Optum EDC Analyzer - Facility ER E&M Leveling Policy

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plans supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

Facility charges for Level 4 (99284/G0383) and Level 5 (99285/G0384) E/M codes in emergency departments should bill correctly and differently for outpatient visits, including emergency visits. According to CMS coding principles for emergency services, facility coding guidelines should follow the CPT code descriptor's intent by linking hospital resource intensity to code effort levels, basing them on hospital facility resources not physician resources, and preventing upcoding or gaming.

Reimbursement Guidelines

Molina Healthcare will use the Optum Emergency Department Claim (EDC) Analyzer to decide the emergency department E/M level that will be paid for certain facility claims. Facilities may see changes to the level 4 or 5 E/M codes they submit to match a lower E/M code determined by the EDC Analyzer or may get a rejection for the code level they submit. For certain facilities who see changes to a level 4 or 5 E/M code, we may estimate payment for the changed code based on past claims experience, and in such case the facility may send a revised claim which we will process based on the new charges sent in accordance with this policy.

Some criteria that may prevent facility claims from being subject to a change or rejection are:

- The patient is moved to inpatient, has outpatient surgery during the same ED visit, or is discharged/transferred to another healthcare facility.
- Critical care patients (99291, 99292).
- The patient is under 2 years old.
- Claims with some diagnosis that when treated in the ED often need more than average resource use, such as a lot of nursing time.
- Patients who have died in the emergency department.
- Claims from facilities billing level 4 and 5 E/M codes that do not differ from the EDC Analyzer.

Claims for services provided in an emergency department should be complete and include all diagnostic services and diagnosis codes related to the emergency department visit and be billed at the right E/M level. Molina Healthcare has the right to deny, review, audit, and take back claims based on medical necessity as described in the above policy. See Optum Emergency Department Claim Analyzer for more

information: emergency-department-claim-analyzer-guide.pdf.

Supplemental Information

Definitions

Term	Definition
CMS	Center for Medicare and Medicaid

State Exceptions

State	Exception
MI	Levels may be changed to 3,4,5

Documentation History

Type	Date	Action
Initial Creation Date	04/26/2024	New Policy
Revised Date	12/16/2024	Updated Template and formatting
Revised Date	08/06/2025	Updated the templated and verified links
Revised Date	08/21/2025	Updated font; updated page number and PI number

References

This policy was developed using:

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

Reference	Link
OPTUM	emergency-department-claim-analyzer-guide.pdf

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.*