KAISER PERMANENTE®

PAYMENT POLICY

Emergency Department (ED) Facility Evaluation and Management (E/M) Coding Policy

Scope

This policy applies to:

☒ Kaiser Permanente Health Plan of Washington	☒ Kaiser Permanente Health Plan of Washington Options, Inc.	
☒ Commercial	☒ Medicare	☐ Medicaid

Policy

Original Effective Date: 04/01/2020

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) will utilize Optum® Emergency Department Claim (EDC) Analyzer™ tool to determine the appropriate and fair level of facility reimbursement for outpatient emergency department (ED) services.

Facilities should code a level of service based on facility resource consumption. The EDC Analyzer™ reviews the diagnoses submitted as well as the facility services performed and then determines the appropriate ED visit level. The intention of the implementation of EDC Analyzer™ is to achieve fair and consistent evaluation and management (E/M) coding and reimbursement of facility outpatient ED claims.

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Billing/Coding Guidelines

All claims must be billed according to Centers for Medicare & Medicaid Services (CMS) guidelines.

CMS indicates facilities should bill appropriately and differentially for outpatient visits, including ED visits. To that end, CMS coding principles applicable to ED services provide that facility coding guidelines should: follow the intent of the CPT® code descriptor in that the guidelines; should be designed to reasonably relate the intensity of hospital resources to the different levels

of effort represented by the code; be based on hospital facility resources and not based on physician resources; and not facilitate upcoding or gaming.

Kaiser Permanente will use the EDC Analyzer™ for outpatient facility ED claims that are submitted with Levels 3, 4 and 5 E/M codes 99283-99285 and G0382 - G0384.

Policy Definitions

E/M – Evaluation and Management

ED – Emergency Department

Critical Care – Direct delivery by a physician(s) medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition. Billed with CPT codes 99291 and 99292 when all the criteria for critical care services are met

Prerequisite(s)

Institutional claims billed with 99283-99285 (ED CPT®), G0382-G0384 (Type B ED HCPCS)

Exclusions

Claims with certain diagnosis codes (e.g. sexual assault, homicidal ideations, bipolar disorder, schizophrenia, etc.).

Claims for children below the age of 2.

Claims for patients who died in the ED or were discharged/transferred to another care setting including observation care.

Claims for patients who received critical care services.

Covid-19 related ER visits for dates of service 02/04/2020 through 05/11/2023.

References

Optum EDC Analyzer Website

Frequently Asked Questions

Q1: Why is Kaiser Permanente implementing an emergency visit Evaluation and Management code review?

A1: To ensure appropriate and fair level of facility reimbursement for outpatient ED services.

Q2: Is this a medical necessity review?

A2. No. EDC Analyzer™ focuses on correct coding and evaluating whether the resources utilized justify the final code billed.

Q3: What criteria are considered in the evaluation?

A3: EDC Analyzer™ reviews the presenting problems defined by the ICD-10 diagnoses codes submitted and the intensity of the diagnostic workup as measured by the diagnostic CPT® codes, as well as any complicating conditions defined by ICD-10 principal and secondary diagnoses codes.

Q4: Are facilities required to bill the same CPT® code as the physician for an ED visit encounter?

A4: No. While the intent of the CPT® visit code should be followed by both facility and physician, facility resource consumption may cause the facility E/M level to be appropriately higher or lower than the physician level.

Q5: What should facilities do to ensure fair reimbursement on submitted ED E/M codes?

A5: UB-04 claims for services rendered in an ED should include all diagnosis and procedure codes relevant to the ED visit and be billed at the appropriate E/M level.

Q6: Are submitted facility E/M codes recoded by the payer to the level designated by the algorithm?

A6: No. The E/M code submitted by the facility is accepted as is. Payment, however, is based on the E/M level aligned with resource utilization as determined by the applied algorithm.

Q7: Is the algorithm applied to facility E/M codes submitted for those admitted to the inpatient facility from the ED?

A7: No. The algorithm is only applied to patients who are discharged from the ED.

Q8: Are facility ED critical care codes subject to the algorithm that determines the level of ED resource utilization?

A8: No. Critical care CPT® codes submitted for services rendered to patients who are discharged from the ED are not subject to the algorithm methodology.

Q9: What is the source and basis for the algorithm applied to facility resource utilization?

A9: A long history of claims coding experience derived from the LYNX E/Point™ product utilized by many facilities nationally. The CMS-based LYNX E/Point solution has been in use since 2001 and is currently used by more than 1500 hospitals, determining appropriate facility ED visit levels for more than 50,000,000 encounters per year. For additional information on this algorithm, please refer to the edcanalyzer.com website.

Revision History

01/09/2024 – Added term date to COVID exclusions

08/15/2022 – Updated policy formatting

04/01/2020 – New policy

Note: This information is intended to serve only as a general reference resource regarding reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, we may use reasonable discretion in interpreting and applying this policy to services being delivered in a particular case. Further, the policy does not cover all issues related to reimbursement for services rendered to our enrollees as legislative mandates, the provider contracts, the enrollee's benefit coverage documents, and the Provider Manual all may supplement or in some cases supersede this policy. This policy may be modified from time to time by publishing a new version of the policy on Kaiser Permanente provider website; however, the information presented in this policy is believed to be accurate and current as of the date of publication.