Reimbursement Policy:

Emergency Department (ED) Facility E&M Coding (Commercial & Medicare)

POLICY NUMBER	EFFECTIVE DATE:	APPROVED BY
RPC20240053	EmblemHealth: 10/01/2024 ConnectiCare: 7/01/2022	**RPC (Reimbursement Policy Committee)**

Reimbursement Guideline Disclaimer: We have policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. We will inform you of new policies or changes in policies through postings to the applicable Reimbursement Policies webpages on emblemhealth.com and connecticare.com. Further, we may announce additions and changes in our provider manual and/or provider newsletters which are available online and emailed to those with a current and accurate email address on file. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in our policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, and medical or drug policies. Finally, this policy may not be implemented the same way on the different electronic claims processing systems in use due to programming or other constraints; however, we strive to minimize these variations.

We follow coding edits that are based on industry sources, including, but not limited to, CPT® guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. We use industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how we handle specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Overview:

This policy describes how EmblemHealth/ConnectiCare reimburses Facility claims billed with Evaluation and Management (E/M) codes Level 3 (99283/G0382), 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.

CMS Coding Principles:

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.

This reimbursement policy applies to services reported using the UB-04 claim form or its electronic equivalent or its successor form. This policy applies to all facilities, including freestanding facilities, that submit ED claims with level 3, 4 or 5 E/M codes for members of the affected plans.

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Reimbursement Guidelines:

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.

EmblemHealth/ConnectiCare will utilize the Optum Emergency Department Claim (EDC) Analyzer™ tool to determine the emergency department level to be reimbursed for certain facility claims. There are several factors taken into account to determine the calculated visit E/M coding levels.

- 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 submitting claims for ED E/M codes may experience adjustments to level 2, 3, 4, or 5 E/M codes to reflect an appropriate level E/M code or may receive a denial, based on the reimbursement structure within their contracts. Facilities may submit reconsideration or appeal requests if they believe a higher-level E/M code is justified, in accordance with the terms of their contract.

To learn more about the EDC Analyzer™, please visit EDCAnalyzer.com.

Criteria that may exclude facility claims from being subject to an adjustment or denial include, but are not limited to:

- The patient is admitted to inpatient or observation*, has an outpatient surgery* during the course of the same ED visit, or is discharged/transferred to other types of health care institutions (Skilled Nursing Facility, Long Term Care Hospital, etc.)
- Critical care patients (99291, 99292)
- The patient is less than 2 years old
- Claims with certain diagnosis 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 *or*
- Claims from facilities billing level 3, 4 and 5 E/M codes that do not deviate from the EDC Analyzer.

Ultimately, the mutual goal of facility coding is to accurately capture ED resource utilization and align that with the E/M CPT® code description for a patient visit per CMS guidance.

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Applicable Codes:

Code	Description	Comments
99281/G0380	Emergency department visit for the evaluation and management, level 1	The facility provides minor interventions that may include no medications or home treatment.
99282/G0381	Emergency department visit for the evaluation and management level 2	The facility provides low complexity interventions and limited resources that may include over the counter medications, basic laboratory services, and/or simple treatments.
99283/G0382	Emergency department visit for the evaluation and management level 3	The facility provides moderate complexity interventions and moderate resources that may include low complexity prescription medications, and/or bedside or minor invasive treatments.
99284/G0383	Emergency department visit for the evaluation and management level 4	The facility provides highly complex interventions and minor intensive resources that may include specialized diagnostic services, moderate complexity prescription medications, and/or moderate invasive treatments.
99285/G0384	Emergency department visit for the evaluation and management level 5	The facility provides extremely complex interventions and intensive resources that may include, highly complex prescription medication that requires physician or other qualified health care professional work and/or clinical staff monitoring well beyond that of therapeutic drug agents, specialized testing resulting in a therapeutic procedure, and/or advanced life-saving treatments.

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Frequently Asked Questions:

1. **Can the facility submit a corrected claim if it determines there were additional diagnosis codes not included on the original claim submission, which could have led to the reimbursement at a lower E/M code level other than the E/M code level originally submitted?**

   If the facility did not include all the relevant and applicable diagnosis codes on its claim, then it could resubmit the claim with appropriate diagnosis code(s) or procedure code(s) which may support the level of E/M code originally submitted. Alternatively, facilities may follow the EmblemHealth/ConnectiCare standard reconsideration and appeals processes for administrative claims determinations if they disagree with the reimbursement.

2. **Is the policy applicable to all emergency departments?**

   Yes, this policy is applicable to all emergency departments (whether facility-based, free standing or otherwise). However, a facility may not experience claim adjustments or denials if its billing of level 3, 4 and 5 E/M codes does not deviate from the EDC Analyzer or it submits claims that otherwise meet one of the criteria for exclusion listed in the policy.

3. **Is there additional information available regarding the Emergency Department Claim (EDC) Analyzer?**

   Yes, additional information can be found at the following link: EDCAnalyzer.com

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

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Revision History

Company(ies)	DATE	REVISION
EmblemHealth	6/14/2024	• Policy expanded to include EmblemHealth Commercial and Medicare Plans **effective 10/1/2024**
ConnectiCare	6/14/2024	• Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number.
ConnectiCare	3/2022	• New Policy effective 7/01/2022