

Payment Policy

Title	Emergency Department Evaluation and Management Level of Service		
Number	CP.PP.431.v1.0		
Last Approval Date	03/13/26	Original Effective Date	07/03/2026
Cross Reference	<ul style="list-style-type: none"> • <i>Contract Exclusions/Disallowed Charges – Inpatient and Outpatient Facility Services</i> • <i>Critical Care in Emergency Department when Patient is Discharged to Home (Facility)</i> • <i>Facility Fees: Clinic Services, Professional Fees, and Specialty Services-Treatment Room</i> • <i>Global Surgery</i> • <i>Preadmission Testing</i> 		

Coverage of any service is determined by a member’s eligibility, benefit limits for the service or services rendered and the application of the Plan’s Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan’s professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose/ Application	To define how the Plan reimburses Evaluation and Management (E&M) levels of service provided within an Emergency Department when billed on an outpatient facility claim.
Scope	Premera Blue Cross, Blue Card Home, and Premera Blue Cross HMO lines of business and products.
Definitions	<p>Type A emergency department: Per the Center for Medicare and Medicaid Services (CMS) a Type A provider-based emergency department “must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department and be open 24 hours a day, 7 days a week; or (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment and be open 24 hours a day, 7 days a week.”</p> <p>Type B emergency department: Per the Center for Medicare and Medicaid Services (CMS): A Type B provider-based emergency department “must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department, and open less than 24 hours a day, 7 days a week; or (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment, and open less than 24 hours a day, 7 days a week; or (3) During the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment, regardless of its hours of operation.”</p>
Policy	The plan requires outpatient emergency department facility claims to be billed using Evaluation and Management (E&M) procedure codes that accurately reflect the level of facility resources utilized.

	<p>Effective for dates of service on and after July 3, 2026 the plan will use the following factors to determine the appropriate level of service that should be allowed for the ED E&M service:</p> <ul style="list-style-type: none"> • Emergent Diagnoses which are determined by the International Classification of Disease (ICD)-10 diagnosis codes submitted in the first three positions on the claim. • Diagnostic Services Performed which is determined by the intensity of the diagnostic workup, as reflected by the Current Procedural Terminology (CPT) diagnostic procedure codes billed • Member Complexity and Comorbidities which is determined by the presence of complicating conditions or circumstances, as identified by the ICD-10 principal, secondary, and external cause of injury diagnosis codes reported on the claim. <p>Claims for services rendered in an Emergency Department must include the appropriate Evaluation and Management (E&M) visit code, along with all related diagnostic and treatment service codes associated with the encounter.</p> <p>Claim reimbursement may be adjusted or denied based on the level of service that is met when the listed factors are reviewed. If denied, an adjusted claim can be submitted reflecting the appropriate level of service.</p>
<p>Codes and Coding Guidelines</p>	<ul style="list-style-type: none"> • 99281-Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional • 99282- Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making • 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 • 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 • G0380- Level 1 hospital emergency department visit provided in a type B emergency department. • G0381- Level 2 hospital emergency department visit provided in a type B emergency department. • G0382- Level 3 hospital emergency department visit provided in a type B emergency department.

	<ul style="list-style-type: none"> • G0383- Level 3 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.
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties, and/or termination of the contract. Disciplinary actions will be determined by the Plan.
Exceptions	<p>Exceptions to the policy may also be made where a provider contract dictates otherwise.</p> <p>The following scenarios are excluded from this policy:</p> <ul style="list-style-type: none"> • Alaska lines of business and products • Premera Blue Cross or Premera Blue Cross Blue Shield of Alaska Individual plans • Claims with a discharge status a code other than 1, 6, or 7 <ul style="list-style-type: none"> ○ 01- Discharged to home or self-care (routine discharge) ○ 06- Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care ○ 07-Left Against Medical Advice or Discontinued care ○ 20-Patient Expired • Claims billed with Critical Care or Observation Services <ul style="list-style-type: none"> ○ Critical care CPT codes 99291-99292 ○ Observation Service codes 99221-99223, 99231-99233, 99234-99346, 99238-99239, and G0378-G0379 • Claims billed with Global Surgical Procedures (defined by 10 or 90 global days per the National Physician Fee Schedule (NPFS)) • Claims for members under the age of 2 or over the age of 70 • Claims billed with a sensitive related diagnosis code (i.e., maternity, mental health, substance abuse)
Laws, Regulations & Standards	N/A
References and Resources	<ul style="list-style-type: none"> • American Medical Association’s Current Procedural Terminology (AMA/CPT) codebook • Center for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) Level II codebook • Center for Medicare and Medicaid Services (CMS), CMS Manual System Pub 100-04 Medicare Claims Processing; transmittal 1139 • Centers for Medicare & Medicaid Services (CMS). Evaluation and Management Services (MLN006764)

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	03/13/26	
Version History	03/13/26	Creation of new policy