Payment Policy: Leveling of Care: Emergency Department Evaluation and Management Overcoding for Professional Services

Reference Number: CC.PP.076
Last Review Date: 04/2025

Coding Implications
Revision Log

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

Policy Overview
Physician medical records should chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient's health history. Documentation should support the medical necessity and appropriateness of the diagnosis and/or therapeutic service(s) provided. General principles of Evaluation and Management (E&M) documentation established by the Centers for Medicare and Medicaid Services (CMS) dictate that providers report diagnosis and treatment codes on the claim form that are consistent with the documentation in the medical record.

Providers should report E&M services as defined by the American Medical Association's (AMA) Current Procedural Terminology (CPT®) documentation criteria and CMS guidelines for reporting those services. There are **three key components** providers must consider when selecting the appropriate level of E&M service provided: history taking, physical examination and medical decision making. Providers should consider the extent of the pertinent history obtained from the patient, the extent of the pertinent examination performed, and the complexity of medical decision-making. When selecting the appropriate level of E&M service, all the key components must **meet or exceed** the stated requirements to qualify for a particular level of E&M service (i.e., office, new patient, inpatient hospital care, office consultations, emergency department services, etc.).

The purpose of this policy is to ensure that the level of E&M service reported by the provider for emergency department (ED) E&M services reflects the level of services performed. When a professional provider submits an ED level of service that exceeds the maximum level of ED E&M service based on the diagnosis and other claim documentation elements, the ED E&M CPT code is reduced to reflect the maximum level of ED service performed.

Application

- Physicians and other qualified health care professionals who provide face-to-face services and report evaluation and management emergency department services reported by a specific CPT® code(s).
- This policy ***does not apply*** edits to facility claims.

Reimbursement
The health plan will implement an automated, pre-payment (after services are rendered, but prior to claims payment) ***claims*** review process to identify professional ED claims that require additional clinical validation.

The prepayment coding algorithm will evaluate each diagnosis code billed in the claim header, along with high-level ED procedure codes (99284 and 99285) at the service line level to select claims for further clinical validation.

Coding validation will include, but is not limited to, the current claim information for the member, member claim history, information on the corresponding facility claim that may identify resources used as part of the ED visit (labs, radiology, pharmaceuticals provided, radiology services) and specialty provider interpretation of diagnostic services performed. Consequently, if the E&M service reported is identified as a higher-level procedure code than what might be expected, the provider reimbursement will be adjusted to reflect the appropriate level of ED E&M service.

The minimum level of service that an E&M code might be reduced to from this claims review is level three (99283) for emergency room services.

ED E&M services will not be denied because of this policy; However, services will be reviewed and may be reduced based on the level of service performed.

Coding and Modifier Information

ED Codes Reviewed on Claims

CPT/HCPCS Code	Descriptor
99284	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
99285	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making

Lowest-level codes which may be recommended for the ED service billed

CPT/HCPCS Code	Descriptor
99283	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making

99284	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making

Modifier	Descriptor
NA	NA

ICD-10 Codes	Descriptor
NA	NA

Definitions:

Evaluation and Management Services
A medical coding process to support medical billing. Health care providers use E&M codes to be reimbursed by Medicare, Medicaid and commercial insurers. These codes describe patient encounters with physicians or other qualified health care professionals and recognize seven components of the patient/physician encounter 1) history; 2) examination; 3) medical decision-making; 4) counseling; 5) coordination of care; 6) nature of presenting problem; and 7) time. E&M standards and guidelines were established by Congress in 1995 and revised in 1997. E&M codes are based on the CPT codes established by the AMA..

Overcoding
Billing procedure codes at a higher level than what is warranted by the clinical documentation.

References
1. *Current Procedural Terminology (CPT®)*, 2025
2. *Centers for Medicare and Medicaid Services,* CMS Manual System and other CMS publications and services.

Revision History	
02/21/2025	Initial Policy Draft
04/22/2025	Updated language in Policy Overview and removed "hospital observation services", added language under Reimbursement regarding coding validation.

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.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.