

Payment Policy: Emergency Department (ED) Evaluation and Management (E&M) Coding for Facility Claims

Reference Number: LA.PP.064
Last Review Date: 6/2026

Coding Implications
Revision Log

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Policy Overview

This policy describes how the Plan adjudicates facility claims billed with Evaluation and Management (E/M) codes at Level 4 (99284/G0383) and Level 5 (99285/G0384) for services rendered in an emergency department. This policy is based on coding principles established by the Centers for Medicare and Medicaid Services (CMS) and the CPT and HCPCS code descriptions.

The purpose of this policy is to define payment criteria for emergency room claims when billed with Level 4 and Level 5 E/M codes to be used in administering benefits.

Application

- This reimbursement policy applies to services reported using the [UB-04](#) claim form or its electronic equivalent (i.e., [837I](#)) or its successor form.
- [Network facility](#) and [non-network facility](#) emergency departments (including hospital emergency departments).
- Free standing emergency departments ([UB-04](#) claims).

Policy Description

It is the policy of the Plan to require providers to comply with CMS coding principles when billing for emergency department services.

CMS indicates facilities should bill appropriately and differentially for outpatient visits, including emergency department visits. To that end, CMS coding principles applicable to emergency department 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.

Reimbursement

[UB-04](#) claims for services rendered in an emergency department should be complete and include all diagnostic services and diagnosis codes relevant to the emergency department visit and be billed at the appropriate E/M level.

The Plan will utilize the Optum Emergency Department Claim (EDC) Analyzer to determine the emergency department E/M for certain facility claims. The EDC Analyzer applies an algorithm that takes three factors into account in order to determine a Calculated Visit Level for the emergency department E/M services rendered. The three factors used in the calculation are as follows:

- Presenting problems – as defined by the ICD-10 reason for visit (RFV) diagnosis;
- Diagnostic services performed – based on intensity of the diagnostic workup as measured by the diagnostic CPT codes submitted on the claim (i.e. lab, x-ray, EKG/RT/other diagnostic, CT/MRI/ultrasound); and
- Patient complexity and co-morbidity – based on complicating conditions or circumstances as defined by the ICD-10 principal, secondary, and external cause of injury diagnosis codes.

Facilities will receive a denial for the level 4 or 5 E/M codes submitted when the EDC Analyzer determines the Calculated Visit Level does not match the emergency department E/M services billed.

The facility may resubmit a [replacement claim](#) which the Plan will adjudicate based on the new charges submitted in accordance with this policy.

If the facility disagrees with the denial, they may submit an appeal or reconsideration request according to the guidelines outlined in the provider manual. Please submit all pertinent medical records for the date of service and procedures billed. *Medical records should not be submitted on the first-time claim submission as first time claim review consists only of a review of the information documented on the claim. Medical records should only be submitted once the provider receives a denial and wishes to request a reconsideration or appeal.*

Criteria that may exclude Facility claims from being subject to an adjustment or denial include:

- The patient is admitted to inpatient, observation, or has an outpatient surgery during the course of the same ED visit;
- Critical care patients (99291, 99292);
- The patient is less than 2 years old;
- Claims with certain diagnoses that when treated in the ED most often necessitate greater than average resource usage, such as significant nursing time;
- Patients who have expired in the emergency department.

For additional information on the EDC Analyzer, visit [EDC Analyzer Details](#).

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor
99284	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
99285	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making
G0383	Level 4 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0384	Level 5 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

Definitions

UB-04

The UB-04, (also known as the CMS 1450) is an institutional claim form used for billing medical and mental health claims.

837I

The 837I (Institutional) is the standard format used by institutional providers to transmit health care claims electronically.

Network Facility

Facilities that are part of a health plan's network of providers with which it has a negotiated discount to provide health care services to its members/enrollees.

Non-network Facility

Facilities that are not part of a health plan's network of providers with which it has a negotiated discount to provide health care services to its members/enrollees.

Replacement Claim

A replacement claim is billed when a specific claim needs to be restated in its entirety, except for the identifying information. The original claim is considered null and void. The information on the replacement claim submission replaces the previous claim. This may include corrections that need to be made to a professional or institutional claim.

Related Policies

Not Applicable

Related Documents or Resources

Not Applicable

References

1. Medicare and Medicaid Programs; Interim and Final Rule Federal Register / Vol. 72, NO. 227 / Tuesday, November 27, 2007 / Rules and Regulations, page 66580, at 66805. Available online at <http://www.gpo.gov/fdsys/pkg/FR-2007-11-27/html/07-5507.htm>
2. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services.
3. Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
4. Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
5. Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) Policy Publications

Revision History	Revision Date	Approval Date	Effective Date
Policy developed.	06/25/26	8/28/26	9/27/26

Important Reminder

This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This payment policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this payment policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This payment policy is the property of LHCC. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

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