Payment Policy: Leveling of Emergency Room Services

Reference Number: TX.PP.053
Product Types: ALL
Effective Date: 10/01/2017
Last Review Date:

Coding Implications
Revision Log

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

Policy Overview
To encourage providers to direct patients to more appropriate care settings, the health plan has adopted a payment strategy that will provide lower levels of reimbursement for services indicating lower levels of complexity or severity rendered in the emergency room.

The purpose of this policy is to define payment criteria for emergency room services to be used in making payment decisions and administering benefits.

Application
Physicians or other qualified health professionals.

Policy Description
The Federal Balanced Budget Act (BBA) of 1997 and the Medicaid statute has established the definition of an "Emergency Medical Condition (EMC)" as follows:

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any body organ or part.

The hospital's Emergency Medical Treatment and Labor Act (EMTALA) provides that a hospital with a dedicated emergency department must provide an appropriate medical screening examination to determine whether or not an emergency medical condition exists. The hospital must also provide stabilizing treatment or an appropriate transfer to a more appropriate setting. The purpose of the medical screening examination is to determine whether or not an emergency medical condition exists.

Prior authorization is not required for emergency medical services.

Nothing in this policy excludes the provider's responsibility to perform the medical screening examination.

Reimbursement

The Center for Medicaid and Medicare 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 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
The health plan's claims processing system will use a coding algorithm strategy to automatically adjudicate emergency department claims based on the applicable ED claim category in accordance with the diagnosis code appearing on the claim.

If the diagnosis code classification falls into a categorization indicating a lower level of complexity or severity, the claim will be paid at the Level 3 emergency department reimbursement level.

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 2016, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current 2016 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.

Emergency Department Services-New or Established Patient

CPT/HCPCS Code	Descriptor
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

CPT/HCPCS Code	Descriptor
	needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function

Definitions

Prudent Layperson – One who possesses an average knowledge of health and medicine who believes an emergency situation exists that may cause 1) serious medical harm, or: 2) serious impairment of bodily function, or: 3) serious dysfunction of any bodily organ.

References

1. *Current Procedural Terminology (CPT®)*, 2016
2. *Centers for Medicare and Medicaid Services*, CMS Manual System and other CMS publications and services.

Revision History	
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.

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.