Priority Health	BILLING POLICY No. 176
Emergency Department Level of Care	
Date of origin: Jan 2026	**Review dates: None Yet Recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

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

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

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. The provider may resubmit the claim with a revised E/M code for denied claims.

Place of service

23 – Emergency department

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.

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.

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 to home, although a smaller subset may ultimately be discharged.

In contrast, 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.

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

Resources

https://www.bcbsm.com/content/dam/microsites/corpcomm/provider/the_record/2022/jul/Record_0722v.shtml
https://www.aetna.com/document-library/healthcare-professionals/documents-forms/ny-em-code-claim-review.pdf
https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/COMM-Emergency-Department-Facility-Evaluation-Mgmt-Policy.pdf
https://static.cigna.com/assets/chcp/secure/pdf/resourceLibrary/clinReimPolsModifiers/R36_Emergency_Room_Services.pdf

DISCLAIMER

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 for 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 to 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