Payment Policy: Leveling of Emergency Room Services

Reference Number: CC.PP.053
Last Review Date: 07/2025

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
To address an identified trend in upcoding by emergency room providers, the health plan has adopted a program integrity strategy that will provide appropriate levels of reimbursement for services indicating lower levels of complexity or severity rendered in the emergency room.

Application
Hospitals, free-standing emergency centers, physicians or other qualified health professionals.

Reimbursement
The Centers for Medicare and Medicaid Services (CMS) affords states the flexibility to independently develop reimbursement methodologies for the use of emergency department services for lower levels of complexity or severity.

When a hospital, free-standing emergency center or physician bills a Level 4 (99284) or Level 5 (99285) emergency room service, with a diagnosis indicating a lower level of complexity or severity, the health plan will reimburse the provider at a Level 3 (99283) reimbursement rate.

Utilization
A coding algorithm was developed with the advice of a panel of emergency department and primary care physicians and based on an examination of a sample of almost 6,000 full emergency department records. Data from these records was used to classify each case into one of four categories. These classifications were then mapped to the discharge diagnosis of each case to determine for each diagnosis the percentage of sample cases that fell into these four categories. The health plan's claims processing system incorporates a list of diagnoses developed by medical directors and compared to the algorithm to adjudicate emergency department claims. The claims processing system looks for diagnoses that involve a lower level of complexity or intensity of services (i.e. that are never or rarely associated with Levels 4 or 5 severity).

If the diagnosis code classification falls into a categorization indicating a lower level of complexity or severity, services billed at a Level 4 or Level 5 severity code, will be reimbursed at the Level 3 emergency department reimbursement level. A provider may appeal if the provider disagrees with how the claim was adjudicated.

Documentation Requirements
The patient's primary discharge diagnosis should be billed in the first diagnosis position on the emergency room claim form.

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
99281	Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional
99282	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making
99283	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making
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

References

1. *Current Procedural Terminology (CPT®)*, 2025
2. *Centers for Medicare and Medicaid Services*, CMS Manual System and other CMS publications and services.

Revision History	
08/10/2017	Initial Policy Draft Created
08/28/2017	Removed “non-emergent” language and replaced with “lower level of complexity or severity.” Removed redundant PLP language in second paragraph.
09/19/2017	Removed “team of physicians and nurses” language

05/17/2018	Removed first paragraph
08/15/2018	Re-worded for clarity
09/01/2019	Reviewed and revised
09/01/2020	Conducted annual review, updated important reminder and copyright dates, removed effective date
09/01/2021	Conducted review, updated policy dates, remove product type
09/01/2022	Conducted review, updated policy dates and copyright dates
03/21/2023	Updated CPT code descriptions (99281-99285) with current terminology
08/22/2023	Conducted review, updated policy dates and copyright dates
11/14/2024	Conducted review, updated policy dates and copyright dates
07/17/2025	Conducted review, updated policy dates and copyright dates

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations 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 plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. 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. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment 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. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

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