Commercial Reimbursement Policy

Subject: **Emergency Department: Leveling of Evaluation and Management Services- Facility**	
Policy Number: **C-13001**	Policy Section: **Facilities**
Last Approval Date: **04/01/2024**	Effective Date: **07/01/2024**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by an Anthem Blue Cross (Anthem) member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, Anthem will publish the most current policy to the website.

Policy

The Health Plan allows reimbursement for facility Emergency Department (ED) providing emergency services unless contracts and/or requirements indicate otherwise.

Reimbursement for emergent facility Emergency Department (ED) services is based on The Health Plan's classification of ED Evaluation and Management (E/M) code levels, as outlined below.

The Health Plan determines the level of ED E/M code by classifying the intensity and/or complexity of resources or interventions a facility utilizes to furnish all services indicated on the claim. Providers must utilize appropriate HIPAA compliant codes for all services rendered during the ED encounter.

Based on this classification, if the E/M code level submitted is higher than the E/M code level supported on the claim, the Health Plan reserves the right to perform one of the following:

- Deny the claim and request resubmission at the appropriate level or request the provider to submit documentation supporting the level billed.
- Recover and/or recoup monies previously paid on the claim in excess of the E/M code level supported.

Exclusions:

- Critical care or outpatient surgery performed during ED visit.
- Member expired in the ED.
- Member admitted inpatient or transferred to another facility.

Note: The Health Plan adheres to the requirements of the Emergency Medical Treatment and Labor Act (EMTALA).

Related Coding

Emergency Department Visits	Emergency Department Visits

Policy History

04/01/2024	Review approved 04/01/2024 and effective 07/01/2024: updated coding section and Definitions section; updated title of policy from Facility Emergency Department
04/20/2018	Review approved
02/22/2013	Initial approval 02/22/2013 and effective 06/01/2013

References and Research Materials

This policy has been developed through consideration of the following:

- American College of Emergency Physicians (ACEP)
- Emergency Medical Treatment and Labor Act (EMTALA)
- Optum EncoderPro 2023

Definitions

Interventions	The staff the facility utilizes, and their work performed.
Resources	Facility building, equipment and/or supplies utilized. Note: Professional provider services are not considered facility interventions or resources.
Intensity and/or Complexity	Quantity, type, or specialization of interventions and/or resources used and the nature of the presenting problem, member age, acuity and diagnostic services performed, as indicated on the claim.
Emergency Services	A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in (a) placing the health of an individual in serious

	jeopardy, (b) serious impairment to bodily function, (c) serious dysfunction of any bodily organ or part, (d) serious disfigurement, or (e) in the case of a pregnant woman, serious jeopardy to the health of the woman or her unborn child.
General Reimbursement Policy Definitions	

Related Policies and Materials

None

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.