TOOL 04

Two routes, one encounter

KEY INSIGHT

The core rule

For most office and outpatient E/M visits, you may select your code level based on **either** Medical Decision Making **or** Total Practitioner Time spent on the date of the encounter. **[1] [2]**

You no longer need to meet a counseling threshold to bill based on time. Choose the route that best reflects the work performed and is most clearly supported by your documentation.

ROUTE A

Choose MDM when...

- The visit required high cognitive effort, but the total time spent was standard or brief.
- You managed high-risk medications or navigated complex diagnostic uncertainty.
- You addressed multiple chronic conditions, even if the face-to-face portion was highly efficient.
- The complexity of the patient's problems, data reviewed, and management risk clearly support a higher level than the time spent.

ROUTE B

Choose total time when...

- Extensive counseling, education, or coordination of care dominated the visit.
- You spent significant time reviewing records or coordinating care *on the same day*, before or after seeing the patient.
- The clinical narrative is relatively simple, but the time required to manage the patient was unusually high.
- The time spent clearly meets the threshold for a higher level, but the MDM elements (Problems, Data, Risk) are borderline.

TOOL 04

Documenting total time

If you select the E/M level based on total time, your documentation must explicitly support it. Do not rely on automated EHR time stamps alone. Your note must include all three of the following.

REQUIRED 1 OF 3

The specific total time

spent by the billing practitioner on the date of the encounter. For example: "Total time spent: 45 minutes."

REQUIRED 2 OF 3

The date

the time was spent, which must be the date of the encounter.

REQUIRED 3 OF 3

A summary of the activities

that comprised that time. For example: "Time included face-to-face evaluation, review of extensive outside records prior to the visit, and care coordination with the specialist following the visit."

WARNING

Do not count

Time spent on separately billable services, such as an EKG interpretation billed separately, or time spent by clinical staff.

CLINICAL PEARL

What a time statement looks like

"Total time spent: 45 minutes on the date of the encounter. Time included face-to-face evaluation, review of extensive outside records prior to the visit, and care coordination with the specialist following the visit."

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Sources: [1] CMS, Evaluation & Management Services. [2] AAPC, Evaluation and Management Coding, E/M Codes.
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