Payment Policy: Leveling of Emergency Room Services

Reference Number: HNCA.PP.053
Product Types: All
Last Review Date: 03/01/2019

Coding Implications
Revision Log

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

Policy Overview
To address an identified trend in upcoding by emergency room providers, the health plan has adopted a program integrity strategy that will provide appropriate levels of reimbursement for services indicating lower levels of complexity or severity rendered in the emergency room.

Application
Hospitals, free-standing emergency centers, physicians or other qualified health professionals.

Reimbursement
The Centers for Medicare and Medicaid Services (CMS) affords states the flexibility to independently develop reimbursement methodologies for the use of emergency department services for lower levels of complexity or severity.

When a hospital, free-standing emergency center or physician bills a Level 4 (99284) or Level 5 (99285) emergency room service, with a diagnosis indicating a lower level of complexity or severity, the provider will receive written notification that a manual review is necessary to determine claims payment.

Utilization
A coding algorithm was developed with the advice of a panel of emergency department and primary care physicians and based on an examination of a sample of almost 6,000 full emergency department records. Data from these records was used to classify each case into one of four categories. These classifications were then mapped to the discharge diagnosis of each case to determine for each diagnosis the percentage of sample cases that fell into these four categories. The health plan's claims processing system incorporates a list of diagnoses developed by medical directors and compared to the algorithm to adjudicate emergency department claims. The claims processing system looks for diagnoses that involve a lower level of complexity or intensity of services (i.e. that are never or rarely associated with Levels 4 or 5 severity).

The Claims adjudication system will identify claims that are billed with a diagnosis code classification that falls into a categorization indicating a lower level of complexity or severity along with an emergency room evaluation and management (E&M) service billed at a Level 4 or Level 5.

Once identified, the service line with the Level 4 or 5 E&M code will be adjudicated with the explanation code: EXbe: DX REQUIRES REVIEW TO QUALIFY FOR HIGH-LEVEL ED PMT.

Furthermore, the provider will receive a written request from the Plan's medical review vendor to submit medical records. Once records are received, the vendor will review the clinical documentation against correct coding guidelines established by the Centers for Medicare and Medicaid Services (CMS) to determine if the information documented in the medical record supports the intensity of E&M service billed.

The results of the review will be sent to the provider and the claim will be reprocessed for payment at the appropriate amount.

A provider may appeal the claim denial or partial payment if the provider disagrees with how the claim was adjudicated.

Documentation Requirements
The patient's primary discharge diagnosis should be billed in the first diagnosis position on the emergency room claim form.

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 2018, 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.

Emergency Department Services – New or Established Patient

CPT/HCPCS Code	Descriptor
99281	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: - A problem focused history; - A problem focused examination; and – Straightforward medical decision making. 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 self-limited or minor.
99282	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: - An expanded problem focused history; - An expanded problem focused examination; and – Medical decision making of low 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 low to moderate severity.

99283	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: - An expanded problem focused history; - An expanded problem focused 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 moderate severity.
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.

References

1. *Current Procedural Terminology (CPT®)*, 2018
2. *Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.*

Revision Log	
08/10/2017	Initial Policy Draft created
08/27/2017	Removed "non-emergent" language and replaced with "lower level of complexity or severity." Removed redundant PLP language in second paragraph.
09/19/2017	Removed "team of physicians and nurses" language
05/17/2018	Removed first paragraph
08/15/2018	Re-worded for clarity
09/13/2018	Removed "Program Integrity Policy" in heading and changed to "Payment Integrity Policy"
03/01/2019	Revised to create state-specific California Health Net policy to include language that explains if a provider bills a lower level of complexity/severity diagnosis along with a Level 4 or Level 5 E&M service, medical records are required to determine claims payment

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.

 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.