CODEX

CODING DECODED

Evaluation and Management (E/M)

A Simplified Guide to E/M Categories, Levels & Special Services for CPC Students

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CODING DECODED

1. Evaluation & Management — General Guidelines

Evaluation and Management (E/M) codes report the work a provider performs when assessing and managing a patient's health. E/M coding is organized in a hierarchy: broad Categories (place or type of service), Sub-Categories (such as New vs. Established Patient, or Initial vs. Subsequent Service), and Levels (the depth of work performed, which determines the specific code).

E/M Categories Include

- Office or Outpatient Visits
- Hospital Inpatient and Observation Care
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Services

Sub-Categories

- New Patient / Established Patient
- Initial or Subsequent Visit

Coding Tip: Each sub-category has its own set of codes and levels. Always add modifier 25 or 57 when an E/M service is billed together with another procedure or service on the same day.

New vs. Established Patient — How to Decide

A patient is "New" if they have not received any professional service from the physician — or another physician of the same specialty/subspecialty in the same group — within the past three years. If they have, the patient is "Established."

Question	If Yes	If No
Received a professional service from this physician or same-specialty group member in the last 3 years?	Established Patient	New Patient
Was the patient admitted to hospital/observation/nursing facility, and did another physician of the same group/specialty already see them this admission/stay?	Report Subsequent visit code	Report Initial visit code

2. Level of Service — How to Select the Correct Code

Once the correct category and sub-category are identified, the coder must determine the Level of Service. This can be established in one of two ways: Medical Decision Making (MDM) or Total Time.

Option A — Level of Medical Decision Making (MDM)

MDM is scored using 3 elements. The final level is based on 2 out of 3 elements being met.

Element	What It Measures	Notes
Diagnosis	Number and complexity of problems addressed at the visit	Refer to the MDM table in the CPT book for level-specific examples
Data	Amount and complexity of data reviewed or ordered (labs, imaging, records, independent interpretation)	Refer to the MDM table for scoring detail
Risk	Risk of complications, morbidity, or mortality from patient management	Considers medications, procedures, and management options

Levels of MDM

- 1. Straightforward
- 2. Low
- 3. Moderate
- 4. High

Option B — Total Time

Time may be used to select the E/M level instead of MDM.

Rule	Correct Approach	Why
When time is used	Check the total time mentioned in the documentation for the date of encounter	Time-based coding requires the total time to be explicitly documented
Codes with strict time thresholds	Some codes (e.g., Critical Care) are based strictly on time — no MDM level is used to decide these	These categories are defined entirely by time spent

Do NOT use MDM to decide the level when time is mentioned in the medical record — choose one method (Time or MDM) as appropriate for that category, not both.

3. E/M Categories & Code Ranges — Quick Reference

Office / Outpatient Visits

Sub-Category	Code Range
New Patient	99202 – 99205
Established Patient	99211 – 99215

Inpatient / Observation Care

Sub-Category	Code Range
Initial Visit	99221 – 99223
Subsequent Visit	99231 – 99233

- Discharge day management is coded separately using codes 99238 & 99239.
- Same-day admission and discharge is coded with 99234 – 99236.

Consultations

Sub-Category	Code Range
Outpatient Consult	99242 – 99245
Inpatient Consult	99252 – 99255

- A consultation must be requested by another physician.
- The consultant must send a written report back to the requesting physician.

Emergency Department (ED / ER)

There is no distinction between New and Established patients in the ED.

Sub-Category	Code Range
No Distinction of New / Established Patient	99281 – 99285

- Critical care services provided in the ED should be coded with 99291 + 99292, not ED E/M codes.
- Time is not a component of ED E/M level selection.

4. Critical Care Services (99291 + 99292)

Critical care codes are time-based and used for the direct delivery of care by a physician to a critically ill or critically injured patient.

Rule	Correct	Incorrect / Watch For
Time counting	Time-based codes — total critical care time is used (even if not continuous on a given date) to select the code	N/A
Included procedures	Some procedures are bundled into critical care and are not reported separately	Do not separately report procedures already included in critical care
Who can bill	Critical care services are delivered directly by a physician to a critically ill or injured patient	N/A
Pediatric / neonatal patients	Use appropriate pediatric/neonatal critical care codes	Inpatient critical care services for pediatric/neonate patients are NOT reported with the adult critical care codes
Minimum time	Critical care must be at least 30 minutes to use these codes	Critical care under 30 minutes should be coded with the appropriate E/M code instead

Prolonged Services — By Clinical Staff on Day of E/M Service

Service	Code
First Hour	99415
Each Additional 30 Minutes	99416

- Physician or other qualified healthcare professional supervision while clinical staff is providing these services is required.
- To be reported only with Office or Outpatient visits (not applicable to other visit types).
- Prolonged clinical staff services must start at least 30 minutes beyond the typical clinical staff time for the visit (refer to the CPT time table).
- Prolonged service by physician / qualified healthcare professional should be reported with 99417 & 99418, not 99415 & 99416.
- Prolonged service less than 30 minutes beyond the first hour or final 30 minutes should not be reported separately.

Prolonged Services — By Provider on Day of E/M Service

Service	Code
Prolonged Outpatient E/M	99417
Prolonged Inpatient E/M	99418

Service	Code

- Report for the total prolonged time (with & without direct patient contact) on the date of encounter.
- Report with the highest E/M level of that particular section (e.g., 99205 for new patient office visit).
- To report a unit of 99417 or 99418, 15 minutes beyond the time required to report the highest level of service must be met (e.g., 99205 requires a minimum of 60 minutes, so 15 minutes beyond this will qualify for the addition of 99417).
- Do not report prolonged services if the time increment is less than 15 minutes, or if it is less than 74 minutes of new patient office visit time (do not report if not beyond 15 minutes of required time).

Prolonged Services — Non Face-to-Face

Reported when service is provided to the patient and/or family/caregiver, not on the day of a face-to-face visit.

Service	Code
First Hour	99358
Each Additional 30 Minutes	99359

- Prolonged service less than 30 minutes should not be reported with these codes.
- Do not report these codes on the same date as other E/M services.
- Prolonged service less than 15 minutes beyond the first hour, or less than 15 minutes beyond the final 30 minutes, should not be reported separately.

5. Preventive Medicine & Newborn Care Services

Preventive Medicine Services

Sub-Category	Code Range
New Patient	99381 – 99387
Established Patient	99391 – 99397

- Same definition of New vs. Established Patient applies as in office/outpatient E/M.
- Codes are selected based on the age of the patient.
- Any office/outpatient E/M service performed for other problems or pre-existing conditions along with a preventive visit should be coded separately, and modifier 25 should be added to the office/outpatient E/M code.
- Do not report an office/outpatient visit code separately if it does not require additional, medically necessary work beyond the preventive visit (e.g., an insignificant or trivial problem).

Newborn Care Services

Service	Code(s)	Notes
Initial Care	99460 / 99461 / 99463	Normal newborn — check the birth location (hospital, birthing center, or other)
Subsequent Care	99462	Follow-up newborn care during the same hospitalization
Attendance at Delivery	99464	As requested by the delivering physician
Resuscitation in Delivery/Birthing Room	99465	Reported when active resuscitation is performed

- Do not report 99464 in conjunction with 99465. Example: if a neonatologist was called for attendance during delivery and ends up performing chest compressions to stabilize the newborn, only report 99465 — not both 99464 and 99465.

6. Pediatric & Neonatal Critical Care Services

Pediatric Critical Care Patient Transport

Service	Code(s)
Critical Care Face-to-Face During Interfacility Transport	99466 + 99467
Physician Supervision During Interfacility Transport	99485 + 99486

- Patient age must be 24 months or younger.
- These services are reported only if critical care was provided during interfacility transport.
- All critical care guidelines apply — less than 30 minutes shouldn't be reported, procedures included in critical care shouldn't be reported separately, and time is based (not necessarily continuous).
- Do not report these codes if critical care was performed after the patient was admitted — use inpatient critical care codes (99471 & 99472) instead.

Inpatient Neonatal & Pediatric Critical Care

Patient Age	Code(s)	Notes
Neonates (28 days or younger)	99468 & 99469	Day-based codes, not time-based
Infant / Child (29 days through 24 months)	99471 & 99472	All critical care guidelines apply
Infant / Child (2 through 5 years)	99475 & 99476	All critical care guidelines apply

- These codes are reported for patients receiving critical care as an inpatient.
- Procedures included in critical care shouldn't be reported separately; time is not necessarily continuous.
- Do not report these codes if critical care was performed in an outpatient setting (hospital outpatient, observation, ED, etc.). For outpatient critical care, use codes 99291 & 99292.

Intensive Care Services (ICU) — 99477 – 99480

Used for a neonate or infant who is not critically ill but requires intensive observation, interventions, and intensive care.