohol) abuse requires structured screening using a formal assessment tool such as AUDIT, DAST, OR ASSIST. These services may be provided by a qualified non-physician health care professional.

Telephone evaluation and management services may be provided by either physicians or qualified non-physician professionals.

Table 57: Telephone E & M Services Time Guidelines [xxxiv]

	Physician	Non-physician
Minutes		
5-10	99441	98966
11-20	99442	98967
21-30	99443	98968

Anesthesia time is reported in increments that are customary for your locality.

The rules for documenting how much time is spent as stated in *CPT 2008* are not very detailed. When discussing the “greater than 50 percent” rule, the following instruction is given: “The extent of counseling and/or coordination of care must be documented in the medical record.”[xxxv] The only other documentation guideline offered refers to critical care services. It reads, “Time spent with the individual patient should be recorded in the patient’s record.”[xxxvi]

Typically physicians state how much time was spent on the encounter note for that day’s service(s). Start and stop times are rarely recorded, especially in in-patient settings because the total time there is often not continuous. Since it is not practicable to record start and stop times in that setting, excluding start and stop times makes sense. Whether it is wise in out-patient settings is debatable. If challenged by an auditor or a patient with a vague memory of how little time was spent, it cannot hurt to document start and stop times.

The 2008 fee schedule for Medicare services includes fees for some, but not all, prolonged face-to-face and floor/unit services and critical care transport services. It does not include non-face-to-face, standby, case management, plan oversight, counseling, telephone, and behavioral change services for alcohol or substance abuse.[xxxvii] Physician’s Fee Schedule Software (available at www.practicetools.biz) includes relative values for many of these services that can be converted to both Medicare and non-Medicare fees.

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 and for services that involve a lot of counseling and/or coordination of care. It is also important 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.

[i] *CPT 2008*, page 5.
[ii] Ibid, page 5.
[iii] Ibid, page 5.
[iv] *A Brief History of Time*, page 145.
[v] *CPT 2008*, pages 9-10.
[vi] Ibid, pages 12-13.
[vii] Ibid, pages 15-16.
[viii] Ibid, pages 16.
[ix] Ibid, pages 22-24.
[x] Ibid, page 24.
[xi] Ibid, page 26.
[xii] Ibid, pages 26-27.
[xiii] Ibid, pages 30-31.
[xiv] *2004 CPT Assistant, August edition.*
[xv] *Merriam-Webster's Collegiate Dictionary, 10th Edition*, page 264.
[xvi] CPT 2008, page 1.
[xvii] Ibid, page 32-33.
[xviii] Ibid, page 1.
[xix] *E&M Chart Auditing*, page 57.
[xx] *CPT 2008*, page 28.
[xxi] Ibid, page 28.
[xxii] Ibid, page 29.
[xxiii] Ibid, page 27.
[xxiv] *CPT 2008*, page 29.
[xxv] Ibid, page 18.
[xxvi] Ibid, page 20.
[xxvii] Ibid, page 31.
[xxviii] Ibid, page 29.
[xxix] Ibid, page 384.
[xxx] Ibid, pages 32-33.
[xxxi] Ibid, page 32.
[xxxii] Ibid, page 33.
[xxxiii] Ibid, page 33.
[xxxiv] Ibid, page 34.
[xxxv] Ibid, page 8.
[xxxvi] Ibid, page 19.
[xxxvii] Medicare Part B Colorado 2009 Fees as posted on the Roadrunner Health web site www.Roadrunnerhealth.com.