In the event of a conflict between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. Plan documents include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents.

In the event of a conflict between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern.

Evaluation and Management of Emergency Department Coding

Policy Number: ECPCP003

Version 2.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: 05/01/2018

Effective Date: 05/30/2018

Description

This Clinical Payment and Coding Policy is intended to ensure that Emergency Department Providers (facilities and physicians or other qualified health care professionals) are reimbursed based on the code or codes that correctly describe the health care services provided. This policy applies to all health care services billed on the CMS 1500 forms and those billed on the UB04 forms. The information in this policy is to serve only as a reference resource regarding clinical payment policy for the Emergency Department Services described and is not intended to be all inclusive. Using the correct combination of code is the key to minimizing delays in claim(s) processing. Please ensure that revenue codes and procedure codes reflect the diagnoses and services rendered.

Reimbursement Information:

The patient's medical record documentation for diagnosis and treatment in the Emergency Department (ED) must indicate the presenting symptoms, diagnoses and treatment plan and a written order by the physician should be clearly documented in the medical record. **Medical records and itemized bills may be requested from the provider to support the level of care that is rendered**. Medical records will be used to determine the extent of history, extent of examination performed, complexity of medical decision making (number of diagnoses or management options, amount and/or complexity of data to be reviewed and risk of complications and/or morbidity or mortality) and services rendered. **This information will be reviewed in conjunction with the level of care billed and evaluated for appropriateness**.

If observation services are billed with any of the ER associated Evaluation and Management codes, MCG Criteria will be used to evaluate the medical necessity of these observation hours.

Coverage is subject to the terms, conditions, and limitations of an individual member's programs or products and the Clinical Payment and Coding Policy criteria listed below. The ED

provides services to patients who are there for immediate medical attention. The physician or other qualified healthcare professional level of service is determined by the following:

1. **Straight Forward Complexity (99281/G0380):**

    The presented problem(s) are self-limited or minor conditions with no medications or home treatment required.

    Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:

    1) A problem focused history;

    2) A problem focused examination; and

    3) 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 **Low Complexity (99282/G0381):**

    The presented problem(s) are of low to moderate severity. Over the counter (OTC) medications or treatment, simple dressing changes; patient demonstrates understanding quickly and easily. Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:

    1) An expanded problem focused history;

    2) An expanded problem focused examination; and

    3) 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.

2. **Moderate Complexity (99283/G0382):**

    The presented problem(s) are of moderate severity. Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:

    1) An expanded problem focused history;

    2) An expanded problem focused examination; and

    3) 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.

3. **Moderate-High Complexity (99284/G0383):**

    Usually, the presented problem(s) are of high severity, and *require urgent evaluation* by the physician but do not pose an immediate significant threat to life or physiologic function.

Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:

1) A detailed history;

2) A detailed examination; and

3) 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.

4. **High Complexity (99285/G0384):**

The presented problem(s) are of high severity and pose an *immediate significant threat* to life or physiologic function. 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:

1) A comprehensive history;

2) A comprehensive examination; and

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

5. Physician direction of Emergency Medical Systems (EMS) emergency care, advanced life support**. (99288)**

6. **Critical Care (99291)**

The assignment of the Critical Care code 99291 likewise follows the same instructions applicable to the six E&M codes listed above. There is a 30-minute time requirement for facility billing of critical care.

1) The administration and monitoring of IV vasoactive medications (such as adenosine, dopamine, labetalol, metoprolol, nitroglycerin, norepinephrine, sodium nitroprusside, etc.) is indicative of critical care.

Instructions for ED Facility CPT ® Coding/HCPCS

The following table has three columns in the guidelines. The far-left column indicates the facility codes and corresponding APC (Ambulatory Payment Classification) levels which are justified by the "Possible Interventions" listed in the middle column. The far-right column labeled "Potential Symptoms/Examples which Support the Interventions" is simply used as an aid to the coder in determining which interventions most likely correspond with a given facility code/APC level. This far right column of "Potential Symptoms/Examples" is not used to determine the appropriate facility code/APC level. The determination of the appropriate facility code/APC level is based

solely on the "Possible Interventions" listed in the middle column. The "Possible Interventions" refer to interventions on the part of the nursing and ancillary staff in the Emergency Department and not to interventions by the emergency physicians. "Possible Interventions" includes some procedure examples which might be billed separately by the facility. The procedures listed serve as a proxy, qualifying the typical intensity of facility services provided for patients requiring them. Such procedure examples are not intended to substitute for or duplicate labor, time or supplies included in separately billable procedures. Levels of "Discharge Instructions" are defined in the last section of these guidelines.

The appropriate facility code/APC level is determined by the interventions (of nursing and ancillary ED staff) as listed in the middle column marked "Possible Interventions". If a given "Possible Intervention" is listed in a section assigned to a specific facility code level, and if no other interventions are provided that fall into a higher facility code level, then the facility code level corresponding to that specific "Possible Intervention" is selected as the appropriate "facility code/APC level". Within a given facility code/APC level, there may be multiple "Possible Interventions" provided, all of which fall into the same facility code/APC level. Whether there is a single "Possible Intervention" or multiple "Possible Interventions"-all of which fall into the same facility code/APC level-the appropriate facility code/APC level to be assigned remains the same. In other words, whether only a single "Possible Intervention" listed at a given facility code level is present or if multiple or all "Possible Interventions" assigned to that facility code level are present-the facility code/APC level is still the same.

In the "Possible Interventions" column, the first sentence states, "Could include interventions from previous (lower) levels, plus any of:" This simply means, for example, that if the highest facility code/APC level achieved by any "Possible Intervention" is a facility code 99283 and APC level 614, then the appropriate facility code to assign is a 99283. The presence of "Possible Interventions" from levels 99281 and/or 99282 in addition to the "Possible Intervention" listed in the 99283 section has no effect on the facility code level assigned. **The facility code level assigned is always the highest level at which a minimum of one "Possible Intervention" is found.**

	Facility Charge Assignment	
Level	**Possible Interventions[1]**	**Potential Symptoms/ Examples which support the Interventions**
I **CPT®** **99281** Type A: APC 609 Type B: APC 626 HCPCS: G0380	Initial Assessment No medication or treatments Rx refill only, asymptomatic Note for Work or School Wound recheck Booster or follow up immunization, no acute injury Dressing changes (uncomplicated) Suture removal (uncomplicated) Discussion of Discharge Instructions (Straightforward)	Insect bite (uncomplicated) Read Tb test
II **CPT®** **99282** Type A: APC 613 Type B: APC 627 HCPCS: G0381	Could include interventions from previous levels, plus any of: Tests by ED Staff (Urine dip, stool hemoccult, Accucheck or Dextrostix) Visual Acuity (Snellen) Obtain clean catch urine Apply ace wrap or sling Prep or assist w/ procedures such as: minor laceration repair, I&D of simple abscess, etc. Discussion of Discharge Instructions (Simple)	Localized skin rash, lesion, sunburn Minor viral infection Eye discharge- painless Ear Pain Urinary frequency without fever Simple trauma (with no X-rays)
III **CPT®** **99283** Type A: APC 614 Type B: APC 628 HCPCS: G0382	Could include interventions from previous levels, plus any of: Receipt of EMS/Ambulance patient Heparin/saline lock (1) Nebulizer treatment Preparation for lab tests described in CPT® (80048-87999 codes)Preparation for EKG Preparation for plain X-rays of only 1 area (hand, shoulder, pelvis, etc.) Prescription medications administered PO Foley catheters; In & Out caths C-Spine precautions Fluorescein stain Emesis/ Incontinence care Prep or assist w/procedures such as: joint aspiration/injection, simple fracture care etc.	Minor trauma (with potential complicating factors) Medical conditions requiring prescription drug management Fever which responds to antipyretics Headache - Hx of, no serial exam Head injury- without neurologic symptoms Eye pain Mild dyspnea -not requiring oxygen

	Mental Health-anxious, simple treatment Routine psych medical clearance Limited social worker intervention Post mortem care Direct Admit via ED Discussion of Discharge Instructions (Moderate Complexity)	
IV **CPT ®** **99284** Type A: APC 615 Type B: APC 629 HCPCS: G0383	Could include interventions from previous levels, plus any of: Preparation for 2 diagnostic tests: (Labs, EKG, X-ray) Prep for plain X-ray (multiple body areas): C-spine & foot, shoulder & pelvis Prep for special imaging study (CT, MRI, Ultrasound, VQ scans) Cardiac Monitoring (2) Nebulizer treatments Port-a-cath venous access Administration and Monitoring of infusions or parenteral medications (IV, IM, IO, SC) NG/PEG Tube Placement/Replacement Multiple reassessments Prep or assist w/procedures such as: eye irrigation with Morgan lens, bladder irrigation with 3-way foley, pelvic exam, etc. Sexual Assault Exam w/ out specimen collection Psychotic patient; not suicidal Discussion of Discharge Instructions (Complex)	Blunt/ penetrating trauma- with limited diagnostic testing Headache with nausea/ vomiting Dehydration requiring treatment Vomiting requiring treatment Dyspnea requiring oxygen Respiratory illness relieved with (2) nebulizer treatments Chest Pain--with limited diagnostic testing Abdominal Pain - with limited diagnostic testing Non-menstrual vaginal bleeding Neurologic symptoms - with limited diagnostic testing
V **CPT ®** **99285** Type A: APC 616 Type B: APC 630 HCPCS: G0384	Could include interventions from previous levels, plus any of: Requires frequent monitoring of multiple vital signs (i.e. 0_2 sat, BP, cardiac rhythm, respiratory rate) Preparation for ≥ 3 diagnostic tests: (Labs, EKG, X-ray) Prep for special imaging study (CT, MRI, Ultrasound, VQ scan) combined with multiple tests or parenteral medication or oral or IV contrast. Administration of Blood Transfusion/Blood Products Oxygen via face mask or NRB Multiple Nebulizer Treatments: (3) or more (if nebulizer is continuous, each 20 minute period is considered treatment) Moderate Sedation Prep or assist with procedures such as: central line insertion, gastric lavage, LP, paracentesis, etc.	Blunt/ penetrating trauma requiring multiple diagnostic tests Systemic multi-system medical emergency requiring multiple diagnostics Severe infections requiring IV/IM antibiotics Uncontrolled DM Severe burns Hypothermia New-onset altered mental status

	Cooling or heating blanket Extended Social Worker intervention Sexual Assault Exam w/ specimen collection by ED staff Coordination of hospital admission/ transfer or change in living situation or site Physical/Chemical Restraints; Suicide Watch Critical Care less than 30 minutes	Headache (severe): CT and/or LP Chest Pain--multiple diagnostic tests/treatments Respiratory illness-- relieved by (3) or more nebulizer treatments Abdominal Pain-- multiple diagnostic tests/treatments Major musculoskeletal injury Acute peripheral vascular compromise of extremities Neurologic symptoms - multiple diagnostic tests/treatments Toxic ingestions Mental health problem - suicidal/ homicidal

Critical Care

Critical Care can be coded based upon either the provision of any of the listed possible interventions or by satisfying the Critical Care definition. A minimum of 30 minutes of care must be provided. Critical Care involves decision-making of high complexity to assess, manipulate, and support impairments of "one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition." This includes, but is not limited to, "the treatment or prevention of further deterioration of central nervous system failure, shock-like conditions, renal, hepatic, metabolic or respiratory failure, post-operative complications or overwhelming infection." Under OPPS, the time that can be reported as Critical Care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient. If the physician and hospital staff or multiple hospital staff members are simultaneously engaged in this active face-to-face care, the time involved can only be counted once.

	Possible Interventions	**Potential Symptoms/Examples which support the Interventions**
CPT® 99291 **Type A: APC 617**	Could include interventions from previous levels, plus any or all of: Multiple parenteral medications requiring constant monitoring Provision of any of the following: Major Trauma care/ multiple surgical consultants	Multiple Trauma; Head Injury with loss of consciousness Burns threatening to life or limb Coma of all etiologies

	Chest tube insertion Major burn care Treatment of active chest pain in ACS Administration of IV vasoactive meds (see guidelines) CPR Defibrillation/ Cardioversion Pericardiocentesis Administration of ACLS Drugs in cardiac arrest Therapeutic hypothermia Bi-PAP/ CPAP Endotracheal intubation Cricothyrotomy Ventilator management Arterial line placement Control of major hemorrhage Pacemaker insertion through a Central Line Delivery of baby	(except hypoglycemic) Shock of all types: septic, cardiogenic, spinal, hypovolemic, anaphylactic Drug Overdose impairing vital functions Life-threatening hyper/ hypo-thermia Thyroid Storm or Addisonian Crisis Cerebral hemorrhage of any type New-onset paralysis Non-hemorrhagic strokes with vital function impairment Status epilepticus Acute Myocardial Infarction Cardiac Arrhythmia requiring emergency treatment Aortic Dissection Cardiac Tamponade Aneurysm; thoracic or abdominal -- leaking or ruptured Tension Pneumothorax Acute respiratory failure, pulmonary edema, status asthmaticus Pulmonary Embolus Embolus of fat or amniotic fluid Acute renal failure Acute hepatic failure Diabetic Ketoacidosis Lactic Acidosis DIC or other bleeding diatheses - hemophilia, ITP, TTP, leukemia, aplastic anemia Major Envenomation by poisonous reptiles

CPT® 99292	As above in additional 30 minute increments. Record the TOTAL critical care time. The first 30-74 minutes equal code 99291. If used, additional 30 minute increments (beyond the first 74 minutes) are coded 99292. Medicare does not pay for code 99292 because it is considered packaged into 99291; however, the services should be reported as appropriate.
Critical Care with Trauma Team Activation **APC 618** **G0390**	In addition to 99291, designated trauma centers may report the Trauma Team Activation code G0390 when a trauma team was activated and all other trauma activation criteria are met.

References:

https://www.cms.gov/Medicare/Coding/ICD10/

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

https://www.acep.org/content.aspx?id=30428

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Clinical Payment and Coding Policy: 001 Observation Services Tool for App MCG Criteria

Policy Update History:

Date	Description
6/22/2017	New policy
	Annual Review-

In the event of conflict the American Medical Associations provides information on Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS) and International Statistical Classification of Disease and Related Health Problems (ICD) defining code definitions and guidelines.

In the event of conflict regarding information submitted per claim forms, refer to user guides located on plan websites.

In the event of conflict regarding documentation requirements for services rendered refer to your provider manual - Quality Improvement Program/Principles of Documentation**.**