Priority Health	BILLING POLICY No. 176
Emergency Department Level of Care	
Date of origin: Jan 2026	**Review dates: 2/2026, 3/2026, 04/2026**

DEFINITION

In line with industry standards and to ensure appropriate and fair level of facility reimbursement for outpatient ED services, Priority Health will be consistently reviewing high level evaluation and management services (E/M's) on a post-payment basis.

POLICY SPECIFIC INFORMATION

Time is not a descriptive component for emergency department (ED) E/M levels of service. Providers must use CPT codes 99282-99285 for ED visits for new and established patients. CPT codes 99281 - 99285 must only be submitted for services provided in an ED as defined by AMA CPT; "as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day," and "organized hospital-based facility" includes hospital owned free-standing EDs.

Providers may experience adjustments to, or denials of ED E/M code reported if the documentation does not support the E/M level submitted. E/M may be downcoded to an appropriate level.

Place of service

23 – Emergency department

Revenue Codes

Listing below is not all inclusive

045X – Emergency Room – General Classification

0981 - Professional Fees (Extension of 096X and 097X)-Emergency Room

Documentation requirements

Documentation must clearly demonstrate the severity of the patient's condition and the resources used.

Documentation must justify the level of E/M service billed. A higher-level E&M code should not be submitted when a lower-level service is appropriate. The amount of documentation alone should not drive code selection; instead, the medical record must clearly support the CPT and ICD codes reported on the claim.

Facility Requirements (Institutional)

Facility coding represents the hospital resources and staff effort utilized during the visit.

- Documentation must clearly demonstrate the scope and severity of the patient's condition and the specific hospital resources (nursing, supplies, equipment) deployed to manage the case.

As per CMS, in the absence of national guidelines, hospitals should use their internal guidelines to report emergency department visits. These guidelines should model the following criteria:

- Mirror the intent of the CPT code lay description relating to the intensity of hospital resources
- Based on hospital resources

- Clear to support accurate payments, be applicable for audits and compliance purposes
- Adhere to HIPAA requirements
- Clinically necessary documentation for patient care
- Should not enable gaming or upcoding
- Guidelines should provide the basis for selection of a code, be well-written and well-documented
- Applied uniformly across patients in the clinic or emergency department
- Should remain stable over time
- Should be easily accessible for review
- Produce coding decisions that can be independently verified by internal staff and external reviewers.

Physician & QHP Requirements (Professional)

Professional coding is driven by the complexity of Medical Decision Making (MDM) as defined by CPT guidelines.

- **History and Physical:** Must be performed only to the extent that is medically appropriate.
- **Level Selection:** Based on the complexity of the MDM, comprising:
    - **Complexity:** Number and nature of problems addressed.
    - **Data:** Amount and complexity of data reviewed and analyzed.
    - **Risk:** Risk of complications and/or morbidity or mortality of patient management.

Audit & Compliance Standards

- A higher-level E/M code must not be submitted when a lower-level service is medically sufficient.
- The medical record must explicitly support the reported CPT and ICD-10 codes to ensure billing compliance

Coding specifics

Claims for services provided in an emergency department should include all diagnosis and procedure codes relevant to the visit and be billed using the appropriate E/M level. **Please note:** Accurate billing of Emergency Department E/M services requires thorough documentation that clearly supports the resources used and the medical decision-making involved in the encounter.

Level 1 and Level 2 encounters generally represent minimal resource utilization and, in many cases, could be managed safely and appropriately in a non-ED setting, such as an outpatient office visit, if available.

Level 3 and Level 4 encounters reflect increasing complexity, urgency, and stabilization needs, requiring a combination of diagnostic and therapeutic services that are uniquely available within the emergency department, including immediate access to professional, specialty, imaging, and laboratory resources.

Levels 3 and 4 Emergency Department visits involve the use of multiple diagnostic and clinical resources, including **two or more diagnostic tests**.

The primary distinction between Level 3 and Level 4 visits is the **complexity and intensity of care required:**

- **Level 3 Emergency Department visits** generally involve patients with **stable medical conditions** that require **limited diagnostic evaluation, treatment, and management.** Care is typically straightforward and involves moderate provider time and resources.

- **Level 4 Emergency Department visits** are characterized by **greater clinical complexity,** requiring **more extensive diagnostic evaluation, increased clinical resources, and additional provider time** to assess and manage the patient's condition.

Patients who consume the greatest amount of emergency department resources—and therefore meet criteria for a Level 5 E/M service—typically require urgent, complex, and multifactorial care delivered at a high intensity. These patients are often admitted to the hospital or are otherwise unable to be safely discharged home, although a smaller subset may ultimately be discharged.

- **Level 5 Emergency Department visits** involve three or more diagnostic tests or advanced imaging such as a CT scan or MRI with contrast and represent the highest level of clinical complexity. These encounters typically require comprehensive diagnostic evaluation, intensive use of resources, and significant provider time due to the severity, acuity, or potential threat to life or bodily function.

CPT codes that will be reviewed:

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

G0384 - Level 5 hospital emergency department visit provided in a type B emergency department

Modifiers

25 – a significant and separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service

27 - Multiple Outpatient Hospital E/M Encounters on the Same Date

UA – Medicaid member admitted

UD – Medicaid member discharged

REFERENCES

AMA CPT manual appendix C – Evaluation and Management Extended Guidelines

Federal register Vol. 72 No. 227 66583 section IX. Hospital Coding and Payments for Visits, 2.C.3 Emergency Department visits, visit reporting guidelines pg. 226

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in

accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Jan 2026	New Policy
Feb 2026	Added clarifying language related to facility and professional documentation requirements Added rev codes Added reference to the federal register
March 2026	Removal of the "applies to" section Removal of the "For Medicare" section related to obtaining a PSOD Addition of the following verbiage to the disclaimer section: "*CMS and/or MDHHS guidelines apply unless otherwise specified in this policy. Where such guidance is absent, this policy applies.*"
April 2026	Clarification on the documentation requirements section of what "should not" Clarification on the coding specifics related to accurate billing and documentation. Addition of general characteristics of Emergency Department visit levels.