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Emergency Department Facility Coding Program Provider Guide

Program Overview

The Emergency Department (ED) Facility Coding Program is a prepay-only facility claim solution used to drive accurate Evaluation and Management (E&M) code assignment for ED visits.

E&M miscoding in the emergency setting is often driven by misalignment between high-level codes and the overall clinical profile of the encounter, such as limited diagnostic activity or the absence of emergent or complicating conditions. The ED Facility Coding Program addresses this by using clinical logic and a step-by-step framework to ensure that high-level E&M codes accurately reflect the complexity and ED resources used.

Specifically, the program**:**

- **Enhances claim-level precision and reduces overpayment risk** by ensuring that ED facility claims with high-level E&M codes are supported by the diagnostic activity and clinical indicators reflective of higher resource use in the facility setting.
- **Assesses the ED E&M level with a multi-step framework** using a curated emergent diagnoses list and assessment of a patient's services, and complicating condition logic.

Aligning E&M Coding to Policy Expectations

The program is grounded in Centers for Medicare & Medicaid Services (CMS) expectations with coding aligned to observed facility resource use.

CMS does not prescribe a national formula for facility E&M level assignment. Instead, each hospital is required to develop and maintain its own internal facility billing guidelines, which must link billed intensity to actual resources used—such as diagnostics, staff involvement, and patient complexity. The American College of Emergency Physicians also states that hospitals must align E&M assignment with documented facility resource consumption, consistent with Outpatient Prospective Payment System (OPPS) principles.

The program evaluates facility ED claims using a structured methodology that mirrors how hospitals are expected to code under OPPS.

The program reflects the policy landscape by:

- Aligning E&M code assignment with observable resource utilization (e.g., diagnostic activity, clinical severity, and care intensity)
- Supporting compliance by focusing on facility, not professional services
- Providing transparent and consistent evaluation criteria to mitigate miscoding risk and reduce unjustified coding variation

E&M Level Assignment

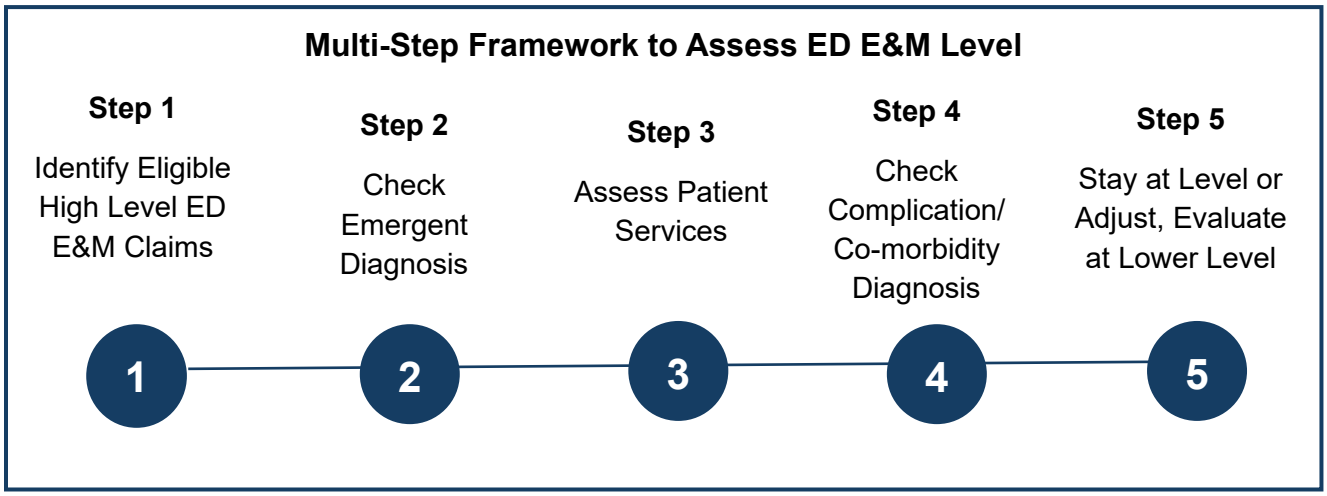
The program applies established policy standards and a structured methodology to define rules that support consistent and accurate E&M code assignment.

E&M levels and corresponding resource intensity:

Visit Level	CPT/HCPCS Code(s)	Typical Encounter Characteristics
Level 1	99281/G0380	Minimal hospital resources used; symptoms often resolve without intervention
Level 2	99282/G0381	Low-level engagement with facility staff and equipment
Level 3	99283/G0382	Utilization of basic diagnostic tools and moderate clinical support
Level 4	99284/G0383	Significant facility resource use, including repeated diagnostics or treatment rounds
Level 5	99285/G0384	Highest level of facility involvement, typically requiring rapid and complex care

Multi-Step Framework for ED E&M Level Assessment

The program assesses the E&M level using a multi-step framework:



Step 1: Program Eligibility – High-Level E&M Claims

The program starts by focusing on the ED claims most prone to miscoding and least supported by high-acuity interventions. Targeting such claims, while excluding variable, complex cases, ensures claims receive the right level of scrutiny.

Eligible Claims	Excluded Claims
• ED facility claims billed with 99284 or 99285 • Patient discharged to home or left against medical advice	• Critical care (99291, 99292) or observation services (G0378, G0379) • Inpatient admissions or other discharge dispositions • Patients under age 2 or over age 70 • Maternity, mental health, substance use, abuse, or self-harm diagnoses • Claims involving a surgical procedure with a 10- or 90-day global period performed during the ED visit

Step 2: Emergent Diagnosis Check

Claims that pass the initial filter are reviewed for the presence of an emergent diagnosis in the first three diagnosis fields. A list curated from 17,000+ possible emergent diagnoses is used to distinguish high acuity claims from routine visits. The list includes, but is not limited to, conditions such as chest pain, respiratory failure, abdominal hemorrhage, pneumonia, bone fracture, and second- or third-degree burns.

The comprehensive list of emergent diagnoses is maintained by a team of clinicians, coders, and industry consultants. It reflects diagnoses commonly recognized as

emergent according to industry standards and is informed by analysis of real-world emergency diagnoses billing patterns.

This evaluation process ensures that only clinically justified encounters remain at high E&M levels. Claims without an emergent diagnosis follow a distinct evaluation pathway with stricter thresholds.

Step 3: Assessment of Patient Services

Next, the program evaluates whether the patient services performed during the ED visit are consistent with the billed E&M level.

The services evaluated include diagnostics, such as lab testing, imaging, and cardiac monitoring; minor procedures; or other patient care-like administration of medicine, with consideration of specific drugs that may require increased monitoring and resource use. The review considers the scope and clinical intensity of these procedures as indicators of hospital resource use.

Claims are evaluated against expected patterns of service delivery for each E&M level to determine coding consistency. This data-driven approach guarantees that high-level codes are reserved for encounters reflecting a greater degree of facility engagement. By evaluating billed services against expected patterns, the program ensures high-level codes are supported by appropriate care.

Step 4: Complicating Diagnosis Check

The program then evaluates whether comorbidities or complicating factors justify the higher level of care.

Claims are assessed for the presence of complicating, co-morbid, or manifestation diagnoses that may indicate greater clinical complexity; for example, chronic kidney disease, hypertension, chronic obstructive pulmonary disease, and hyponatremia. To identify these conditions, the program leverages a curated diagnosis list that includes standard CMS Complications/Comorbidities (CC), Major Complications/Comorbidities (MCC), and manifestation codes.

When present, such diagnoses signal a higher level of patient acuity or risk and may justify maintaining a higher-level E&M code, even when other indicators are marginal.

Step 5: Final E&M Level Assignment

After completing the previous steps, the program provides a structured, rules-based determination of the appropriate E&M level.

The assessment is based on the presence of an emergent diagnosis, the assessment of patient services, and the existence of complicating diagnoses. The billed E&M level is either:

- Confirmed at billed level
- Denied at the billed level
- Adjusted by one level
- Adjusted by two levels

Level adjustments follow a transparent, rule-based matrix and claims are always evaluated using a consistent and repeatable logic engine. Every claim ends with a defensible outcome, confirmed, denied, or adjusted, based on consistent logic, clinical evidence, and plan policy.

ED visit examples

Clear-Cut Adjustment: Absence of Emergent Indicators

This example highlights a straightforward case where a 99284 code is adjusted by two levels due to the lack of supporting clinical complexity. When no emergent diagnosis, diagnostic tests, or comorbidities are present, high-level E&M codes are subject to two levels of adjustment.

Emergent Diagnosis Check: None ❭ **Patient Services:** No Additional Services ❭ **Complication or Co-morbidity Diagnosit Check:** None ❭ **Result:** Adjust by two levels to 99282

Code	Description	Age	Discharge Status	Revenue Code	Bill Type	Diagnosis	Description	Additional Procedures
99284	Level 4 ED Visit	8	01 (home)	450	131	H66.92	Otitis Media	None

Marginal Complexity: Limited Diagnostics Lead to Moderate Adjustment

This case illustrates how a 99285 code is adjusted by one level due to low intensity of services and lack of additional complexity, despite the presence of an emergent diagnosis. Even with an emergent diagnosis, limited diagnostic services and absence of complicating factors may not justify a high-level E&M code.

Emergent Diagnosis Check: Yes ❯ **Patient Services:** Low Intensity Services ❯ **Complication or Co-morbidity Diagnosis Check:** None ❯ **Result:** Adjust by one level to 99284

Code	Description	Age	Discharge Status	Revenue Code	Bill Type	Diagnosis	Description	Additional Procedures	Additional Procedures Descriptions
99285	Level 5 ED Visit	42	01 (home)	450	131	R10.32	Left Lower Quad Pain (on the emergent diagnosis list)	74176 81003	CT Abdomen Urinalysis

Appropriate Coding: Comprehensive Evaluation Justifies High-Level E&M

This scenario shows a correctly coded 99285, where the clinical complexity and services rendered align with the billed E&M level. Presence of emergent diagnosis, extensive diagnostics, and complicating factors support the original high-level E&M code.

99285 is submitted for a 50-year-old patient for other chest pain (emergent diagnosis), with extensive diagnostics (X-ray, metabolic panel, troponin, CBC, influenza probe, ECG, multiple IV infusions and injections), and type 2 diabetes (co-morbidity). Results are confirmed at the original billed level.

Emergent Diagnosis Check: Yes ❭ **Patient Services:** Extensive Services ❭ **Complication or Co-morbidity Diagnosis Check:** Yes ❭ **Result:** Do **not** adjust

Code	Description	Age	Discharge Status	Revenue Code	Bill Type	Diagnosis	Description	Additional Procedures	Additional Procedures Descriptions	Diagnosis	Description
99285	Level 5 ER Visit	50	01 (home)	450	131	R07.89	Other Chest Pain (on the emergent diagnosis list)	71045 80048 84484 85025 87502 93005 96361 96374 96375	X-RAY EXAM CHEST 1 VIEW METABOLIC PANEL TROPONIN QUANT COMPLETE CBC INFLUENZA DNA AMP PROBE ELECTROCARDIOGRAM TR HYDRATE IV INFUSION THER INJ IV PUSH INJ NEW DRUG	E11.9	Type 2 Diabetes (in the co-morbidity diagnoses list)