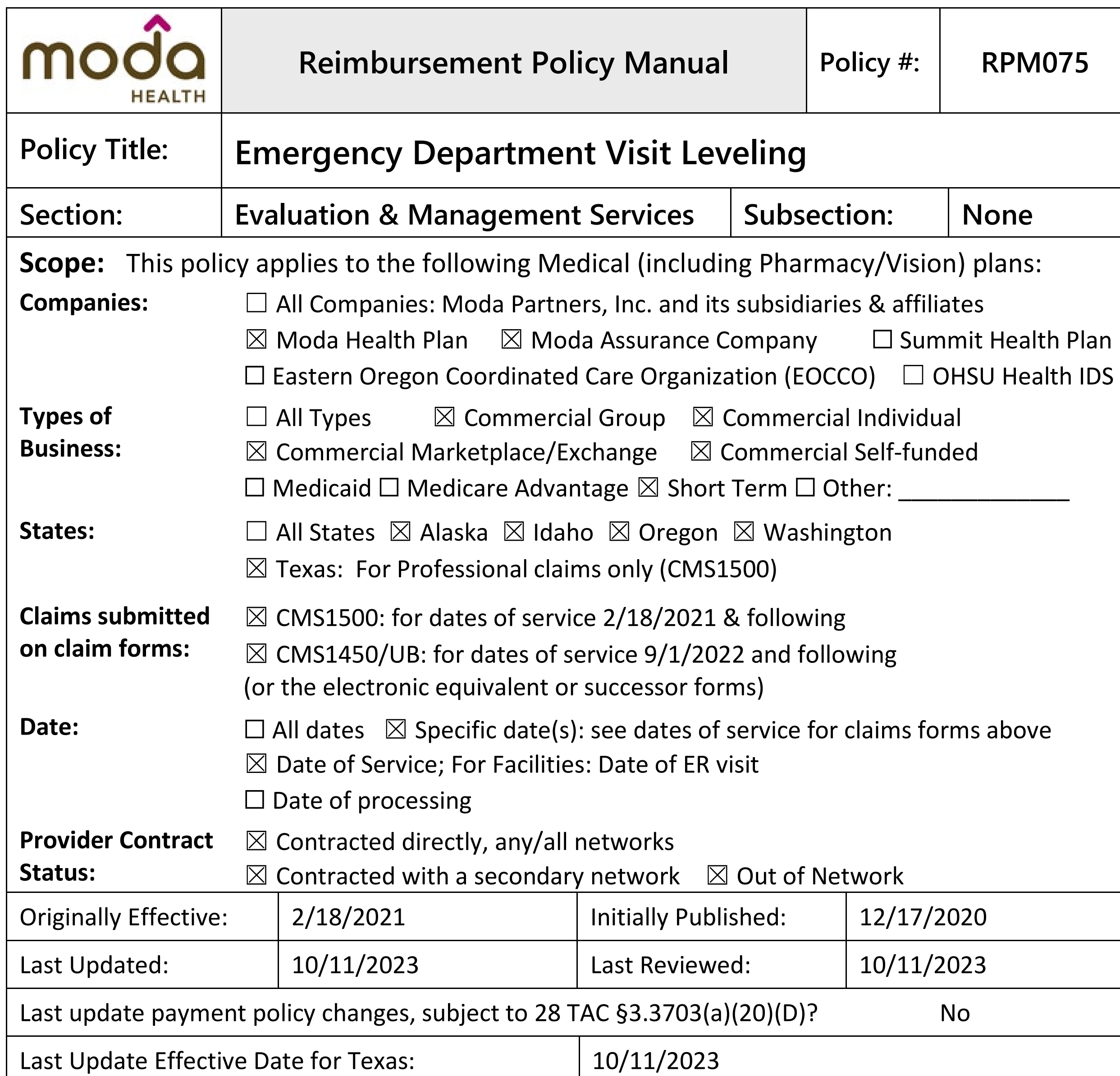

moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM075
Policy Title:	**Emergency Department Visit Leveling**		
Section:	**Evaluation & Management Services**	**Subsection:**	**None**

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:
☐ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates
☒ Moda Health Plan ☒ Moda Assurance Company ☐ Summit Health Plan
☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS

Types of Business:
☐ All Types ☒ Commercial Group ☒ Commercial Individual
☒ Commercial Marketplace/Exchange ☒ Commercial Self-funded
☐ Medicaid ☐ Medicare Advantage ☒ Short Term ☐ Other: ______________

States:
☐ All States ☒ Alaska ☒ Idaho ☒ Oregon ☒ Washington
☒ Texas: For Professional claims only (CMS1500)

Claims submitted on claim forms:
☒ CMS1500: for dates of service 2/18/2021 & following
☒ CMS1450/UB: for dates of service 9/1/2022 and following
(or the electronic equivalent or successor forms)

Date:
☐ All dates ☒ Specific date(s): see dates of service for claims forms above
☒ Date of Service; For Facilities: Date of ER visit
☐ Date of processing

Provider Contract Status:
☒ Contracted directly, any/all networks
☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	2/18/2021	Initially Published:	12/17/2020
Last Updated:	10/11/2023	Last Reviewed:	10/11/2023
Last update payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)?		No	
Last Update Effective Date for Texas:		10/11/2023	

Reimbursement Guidelines

A. General

Emergency department (ED) professional evaluation and management (E/M) services are reimbursed based on the level of acuity, complexity, and severity. Reimbursement determinations are based on:

- Medical necessity/utilization criteria (see "Leveling of Emergency Room Services," Moda Health Medical Necessity Criteria [A]).
- The patient's primary discharge diagnosis.
- The patient's age.

B. Controlling Factor for Level of Service

Medical complexity is the controlling factor when determining level of service for Evaluation and Management (E&M) codes. The key components (history, exam, medical decision making) to support the level of service must be documented, but if medical complexity does not support the same level of service supported by the three key components, medical complexity (i.e., risk), becomes the controlling factor.

C. Leveling Adjustments

1. When a physician bills a Level 4 (99284) or Level 5 (99285) emergency room E/M service, with a diagnosis indicating a lower level of acuity, complexity, or severity, the service will automatically be reimbursed at the Level 3 (99283) reimbursement rate.

    a. The submitted procedure code will be changed to 99283 in the claims processing system and on the Explanation of Payment (EOP) and 835 electronic file. This change is required in order to price the line item at the Level 3 (99283) reimbursement rate.

    b. The line item will be processed with the following explanation code.

EX code w51	The information furnished does not substantiate the need for the billed level of service.
CARC 150	Payer deems the information submitted does not support this level of service.
RARC M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office.

    c. Please note that "…the billed level of service…" and "…this level of service…" in the explanation code, CARC, and RARC refers to the Level 4 (99284) or Level 5 (99285) emergency room E/M service submitted on the incoming claim and not the Level 3 (99283) emergency room E/M procedure code used for processing and pricing the line item.

2. A provider may submit a written appeal if the provider disagrees with how the claim was adjudicated.

D. Determining Level of Acuity and Risk for ED Visit

1. Medical complexity (risk) is evaluated during adjudication by using the primary discharge diagnosis code.

2. A list of diagnosis codes that have been deemed to represent low acuity non-emergent conditions is used for the adjudication analysis during claims processing. This list of diagnosis codes has been developed by a group of emergency department physicians, state Medicaid chief medical officers, and other clinical medical professional providers. (Mercer[5], NJMMIS[6], NJ-ACEP[7])

E. Coding Requirements

Bill the patient's primary discharge diagnosis in the first diagnosis position on the emergency room visit claim form.

F. Reconsiderations

1. When submitting a written appeal, include medical records for review in addition to the appeal letter summarizing the basis for appeal.
2. The appeal and medical records will be reviewed by Healthcare Services to determine if the level of acuity, complexity, and severity supports a Level 4 or Level 5 Emergency Department Service.
3. Additional factors that may warrant a Level 4 or Level 5 emergency department E/M service to be allowed upon reconsideration include, but are not limited to:
   a. The patient expired in the ED.
   b. The patient was admitted to Inpatient care.
   c. The patient was transferred to another hospital or other type of health care institution.
   d. A respiratory intubation procedure was performed.
   e. The patient was admitted for an outpatient surgery.
   f. Critical care [evaluation and management] services were provided in the emergency department.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AHA	=	American Hospital Association
AMA	=	American Medical Association
APC	=	Ambulatory Payment Classification
ASC	=	Ambulatory Surgery Center
ASO	=	Administrative Services Only
CAH	=	Critical Access Hospital
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
ED	=	Emergency Department (also known as/see also ER)
EOB	=	Explanation of Benefits
EOP	=	Explanation of Payment

Acronym or Abbreviation		Definition
ER	=	Emergency Room (also known as/see also ED)
FAH	=	Federation of American Hospitals
HAC	=	Hospital Acquired Condition
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as “hick picks”)
HFMA	=	Healthcare Financial Management Association
HIPAA	=	Health Insurance Portability and Accountability Act
ICD	=	International Classification of Diseases
ICD-10	=	International Classification of Diseases, Tenth Edition
ICD-10-CM	=	International Classification of Diseases, Tenth Edition, Clinical Modification
ICD-10-PCS	=	International Classification of Diseases, Tenth Edition, Procedure Coding System
LANE	=	Low Acuity Non-Emergent
MCG	=	Milliman Care Guidelines
MPFSDB	=	(National) Medicare Physician Fee Schedule Database (aka RVU file)
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka “CCI”)
NUBC	=	National Uniform Billing Committee
NUCC	=	National Uniform Claim Committee
OPPS	=	Outpatient Prospective Payment System
PDR	=	Payment Disbursement Register
POA	=	Present on Admission
RPM	=	Reimbursement Policy Manual (e.g., in context of “RPM052” policy number, etc.)
RVU	=	Relative Value Unit
TOB	=	Type of Bill
UB	=	Uniform Bill
UHDDS	=	Uniform Hospital Discharge Data Set

Definition of Terms

Term	Definition
Acuity	The severity of a patient’s illness and the level of attention or service he or she will need from professional staff. (Taber’s[8])

Term	Definition
Medical Complexity	A reference to the medical decision making needed and the level of risk involved in assessing and treating the patient's condition.
Non-Emergent Condition	Conditions for which a delay of several hours for a medical screening examination and treatment would not increase the likelihood of an adverse outcome. (Moda[A], KMR[9])

Procedure codes (CPT & HCPCS):

Code	Code Description
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.

Code	Code Description
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
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)

Place of Service code:

Note: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service. (CMS MM9726[3])

Code	Short Description	Place of Service Code Long Description
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

Coding Guidelines & Sources – (Key quotes, not all-inclusive)

"Select the Appropriate Level of E/M Services Based on the Following

1. For the following categories/subcategories, **all of the key components**, ie, history, examination, and medical decision making, must meet or exceed the stated requirements to qualify for a particular level of E/M service: … emergency department services…" (AMA[1])

"**Question**

When a physician sees a patient in the emergency room, and the severity of the patient's injuries prevent the physician from performing a comprehensive history, can code 99285, Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status, still be reported? The physician was able to obtain history information from another source but could not perform the review of systems due to the patient's condition.

AMA Comment

The emergency department services codes 99281-99285 require the performance of all three key components to report a given level of service. However, code 99285 is unique in that it indicates that the three key components are required within the constraints imposed by the urgency of the patient's clinical condition and mental status. This means that the patient's condition may preclude the completion of the comprehensive history and/or the comprehensive examination normally required when reporting this code.

Use of code 99285 is not limited to instances in which the physician is unable to obtain any history; rather, the code may be reported when the patient's condition would normally require this level of service, but the physician was unable to complete a comprehensive level history or examination." (AMA[2])

"Key component. For emergency department services, all three components (history, exam, and medical decision making) are crucial for selecting the correct code and must be adequately documented in the medical record to substantiate the level of service reported." (Optum360[3])

“NOTE: The severity of the patient’s problem, while taken into consideration when evaluating and treating the patient, does not automatically determine the level of E/M service unless the medical record documentation reflects the severity of the patient’s illness, injury, or condition in the details of the history, physical examination, and medical decision making process. Federal auditors will “downcode” the level of E/M service despite the nature of the patient’s problem when the documentation does not support the E/M code reported.” (Optum360[4])

Cross References

A. “Leveling of Emergency Room Services,” Moda Health Medical Necessity Criteria.

References & Resources

1. AMA. “Evaluation and Management (E/M) Services Guidelines.” Current Procedural Terminology (CPT) – Professional Edition 2020. 2020. Page 10.

2. AMA. “Coding Consultation: Evaluation and Management.” CPT Assistant, September 2002, page 11.

3. Optum360. “Appendix C — Evaluation and Management Extended Guidelines, Emergency Department Services, New or Established Patient.” Current Procedural Coding Expert. 2019. Page 618, Footnote 1.

4. Optum360. “Current Procedural Coding Expert, Appendix C — Evaluation and Management Extended Guidelines, Emergency Department Services, New or Established Patient.” Current Procedural Coding Expert. 2019. Page 618, Footnote 3.

5. Mercer. “Addressing the Problem of Low Acuity Non-Emergent ED Visits.” Mercer Government Human Services Consulting. 2019. Last accessed November 30, 2020. https://www.mercer-government.mercer.com/content/dam/mercer-subdomains/us-government/attachments/secured-fact-sheets/6009740b(21)-HB%20Addressing%20the%20Problem%20of%20Low%20Acuity%20in%20Non-Emergent%20ED%20Visits%20(LANE%20Sell%20Sheet)_V2c_AP_SEC.pdf .

6. NJMMIS. “Triage Fee Reimbursement For Non-Emergent Emergency Room Visits.” State of New Jersey Department of Human Services Division of Medical Assistance & Health Services, Medicaid Newsletter, November 2018, Volume 28, No. 20. Last accessed November 30, 2020. https://www.njmmis.com/downloadDocuments/28-20.pdf .

7. NJ-ACEP (NJMMIS Newsletter posting). “Triage Fee Reimbursement For Non-Emergent Emergency Room Visits.” American College of Emergency Physicians, New Jersey Chapter (NJ-ACEP).
https://www.njacep.org/Portals/0/Medicaid%20Newsletter%20Nov%202018%20Vol%2028%20No%2020%20-%20ED%20Triage%20Reimbursement%20Non-emergent%20Diagnosis%20Codes.pdf .

8. Taber’s Online. Unbound Medicine, Inc. Last accessed November 30, 2020.
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Dictionary/745988/all/acuity#:~:text=acuere%2C%20to%20sharpen%5D-,1.,%2Dk%C5%AB%E2%80%B2%C4%ADt%2D%C4%93) .

9. KMR. “TRIAGE in the Emergency Department.” Key Medical Resources, Inc. Last updated August 2018; last accessed November 30, 2020. http://www.keymedinfo.com/site/667KeyM/Key_Medical_Home_Study_-_Triage_in_Emergency_Department_Using_ESi_(5_Levels)_Self_Study_8.2015_in_PDF_Format_for_email_and_posting.pdf

Background Information

A trend in upcoding by emergency room providers has been identified. Moda Health has adopted a strategy and policy that combines utilization review and program integrity to provide appropriate levels of reimbursement for services indicating lower levels of acuity, complexity, or severity rendered in the emergency room.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member’s medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS’ National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member’s medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member’s medical benefit plan, the member’s medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider’s agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
10/11/2023	Annual Review/Formatting Update: Minor rewording; no changes to meaning or content.
2/8/2023	Clarification/Update Section F.2: Added “…by Healthcare Services…”

Date	Summary of Update
12/14/2022	Format/Update Scope, States: Idaho added. Cross References: Hyperlink added.
7/19/2022	Clarification/Update: Header: Corrected Companies & Types of Business to reflect Commercial plans only.
6/8/2022	Revision/update New header added. Scope: Added effective for facility claims; Texas excluded. Acronyms: 5 entries added. Policy History: Added.
12/17/2020	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
2/18/2021	Original Effective Date (with or without formal documentation). Policy based on a decision by Healthcare Services and Claims executives and industry analysis of medical complexity of emergency department visits. (Mercer[5], NJMMIS[6], NJ-ACEP[7])