

Evaluation and Management (E/M) Coding Guide

Last revised: March 2026



Purpose

This policy is intended to address the evaluation and management (E/M) services and to promote correct coding and billing practices. The goal is to ensure consistent and appropriate selection of E/M codes throughout the network and keep medical costs consistent.

The E/M coding section of the CPT® book is divided into broad categories with further subcategories which describe various E/M service classifications. The classification of the E/M service is important because the nature of the work varies by type and place of service, the patient's medical status, and other code criteria, along with the amount of the provider's work and documentation required. The key components appear in the descriptors for most basic E/M codes and many code categories describe increasing levels of complexity.

Providers are encouraged to consult the most current CPT® Professional Edition published by the American Medical Association at www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf to ensure that the most current applicable guidelines are followed.

Evaluation and management overview

The E/M guidelines have various sections including:

- Office or Other Outpatient Services (99202-99215)
- Telemedicine Services (98000-98016)
- Hospital Inpatient and Observation Care Services (99221-99239)
- Consultations (99242-99255)
- Emergency Department Services (99281-99288)
- Nursing Facility Services (99304-99316)
- Home or Residence Services (99341-99350)
- Prolonged Service with or without direct patient contact on the date of an evaluation and management service (99358-99360)

The E/M section (98000-98016, 99202-99499) includes many code categories that may have specific guidelines, or the codes may include specific details. The E/M guidelines mentioned in this guide are written for the above-mentioned categories.

The E/M section of the AMA CPT® manual is divided into broad categories (office visits, hospital inpatient or observation care visits, and consultations, etc.) Most of the broad categories are further divided into two or more subcategories of E/M services (ex. new patient and established patient, initial and subsequent, etc.). The basic format of E/M services with levels are based on medical decision making (MDM) or time. Place of service (POS) and service type are defined by the location where the encounter with the patient and/or family/caregiver occurs.

New and established patients

To distinguish between new and established patients for **professional services**, consider services rendered by physicians or qualified health care professionals (QHP) who may report E/M services. A new patient is one who **has not** received any professional services from the physician/other QHP of the **same specialty and subspecialty** who belongs to the same group practice within the past three years.

An established patient is one who **has** received professional services from the physician/other QHP or another physician/other QHP of the **same specialty and subspecialty** who belongs to the same group practice within the past three years.

**Note that distinguishing between a new vs. established patient in an FQHC setting differs. Please refer to Chapter 13 of the Medicare Claims Processing Manual (70.3) New Patient Adjustment.*

When a physician/other QHP is on call for or covering for another physician/other QHP, the patient's encounter will be classified as it would have been by the physician/other QHP who is not available. Advanced practice nurses and physician assistants working with physicians are considered as working in the same specialty and subspecialty as the physician.

No new vs. established patient distinction is made in the emergency department.

Initial and subsequent services (inpatient and observation care)

Some categories do not distinguish between new and established patients (eg, hospital inpatient and observation care). Rather than differentiating between new and established patients, these services are differentiated by initial service or subsequent service.

An **initial service** is when the patient has not received professional service(s) from the physician/ other QHP or another physician/QHP of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.

A **subsequent service** is when the patient has received professional service(s) from the physician/other QHP, or another physician/QHP of the exact same specialty and subspecialty who belongs to the same group practice during the admission and stay.

When a physician/other QHP is on call for or covering for another physician/other QHP, the patient's encounter will be classified as if it would have been by the physician/other QHP that is unavailable. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the same specialty or subspecialty as the physician.

Split or shared visits

Physicians/other QHPs may work together during a single E/M service. If the physician/other QHP performs a substantive portion of the encounter, it should be reported by the professional that spent a majority of the face-to-face or non-face-to-face time performing the service. E/M services based on MDM require that the physician/other QHP that made or approved the management plan, considering **the number and complexity of problems addressed during the encounter**, takes responsibility for the plan, including the **risk of complications, and/or morbidity/mortality of patient management**.

Services reported separately

Any identifiable procedure or service (identified with a CPT code) on the same date of service (DOS) as an E/M may be reported separately.

The ordering or performance and/or interpretation of a diagnostic test or interpretation of an encounter are not included in determining the level of an E/M service when the professional interpretation of the test(s) or study is reported separately.

Policy

CareOregon must comply with industry standard coding guidelines, and all reported services must be supported by the medical record. CareOregon conducts periodic analysis of current and historical claim data and may request medical records to ensure accurate and appropriate reimbursement for E/M services that are frequently miscoded and up coded.

The code(s) reported by physicians or other health care professionals should best represent the services provided based on the American Medical Association (AMA) and CMS documentation guidelines.

If the E/M code submitted is higher than the E/M level supported, CareOregon may:

- Adjust reimbursement to reflect the lower level of E/M
- Deny the claim. Providers will have the right to appeal by following the dispute resolution process
- Recover payment(s) previously made on the claims that exceed the determined appropriate E/M level

In alignment with Office and Outpatient Evaluation and Management Coding Guidelines (99202-99205, 99211-99215) changes that were effective January 1, 2021, the CPT codes section for Non-Office E/M Visits (99221-99223, 99231-99239), Consultations codes (99242-99245, 99252-99255), Emergency Department Services codes (99281-99285), Nursing Facility Services codes (99304-99310, 99315, 99316), Home or Residence Services codes (99341,99342, 99344, 99345, 99347-99350) were revised January 1, 2023.

Except for CPT codes 99281-99285, providers may choose the appropriate E/M level of care based on either time or medical decision making (MDM). CPT codes 99281-99285 use only MDM to determine level of care.

Selecting the level of service (LOS) based on time

Time documentation criteria for time spent face-to-face or non-face-to-face may include, but not limited to:

- Examination/evaluation
- Counseling/education
- Prep time for patient history/test reviews
- Documentation/interpretation
- Care coordination/referring and communication with other health care providers
- Orders for tests, procedures and medication

Time documentation criteria for time spent face-to-face or non-face-to-face may not include:

- Time spent by clinical staff
- Patient wait time for physician or other health care providers
- Additional distinct service procedures provided the same day as the evaluation and management service

Selecting the level of services based on medical decision making (MDM)

- Number and complexity of problem(s) addressed
- Amount and/or complexity of data reviewed and analyzed
 - Orders for, and interpretation of data from a test or image cannot be included when determining the E/M level of service if the test or image interpretation is billed separately
- Risk of complications and/or morbidity or mortality of patient management
 - CareOregon will continue to use the definitions from the CMS Manual System's Pub 100 Medicare Claims Processing, 40.1-Definition of a Global Surgical Package, "Codes with "090" in Field 16 are major surgeries. Codes with "000" or "010" are either minor surgical procedures or endoscopies."

When determining the level of MDM, two of the three elements for that level must be met or exceeded.

Additional information regarding the code selection based on Time or MDM and the requirements for each can be found in the most current edition of the American Medical Association CPT codebook.

New patient or established patient status for emergency department visits:

Time is not a descriptive component for emergency department E/M levels of service. Providers must use CPT codes 99281-99285 for emergency department visits for both established patients and new patients for the emergency department visits. (Note: Providers or other health care professionals who are requested to serve as a consult should utilize the appropriate E/M code administered.)

Note: CPT codes 99281-99285 must only be submitted for services provided in an emergency department as defined by AMA CPT; "as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day," and "organized based facility" includes hospital owned free-standing emergency departments.

Definitions

Clinical staff: Staff that work with the supervision of a physician or other QHP that is allowed by law, regulation, and facility policy to perform or assist in performing a specified professional service but does not individually report that professional service because clinical staff is not eligible to independently bill. Examples include medical assistants, LPNs, RNs and similar licensed or unlicensed roles, who work with or in support of the rendering provider, but is not the rendering provider.

Encounter: Interaction between a covered member and a health care provider for which evaluation and management service or other service(s) are rendered and results in a claim submission.

Evaluation and management: Evaluation and management (E/M) codes represent services by a physician (or other health care professional) in which the provider is either evaluating or managing a patient's health. Procedures such as diagnostic tests, radiology, surgery, and other therapies are not considered evaluation and management services.

FQHC: Federally Qualified Health Center

Level of service (LOS): the complexity and extent of evaluation and management (E/M) services provided to a patient during a clinical encounter.

Medical decision making (MDM): It reflects the complexity of the cognitive work performed by the provider during a patient encounter. MDM measures how difficult it was to assess, diagnose, and manage the patient's condition, based on standardized criteria.

Qualified Health Care Professional (QHP): an individual that is qualified by training, education, licensure and/or regulation of any applicable license and/or facility privileging who performs a professional service within their scope of practice and independently reports that professional service. Examples include NP, PA, CNS, CNM, CSW, PT, etc.

Upcoding: Upcoding occurs when a health care provider has submitted codes for more severe conditions than are diagnosed to receive higher reimbursement.

References

Centers for Medicare & Medicaid Services. (2025). Medicare Benefit Policy Manual: Chapter 13 – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services (Rev. 13133). Section 70.3: FQHC PPS Payment Rate and Adjustments. <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c13.pdf>

Association, American M. CPT Professional 2026. Available from: VitalSource Bookshelf, American Medical Association (AMA), 2025.

American Medical Association. CPT® Evaluation and Management (E/M) Code Descriptors and Guidelines. 2023, American Medical Association, www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

Centers for Medicare & Medicaid Services. Evaluation and Management Services. Medicare Learning Network®, updated 2024, www.cms.gov/files/document/mln006764-evaluation-management-services.pdf

This document is provided for informational purposes only and should not be construed as legal advice. Any cited statutes are current as of the date of publication of this guide.

These guidelines have been developed to accompany and complement the official conventions and instructions provided within the American Medical Association's Current Procedural Terminology (CPT®) itself. Additions and deletions conform it to the most recent publications of CPT® and HCPCS Level II and to changes in CareOregon and its affiliates coverage policy and payment status, and as such these guidelines are current as of 01/01/2026. Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful. CareOregon and its affiliates make no claim, promise, or guarantee of any kind about the accuracy, completeness, or adequacy of the content for a specific claim, situation, or provider office application, and expressly disclaim liability for errors and omissions in such content. As CPT® codes change annually, you should reference the current version of published coding guidelines and/or recommendations from nationally recognized coding organizations for the most detailed and up-to-date information.

CPT® is a registered trademark of the American Medical Association.
Copyright © American Medical Association. All rights reserved.