Using Time to Determine E&M Code Levels
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Prior to 1992, for the purpose of determining an Evaluation and Management (E&M) code level, time was implicit in the code definitions. CPT® made time explicit in 1992 and time was only used to determine an E&M code level when at least 50% of the total exam times was taken up with patient counseling and coordination of care. In 2021, CPT® changed the definitions for the E&M code levels. Currently, the provider has the choice to determine the E&M code level either by the level of Medical Decision Making (MDM) or by time. Any E&M code level for a visit can be determined by the total time spent by physician/Other Qualified Health Care Professional (QHP) on date of the patient encounter. A specific time is defined for each E&M code level (see chart below).

The time use guidelines require a face-to-face physician- patient encounter. The time spent by clinical staff cannot count toward the total time since staff time is considered to be a practice expense. If a provider only spent time in the supervision of clinical staff who are actually performing the service for the patient then the 99211 code would apply. Again, only provider time counts toward the total time of an E&M encounter. Provider time spent on the day of the patient encounter can be used for a number of tasks related to a patient visit such as the following:

1. Preparing to see patient - like reviewing of tests or past history
2. Obtaining and/or reviewing separately obtained history
3. Performing medically appropriate examination and/or evaluation
4. Counseling and educating of the patient/family/caregiver
5. Ordering medications, tests, or procedures
6. Referring and communicating with other health care professionals - not separately reported
7. Documenting clinical information in electronic or other health record
8. Independently interpreting results-not separately reported - and communicating results to the patient/family/caregiver
9. Care coordination – when not separately reported

Time spent by any provider in the performance of other services that are reported separately (such as Special Ophthalmologic Services like OCT and visual fields, travel to a clinic, and general teaching when the discussion with the intern or resident are not limited to the discussion that is required for management of a specific patient on the day of an encounter cannot be counted toward total time.

In 2024, CPT® revised the required time thresholds that must be met, eliminating the time ranges that were previously used. The new times for any specific code level must be met or exceed by 15 minutes before a code choice can be moved up to the next level.

Prolonged services code (99417) reporting requires a minimum of 15 minutes per unit of time used beyond the times indicated for 99205 or 99215 code levels. 99417 is only used when the office or other outpatient service has been selected using time alone as the basis and only after the amount of time spent time exceeds the required time to report the highest-level service (99205 or 99215). This means that the 99205 or 99215 time has been exceeded by 15 minutes (see chart attached).

CPT® has added two codes that can be used for prolonged service before or after the day of direct patient care – 99358 and 99359. This service must be related to a patient's face-to-face service that has occurred or will occur and be relate to ongoing management of that patient. This time can be counted even when the time spent is not continuous time. For example, this type of service might involve extensive past patient record review, obtaining prior approvals or other services required for that patient's care (see chart attached). At this time, CMS has replaced 99417, 99358 and 99359 with G2212 when reporting prolonged time to Medicare.

There are codes for Prolonged Staff Service which could be reported once a day and required direct physician supervision. There would be little need for this code in the typical eye care practice, however.

When using time to determine the level of E&M code for a specific encounter, the chart documentation needs to indicate the total time spent on an encounter AND the documentation needs to be in enough detail for any auditor to

understand specifically how the time was spent. Medical necessity is still important and the medical record must be clear in this regard. … Happy Coding

2024 CPT® E&M Time for Each Code Level

Code	Time
99211	Not application
99202	15 minutes
99212	10 minutes
99203	30 minutes
99213	20 minutes
99204	45 minutes
99214	30 minutes
99205	60 minutes
99215	40 minutes

99417 Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time

(List separately in addition to codes 99205, 99215 for office or other outpatient E&M services)
(Use 99417 in conjunction with 99205, 99215)
(Do not report 99417 on same date of service as 99354, 99355, 99358, 99359, 99415, 9416)
(Do not report 99417 for any time unit less than 15 minutes)

(CMS) G2212: Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact

(Addition to CPT codes 99205, 99215 for office or other outpatient evaluation & management services)
(Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416)
(Do not report G2212 for any time unit less than 15 minutes)

CMS Prolonged Services Required Times (CPT 99417 or CMS G2212)

Table 2. Codes for Billing Prolonged Office or Outpatient E/M Visits

Codes	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and G2212 x 2	104-118 minutes
99215	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84-98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes	99 or more

* Total time is all of the reportable time, including prolonged time, you spend with the patient on the date of service of the visit.

99358 Prolonged evaluation and management service before and/or after direct patient care; first hour

99359 ;each additional 30 minutes

((List separately in addition to code for prolonged service)
(Use 99359 in conjunction with 99358)
(Do not report 99358, 99359 on the same date of service as 99XXX)
(Do not report 99358, 99359 during the same month with 99484, 99487-99489, 99490, 99491, 99492, 99493, 99494)
(Do not report 99358, 99359 when performed during service time of codes 99495 or 99496, if reporting 99495 or 99496)