Emergency Department Facility Evaluation and Management Services

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Important Note About This Policy

Oscar's reimbursement policies serve as a guide to assist providers with accurate claims submission and outline the basis for reimbursement if the service is a covered benefit. Coverage does not guarantee reimbursement; services must meet authorization and medical necessity guidelines for the procedure, diagnosis, and member's state of residence.

Our policies provide general reference for described services and do not cover every aspect of reimbursement. Other factors may supplement, modify, or supersede this policy, including legislative mandates, provider contracts, member benefit documents, and/or other reimbursement, medical, or drug policies. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

Providers are responsible for submission of accurate documentation of services performed. 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 PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Oscar routinely updates reimbursement policies, and new versions are published on this website. If you print a copy of this policy, please be aware that the policy may be updated later. Oscar communicates policy updates to providers via update notifications.

Description

The Centers for Medicare and Medicaid Services (CMS) defines coding principles applicable to emergency department services. These guidelines base the level of service on facility resources used. CMS indicates facilities should bill appropriately and differentially for outpatient visits, including emergency department visits. To that end, CMS coding principles 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 up-coding or gaming.

Policy

This policy describes how Oscar reimburses facility claims (UB04) billed with Evaluation and Management (E/M) codes level 4 (99284) and level 5 (99285) for services rendered in an emergency department. This policy is based on coding principles established by CMS, and the CPT and HCPCS code descriptions and is applicable to in-network and out-of-network providers

Facilities are entitled to submit CPT® E/M codes on a UB form in addition to the E/M's submitted by the emergency department physician. Facility resource consumption drives the eligible E/M level submitted whereas physician resources drive the physician emergency department E/M level as outlined by CPT®. An applied algorithm that accounts for diagnoses submitted as well as facility services ordered and performed determines the likely appropriate level of the facility E/M reimbursement. Given the inherent variability and complexity relating to the higher level E/M codes (99284 and 99285) the algorithm will verify whether the higher level

codes are accurately reflecting the complexity of the visit and if not, the emergency department E/M reimbursement will reflect the algorithm output. Since the focus is on purely the level 4 and 5 codes, coding recommendations will only focus on a reduction in code levels. This will result in:

1. Fair and appropriate facility reimbursement for emergency department services rendered
2. Reduction in facility up coding and corresponding overpayment.

Reimbursement Guidelines

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.

Oscar will utilize the Optum Emergency Department Claim (EDC) Analyzer™ tool to determine the emergency department level to be reimbursed for certain facility claims. There are several factors taken into account to determine the calculated visit E/M coding levels.

- 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 submitting claims for emergency department E/M codes may experience adjustments to level 4 or 5 E/M codes to reflect an appropriate level E/M code or may receive a denial, based on the reimbursement structure within their contracts. Facilities may submit reconsideration or appeal requests if they believe a higher-level E/M code is justified, in accordance with the terms of their contract.

Ultimately, the mutual goal of facility coding is to accurately capture emergency department resource utilization and align that with the E/M CPT® code description for a patient visit per CMS guidance.

To learn more about the EDC Analyzer™, please see the Emergency Department Claim Analyzer Guide.

Frequently Asked Questions

Q: Are facilities required to bill the same CPT code as the physician for an emergency department visit encounter?
A: No. While the intent of the CPT visit code should be followed by both facility and physician, facility resource utilization may cause the facility E/M level to be appropriately higher or lower than the physician level.

Q: What should facilities do to ensure fair and appropriate reimbursement on submitted emergency department E/M codes?
A: UB Claims for services rendered in an emergency department should include all diagnosis and procedure codes relevant to the emergency department visit and be billed at the appropriate E/M level.

Q: Are submitted facility E/M codes recorded by the payer to the level designated by the algorithm?
A: No. The E/M code submitted by the facility is accepted as is. Payment, however, is based on the E&M level aligned with resource utilization as determined by the applied algorithm.

Q: Is the algorithm applied to facility E/M codes submitted for those admitted to the inpatient facility from the emergency department?
A: No. The algorithm is only applied to patients who are discharged from the emergency department.

Q: Are facility emergency department critical care codes subject to the algorithm that determines the level of emergency department resource utilization?
A: No. Critical care CPT codes submitted for services rendered to patients who are discharged from the emergency department are not subject to the algorithm methodology.

Q: Does this methodology apply to all emergency departments or only select emergency departments determined by the payer?
A: The methodology applies to all participating and non-participating emergency departments who treat eligible members.

Q: Does the application of the algorithm only result in lower facility payments for submitted emergency department E/M CPT codes?
A: Yes. Since the algorithm is focusing on resource utilization relating to the highest level E/M codes (99284 and 99285), the resulting payment level may be the same or less than the allowed amount for the submitted facility emergency department E/M code.

Related Policies

Evaluation and Management Services

References

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. American Medical Association (AMA), Current Procedural Terminology (CPT®) and associated publications and services
3. Centers for Medicare and Medicaid Services (CMS), CMS Manual System and other CMS publications and services
4. CMS, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
5. CMS, National Correct Coding Initiative (NCCI) Policy Publications
6. EDC Analyzer™ Definitions Manual
7. American College of Emergency Physicians ED Facility Level Coding Guidelines

Publication History

Date	Action/Description
01/12/2026	Original Documentation based on information already contained within Oscar's Evaluation an Management Services Reimbursement Policy.