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

As part of our continued efforts to reinforce accurate coding practices, Magnolia Health Plan will implement the following new Emergency Department (ED) outpatient facility Evaluation and Management (E/M) coding reimbursement policy and procedure. This policy applies to the following lines of business as of the dates shown below:

- MSCAN, effective July 1, 2019
- CHIP, effective July 1, 2019
- Ambetter, effective July 1, 2019
- Allwell, effective July 1, 2019

This policy focuses 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. This policy was developed using our national experience to address inconsistencies in coding accuracy and is 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.

This policy 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 affected lines of business, regardless of whether they're under contract to participate in our network.

The implementation of this policy is in an effort to comply with the CMS Informational Bulletin dated 1/16/14 with the subject:

Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings

https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-16-14.pdf

In this bulletin, CMS discusses their collaborations with states in order to reduce costs, improve the patient experience, and improve the health of our populations. CMS does outline in the bulletin that states have flexibility to develop payment methodologies for non-emergency use of ED services. States are also permitted to vary payments to providers, as long as payments are "consistent with efficiency, economy and quality of care" and are sufficient to ensure access to services similar to the access for the general population. A number of states have adopted payment strategies to reduce inappropriate ED use. Under one such strategy, the state will provide lower levels of payment for a non-emergent visit to the ED, as determined retrospectively by chart review, or based on a coding algorithm.

Magnolia Health Plan will be investigating the other strategies brought forth in the CMS bulletin in the future.

As part of the implementation of this policy, 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

The goal of the Optum Emergency Department Claim (EDC) Analyzer is to achieve fair and consistent E/M coding and reimbursement of facility outpatient emergency department claims. The EDC Analyzer™ systematically evaluates each ED visit level code in the context of other claim data (i.e., diagnosis codes, procedure codes, patient age, and patient gender) to ensure that it reasonably relates to the intensity of hospital resource utilization as required per CMS Guidelines. The methodology used by the EDC Analyzer™ is based on Optum's Lynx™ tool, which is used by 1,500 facilities nationwide to code outpatient emergency department claims. This shared methodology between payers and providers promotes transparency in the coding and reimbursement process.

When a claim is processed through the Analyzer tool, a numbered weighting for each of three factors is assigned.

- Step 1 is Standard Costs, which assigns a standard cost weight to the visit based on evaluation of demographic characteristics and presenting problem.
- Step 2 is Extended Costs, which assigns an extended cost weight according to the intensity of the diagnostic workup based on diagnostic CPT codes.
- Step 3 is Patient Complexity Costs, which assigns a weight based on whether the patient has any conditions or has experienced any circumstances that may increase the complexity of the visit.

The weight numbers from each of these steps are added together to determine the total weight of the claim. The appropriate level of E/M service is then assigned based on this number.

For a more in-depth look at each of the EDC Analyzer Tool steps and to view specific claim examples, please visit EDCAnalyzer.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 Magnolia Health Plan. 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 Network Representative. Thank you for your continued partnership.