In the event of a conflict between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. Plan documents include but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents.

In the event of a conflict between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provider Covered Services to eligible member(s) and/or plans, the provider contract will govern.

Providers are responsible for accurately, completely, and legibly documenting the services performed including any preoperative work up. Billing office is expected to submit claims for services rendered using valid codes from the Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), National Drug Codes NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines. Claims are subject to the code auditing protocols for services/procedures billed.

Facility & Professional Coding of Evaluation and Management of Emergency Department Services

Policy Number: CPCP003

Version 7.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: 11/15/2018

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Description

This Clinical Payment and Coding Policy is intended to ensure that Emergency Department Providers (facilities and physicians or other qualified health care professionals) are reimbursed based on the code or codes that correctly describe the health care services provided. This policy applies to all health care services billed on CMS 1500 forms and UB04 forms. The information in this policy is to serve only as a reference resource for the Emergency Department Services described and is not intended to be all-inclusive. This policy applies to In-network and out of network facilities and providers submitting emergency department claims. Using the correct combination of code(s) is the key to minimizing delays in claim(s) processing. Claims submissions for facility claims must contain revenue codes that reflect the diagnosis and services rendered.

Reimbursement Information:

The patient's medical record documentation for diagnosis and treatment in the Emergency Department (ED) must indicate the presenting symptoms, diagnoses and treatment plan and a written order by the provider.

All contents of medical records should be clearly documented. **Medical records and itemized bills may be requested from the provider to support the level of care that is rendered**. Medical records will be used to determine the extent of history, the extent of examination performed, the complexity of medical decision-making (number of diagnoses or management options, amount and/or complexity of data to be reviewed and risk of complications and/or morbidity or mortality) and services rendered. This information in conjunction with the level of care billed will be reviewed and evaluated for appropriateness.

If observation services are billed with any of the ED associated Evaluation and Management (E/M) codes, MCG Criteria will be used to evaluate the medical necessity of these observation hours.

Coverage is subject to the terms, conditions, and limitations of the member's benefits and the Clinical Payment and Coding Policy criteria listed below.

Level of Care for Symptoms and Services

The chart below contains the guideline for appropriate facility ED billing for each defined Level of Care. The CPT code/level of care corresponds to the "Possible Services Rendered" listed in column two and/or the HCPCS listed in column three. The last column is symptoms that support the possible services provided and is not an all-inclusive list of items.

The appropriate level of care may be determined by the services that were administered to the member. These services will be reviewed using standard medical guidelines as outlined in the examples provided below along with the member's benefits. A facility code level of care can encompass multiple "Possible Services Provided" and is not limited to one service that may be captured on the chart below. At least one service under the facility code level for a "Possible Service Provided" must be documented in the member's records to request reimbursement for that level of care facility code.

Facility Level of Care Guideline

The facility level of care is determined by the following:

CPT Code	Possible Services Rendered	HCPCS	Possible Symptoms
99281	• Initial Assessment • No care rendered by a provider • Medication refill • Work or school excuse • Wound recheck- simple • Booster or follow up immunization only • Wound dressing changes (uncomplicated) • Suture removal (uncomplicated)	G0380	• An insect bite (uncomplicated) • Read Tb test
99282	**Any items or services from 99281 and:** • POC testing by ED Staff (Urine dipstick, stool occult blood, glucose) • Visual acuity exam • Collection of specimens by lab • Cast removal by ED staff • Repair of the wound with a skin adhesive • Non-prescription medication administered • EKG	G0381	• A Localized skin rash or lesion • A sunburn • A minor viral infection • An eye discharge- painless • Ear Pain • Or urinary frequency without fever

Facility Level of Care Guideline (cont.)

CPT Code	Possible Services Rendered	HCPCS	Possible Symptoms
	• Prep or assist with procedures such as minor laceration repair, I&D of simple abscess, etc.		
99283	**Any items or services from 99281, 99282 and:** • Receipt of EMS/Ambulance patient • Heparin/saline lock – no parenteral medications or fluids • One nebulizer treatment • Preparation for lab tests described in CPT (80048-87999 codes) • Preparation for plain X-rays of 1 or 2 more body areas (not above/below joint of the same limb) • Prescription medications non-parenteral • Foley catheters placement; In & out catheterization • C-spine precautions – cervical stabilization device present • Corneal exam with dye • Epistaxis with packing • Oxygen therapy • Emesis/Incontinence care • Prep or assist with procedures such as joint aspiration/injection, simple fracture care etc. • Mental health anxiety with simple treatment • Routine psych medical clearance • Post-mortem care • Direct admit via ED	G0382	• Minor trauma with potential complicating factors) • A medical condition(s) requiring prescription drug management • A fever which responds to antipyretics • A headache – simple, history of; no serial exam • A head injury- without neurologic symptoms • Eye pain (corneal abrasion or simple infection) • Mild dyspnea - not requiring oxygen • Cellulitis • Abdominal pain, simple • Non-confirmed overdose • Anxiety, simple treatment • GI bleed – fissure or hemorrhoid
99284	**Any items or services from 99281, 99282, 99283 and:** • Preparation for two or more diagnostic tests (Labs, EKG, X-ray) • Prep for one special imaging study (CT, MRI, Ultrasound, VQ scans) • Two nebulizer treatments • Port-a-cath venous access • Administration and monitoring of parenteral medications (IV, IM, IO, SC) NG/PEG • Tube placement/replacement multiple reassessments • Prep or assist with procedures such as eye irrigation with Morgan lens, bladder irrigation with 3-way Foley, pelvic exam (no forensic collection) etc. • Sexual assault exam without specimen collection • Psychotic patient; not suicidal	G0383	• Blunt/penetrating trauma- with limited diagnostic testing • A headache –Complex (no lumbar puncture (LP) • Head injury with loss of consciousness (LOC) • Dehydration requiring treatment • Dyspnea requiring oxygen • Respiratory illness relieved with (2) nebulizer treatments • Chest Pain—Simple, with limited diagnostic testing

Facility Level of Care Guideline (cont.)

CPT Code	Possible Services Rendered	HCPCS	Possible Symptoms
			• Abdominal Pain - Complex (multiple diagnostics and special imaging) • Non-menstrual vaginal bleeding • Neurologic symptoms –Simple with limited diagnostic testing
99285	**Any items or services from 99281, 99282, 99283, 99284 and:** • Cardiac monitoring for potential life-threatening conditions • More than one special imaging study (CT, MRI, VQ scan) combined with multiple tests or parenteral medication • Administration of blood transfusion/blood products • Oxygen via face mask or NRB • Multiple nebulizer treatments: three or more (if the nebulizer is continuous, each 20-minute period is considered treatment) • Procedural sedation • Prep or assist with procedures such as central line insertion, gastric lavage, LP, paracentesis, etc. • Temperature instability requiring intervention • Use of specialized resources – social services, police, crisis management • Sexual Assault exam with forensic specimen collection by Emergency Department staff • Coordination of hospital admission/ transfer for a higher level of care • Physical/chemical restraints • Need for 1:1 sitter • ICU admission not otherwise meeting critical care criteria	G0384	• Blunt/penetrating trauma requiring multiple diagnostic tests of multiple organ systems or major musculoskeletal injury • Systemic multi system medical emergency requiring multiple diagnostic tests • Severe infections requiring IV/IM antibiotics • Uncontrolled diabetes mellitus (DM) - symptoms of diabetic ketoacidosis (DKA) or hyperglycemic hyperosmolar nonketotic (HHNK) • Severe burns • Hypothermia • New-onset altered mental status • A headache (severe); CT and/or Lumbar puncture (LP) • Chest Pain—Complex with multiple diagnostic tests/treatments • Respiratory illness - relieved by 3 or more nebulizer treatments • Abdominal pain - Complex with multiple diagnostic tests/treatments

Facility Level of Care Guideline (cont.)

CPT Code	Possible Services Rendered	HCPCS	Possible Symptoms
			• Active gastrointestinal bleeding • Epistaxis – Complex • Acute peripheral vascular compromise of extremities • Neurologic symptoms - multiple diagnostic tests/treatments • Toxic ingestions • Mental health problem - suicidal/homicidal

*** Critical care is not billed with 99281-99285**

CPT Code	Possible Services Rendered		Possible Symptoms

99291
*First 30-74 minutes
	Any items from the above levels of care plus
	• Parenteral medications requiring continuous vital sign monitoring
	• Provision of any of the following:
	  • Major trauma care/ multiple surgical consultants
	  • Chest tube insertion
	  • Major burn care
	  • Treatment of active chest pain ACS
	  • CPR
	  • Defibrillation/ cardioversion
	  • Pericardiocentesis
	  • Administration of ACLS drugs in cardiac arrest
	  • Therapeutic hypothermia
	  • Non-invasive ventilation
	  • Endotracheal intubation
	  • Emergent airway intervention
	  • Ventilator management
	  • Line placement for monitoring
	  • Major hemorrhage
	  • Pacing (including external)
	  • Delivery of baby
			• Burns threatening to life or limb
			• Coma of all etiologies (except hypoglycemic)
			• Shock of all types
			• Any condition causing impairment of vital functions
			• Life-threatening hyper/hypothermia
			• Thyroid storm or Addisonian crisis
			• Cerebral hemorrhage of any type
			• New-onset paralysis
			• Status epilepticus
			• Acute myocardial Infarction
			• Cardiac tamponade aneurysm; thoracic or abdominal - leaking or ruptured
			• Acute respiratory failure, pulmonary edema, status asthmaticus

Facility Level of Care Guideline (cont.)

CPT Code	Possible Services Rendered	HCPCS	Possible Symptoms
			• Embolus of fat or amniotic fluid • Acute hepatic failure • Diabetic Ketoacidosis • Active bleeding from DIC or other bleeding diatheses
99292 * Each additional 30 minutes	Critical care, evaluation and, management of the critically ill or critically injured patient; List separately in addition to code for primary service.		

Professional Level of Service Guideline

The physician or other qualified healthcare professional level of service is determined by the following:

1. **Straight Forward Complexity (99281/G0380):**

   The presented problem(s) are self-limited or minor conditions with no medications or home treatment required.

   Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:

   1. A problem focused history;
   2. A problem focused examination; and
   3. Straightforward medical decision making

   Counseling and/or coordination of care with other physicians, other qualified healthcare 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.

2. **Low Complexity (99282/G0381):**

   The presented problem(s) are of low to moderate severity. Over the counter (OTC) medications or treatment, simple dressing changes; the patient demonstrates understanding quickly and easily. Emergency department visit for the evaluation and management of a patient, which requires these 3 elements:

   1. An expanded problem focused history;
   2. An expanded problem focused examination; and
   3. 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 needs. Ususally, the presenting problem(s) are of high severity and pose an immedicate signficant threat to lif or physiologic function.

3. **Moderate Complexity (99283/G0382):**

The presented problem(s) are of moderate severity. Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:

1. An expanded problem focused history;
2. An expanded problem focused examination; and
3. 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.

4. **Moderate-High Complexity (99284/G0383):**

Usually, the presented problem(s) are of high severity and *require urgent evaluation* by the physician but do not pose an immediate significant threat to life or physiologic function. Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:

1. A detailed history;
2. A detailed examination; and
3. Medical decision making of moderate complexity.

Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

5. **High Complexity (99285/G0384):**

The presented problem(s) are of high severity and pose an *immediate significant threat* to life or physiologic function. 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:

1. A comprehensive history;
2. A comprehensive examination; and
3. 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.

6. Physician direction of Emergency Medical Systems (EMS) emergency care, advanced life support**. (99288)**

7. **Critical Care (99291)**

   The assignment of the Critical Care code 99291 likewise follows the same instructions applicable to the six E&M codes listed above. There is a 30-minute time requirement for facility billing of the critical care.

   1) The administration and monitoring of IV vasoactive medications (such as adenosine, dopamine, labetalol, metoprolol, nitroglycerin, norepinephrine, sodium nitroprusside, etc.) are indicative of critical care.

8. **Critical Care (99292)**

   As above in additional 30-minute increments. Record the total critical care time. The first 30- 74 minutes equal code 99291. If this is used, additional 30-minute increments beyond the first 74 minutes are coded 99292.

References:

https://www.cms.gov/Medicare/Coding/ICD10/

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

https://www.acep.org/administration/reimbursement/ed-facility-level-coding-guidelines/#sm.00009vuj7rf17custso1ixkas7dbh

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Clinical Payment and Coding Policy: 001 Observation Services Tool for App MCG Criteria

Policy Update History:

Date	Description
06/22/2017	New policy
04/20/2018	Annual Review
11/15/2018	Policy coding and MCG updates