Payment Policy: Emergency Department (ED) Evaluation and Management (E&M) Coding for Facility Claims

Reference Number: CC.PP.064
Last Review Date: 01/2025

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
This policy describes how the Plan reimburses facility claims billed with Evaluation and Management (E/M) codes at Level 4 (99284/G0383) and Level 5 (99285/G0384) for services rendered in an emergency department. This policy is based on coding principles established by the Centers for Medicare and Medicaid Services (CMS) and the CPT and HCPCS code descriptions.

The purpose of this policy is to define payment criteria for emergency room claims when billed with Level 4 and Level 5 E/M codes to be used in making payment decisions and administering benefits.

Application
- This reimbursement policy applies to services reported using the UB-04 claim form or its electronic equivalent (i.e., 837I) or its successor form.
- Network and non-network facility emergency departments (including hospital emergency departments).
- Free standing emergency departments (UB-04 claims).

Policy Description
It is the policy of the Plan to require providers to comply with CMS coding principles when billing for emergency department services.

CMS indicates facilities should bill appropriately and differentially for outpatient visits, including emergency department visits. To that end, CMS coding principles applicable to emergency department services provide that facility coding guidelines should: follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code; be based on hospital facility resources and not based on physician resources; and not facilitate upcoding or gaming.

Reimbursement
UB-04 claims for services rendered in an emergency department should be complete and include all diagnostic services and diagnosis codes relevant to the emergency department visit and be billed at the appropriate E/M level.

The Plan will utilize the Optum Emergency Department Claim (EDC) Analyzer to determine the emergency department E/M level to be reimbursed for certain facility claims. The EDC Analyzer applies an algorithm that takes three factors into account in order to determine a Calculated Visit

Level for the emergency department E/M services rendered. The three factors used in the calculation are as follows:

- Presenting problems – as defined by the ICD-10 reason for visit (RFV) diagnosis;
- Diagnostic services performed – based on intensity of the diagnostic workup as measured by the diagnostic CPT codes submitted on the claim (i.e. lab, x-ray, EKG/RT/other diagnostic, CT/MRI/ultrasound); and
- Patient complexity and co-morbidity – based on complicating conditions or circumstances as defined by the ICD-10 principal, secondary, and external cause of injury diagnosis codes.

Facilities may experience adjustments to the level 4 or 5 E/M codes submitted to reflect a lower E/M code calculated by the EDC Analyzer or may receive a denial for the code level submitted. For certain facilities who experience adjustments to a level 4 or 5 E/M code, the Plan may estimate reimbursement for the adjusted code based on historical claims experience, and in such event the facility may resubmit an adjusted claim which the Plan will adjudicate based on the new charges submitted in accordance with this policy.

Criteria that may exclude Facility claims from being subject to an adjustment or denial include:

- The patient is admitted to inpatient, observation, or has an outpatient surgery during the course of the same ED visit;
- Critical care patients (99291, 99292);
- The patient is less than 2 years old;
- Claims with certain diagnoses that when treated in the ED most often necessitate greater than average resource usage, such as significant nursing time;
- Patients who have expired in the emergency department.

For additional information on the EDC Analyzer, visit EDCAnalyzer.com.

Documentation Requirements
NA

Coding and Modifier Information
This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor
99284	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
99285	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making
G0383	Level 4 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0384	Level 5 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

Modifier	Descriptor
NA	

ICD-10 Codes	Descriptor
NA	NA

Definitions

UB-04
The UB-04, (also known as the CMS 1450) is an institutional claim form used for billing medical and mental health claims.

837I
The 837I (Institutional) is the standard format used by institutional providers to transmit health care claims electronically.

Network Facility
Facilities that are part of a health plan's network of providers with which it has a negotiated discount to provide health care services to its members.

Non-network Facility
Facilities that are not part of a health plan's network of providers with which it has a negotiated discount to provide health care services to its members.

Replacement Claim
A replacement claim is billed when a specific claim needs to be restated in its entirety, except for the identifying information. The original claim is considered null and void. The information on the replacement claim submission replaces the previous claim. This may include corrections that need to be made to a professional or institutional claim.

Related Documents or Resources
NA

References

1. Medicare and Medicaid Programs; Interim and Final Rule Federal Register / Vol. 72, NO. 227 / Tuesday, November 27, 2007 / Rules and Regulations, page 66580, at 66805. Available online at http://www.gpo.gov/fdsys/pkg/FR-2007-11-27/html/07-5507.htm

2. American Medical Association, *Current Procedural Terminology (*CPT®) and associated publications and services.

3. Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

4. Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

5. Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) Policy Publications

Revision History	
10/30/2018	Initial Policy Draft
12/01/2019	Review conducted
12/01/2020	Annual review conducted, updated important reminder and copyright dates
12/01/2021	Annual review conducted, removed product type, updated copyright dates
12/01/2022	Conducted annual review, updated policy dates, fixed web links
12/14/2023	Conducted annual review, updated policy dates, confirmed CPT descriptor language
01/27/2025	Conducted annual review, updated policy dates, confirmed CPT descriptor language

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to

recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.