Revised Emergency Department (ED) Outpatient Facility Evaluation and Management (E/M) Coding Policies – Effective August 1, 2019

As part of our continued efforts to reinforce accurate coding practices, Molina Healthcare of New Mexico will revise the current Emergency Department (ED) outpatient facility Evaluation and Management (E/M) coding reimbursement policy and procedure. This revision applies to the following plans as of the dates shown below:

Molina Health Benefit Exchange Products (Marketplace), Molina Medicare Options, Molina Medicare Options Plus, and Dual Options, effective August 1, 2019.

These policies focus on outpatient facility ED claims that are submitted with level 1 (99281, G0380), level 2 (99282, G0381), level 3 (99283, G0382), level 4 (99284, G0383), or level 5 (99285, G0384) E/M codes. These policies were developed using our national experience to address inconsistencies in coding accuracy and were based on the E/M coding principles created by the Centers for Medicare and Medicaid Services (CMS) that require hospital ED facility E/M coding guidelines to follow the intent of CPT® code descriptions and reasonably relate to hospital resource use.

These policies will apply to all facilities, including freestanding facilities, that submit ED claims with level 1, 2, 3, 4, or 5 E/M codes for members of the above referenced plans, regardless of whether they're under contract to participate in our network.

As part of the implementation of these policies and procedures, we will begin using the Optum Emergency Department Claim (EDC) Analyzer tool, which determines appropriate E/M coding levels based on data from the patient's claim including the following

- Patient's presenting problem
- Diagnostic services performed during the visit
- Any patient complicating conditions

To learn more about the EDC Analyzer™ tool, please visit ﷺEDCAnalyzer.com.

Facilities submitting claims for ED E/M codes may experience adjustments to level 1, 2, 3, 4, or 5 E/M codes to reflect an appropriate level E/M code or may receive a denial, based on the reimbursement structure within their contracts with PAYER. Facilities will have the opportunity to submit reconsideration or appeal requests if they believe a higher-level E/M code is justified, in accordance with the terms of their contract.

Criteria that may exclude outpatient facility claims from these policies include, but are not limited to:

- Claims for patients who were admitted from the emergency department or transferred to another health care setting (Skilled Nursing Facility, Long Term Care Hospital, etc.)
- Claims for patients who received critical care services (99291, 99292)
- Claims for patients who are under the age of 2 years
- Claims with certain diagnosis codes that when treated in the ED most often necessitate greater than average resource usage, such as significant nursing time
- Claims for patients who expired in the ED

Ultimately, the mutual goal of facility coding is to accurately capture ED resource utilization and align that with the E/M CPT® code description for a patient visit per CMS guidance.

If you need further information, please contact your Provider Network Representative.