Applicable To:
Medicare

Claims & Payment Policy: Emergency Department Facility Coding

Policy Number: CPP - 105

Original Effective Date:
Revised Date(s):
08/01/2019

BACKGROUND

Facility coding guidelines are inherently different from professional coding guidelines. Facility coding reflects the volume and intensity of resources utilized by the facility to provide patient care, whereas professional codes are determined based on the complexity and intensity of provider performed work and include the cognitive effort expended by the provider. As such, there is no necessary correlation between facility and professional coding, and thus no rational basis for the application of one set of derived codes-- either facility or professional-- over the other.

According to the American College of Emergency Physicians (ACEP), there is no current national standard for hospital assignment of Evaluation & Management (E&M) code levels for outpatient services in the Emergency Department (ED). However, ED facility billing is dependent upon resource consumption and a diagnosis alone does not translate to a specified Current Procedural Terminology (CPT®) Code. The Centers for Medicare & Medicaid Services (CMS) require each hospital to establish its own facility billing guidelines. The CMS Outpatient Prospective Payment System (OPPS) lists eleven criteria that must be met for facility coding guidelines. The guidelines should:

1. Follow the intent of the associated 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.
2. Be based on hospital facility resources. The guidelines should not be based on physician resources.

3. be clear to facilitate accurate payments and be usable for compliance purposes and audits.
4. meet HIPAA requirements.
5. only require documentation that is clinically necessary for patient care.
6. not facilitate up coding or gaming.
7. be in writing, or recorded, well-documented and provide the basis for selection of a specific code.
8. be applied consistently across patients in the clinic or emergency department to which they apply.
9. not change with great frequency.
10. be readily available for fiscal intermediary review.
11. result in coding decisions that could be verified by other hospital staff, as well as outside sources.

CMS indicates facilities should bill appropriately and differentially for outpatient visits, including emergency department visits. To that end, CMS coding principles that apply to emergency department services state that facility coding guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code.

POSITION STATEMENT

The Health Plan has implemented a policy to ensure that facilities billing with a UB-04 form use high-level Emergency Department Evaluation & Management (E&M) codes accurately and responsibly. High-level E&M codes include Level 3 codes (99283/G0382), Level 4 codes (99284/G0383) and Level 5 codes (99285/G0384). As noted by ACEP, appropriate billing is dependent on the interventions performed by a facility's registered nurses and ancillary staff. Placing a high level code on an Emergency Department facility claim signifies that considerable resources were utilized during the member's time in the Emergency Department. High-level codes are expected to be used for final diagnoses that signify a serious threat to the member's well-being.

Prepay Review

Should the health Plan review a Level 3, 4 or 5 claim, and the diagnoses/codes on the claim do not support the level billed, WellCare will reimburse the hospital at Level 2 (99282/G0381), Level 3 (99283/G0382) or Level 4 (99284/G0383), as appropriate and depending its findings.

Post Pay Review

The Health plan may retrospectively audit providers regarding the use of high-level ED codes. Should WellCare review a Level 3, 4 or 5 claim, and the diagnoses/codes on the claim do not support the level billed, WellCare will issue a finding and recovery letter to the facility.

Factors Considered

In its review, the health plan takes into consideration the following:

- The level billed by the facility, in accordance with the ICD-10 reason for visit diagnosis;
- Patient complexity and co-morbidity as defined by the primary and subsequent diagnoses (ICD-10);
- CPT® codes on the facility claim (includes Lab, X-ray, EKG/RT/Other Diagnostic, CT/MRI/Ultrasound, etc.);
- The member's age.

Additional Information

The following claims will be excluded from The Health Plan review of ED facility coding:

- Claims for children less than 2 years of age;
- Claims for members admitted to the hospital as inpatient; and
- Claims for members who have expired in the Emergency Department.

UB-04 claims for Emergency Department services should include all ancillary services provided during the Emergency Department encounter and all services must be noted in the member's medical record. Hospitals must submit claims that accurately reflect services performed and resources utilized in the Emergency Department. Should the facility disagree with the reimbursement of an ED service, it may exercise dispute rights available under its contract, if applicable, and under state or federal law.

CODING & BILLING

99281 (G0380) Emergency department visit for the evaluation and management of a patient (Level 1)
99282 (G0381) Emergency department visit for the evaluation and management of a patient (Level 2)
99283 (G0382) Emergency department visit for the evaluation and management of a patient (Level 3)
99284 (G0383) Emergency department visit for the evaluation and management of a patient (Level 4)
99285 (G0384) Emergency department visit for the evaluation and management of a patient (Level 5)

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES

1. American College of Emergency Physicians. Available online at https://www.acep.org/administration/reimbursement/reimbursement-faqs/apc-ambulatory-payment-classifications-faq/

2. 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 https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/Downloads/cms1392fc.pdf

3. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services
4. Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
5. Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
6. Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) Policy Publications

IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan's contract with Medicare and/or a state's Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable including, but not limited to, *Pre-Payment and Post-Payment Review*.
- The provisions of the contract between the provider and the health plan; and
- The terms of a member's particular benefit plan, including those terms outlined in the member's Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member's policy documents, the terms of a member's benefit plan will always supersede the CPP.
The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT®, HCPCS©, or ICD-10 code. Always consult the member's benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member's eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan's policies. Services must be medically necessary in order to be covered.

References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication.

CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at www.wellcare.com.

'Ohana Health Plan,~ (WellCare Medicare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)

RULES, PRICING & PAYMENT COMMITTEE HISTORY AND REVISIONS

Date	Action
11/06/2018	• Approved by RPPC