Using Time to Select an Evaluation and Management (E/M) Code

Understanding the AMA 2021 and 2023 CPT® Guidelines

Overview

Beginning in 2021 (for office/outpatient visits) and expanding in 2023 (to additional settings), the American Medical Association (AMA) revised the Evaluation and Management (E/M) guidelines to allow clinicians to select the E/M level based on either:

1. Medical Decision Making (MDM), or
2. Total time personally spent by the physician or other qualified health care professional (QHP) on the date of the encounter.

This time-based method acknowledges that a significant portion of clinical work occurs outside face-to-face interaction, including preparation, documentation, coordination, and patient counseling.

Defining a Qualified Health Care Professional (QHP)

The AMA defines a Qualified Health Care Professional (QHP) as: "An individual who, by education, training, licensure/regulation, and facility privileging, performs a professional service within their scope of practice and independently reports that professional service." (AMA CPT® Professional Edition, 2023 E/M Guidelines section)

Examples of QHPs include physicians (MD/DO), nurse practitioners (NPs), physician assistants (PAs), certified nurse midwives (CNMs), and clinical nurse specialists (CNSs). Clinical staff such as RNs, LPNs, or medical assistants are not QHPs, and their time does not count toward total time when time-based code selection is used.

What "Time" Means in the E/M Context

When time determines the level of service, the total time personally spent by the physician or QHP on the date of the encounter is used. This includes both face-to-face and non-face-to-face work directly related to that patient's care. Only activities on the same calendar date may be counted.

Activities That Count Toward Total Time

- Preparing to see the patient (reviewing results, records, or prior history)
- Obtaining and/or reviewing separately obtained history (e.g., caregiver input)
- Performing the medically appropriate exam and evaluation
- Counseling and educating the patient, family, or caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health professionals (when not separately reported)
- Documenting clinical information in the EHR

- Independently interpreting results (if not separately billed) and communicating findings
- Coordinating care for the patient's current condition (when not separately reported)

Activities That Do Not Count

- Work done by clinical staff (MAs, nurses, scribes)
- Services that are separately reported (e.g., procedures)
- Work performed on different calendar dates
- General teaching unrelated to the patient's care
- Travel or non-clinical administrative tasks

Time Thresholds for Code Selection

New Patient Office/Outpatient Visit (99202–99205):

Code	Time Range (Total QHP Time)
99202	15–29 minutes
99203	30–44 minutes
99204	45–59 minutes
99205	60–74 minutes

Established Patient Office/Outpatient Visit (99212–99215):

Code	Time Range (Total QHP Time)
99212	10–19 minutes
99213	20–29 minutes
99214	30–39 minutes
99215	40–54 minutes

Prolonged Services and Medicare Code G2212

When a visit exceeds the highest listed time for the base E/M code (e.g., 99205 or 99215), clinicians may add a prolonged services code to represent additional time spent on the same date.

AMA CPT® Prolonged Services Codes:
- 99417: Office/outpatient (used with 99205 or 99215); each additional 15 minutes beyond the minimum time.

CMS/Medicare Prolonged Services Code – G2212:
Medicare uses HCPCS code G2212 for prolonged office or other outpatient visits. This code starts when total time exceeds the CMS threshold time, which is typically longer than the

AMA's minimum. The MUE (Medically Unlikely Edit) for G2212 is 6. An MUE is a claim-level edit that sets a maximum number of units a provider can bill for a single patient on a single day.

Examples:
- For a new patient (99205) visit lasting 89 minutes → report 99205 + G2212 × 1
- For an established patient (99215) visit lasting 69 minutes → report 99215 + G2212 × 1
Each additional 15-minute increment beyond these thresholds adds another unit of G2212.

Key differences:
- AMA 99417 counts from the minimum time required for 99205/99215.
- CMS G2212 counts after the maximum threshold time.
- Always verify payer policy: commercial plans follow 99417; Medicare uses G2212.

Example Documentation

"Total QHP time today: 90 minutes — reviewed prior cardiology and imaging records, counseled patient and spouse, documented in EHR, coordinated care with cardiologist. Code selection based on time: 99205 + G2212 × 1 (Medicare)."

References

• American Medical Association. (2023). CPT® Evaluation and Management (E/M) Office or Other Outpatient and Prolonged Services Code and Guideline Changes.
• American Medical Association. (2023). CPT® Professional Edition: Evaluation and Management Services Guidelines.
• Centers for Medicare & Medicaid Services (CMS). (2023). HCPCS G2212 – Prolonged Office or Other Outpatient E/M Service Time Thresholds.
• American Academy of Family Physicians (AAFP). (2021). Understanding 2021 Office Visit Coding Changes.
• AAPC. (2022). Determining Condition Complexity for E/M Leveling.

Disclosure: This article was developed and adapted for educational use by Sara Kroeplin, RHIA, based on official AMA and CMS documentation standards. Portions of this summary were created with assistance from ChatGPT (OpenAI) and reviewed for accuracy and compliance.