BlueCross BlueShield of Texas

CLINICAL PAYMENT AND CODING POLICY

In the event of a conflict between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. Plan documents include but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions and other coverage documents.

In the event of a conflict between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern.

Providers are responsible for accurately, completely, and legibly documenting the services performed including any preoperative workup. The billing office is expected to submit claims for services rendered using valid codes from the Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry-standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), National Drug Codes (NDC) ,Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines. Claims are subject to the code edit protocols for services/procedures billed.

Emergency Department Evaluation and Management (E/M) Services Coding – Facility Services

Policy Number: CPCP003

Version 4.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: 10/04/2019

Plan Effective Date: January 25, 2020 (Blue Cross and Blue Shield of Texas Only)

Description

This Clinical Payment and Coding Policy is intended to provide guidance for Emergency Department (ED) Providers (facilities) submitting reimbursement for the code(s) that correctly describe the health care services rendered. The information in this policy services only as a reference resource for the ED Services described and is not intended to be all inclusive. This policy applies to all health care services billed on CMS 1500 and/or UB 04 forms. This policy applies to in-network and out-of-network facilities submitting ED claims (Place of services - 23).

Claim submissions coded with the correct combination of procedure code(s) is critical to minimizing potential delays in claim(s) processing. Facility claim submissions must contain revenue codes that reflect the services rendered.

Reimbursement Information:

The patient's medical record documentation for diagnosis and treatment in the ED must indicate the presenting symptoms, diagnoses and treatment plan and written order by the provider. All contents of medical records should be clearly documented. **Medical records and itemized bills may be requested from the facility/provider for review to validate the level of care and services billed**.

If observation services are billed with any of the ED associated Evaluation and Management (E/M) codes, MCG Criteria will be used to evaluate observation hours.

BlueCross BlueShield of Texas

Facility Level of Care Guideline

The chart below contains guidelines for appropriate facility ED billing for each defined Level of Care. The CPT code (level of care) corresponds to the "Possible Services Rendered" column and/or the HCPCS Code column. The "Possible Symptoms" column lists symptoms that support the possible services provided (list is not all-inclusive). The "Possible Symptoms" outlined below do not determine the facility level of care.

The appropriate facility level of care is determined by the services rendered. The review of services will be conducted in accordance with the member benefits using standard medical guidelines as outlined in the chart below. A facility level of care may encompass multiple "Possible Services Rendered" and may not be limited to one service outlined in the chart below.

At least one service under the "Possible Service Rendered" column must be documented in the member medical record to satisfy reimbursement requirements for the CPT or HCPCS billed for the facility level of care code.

The facility level of care is determined by the following:

CPT CODE	POSSIBLE SERVICES RENDERED	HCPCS CODE	POSSIBLE SYMPTOMS
99281	• Initial Assessment • No care rendered by provider (e.g., elopes prior to evaluation) • Medication refill (e.g., behavior health or emergency need) • Work or school excuse • Wound recheck- simple • Booster or follow up immunization only • Wound dressing changes (uncomplicated) • Suture removal (uncomplicated)	G0380	• An insect bite (uncomplicated) • Read TB test
99282	**Any items or services from 99281 and:** • POC testing by ED Staff (Urine dipstick, stool occult blood, glucose) • Visual acuity exam • Collection of specimens by lab • Cast removal by ED staff • Repair of wound with skin adhesive • Non-prescription medication administered • Prep or assist with procedures such as simple/minor laceration repair, I&D of simple abscess, etc.	G0381	• A Localized skin rash or lesion • A sunburn • A minor viral infection • An eye discharge-painless • Ear Pain • Or urinary frequency without fever
99283	**Any items or services from 99281, 99282 and:** • Receipt of EMS/Ambulance patient • Heparin/saline lock – no parenteral medications or fluids • One nebulizer treatment • Preparation for lab tests described in CPT (80048-87999 codes) • Preparation for plain X-rays of 1 or 2 more body areas (not above/below joint of same limb) • Prescription medications non-parenteral • Foley catheters placement; In & out catheterization • C-spine precautions – cervical stabilization device present • Corneal exam with dye • Epistaxis with packing • Oxygen therapy • Emesis/Incontinence care • Prep or assist with procedures such as joint aspiration/ injection. simple fracture care, intermediate/complex laceration repair, etc. • Mental health anxiety with simple treatment • Routine psych medical clearance	G0382	• Minor trauma (with potential complicating factors) • A medical condition(s) requiring prescription drug management • A fever which responds to antipyretics • Headache – Simple, Hx of, no serial exam • A head injury-without neurologic symptoms

CPT CODE	POSSIBLE SERVICES RENDERED	HCPCS CODE	POSSIBLE SYMPTOMS
99283 (cont.)	• Post mortem care • Direct admit via ED • Discharged w/prescription medication	G0382	• Eye pain (corneal abrasion or simple infection) • Mild dyspnea -not requiring oxygen • Cellulitis • Abdominal pain, simple • Non-confirmed overdose • Anxiety, simple treatment • GI bleed – fissure or hemorrhoid
99284	**Any items or services from 99281, 99282, 99283 and:** • Prep for one special imaging study (CT, MRI, Ultrasound, VQ scans) • Two nebulizer treatments • Port-a-Cath venous access • Administration and monitoring of parenteral medications (IV, IM, IO, SC) NG/PEG • Tube placement/replacement multiple reassessments • Prep or assist with procedures such as eye irrigation with Morgan lens, bladder irrigation with 3-way Foley, pelvic exam (no forensic collection), etc. • Sexual assault exam without specimen collection • Psychotic patient; not suicidal • EKG	G0383	• Blunt/ penetrating trauma- with limited diagnostic testing • Headache – Complex (no LP) • Head injury with loss of consciousness (LOC) • Dehydration requiring treatment • Dyspnea requiring oxygen • Respiratory illness relieved with (2) nebulizer treatments • Chest Pain— Simple, with limited diagnostic testing • Abdominal Pain - Complex (multiple diagnostics and special imaging) • Non-menstrual vaginal bleeding • Neurologic symptoms – Simple with limited diagnostic testing

CPT CODE	POSSIBLE SERVICES RENDERED	HCPCS CODE	POSSIBLE SYMPTOMS
99285	**Any items or services from 99281, 99282, 99283, 99284 and:** • More than one special imaging study (CT, MRI, VQ scan) combined with multiple tests of parenteral medications. • Administration of blood transfusion/blood products • Oxygen via face mask or NRB • Multiple nebulizer treatments: three or more (if the nebulizer is continuous, each 20-minute period is considered treatment) • Procedural sedation • Prep or assist with procedures such as central line insertion, gastric lavage, LP, paracentesis, etc. • Temperature instability requiring intervention • Use of specialized resources – social services, police, crisis management • Sexual Assault exam with forensic specimen collection by Emergency Department staff • Coordination of hospital admission/transfer for higher level of care • Physical/chemical restraints • Need for 1:1 sitter • ICU admission not otherwise meeting critical care criteria	G0384	• Blunt/ penetrating trauma requiring multiple diagnostic tests of multiple organ systems or major musculoskeletal injury • Systemic multi-system medical emergency requiring multiple diagnostic tests • Severe infections requiring IV/IM antibiotics • Uncontrolled diabetes mellitus (DM) – symptoms of diabetic ketoacidosis (DKA) or hyperglycemic hyperosmolar nonketotic (HHNK) • Severe burns • Hypothermia • New-onset altered mental status • Headache (severe): CT and/or lumbar puncture (LP) • Chest Pain—Complex with multiple diagnostic tests/treatments • Respiratory illness--relieved by (3) or more nebulizer treatments • Abdominal Pain—Complex with multiple diagnostic tests/treatments • Active gastrointestinal (GI) bleeding • Epistaxis – Complex • Acute peripheral vascular compromise of extremities • Neurologic symptoms - multiple diagnostic tests/treatments • Toxic ingestions • Mental health problem - suicidal/ homicidal

CPT CODE	POSSIBLE SERVICES RENDERED	POSSIBLE SYMPTOMS
99291* First 30-74 minutes	**Any items from the above levels of care plus** • **Parenteral medications requiring continuous vital sign monitoring** • **Provision of any of the following:** ○ Major trauma care/ multiple surgical consultants ○ Chest tube insertion ○ Major burn care ○ Treatment of active chest pain ACS ○ CPR ○ Defibrillation/ cardioversion ○ Pericardiocentesis ○ Administration of ACLS drugs in cardiac arrest ○ Therapeutic hypothermia ○ Non-invasive ventilation ○ Endotracheal intubation ○ Emergent airway intervention ○ Ventilator management ○ Line placement for monitoring ○ Major hemorrhage ○ Pacing (including external) ○ Delivery of baby	• Burns threatening to life or limb • Coma of all etiologies (except hypoglycemic) • Shock of all types • Any condition causing impairment of vital functions • Life-threatening hyper/hypo-thermia • Thyroid Storm or Addisonian crisis • Cerebral hemorrhage of any type • New-onset paralysis • Status epilepticus • Acute Myocardial Infarction • Cardiac tamponade aneurysm; thoracic or abdominal- leaking or ruptured • Acute respiratory failure, pulmonary edema, status asthmaticus • Embolus of fat or amniotic fluid • Acute hepatic failure • Diabetic Ketoacidosis • Active bleeding from DIC or other bleeding diatheses
99292 Each additional 30 minutes	Critical care, evaluation and management of the critically ill or critically injured patient; list separately in addition to code for primary service.	

NOTES:

Critical care may only be billed as CPT codes 99291-99292.

*For Critical Care First Hour (99291), the administration and monitoring of IV vasoactive medications (such as adenosine, dopamine, labetalol, metoprolol, nitroglycerin, norepinephrine, sodium nitroprusside, continuous infusion (drips), etc.) are indicative of critical care.

REFERENCES:

Department of Health and Human Services Centers for Medicare & Medicaid Services, Evaluation and Management Services Guide

Copyright © 2011 American College of Emergency Physicians - ED Facility Level Coding Guidelines

POLICY UPDATE HISTORY:

DATE	DESCRIPTION
06/22/2017	New policy – CPCP003 Facility & Professional Coding of Evaluation and Management Emergency Department Services
04/20/2018	Annual Review
11/15/2018	Policy coding and MCG updates
10/04/2019	Policy revision, removal of professional piece

File is in portable document format (PDF). To view this file, you may need to install a PDF reader program. Most PDF readers are a free download. One option is Adobe® Reader® which has a built-in screen reader. Other Adobe accessibility tools and information can be downloaded at http://access.adobe.com.

By clicking this link, you will go to a new website/app ("site"). This new site may be offered by a vendor or an independent third party. The site may also contain non-Medicare related information. In addition, some sites may require you to agree to their terms of use and privacy policy.