Payment Policy: Emergency Department Facility Coding

Reference Number:
WC.KY.PP.105
WellCare of Kentucky
Date of Last Revision: 01/2023

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

Description

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:

- 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.
- be based on hospital facility resources versus physician resources.
- be clear to facilitate accurate payments and be usable for compliance purposes and audits.
- meet HIPAA requirements.
- only require documentation that is clinically necessary for patient care.
- not facilitate upcoding or gaming.
- be in writing, or recorded, well-documented and provide the basis for selection of a specific code.
- be applied consistently across patients in the clinic or emergency department to which they apply.

- not change with great frequency.
- be readily available for fiscal intermediary review.
- 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.

Policy/Criteria
WellCare Health Plans (WellCare) has collaborated with Optum and their Emergency Department Claim (EDC) Analyzer tool to implement 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 (99293/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 WellCare review a Level 3, 4 or 5 claim through Optum's EDC Analyzer tool, and the diagnoses/codes on the claim do not support the level billed, WellCare will reimburse the hospital at Level 2 (99283/G0382), Level 3 (99283/G0382) or Level 4 (99284/G0383), as appropriate; depending on its findings.

Post Pay Review
WellCare may retrospectively audit providers regarding the use of high-level ED codes. Should WellCare review a Level 3, 4 or 5 claim through Optum's EDC Analyzer tool,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 by the EDC Analyzer Tool
In its review, WellCare 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.

Website Tool for Providers

For more details visit EDCAnalyzer.com. This website provides additional detail on the editing logic when evaluating a billed claim. It also provides claim example scenarios and explains exactly how the evaluation/weighting resulted in a final payment level. The website also provides a" Try a Claim!" feature where providers may enter information from a sample claim to see how the EDC Analyzer will evaluate the specific codes billed on a claim.

Reimbursement Guidelines

The following claims will be excluded from WellCare's review of ED facility coding:

- Claims for children less than 6 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 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 2022, 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.

CPT/HCPCS Codes	Descriptor
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)

Modifier	Descriptor
Not Applicable	Not Applicable

ICD-10 Codes	Descriptor
Not Applicable	Not Applicable

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
7. *Current Procedural Terminology (CPT®)*, 2022

Revision History	
11/06/2018	Initial Policy Draft; Approved by RPPC
8/24/2022	Template revision
12/30/2022	State-specific customizations added

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.

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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.