EMERGENCY DEPARTMENT (ED) FACILITY EVALUATION AND MANAGEMENT (E&M) CODING POLICY (CES)

Policy Number: ADMINISTRATIVE 273.1 T0 **Effective Date**: October 1, 2020

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Related Policies

None

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

APPLICATION

This reimbursement policy applies to services reported using the UB-04 claim form or its electronic equivalent or successor form. This policy applies to claims submitted on such forms by network and non-network facility emergency departments (including hospital emergency departments) and free-standing emergency departments (UB Claims).

OVERVIEW

This policy describes how Oxford reimburses UB claims billed with Evaluation and Management (E/M) codes Level 4 (CPT code 99284/HCPCS code G0383) and Level 5 (CPT code 99285/HCPCS code 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.

REIMBURSEMENT GUIDELINES

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.

Oxford 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, we may estimate reimbursement for the adjusted code based on historical claims experience, and in such event the facility may resubmit an adjusted claim which we 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 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;
- Critical care patients (CPT codes 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 4 and 5 E/M codes that do not disparately deviate from the EDC Analyzer.

Oxford and Optum are related companies through common ownership by UnitedHealth Group. For additional information on the EDC Analyzer, visit EDCAnalyzer.com.

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies may apply.

CPT Code	Description
99284	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99285	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

CPT Code	Description
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)

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HCPCS Code	Description
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)

QUESTIONS AND ANSWERS

1	**Q:**	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?
	A:	If the facility did not include all of 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 Oxford standard reconsideration and appeals processes for administrative claims determinations as outlined in the administrative guide if they disagree with the reimbursement.
2	**Q:**	Is the policy applicable to all emergency departments?
	A:	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 4 and 5 E/M codes does not disparately deviate from the EDC Analyzer or it submits claims that otherwise meet one of the criteria for exclusion listed in the policy.
3	**Q:**	Is there additional information available regarding the Emergency Department Claim (EDC) Analyzer?
	A:	Yes, additional information can be found at the following link: EDCAnalyzer.com.

REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed, and approved by UnitedHealthcare Reimbursement Policy Oversight Committee. [*2019R6003A*]

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.

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

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

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

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

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
10/01/2020	• New Reimbursement Policy