If a conflict arises 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. If a conflict arises between a CPCP 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. "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 IL may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. Blue Cross and Blue Shield of IL has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of 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 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.

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

Emergency Department Services Evaluation and Management - E/M Coding - Professional Services

Policy Number: CPCP042

Version 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: September 24, 2024

Plan Effective Date: September 24, 2024

Description

This policy applies to professional providers (physicians or other qualified health care professionals) who bill for Emergency Department Evaluation and Management services on CMS 1500 forms. The information in this policy serves as a reference resource for the E/M services described and is not intended to be all inclusive. Claims may be subject to review before payment can be made.

Professional claims submissions should contain the appropriate CPT, HCPCS, NDC codes and all applicable ICD diagnosis codes. The code(s) reported by providers should best represent the services provided based on the AMA and CMS documentation guidelines. Accurate coding translates clinical documentation into uniform diagnostic and procedural data sets and provides the details of the services reported and rendered to the member. Each E/M service provided should be carefully documented. Failure to adhere to coding and billing policies may impact claims processing and reimbursement.

E/M services are visits performed by physicians and other qualified healthcare professionals to assess and manage a patient's health.

Reimbursement Information

The member's medical record documentation of services rendered by the provider must indicate the chief complaint, diagnoses and treatment plan, all tests and imaging, and all written-orders by the provider. All contents of medical records should be clearly documented and signed, including clinical notes, consultation notes, lab testing, pathology testing and radiology testing.

Medical records and itemized bills may be submitted by the provider to validate the site of service, level of care rendered, and services billed were accurately reported. Claim submissions may be reviewed to determine the level of medical decision making/MDM and services that were rendered. This information, in conjunction with the level of services billed for the level of care rendered, may be reviewed, and evaluated to determine if the level of service was appropriately billed.

Professional- Levels of Emergency Department E/M Services

The Emergency Department's E/M level is determined by MDM. Time is not a descriptive component for the emergency department levels of E/M services. The E/M Emergency Department visit CPT codes are inclusive of medically appropriate history and/or physical examination when performed. The policy does not require documentation of the extent of history, or the extent of examination performed components for eligible reimbursement. There are four levels of MDM: straightforward, low, moderate, and high. MDM is measured by three separate elements as defined within this policy. To qualify for a specific type of MDM, 2 of the 3 elements must either be met or exceeded.

Type of Medical Decision Making:	**Straight Forward**	**Low Complexity**	**Moderate Complexity**	**High Complexity**
1. Number and Complexity of Problems	**Minimal** 1 self-limited or	**Low** • 2 or more self-limited or	**Moderate** • 1 or more chronic	**High** • 1 or more chronic

Addressed at the Encounter	minor problem.	minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury; or • 1 stable, acute illness; or • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	illnesses with mild exacerbation, progression, or side effects of treatment; or • 2 or more stable, chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute, complicated injury	illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function
2. Amount and/or Complexity of Data to be Reviewed	**Minimal or None**	**Limited**	**Moderate**	**Extensive**
3. Risk of Significant Complications, Morbidity, and/or Mortality	**Minimal** risk of morbidity from additional diagnostic testing or treatment	**Low** risk of morbidity from additional diagnostic testing or treatment	**Moderate** risk of morbidity from additional diagnostic testing or treatment	**High** risk of morbidity from additional diagnostic testing or treatment

Note, Level of MDM does not apply to CPT code 99281.

E/M CPT Codes -The inclusion of a code below does not guarantee reimbursement. For a current list of E/M codes with details, refer to the most recent version of the American Medical Association CPT codebook. This policy does not apply to all E/M codes listed in the E/M section of the CPT Codebook. CPT codes listed below may be subject for review before payment can be made:

CPT Code	Description
99281	ER visit, doctor services: Emergency Department visit for the evaluation and management of patient not requiring the presence of a physician/QHP.
99282	ER visit, doctor services: Emergency Department visit for the evaluation and management of patient, resulting in straightforward MDM.
99283	ER visit, doctor services: Emergency Department visit for the evaluation and management of patient, resulting in low level MDM.
99284	Doctor visit, ER: Emergency Department visit for the evaluation and management of patient, resulting in moderate MDM.
99285	Doctor visit, ER: Emergency Department visit for the evaluation and management of patient, resulting in a high-level MDM.

References

Centers for Medicare & Medicaid Services (2024). Medicare Claims Processing Manual. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912

Policy Update History

07/21/2023	New policy
09/24/2024	Annual Review