Reference Sheet

Definitive Guide to Documenting Time

Accurate until 12/31/2022 and the rule change

Type of Visit	What to Document	Comments	Example
Office/Outpatient codes 99202-99215	• Total time spent on the day of the encounter	• Include practitioner time only • Include direct patient care and non-face-to-face time	"I spent 35 minutes reviewing the record, seeing the patient and documenting in the EHR."
E/M Service Based on Time Inpatient Status **(1995/1997 Guidelines)**	• Document total unit time. • Note that over half of the unit time was face-to-face with the patient in discussion. • Briefly describe discussion.	Over half of total time must be with patient ***or*** coordination of care while on unit to use time for inpatient services.	"I spent 30 minutes on the unit, over half of which was in the patient and coordinating care."
E/M and Prolonged Services Prior to 2023	• Document start and stop times. • Note that the additional, prolonged services were face-to-face with the patient.	Medicare requires stop and start, not CPT®.	"Visit started at 8:45, ended at 10:20. Prolonged time was face-to-face with patient."
Critical Care	• Document total time (exclusive of procedures). • Time spent updating family is not included in critical care time. • Include time on unit caring for patient: at bedside, writing notes, reviewing data, discussion with other healthcare professionals.	Updating family is not counted in critical care time. May include time spent with family member if need to obtain history and patient cannot provide or if family is decision maker.	"I spent 45 minutes caring for this critically ill patient, exclusive of procedures and updating family members."