Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-037		
Subject:	Emergency Evaluation and Management Coding Guidelines		
Effective Date:	August 27, 2018	**End Date:**	
Issue Date:	January 15, 2024	**Revised Date:**	January 2024
Date Reviewed:	October 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☐				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

Currently, there is no national standard for hospital assignment of Evaluation and Management (E/M) code levels for outpatient services in the Emergency Department (ED).This policy provides guidance for how the Plan reimburses UB claims billed with E/M for appropriate levels of service based on the complexity of patient condition rendered in the outpatient ED.

The Plan reviews these E/M claims for the appropriate level of care on a prepayment basis and adjusts any claims that are overbilled. This policy is based on coding principles established by the Centers for Medicare and Medicaid Services (CMS), and the CPT and HCPCS code descriptions. This policy applies to services reported using the UB-04 claim form or its electronic equivalent or its successor form. It also applies to claims submitted on such forms by network and non-network facility emergency departments (including hospital emergency departments) and free-standing emergency departments (UB Claims).

REIMBURSEMENT GUIDELINES:

ED visits should be coded based on hospital resource utilization, which is dictated by the patient's clinical condition and the treatment provided. There are five visit levels that the ED can utilize when submitting a claim. Level one (1) is the least resource-intensive while a level five (5) is the most resource-intensive. These visit levels are represented by the E&M procedure codes shown in the table below.

Codes	Explanation and Purpose	ED Level
99281 G0380	Used for very simple and limited services. The presenting problem is minor.	Level 1
99282 G0381	Typically assigned for an acute episodic illness and/or minor injury evaluation. The presenting problem is of low to moderate severity.	Level 2
99283 G0382	Generally, requires additional facility resources such as x-ray, laboratory tests, or additional nursing time. The presenting problem is of moderate complexity.	Level 3
99284 G0383	For encounters associated with acute illness or injury that requires prolonged evaluation and typically diagnostic studies, repeat nursing evaluations, or other therapeutic interventions. The presenting problem is high severity requiring urgent evaluation.	Level 4
99285 G0384	For encounters that are associated with serious presenting symptoms, often a life-threatening disease or injury, requiring treatment that is complex and/or resource intensive. The presenting problem is of high severity and/or poses an immediate significant threat to life of physiological function.	Level 5

CMS requires 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 reasonably relate the intensity of hospital resources to the different levels of effort represented by the code. CMS offers the following broad parameters for a hospital to develop facility billing guidelines:

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 versus 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 upcoding 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. UB-04 claims for services rendered in an ED should be complete and include all diagnostic services and diagnosis codes relevant to the ED visit and be billed at the appropriate E/M level.

Consistent with other insurers, the Plan is aware that the lack of uniform standards, unpoliced by CMS, has resulted in abuse of ER services coding inconsistent with the stated CMS guideline that a hospital's own guidelines should "not facilitate upcoding or gaming". High level E/M codes include level three (3) codes (99293/G0382), level four (4) codes (99284/G0383) and level five (5) codes (99285/G0384). Appropriate billing is dependent on the interventions performed by a facility's registered nurses and ancillary staff. Placing a high-level code on an ED facility claims signifies that considerable resources were utilized during the member's time in the ED. High level codes are expected to be used for final diagnoses that signify a serious threat to the member's well-being.

The Plan will analyze outpatient ED claims using the OPTUM Analyzer® to determine the appropriate E/M level to be reimbursed for certain facility claims. An algorithm is applied that takes three factors into account (see below) in order to determine a Calculated Visit Level for the ED E/M services rendered. The three factors used in the calculation are as follows:

- Presenting problems – as defined by the ICD-10 reason for visit (RFV) diagnosis.
- Diagnostic services performed – based on intensity of the diagnostic workup as measured by the diagnostic CPT codes submitted on the claim (i.e., lab, x-ray, EKG/RT/other diagnostic, CT/MRI/ultrasound); and,
- Patient complexity and co-morbidity – based on complicating conditions or circumstances as defined by the ICD-10 principal, secondary, and external cause of injury diagnosis codes.

Applicable codes:

99281	99282	99283	99284	99285
G0380	G0381	G0382	G0383	G0384

Facilities may experience a downgraded payment from the higher-level E/M code to the appropriate lower-level E/M code.

Criteria that may exclude Facility claims from being subject to an adjustment or denial include:

- The patient is admitted to inpatient or observation
- Critical care patients (99291, 99292)
- The patient is less than 2 years old
- Claims with certain diagnoses that when treated in the ED most often necessitate greater than average resource usage, such as significant nursing time
- Patients who have expired in the emergency department

Note: Providers will receive notification of any downgraded claims and have an opportunity to appeal.

DOCUMENTATION GUIDELINES:

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from 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"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines. Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment, and coding policies as well as coding software logic.

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-035: Correct Coding Guidelines

REFERENCES:

- CMS-1392-FC Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates, the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates, the Hospital Inpatient Prospective Payment System and FY 2008 Payment Rates; and Payments for Graduate Medical Education for Affiliated Teaching Hospitals in Certain Emergency Situations Medicare and Medicaid Programs: Hospital Conditions of Participation; Necessary Provider Designations of Critical Access Hospitals

- Federal Register / Vol. 72, No. 227 / Tuesday, November 27, 2007 / Rules and Regulations

- American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services.

- Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

- Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) Policy Publications

- American Academy of Pediatrics; AAP Publications, AAP News: Emergency department E/M codes revised for 2023

- Optum: EDC Analyzer - Optum, Inc

POLICY UPDATE HISTORY INFORMATION:

8 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy
5 / 2023	Updated policy with direction on the analyzing of code levels
9 / 2023	Updated policy with more detailed direction on the analyzing of code levels
1 / 2024	Removed outpatient as an exclusion criteria

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-037		
Subject:	Emergency Evaluation and Management Coding Guidelines		
Effective Date:	August 27, 2018	**End Date:**	
Issue Date:	September 1, 2023	**Revised Date:**	September 2023
Date Reviewed:	April 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☐				

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Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

Currently, there is no national standard for hospital assignment of Evaluation and Management (E/M) code levels for outpatient services in the Emergency Department (ED).This policy provides guidance for how the Plan reimburses UB claims billed with E/M for appropriate levels of service based on the complexity of patient condition rendered in the outpatient ED.

The Plan reviews these E/M claims for the appropriate level of care on a prepayment basis and adjusts any claims that are overbilled. This policy is based on coding principles established by the Centers for Medicare and Medicaid Services (CMS), and the CPT and HCPCS code descriptions. This policy applies to services reported using the UB-04 claim form or its electronic equivalent or its successor form. It also applies to claims submitted on such forms by network and non-network facility emergency departments (including hospital emergency departments) and free-standing emergency departments (UB Claims).

REIMBURSEMENT GUIDELINES:

ED visits should be coded based on hospital resource utilization, which is dictated by the patient's clinical condition and the treatment provided. There are five visit levels that the ED can utilize when submitting a claim. Level one (1) is the least resource-intensive while a level five (5) is the most resource-intensive. These visit levels are represented by the E&M procedure codes shown in the table below.

Codes	Explanation and Purpose	ED Level
99281 G0380	Used for very simple and limited services. The presenting problem is minor.	Level 1
99282 G0381	Typically assigned for an acute episodic illness and/or minor injury evaluation. The presenting problem is of low to moderate severity.	Level 2
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99284 G0383	For encounters associated with acute illness or injury that requires prolonged evaluation and typically diagnostic studies, repeat nursing evaluations, or other therapeutic interventions. The presenting problem is high severity requiring urgent evaluation.	Level 4
99285 G0384	For encounters that are associated with serious presenting symptoms, often a life-threatening disease or injury, requiring treatment that is complex and/or resource intensive. The presenting problem is of high severity and/or poses an immediate significant threat to life of physiological function.	Level 5

CMS requires 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 reasonably relate the intensity of hospital resources to the different levels of effort represented by the code. CMS offers the following broad parameters for a hospital to develop facility billing guidelines:

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 versus 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 upcoding 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. UB-04 claims for services rendered in an ED should be complete and include all diagnostic services and diagnosis codes relevant to the ED visit and be billed at the appropriate E/M level.

Consistent with other insurers, the Plan is aware that the lack of uniform standards, unpoliced by CMS, has resulted in abuse of ER services coding inconsistent with the stated CMS guideline that a hospital's own guidelines should "not facilitate upcoding or gaming". High level E/M codes include level three (3) codes (99293/G0382), level four (4) codes (99284/G0383) and level five (5) codes (99285/G0384). Appropriate billing is dependent on the interventions performed by a facility's registered nurses and ancillary staff. Placing a high-level code on an ED facility claims signifies that considerable resources were utilized during the member's time in the ED. High level codes are expected to be used for final diagnoses that signify a serious threat to the member's well-being.

The Plan will analyze outpatient ED claims using the OPTUM Analyzer® to determine the appropriate E/M level to be reimbursed for certain facility claims. An algorithm is applied that takes three factors into account (see below) in order to determine a Calculated Visit Level for the ED E/M services rendered. The three factors used in the calculation are as follows:

- Presenting problems – as defined by the ICD-10 reason for visit (RFV) diagnosis.
- Diagnostic services performed – based on intensity of the diagnostic workup as measured by the diagnostic CPT codes submitted on the claim (i.e., lab, x-ray, EKG/RT/other diagnostic, CT/MRI/ultrasound); and,
- Patient complexity and co-morbidity – based on complicating conditions or circumstances as defined by the ICD-10 principal, secondary, and external cause of injury diagnosis codes.

Applicable codes:

99281	99282	99283	99284	99285
G0380	G0381	G0382	G0383	G0384

Facilities may experience a downgraded payment from the higher-level E/M code to the appropriate lower-level E/M code.

Criteria that may exclude Facility claims from being subject to an adjustment or denial include:

- The patient is admitted to inpatient, observation, or has an outpatient surgery during the course of the same ED visit
- Critical care patients (99291, 99292)
- The patient is less than 2 years old
- Claims with certain diagnoses that when treated in the ED most often necessitate greater than average resource usage, such as significant nursing time
- Patients who have expired in the emergency department

Note: Providers will receive notification of any downgraded claims and have an opportunity to appeal.

DOCUMENTATION GUIDELINES:

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from 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"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines. Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment, and coding policies as well as coding software logic.

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-035: Correct Coding Guidelines

REFERENCES:

- CMS-1392-FC Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates, the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates, the Hospital Inpatient Prospective Payment System and FY 2008 Payment Rates; and Payments for Graduate Medical Education for Affiliated Teaching Hospitals in Certain Emergency Situations Medicare and Medicaid Programs: Hospital Conditions of Participation; Necessary Provider Designations of Critical Access Hospitals
- Federal Register / Vol. 72, No. 227 / Tuesday, November 27, 2007 / Rules and Regulations
- American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services.
- Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
- Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) Policy Publications
- American Academy of Pediatrics: AAP Publications, AAP News: Emergency department E/M codes revised for 2023
- Optum: EDC Analyzer - Optum, Inc

POLICY UPDATE HISTORY INFORMATION:

8 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy
5 / 2023	Updated policy with direction on the analyzing of code levels
9 / 2023	Updated policy with more detailed direction on the analyzing of code levels

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-037		
Subject:	Emergency Evaluation and Management Coding Guidelines		
Effective Date:	August 27, 2018	**End Date:**	
Issue Date:	May 1, 2023	**Revised Date:**	May 2023
Date Reviewed:	February 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☐				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy provides guidance for how the Plan reimburses UB claims billed with Evaluation and Management (E/M) for appropriate levels of service based on the complexity of patient condition rendered in the outpatient Emergency Department (ED). The Plan reviews these E/M claims for the appropriate level of care on a prepayment basis and adjusts any claims that are overbilled. This policy is based on coding principles established by the Centers for Medicare and Medicaid Services (CMS), and the CPT and HCPCS code descriptions. This policy applies to services reported using the UB-04 claim form or its electronic equivalent or its successor form. It also applies to claims submitted on such forms by network and non-network facility emergency departments (including hospital emergency departments) and free-standing emergency departments (UB Claims).

REIMBURSEMENT GUIDELINES:

UB-04 claims for services rendered in an ED should be complete and include all diagnostic services and diagnosis codes relevant to the ED visit and be billed at the appropriate E/M level.

The Plan will analyze outpatient ED claims to determine the appropriate E/M level to be reimbursed for certain facility claims. An algorithm is applied that takes three factors into account (see below) in order to determine a Calculated Visit Level for the ED E/M services rendered. The three factors used in the calculation are as follows:

- Presenting problems – as defined by the ICD-10 reason for visit (RFV) diagnosis.

- Diagnostic services performed – based on intensity of the diagnostic workup as measured by the diagnostic CPT codes submitted on the claim (i.e., lab, x-ray, EKG/RT/other diagnostic, CT/MRI/ultrasound); and,
- Patient complexity and co-morbidity – based on complicating conditions or circumstances as defined by the ICD-10 principal, secondary, and external cause of injury diagnosis codes.

Applicable codes: 99281 99282 99283 99284 99285 G0383 G0384

Facilities may experience a downgraded payment from the higher-level E/M code to the appropriate lower-level E/M code.

Criteria that may exclude Facility claims from being subject to an adjustment or denial include:

- The patient is admitted to inpatient, observation, or has an outpatient surgery during the course of the same ED visit.
- Critical care patients (99291, 99292).
- The patient is less than 2 years old.
- Claims with certain diagnoses that when treated in the ED most often necessitate greater than average resource usage, such as significant nursing time.
- Patients who have expired in the emergency department.

Note: Providers will receive notification of any downgraded claims and have an opportunity to appeal.

DOCUMENTATION GUIDELINES:

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from 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"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines. Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment, and coding policies as well as coding software logic.

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-035: Correct Coding Guidelines

REFERENCES:

- CMS-1392-FC Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates, the Ambulatory Surgical Center Payment System and CY

2008 Payment Rates, the Hospital Inpatient Prospective Payment System and FY 2008 Payment Rates; and Payments for Graduate Medical Education for Affiliated Teaching Hospitals in Certain Emergency Situations Medicare and Medicaid Programs: Hospital Conditions of Participation; Necessary Provider Designations of Critical Access Hospitals

- Federal Register / Vol. 72, No. 227 / Tuesday, November 27, 2007 / Rules and Regulations
- American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services.
- Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
- Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) Policy Publications
- American Academy of Pediatrics; AAP Publications, AAP News: Emergency department E/M codes revised for 2023

POLICY UPDATE HISTORY INFORMATION:

8 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy
5 / 2023	Updated policy with direction on the analyzing of code levels

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-037		
Subject:	Emergency Evaluation and Management Coding Guidelines		
Effective Date:	August 27, 2018	**End Date:**	
Issue Date:	January 3, 2022	**Revised Date:**	January 2022
Date Reviewed:	October 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☐				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy notifies facility providers that The Plan will align with the Centers for Medicare & Medicaid Services (CMS) and will recognize the Facility's policy guidelines for assigning emergency Evaluation & Management (E & M) coding if it meets the 11 guideline principles outlined on this policy.

BACKGROUND:

Since April 7, 2000, CMS instructed hospitals to report facility resources for emergency department hospital outpatient visits using the CPT E & M codes and to develop internal hospital guidelines for reporting the appropriate visit level. The ultimate goal is to create national guidelines for hospital coding of emergency department visits.

CMS has reiterated their goal to create national guidelines since CY 2000 but no national guidelines have been implemented as of CY 2018. CMS has communicated a set of principles that any national guidelines for facility visit coding should satisfy.

REIMBURSEMENT GUIDELINES:

Until national guidelines are established, hospitals should continue using their own internal guidelines to determine the appropriate reporting of different levels of emergency department visits. All internal hospital-specific guidelines for reporting visits must meet the 11 guideline principles listed below. [CMS-1392-FC]

(**1**) The coding guidelines should follow the intent of the 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**) The coding guidelines should be based on hospital facility resources. The guidelines should not be based on physician resources.
(**3**) The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits.
(**4**) The coding guidelines should meet the HIPAA requirements.
(**5**) The coding guidelines should only require documentation that is clinically necessary for patient care.
(**6**) The coding guidelines should not facilitate upcoding or gaming.
(**7**) The coding guidelines should be written or recorded, well-documented, and provide the basis for selection of a specific code.
(**8**) The coding guidelines should be applied consistently across patients in the clinic or emergency department to which they apply.
(**9**) The coding guidelines should not change with great frequency.
(**10**) The coding guidelines should be readily available for fiscal intermediary (or, if applicable, MAC) review.
(**11**) The coding guidelines should result in coding decisions that could be verified by other hospital staff, as well as outside sources.

The Plan requires providers remain compliant with their own internal policies governing facility emergency E & M coding. The Plan may request copies of current facility E & M coding policies and use these for audit purposes.

To the extent that facilities use either customized or off the shelf computerized point systems to determine emergency department visit levels such facilities should make inquiries to understand and document system logic including any changes. This would facilitate audits including audit re-performance of calculations. Such inquiries/documentation shall remain current for audit verification purposes.

REFERENCES:

- CMS-1392-FC Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates, the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates, the Hospital Inpatient Prospective Payment System and FY 2008 Payment Rates; and Payments for Graduate Medical Education for Affiliated Teaching Hospitals in Certain Emergency Situations Medicare and Medicaid Programs: Hospital Conditions of Participation; Necessary Provider Designations of Critical Access Hospitals

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POLICY UPDATE HISTORY INFORMATION:

8 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy

Highmark Reimbursement Policy Bulletin

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HISTORY VERSION

Bulletin Number:	RP-037		
Subject:	Emergency Evaluation and Management Coding Guidelines		
Effective Date:	August 27, 2018	**End Date:**	
Issue Date:	November 1, 2021	**Revised Date:**	July 2021
Date Reviewed:	July 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☐	**NY** ☒
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PURPOSE:

This policy notifies facility providers that The Plan will align with the Centers for Medicare & Medicaid Services (CMS) and will recognize the Facility's policy guidelines for assigning emergency Evaluation & Management (E & M) coding if it meets the 11 guideline principles outlined on this policy.

BACKGROUND:

Since April 7, 2000, CMS instructed hospitals to report facility resources for emergency department hospital outpatient visits using the CPT E & M codes and to develop internal hospital guidelines for reporting the appropriate visit level. The ultimate goal is to create national guidelines for hospital coding of emergency department visits.

CMS has reiterated their goal to create national guidelines since CY 2000 but no national guidelines have been implemented as of CY 2018. CMS has communicated a set of principles that any national guidelines for facility visit coding should satisfy.

REIMBURSEMENT GUIDELINES:

Until national guidelines are established, hospitals should continue using their own internal guidelines to determine the appropriate reporting of different levels of emergency department visits. All internal hospital-specific guidelines for reporting visits must meet the 11 guideline principles listed below. [CMS-1392-FC]

(**1**) The coding guidelines should follow the intent of the 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**) The coding guidelines should be based on hospital facility resources. The guidelines should not be based on physician resources.
(**3**) The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits.
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POLICY UPDATE HISTORY INFORMATION:

8 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy

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Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒		
Applicable Claim Type	**UB**	☒	**1500**	☐		

Reimbursement Policy designation of Professional or Facility application is respective to how the provider is contracted with The Plan. Provider contractual agreement terms in direct conflict with this Reimbursement Policy may supersede this Policy's direction and regional applicability.

PURPOSE:

This policy notifies facility providers that The Plan will align with the Centers for Medicare & Medicaid Services (CMS) and will recognize the Facility's policy guidelines for assigning emergency Evaluation & Management (E & M) coding if it meets the 11 guideline principles outlined on this policy.

BACKGROUND:

Since April 7, 2000, CMS instructed hospitals to report facility resources for emergency department hospital outpatient visits using the CPT E & M codes and to develop internal hospital guidelines for reporting the appropriate visit level. The ultimate goal is to create national guidelines for hospital coding of emergency department visits.

CMS has reiterated their goal to create national guidelines since CY 2000 but no national guidelines have been implemented as of CY 2018. CMS has communicated a set of principles that any national guidelines for facility visit coding should satisfy.

REIMBURSEMENT GUIDELINES:

Until national guidelines are established, hospitals should continue using their own internal guidelines to determine the appropriate reporting of different levels of emergency department visits. All internal hospital-specific guidelines for reporting visits must meet the 11 guideline principles listed below. [CMS-1392-FC]

(**1**) The coding guidelines should follow the intent of the 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**) The coding guidelines should be based on hospital facility resources. The guidelines should not be based on physician resources.

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

The Plan requires providers remain compliant with their own internal policies governing facility emergency E & M coding. The Plan may request copies of current facility E & M coding policies and use these for audit purposes.

To the extent that facilities use either customized or off the shelf computerized point systems to determine emergency department visit levels such facilities should make inquiries to understand and document system logic including any changes. This would facilitate audits including audit re-performance of calculations. Such inquiries/documentation shall remain current for audit verification purposes.

REFERENCE:

CMS-1392-FC Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates, the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates, the Hospital Inpatient Prospective Payment System and FY 2008 Payment Rates; and Payments for Graduate Medical Education for Affiliated Teaching Hospitals in Certain Emergency Situations Medicare and Medicaid Programs: Hospital Conditions of Participation; Necessary Provider Designations of Critical Access Hospitals
Federal Register / Vol. 72, No. 227 / Tuesday, November 27, 2007 / Rules and Regulations