# Payment Policy: Leveling of Emergency Room Services

Reference Number: CC.PP.053
Last Review Date: 11/2024

Coding Implications
Revision Log

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

**Policy Overview**
To address an identified trend in upcoding by emergency room providers, the health plan has adopted a program integrity strategy that will provide appropriate levels of reimbursement for services indicating lower levels of complexity or severity rendered in the emergency room.

**Application**
Hospitals, free-standing emergency centers, physicians or other qualified health professionals.

**Reimbursement**
The Centers for Medicare and Medicaid Services (CMS) affords states the flexibility to independently develop reimbursement methodologies for the use of emergency department services for lower levels of complexity or severity.

When a hospital, free-standing emergency center or physician bills a Level 4 (99284) or Level 5 (99285) emergency room service, with a diagnosis indicating a lower level of complexity or severity, the health plan will reimburse the provider at a Level 3 (99283) reimbursement rate.

**Utilization**
A coding algorithm was developed with the advice of a panel of emergency department and primary care physicians and based on an examination of a sample of almost 6,000 full emergency department records. Data from these records was used to classify each case into one of four categories. These classifications were then mapped to the discharge diagnosis of each case to determine for each diagnosis the percentage of sample cases that fell into these four categories. The health plan's claims processing system incorporates a list of diagnoses developed by medical directors and compared to the algorithm to adjudicate emergency department claims. The claims processing system looks for diagnoses that involve a lower level of complexity or intensity of services (i.e. that are never or rarely associated with Levels 4 or 5 severity).

If the diagnosis code classification falls into a categorization indicating a lower level of complexity or severity, services billed at a Level 4 or Level 5 severity code, will be reimbursed at the Level 3 emergency department reimbursement level. A provider may appeal if the provider disagrees with how the claim was adjudicated.

**Documentation Requirements**
The patient's primary discharge diagnosis should be billed in the first diagnosis position on the emergency room claim form.

**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 2024, 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 Code | Descriptor |
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| 99281 | Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional |
| 99282 | Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making |
| 99283 | Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making |
| 99284 | Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. |
| 99285 | Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making |

**References**

1. *Current Procedural Terminology (CPT®)*, 2024
2. *Centers for Medicare and Medicaid Services*, CMS Manual System and other CMS publications and services.

| Revision History | |
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| 08/10/2017 | Initial Policy Draft Created |
| 08/28/2017 | Removed “non-emergent” language and replaced with “lower level of complexity or severity.” Removed redundant PLP language in second paragraph. |
| 09/19/2017 | Removed “team of physicians and nurses” language |

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| 05/17/2018 | Removed first paragraph |
| 08/15/2018 | Re-worded for clarity |
| 09/01/2019 | Reviewed and revised |
| 09/01/2020 | Conducted annual review, updated important reminder and copyright dates, removed effective date |
| 09/01/2021 | Conducted review, updated policy dates, remove product type |
| 09/01/2022 | Conducted review, updated policy dates and copyright dates |
| 03/21/2023 | Updated CPT code descriptions (99281-99285) with current terminology |
| 08/22/2023 | Conducted review, updated policy dates and copyright dates |
| 11/14/2024 | Conducted review, updated policy dates and copyright dates |

**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.

Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**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.