UnitedHealthcare Community Plan

REIMBURSEMENT POLICY
UB-04
Policy Number 2020R6003A

Emergency Department (ED) Facility Evaluation and Management (E&M) Coding Policy, Facility

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

This reimbursement policy applies to services reported using the UB-04 claim form or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network facility emergency departments (including hospital emergency departments) and free-standing emergency departments (UB Claims).

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Policy

Overview

This policy describes how UnitedHealthcare Community Plan reimburses UB claims billed with Evaluation and Management (E/M) codes Level 4 (99284/G0383) and Level 5 (99285/G0384) for services rendered in an emergency

department. This policy is based on coding principles established by the Centers for Medicare and Medicaid Services (CMS)[1], and the CPT and HCPCS code descriptions from the American Medical Association[3].

CMS Coding Principles
CMS indicates facilities should bill appropriately and differentially for outpatient visits, including emergency department visits. To that end, CMS coding principles[1] applicable to emergency department services provide that facility coding guidelines should: follow the intent of the 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 and not based on physician resources; and not facilitate upcoding or gaming.[1]

Reimbursement Guidelines

UB-04 Claims for services rendered in an emergency department should be complete and include all diagnostic services and diagnosis codes relevant to the emergency department visit and be billed at the appropriate E/M level

UnitedHealthcare Community Plan will utilize the Optum Emergency Department Claim (EDC) Analyzer to determine the emergency department E/M level to be reimbursed for certain facility claims. The EDC Analyzer applies an algorithm that takes three factors into account in order to determine a Calculated Visit Level for the emergency department E/M services rendered. The three factors used in the calculation are as follows:

- Presenting problems – as defined by the ICD-10 reason for visit (RFV) diagnosis;
- Diagnostic services performed – based on intensity of the diagnostic workup as measured by the diagnostic CPT codes submitted on the claim (i.e. Lab, X-ray, EKG/RT/Other Diagnostic, CT/MRI/Ultrasound); and
- Patient complexity and co-morbidity – based on complicating conditions or circumstances as defined by the ICD-10 principal, secondary, and external cause of injury diagnosis codes.

Facilities may experience adjustments to the level 4 or 5 E/M codes submitted to reflect a lower E/M code calculated by the EDC Analyzer or may receive a denial for the code level submitted. For certain facilities who experience adjustments to a level 4 or 5 E/M code, we may estimate reimbursement for the adjusted code based on historical claims experience, and in such event the facility may resubmit an adjusted claim which we will adjudicate based on the new charges submitted in accordance with this policy.

Criteria that may exclude Facility claims from being subject to an adjustment or denial include:

- The patient is admitted to inpatient, observation, or has an outpatient surgery during the course of the same ED visit;
- Critical care patients (99291, 99292);
- The patient is less than 2 years old;
- Claims with certain diagnosis that when treated in the ED most often necessitate greater than average resource usage, such as significant nursing time;
- Patients who have expired in the emergency department; or
- Claims from facilities who's billing of level 4 and 5 E/M codes does not disparately deviate from the EDC Analyzer.

UnitedHealthcare Community Plan and Optum are related companies through common ownership by UnitedHealth Group. For additional information on the EDC Analyzer, visit EDCAnalyzer.com.

Questions and Answers	
1	**Q:** What steps can a facility take if they disagree with reimbursement at a lower E/M code level instead of the submitted E/M code level 4 or 5? **A:** The facility may follow the UnitedHealthcare Community Plan standard reconsideration and appeals processes for administrative claims determinations as outlined in the administrative guide. For example, if the facility did not

	include all of the relevant and applicable diagnosis codes on its claim, then it could use such processes to resubmit the claim with an appropriate diagnosis code which may support the level of E/M code originally submitted.
2	**Q:** Is the policy applicable to all emergency departments? **A:** Yes, this policy is applicable to all emergency departments (whether facility-based, free standing or otherwise). However, a facility may not experience claim denials if its billing of level 4 and 5 E/M codes does not disparately deviate from the EDC Analyzer or it submits claims that otherwise meet one of the criteria for exclusions listed in the policy.
3	**Q:** Is there additional information available regarding the Emergency Department Claim (EDC) Analyzer? **A:** Yes, additional information can be found at the following link: edcanalyzer.com

Codes

CPT code section - "CPT copyright 2020 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association."

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 needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)
G0383	Level 4 hospital emergency department visit provided in a type B emergency department
G0384	Level 5 hospital emergency department visit provided in a type B emergency department

Resources

1. 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 http://www.gpo.gov/fdsys/pkg/FR-2007-11-27/html/07-5507.htm
2. Individual state Medicaid regulations, manuals & fee schedules
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) publications

History	
3/23/2020	Policy Year and Version Change Removed old title section, added policy number to header Footer section: Updated copyright year from “2018” to “2020” State exception section: Removed reference to Louisiana History section: Removed all files and references to Louisiana contained in the body of the policy, information has been moved to the “Louisiana Only” policy
11/7/2019	Added policy exception for Louisiana
9/01/2018	Reimbursement Guidelines Section: Process changed to reflect facilities may experience adjustments to level 4 or 5 E/M codes instead of denials.
6/01/2018	Policy implemented by UnitedHealthcare Community & State
8/25/2017	Policy approved by the Reimbursement Policy Oversight Committee