Update to the Emergency Department Facility Coding Reimbursement Policy – Effective July 1, 2019

To help reinforce accurate coding practices, we're updating our Emergency Department (ED) Facility Evaluation and Management (E/M) Coding Reimbursement starting July 1, 2019. This policy is based on the Centers for Medicare & Medicaid Services (CMS) E/M coding principles that require hospital E/M codes to match CPT® code descriptions and reasonably relate to hospital resource use.

How the New Policy Works

We'll continue to use the Optum Emergency Department Claim (EDC) Analyzer tool, which looks at the patient's presenting problem, diagnostic services performed and patient comorbidities to determine accurate coding. We'll focus on facility ED claims that are submitted with these E/M codes:

- Level 4 (99284, G0383)
- Level 5 (99285, G0384)

When claims submitted for ED E/M services don't align with the EDC Analyzer tool, facilities may receive an adjustment for the level 4 or 5 E/M codes submitted to reflect a more appropriate level.

If you receive an adjustment or denial and you believe a higher level E/M code is justified, you'll have the option of submitting a reconsideration or appeal request, according to the terms of your contract and/or the UnitedHealthcare Administrative Guide. Please visit UHCCommunityPlan.com > For Health Care Professionals > (select your state) > Provider Administrative Manual.

Policy Exclusions

This policy will apply to both participating and non-participating facilities that submit ED claims with level 4 and 5 E/M codes for our members. However, not every outpatient facility claim will be included in this policy. Some claims will be excluded if they involve:

- Admissions from the emergency department
- Critical care patients
- Patients younger than 2
- Claims with diagnosis codes that usually require significant nursing time and other extensive resource usa
- Patients who have expired in the emergency department
- Claims from facilities whose level 4 and 5 E/M code billing usually aligns with the EDC Analyzer tool

Once the policy is implemented, you can learn more about it at UHCprovider.com > Menu > Policies and Protocol > Community Plan Policies > Reimbursement Policies for Community Plan.

Doc#: PCA-1-015903-05202019_05312019

UnitedHealthcare Community Plan

We're Here to Help

If you have questions about policy updates, please contact your Network Account Manager or Provider Advocate. Thank you.

Note About Reimbursement Policies

As with all UnitedHealthcare Community Plan policies, other factors affecting reimbursement may supplement, modify or in some cases supersede this policy. These factors include but are not limited to federal and/or state regulatory requirements, physician or other provider contracts, and/or the member's benefit coverage documents. Unless otherwise noted, these reimbursement policies apply to services reported using the CMS-1500 or its electronic equivalent, or its successor form.

UnitedHealthcare Community Plan reimbursement policies don't address all issues related to reimbursement for services rendered to our members, such as the member's benefit plan documents, our medical policies and the UnitedHealthcare Community Plan Administrative Guide or Care Provider Manual. Meeting the terms of a particular reimbursement policy is not a guarantee of payment. Likewise, retirement of a reimbursement policy affects only those system edits associated with the specific policy being retired. Retirement of a reimbursement policy is not a guarantee of payment. Other applicable reimbursement and medical policies and claims edits will continue to apply.

If there's an inconsistency or conflict between the information in this provider notification and the posted policy, the provisions of the posted reimbursement policy prevail.

PCA-1-015903-05202019_05312019

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