Optum EDC Analyzer - Facility ER E&M Leveling Prepayment

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

Facility charges for Level 4 (99284/G0383) and Level 5 (99285/G0384) E/M codes in emergency departments should bill correctly and differently for outpatient visits, including emergency visits. According to CMS coding principles for emergency services, facility coding guidelines should follow the CPT code descriptor's intent by linking hospital resource intensity to code effort levels, basing them on hospital facility resources not physician resources, and preventing upcoding or gaming.

Reimbursement Guidelines

Molina Healthcare will use the Optum Emergency Department Claim (EDC) Analyzer to decide the emergency department E/M level that will be paid for certain facility claims. Facilities may see changes to the level 4 or 5 E/M codes they submit to match a lower E/M code determined by the EDC Analyzer or may get a rejection for the code level they submit. For certain facilities who see changes to a level 4 or 5 E/M code, we may estimate payment for the changed code based on past claims experience, and in such case the facility may send a revised claim which we will process based on the new charges sent in accordance with this policy.

Some criteria that may prevent facility claims from being subject to a change or rejection are:

❖ The patient is moved to inpatient, has an outpatient surgery during the same ED visit, or is discharged/transferred to another healthcare facility.
❖ Critical care patients (99291, 99292).
❖ The patient is under 2 years old.
❖ Claims with some diagnosis that when treated in the ED often need more than average resource use, such as a lot of nursing time.
❖ Patients who have died in the emergency department.
❖ Claims from facilities billing level 4 and 5 E/M codes that do not differ from the EDC Analyzer.

Claims for services provided in an emergency department should be complete and include all diagnostic services and diagnosis codes related to the emergency department visit and be billed at the right E/M level. Molina Healthcare has the right to deny, review, audit, and take back claims based on medical necessity as described in the above policy. See Optum Emergency Department Claim Analyzer for more information: (https://edcanalyzer.com/).

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508 Approval Date:

Supplemental Information

Definitions

Term	Definition
CMS	the Centers for Medicare & Medicaid Services. It is a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
CPT	
HCPCS	

State Exceptions

State	Exception

Documentation History

Type	Date	Action
Published		
Revised Date		

References

This policy was developed using.

- CMS
- State Medicaid Regulatory Guidance
- State Contracts
- https://edcanalyzer.com/