BlueCross BlueShield of New Mexico

Reimbursement Policy

Policy Number: RP003

Policy Title: Emergency Department Services Evaluation and Management (E/M) Coding – Facility Services

Approval Date: Oct. 26, 2026

Effective Date: Nov. 6, 2026

Policy Disclaimer

If a conflict arises between a Reimbursement Policy and any Plan document under which a member is entitled to covered services, the Plan document will govern. If a conflict arises between a reimbursement 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's contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, Benefit Booklets, Summary Plan Descriptions and other coverage documents. Blue Cross and Blue Shield of New Mexico may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSNM has full and final discretionary authority for their interpretation and application to the extent provided under any applicable Plan documents.

Providers are responsible for submitting 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 approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology (CPT®) Assistant, Healthcare Common Procedure Coding System, ICD-10-CM and ICD-10-PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare & Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services and procedures billed. Claim submissions are subject to claim review, including but not limited to, any terms of benefit coverage, provider contract language, medical policies and reimbursement policies, as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Description

This policy is intended to provide information for Emergency Departments (or ED) in facility settings that bill for services rendered using the Centers for Medicare and Medicaid Services (CMS) 1500 and/or UB04 forms. Appropriate coding should be submitted that correctly describes the health care services rendered. The information in this policy pertains to ED Services described and is not intended to be all inclusive. In addition, this policy applies to In-network and out of network facilities submitting ED claims (Place of Service (POS) - 23).

Claim submissions coded with the correct combination of procedure code(s) is critical to minimizing potential delays in claim(s) processing. ICD-10 CM diagnosis codes billed should reflect the issues addressed during the ED encounter. Claim submissions must contain revenue codes that reflect the services rendered. A revenue code and corresponding Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) code must be compatible.

CMS Coding Principles - CMS has indicated coding principles applicable to ED services are to include coding guidelines that should be based on facility resources.

Reimbursement Information

The Plan reserves the right to request supporting documentation. Failure to adhere to coding and billing policies may impact claims processing and reimbursement.

The member's medical record documentation for the diagnosis and treatment of services rendered in the ED must indicate the presenting symptoms, diagnoses, treatment plan, and a written order by the provider. All contents of medical records should be clearly documented. Medical records and itemized bills may be requested from the facility/provider for review to validate the site of service, level of care, and that the services billed were accurately reported.

Services provided while a member is in observation status do not apply to the determination of the E/M facility code, except as noted below or per provider contract.

Emergency Department Facility Level of Care

The chart below is a guideline for appropriate facility ED billing for each defined level of care.

The *CPT/HCPCS Code* (level of care) column corresponds to the *Possible Services Rendered* column.

The appropriate facility level of care is determined by the services rendered. A review of

services may be conducted in accordance with the member's benefits using standard medical guidelines as outlined in the chart below. A facility level of care may encompass multiple possible services rendered and may not be limited to one service outlined in the chart below.

At least one service under the *Possible Services Rendered* column must be documented in the member's medical record to satisfy reimbursement requirements for the CPT or HCPCS billed for the facility level of care code.

CPT/HCPCS CODE	POSSIBLE SERVICES RENDERED - ED Services
99281 Emergency dept. visit, Minor or self-limiting complaint **G0380** Level 1 hospital ED visit provided in a type B ED	• Initial Assessment • No care rendered by provider • Medication refill • Work or school excuse • Wound recheck- simple • Booster or follow up immunization only • Wound dressing changes (uncomplicated) • Suture removal (uncomplicated)
99282 Emergency dept. visit **G0381** Level 2 hospital ED visit provided in a type B ED	• Point of Care testing by ED Staff (Urine dipstick, stool occult blood, glucose) • Visual acuity exam • Collection of specimens by lab • Cast removal by ED staff • Repair of wound with skin adhesive • Non-prescription medication administered • Prep or assist with procedures such as simple/minor laceration repair, incision & drainage of simple abscess, etc.
99283 Emergency dept. visit **G0382** Level 3 hospital ED visit provided in a type B ED	• Receipt of Emergency Medical Services/ambulance patient (member) • Heparin/saline lock – no parenteral medications or fluids • One nebulizer treatment • Preparation for lab tests described in CPT (80048-87999 codes) • Preparation for plain X-rays of 1 or 2 more body areas (not above/below joint of same limb) • Prescription medications non-parenteral • Foley catheter placement; In & out catheterization

	• C-spine precautions – cervical stabilization device present • Corneal exam with dye • Epistaxis with packing • Oxygen therapy • Emesis/incontinence care • Prep or assist with procedures such as joint aspiration/injection, simple fracture care, intermediate/complex laceration repair, etc. • Mental health anxiety with simple treatment • Routine psychiatric medical clearance • Post-mortem care • Direct admit via ED • Discharged w/prescription medication
99284 Emergency dept. visit **G0383** Level 4 hospital ED visit provided in a type B ED	• Prep for one special imaging study (Computed Tomography (CT) scan, Magnetic Resonance Imaging, Ultrasound, Ventilation-Perfusion (V/Q) scans) • Two nebulizer treatments • Port-a-cath venous access • Administration and monitoring of parenteral medications (IV, IM, IO, SC) (not injection of local anesthesia or immunization boosters) • Nasogastric tube/Percutaneous Endoscopic Gastrostomy tube placement/replacement or multiple reassessments of the NG/PEG tube placed • Prep or assist with procedures such as eye irrigation with Morgan lens, bladder irrigation with 3-way Foley, pelvic exam (no forensic collection), etc. • Sexual assault exam without specimen collection • Psychotic patient (member); not suicidal • EKG
99285 Emergency dept. visit **G0384** Level 5 hospital ED visit provided in a type B ED	• More than one special imaging study (CT, MRI, Ultrasound, VQ scans) combined with multiple tests or parenteral medication • Administration of blood transfusion/blood products • Oxygen via face mask or non-rebreather mask • Multiple nebulizer treatments: three or more

	(if the nebulizer is continuous, each 20-minute period is considered treatment) • Procedural sedation • Prep or assist with procedures such as central line insertion, gastric lavage, lumbar puncture, paracentesis, etc. • Temperature instability requiring intervention • Use of specialized resources – social services, police, crisis management • Sexual assault exam with forensic specimen collection by ED staff • Coordination of hospital admission/transfer for higher level of care. The continuation of ED services while in observation status is not considered a higher level of care. • Physical/chemical restraints • Need for 1:1 sitter • Intensive Care Unit (ICU) admission not otherwise meeting critical care criteria • Serial cardiac studies (EKG and/or cardiac enzymes) whether or not performed while member in observation status

CPT CODE	POSSIBLE SERVICES RENDERED - Critical Care Services

99291[1]
Critical care, first hour
First 30-74 minutes
	• Parenteral medications requiring continuous vital sign monitoring
	• Provision of any of the following:
	  • Major trauma care/multiple surgical consultants
	  • Chest tube insertion
	  • Major burn care
	  • Treatment of active chest pain in acute coronary syndrome
	  • Cardiopulmonary resuscitation
	  • Defibrillation/cardioversion
	  • Pericardiocentesis
	  • Administration of advanced cardiovascular life support drugs in cardiac arrest
	  • Therapeutic hypothermia
	  • Non-invasive ventilation
	  • Endotracheal intubation

	• Emergent airway intervention • Ventilator management • Line placement for monitoring • Major hemorrhage • Pacing (including external) • Delivery of baby [1] For *Critical Care First Hour* (99291), the administration and monitoring of IV vasoactive medications (such as adenosine, dopamine, labetalol, metoprolol, nitroglycerin, norepinephrine, sodium nitroprusside, continuous infusion (drips), etc.) are indicative of critical care.
99292 Critical care additional 30 min	Critical care, evaluation and management of the critically ill or critically injured member; List separately in addition to code for primary service.

[1]Critical care services may only be billed with CPT codes 99291-99292.

The Plan requires outpatient facility providers to indicate the most appropriate HCPCS and/or CPT code(s) in addition to revenue codes, when required, such as, 0450, 0451, 0452, 0456 and 0459 for electronic outpatient facility claims unless otherwise specified in the provider contract. Claims may be denied if a corresponding HCPCS or CPT code is not submitted with the appropriate revenue code. These codes should be submitted on the same line for accurate claims processing. If more than one HCPCS or CPT code is needed for a revenue code, the revenue code should also appear on a separate line.

Additional Resources

Reimbursement Policy (formerly known as Clinical Payment and Coding Policy)

RP001 Observation Services Policy

RP018 Revenue Codes Requiring Supporting CPT, HCPCS and/or NDC Codes - Outpatient Facility Claims

RP031 Trauma Activation - Facility

References

Department of Health and Human Services Centers for Medicare & Medicaid Services, Evaluation and Management Services Guide. Accessed May 14, 2026:

CPT copyright 2025 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

Centers for Medicare & Medicaid Services (2026). Healthcare Common Procedure Coding System (HCPCS). Accessed Oct. 1, 2026.

Optum. Copyright 2026. Uniform Billing Editor. Optuminsight. Revenue Code 0450-0452. 0456, and 0459

Policy History

Approval Date	Description
05/01/2018	New Policy
11/15/2018	Policy coding and MCG updates
10/04/2019	Policy revision, removal of professional piece.
11/06/2020	Annual Review, Disclaimer update, Verbiage update
12/01/2021	Annual Review
01/30/2023	Annual Review
07/20/2023	Verbiage update
07/22/2024	Annual Review
09/26/2025	Annual Review; Grammatical and formatting updates; Additional Resources updated; References updated; Policy Update History updated.
10/26/2026	Annual Review; Additional Resources and Reference added.