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Originated Department	Clinical Operations

Emergency Department (ED) Evaluation and Management (E&M) Coding

Audience
Medical Management

Purpose
<p>Payment policies provide general support for applying Mountain Health CO-OP member policy document coverage decisions, and the member-specific benefit plan document must be referenced. The terms of the member-specific Policy document may differ from the standard benefit plan based on this payment policy. If there is a conflict between a member-specific policy document and the Mountain Health CO-OP payment policy, the document supersedes this policy. Any person(s) applying this payment policy must identify member eligibility, the member-specific policy document, and related policies or guidelines before applying this payment policy, including the existence of any state or federal guidance. Mountain Health CO-OP payment policies are designed for informational purposes only and are not an authorization, explanation of benefits, or contract. Receipt of benefits is subject to the satisfaction of all terms and conditions of the member-specific policy document coverage. Mountain Health CO-OP reserves the sole discretionary right to modify all policies and guidelines at any time.</p>

Definition
<p>This policy is intended to address Evaluation and Management (E/M) services.</p> <p>The E/M coding section of the CPT® book is divided into broad categories with further sub-categories which describe various E/M service classifications.</p> <p>The classification of the E/M service is important because the nature of the work varies by type of service, place of service, the patient’s medical status, and other code criteria, along with the amount of provider 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.</p>

This reimbursement policy explains when medical records may be requested to ensure that the appropriate level of CPT E/M code is reimbursed based on the health care services provided. The code(s) reported by physicians or Other Qualified Health Care Professionals should best represent the services provided based on the American Medical Association (AMA) and CMS documentation guidelines.

E/M codes that have levels of services include a medically appropriate history and/or physical examination when performed on the date of the encounter. However, the extent of history and/or physical examination is not a component in the selection of the level of E/M service. Providers must select the appropriate level of E/M services based on 1) the level of MDM, or 2) the total time for the E/M services performed on the date of the encounter. Documentation must include a medically appropriate history and physical exam.

Policy/Procedure

Selecting the Level of Service 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)

1. Number and complexity of problem(s) addressed
2. Amount and/or complexity of data reviewed and analyzed
 - a. 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
3. Risk of complications and/or morbidity or mortality of patient management

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.

Note: A providers' level of care escalation data and parenteral narcotic use data may be compared to their historical data and to peer data.

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 Qualified 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.

Providers may experience adjustments to, or denials of the office visit or other outpatient E/M code or emergency department E/M code reported if the documentation does not support the E/M level submitted. The provider may resubmit the claim with a revised E/M code for denied claims.

Chronic Care Management Services

Chronic Care Management codes (99490 and 99491) may only be reported by the single physician or other QHP who provides the care management role with the member for the calendar month. CCM services are management and support services that are provided by clinical staff, under the direction of a physician or other QHP, or may be provided personally by a physician or other QHP to a member that is residing in a home or in a domiciliary, rest home, or assisted living facility. These services are provided when a medical and/or psychosocial need of the member requires establishing, implementing, revising, or monitoring the care plan.

Applicable Codes

CPT Codes

99202	99203	99204	99205	99211	99212	99213	99214	99215
99221	99222	99223	99231	99232	99233	99234	99235	99236
99238	99239	99242	99243	99244	99245	99252	99253	99254
99255	99281	99282	99283	99284	99285	99288	99291	99292
99304	99305	99306	99307	99308	99309	99310	99315	99316
99341	99342	99344	99345	99347	99348	99349	99350	

References

1. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services.
2. Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
3. Novitas Solutions – Medicare Part B: “Evaluation & Management Services: Medical Decision Making: <https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00005056>

Vendors

- HPS

Review/Revision/Approval History	
Date	Description
10/13/2025	Adopted

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The codes for treatments and procedures applicable to this policy are included for informational purposes. Including or excluding a procedure, diagnosis, or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as they apply to an individual member.

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