Time

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the other E/M services when counseling and/or coordination of care dominates the service. When time is used to select the appropriate level for E/M services codes, time is defined by the service descriptors. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

Total Time on date of encounter includes the face-to-face and non-face-to-face time spent by physician and/or other qualified health care professional.

Total Time activities include:

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

CODE	TIME EQUIVALENT
New Patient — 99202	15–29 minutes
99203	30–44 minutes
99204	45–59 minutes
99205	60–74 minutes
Established Patient 99201 — deleted	**Code deleted**
99211	No time established
99212	10–19 minutes
99213	20–29 minutes
99214	30–39 minutes
99215	40–54 minutes

Note: For office/outpatient E/M visits, the 1995 and 1997 E/M guidelines will no longer be used.

The extent of History and physical examination is not an element in selection of office or other outpatient services.
Office and outpatient services include medically appropriate history and/or physical examination when performed.
The nature and extent of history and/or physical examination are determined by professional reporting of the service.
Care team(s) may collect information from patient or caregiver via multiple methods (e.g., portal, questionnaire) for review by reporting provider.