Reimbursement Policy	
Title: Emergency Department Evaluation & Management Codes-Facility	
Policy Number: RP-F-575X	**Application:** All Medica members
Last Reviewed:	**Effective Date:** 6/1/2024
Related Policies: CCI Editing: Facility	

Disclaimer: *This reimbursement policy is intended to provide general guidance regarding Medica's policy for the services described and does not constitute a guarantee of payment. You are responsible for submitting accurate claims. Factors affecting claims reimbursement may include, but are not limited to, state and federal laws, regulations and accreditation requirements, along with administrative services agreements, provider contracts, and benefit coverage documents. Coding methodology and industry standards are also considered in developing reimbursement policy.*

Medica routinely updates reimbursement policies, and new versions are published on this website. If you print a copy of this policy, please be aware that the policy may be updated later, and you are responsible for the information contained in the most recent online version. Medica communicates policy updates to providers via Medica's monthly e-newsletter, Medica Connections®, as well as through Medica Provider Alerts.

All content included on the provider portion of medica.com is an extension of providers' administrative requirements, which all Medica network providers are contractually obligated to follow.

Summary:

This policy has been established to provide reimbursement guidelines for the reporting of Emergency Department Evaluation & Management codes. These codes are eligible for reimbursement when billed at the appropriate level per coding and reimbursement policy guidelines. This policy applies to outpatient facility claims reported on a UB-04 or its electronic equivalent.

Policy Statement:

Medica follows the Centers for Medicare and Medicaid Services (CMS), Current Procedural Terminology (CPT®) and interpretative sources based on specialty society guidelines for the reimbursement of Emergency Department Evaluation &Management (E/M) codes.

Per CMS and CPT®, emergency department service codes describe E/M services provided to patients in the emergency department (ED). ED codes are typically reported per day and do not distinguish between new or established patients. There are five levels of ED services codes that should be billed based on the level of the Medical Decision Making (MDM) as defined for each service (not applicable to HCPCS code 99281) *or* the total time for E/M services performed on the date of the patient encounter as outlined in CPT® guidelines.

This policy addresses how Medica reimburses the Levels 4 and 5 Emergency Department HCPCS codes: 99284, 99285, G0383 and G0384. Medica utilizes the Optum Emergency Department Claim (EDC) Analyzer tool to determine the appropriate level of coding as submitted by the facility.
Factors included in the EDC Analyzer's algorithm include:

- *Presenting problems*
- *Diagnostic services performed during the patient encounter.*

- *Patient's condition: complexity and co-morbidities*

Claims submitted with Levels 4 and 5 Emergency Department E/M codes will be pre-payment reviewed by the EDC Analyzer Tool to determine if the level of service submitted was appropriate. If the tool finds that a lower level of service should have been submitted, the line will be denied as the information submitted does not support this level of service. If a provider disagrees with the findings, an appeal may be filed along with supporting documentation.

Code Lists:	
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)

Definitions:	
Diagnostic services performed	Services such as labs, x-rays, EKG, CT/MRI/US, etc.
Patient complexity and co-morbidity	Based on complicating conditions as defined by the principal, secondary and external cause of injury diagnosis codes.
Presenting problems	The reason for visit (RFV) defined by the diagnosis codes reported on the claim.

Exclusions/Exemptions:
• Claims for patients who were admitted from the emergency department or transferred to another health care setting (Long Term Care Hospital, Skilled Nursing Facility, etc.). • Claims for patients who received critical care services (99291, 99292). • Claims for patients who are under the age of 2 years old. • Claims for patients who expired in the ED.

Q & A:
Q: Are the findings/adjustments due to the Optum EDC Analyzer tool appealable? **A:** Yes, an Appeal may be filed along with supporting documentation. **Q:** What resources are available for the Optum EDC Analyzer tool? **A:** You can find specific information regarding the tool on the EDC Analyzer website. EDC Analyzer - Optum, Inc

Resources:
Centers for Medicare and Medicaid Services (CMS)
Current Procedural Terminology (CPT®)
Healthcare Common Procedure Coding System (HCPCS)

Effective Date:	6/1/2024

Revision Updates:	
6/1/2024	New policy approved by the Reimbursement Policy Oversight Committee.