Emergency Department Evaluation and Management, Facility

Reimbursement Policy ID: RPC.0130.7100

Recent review date: 11/2025

Next review date: 08/2027

AmeriHealth Caritas Delaware reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas Delaware may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy outlines methodology utilized by AmeriHealth Caritas Delaware to determine appropriate reimbursement for Evaluation and Management (E/M) services rendered in an Emergency Department (ED) and reported by the facility on claim form UB-04 (CMS-1450).

Exceptions

Reimbursement of ED and/or Critical Care E/M services reported on claim form CMS-1500 is not addressed in this policy. (Refer to RPC.0066.7100 Evaluation and Management.)

Reimbursement Guidelines

For accurate reimbursement of facility claims the appropriate level E/M code for the complexity level of the visit must be billed. The codes used are based on facility guidelines, 99281-99285 or G0380-G0384. Correct codes for diagnostic and treatment services performed during the visit must also be submitted for reimbursement. ICD-10-CM diagnosis codes relevant to the reason for the patient's visit and any other complicating conditions or circumstances must also be submitted on the claim.

ED visit services include emergency room (emergency and non-emergency) visits. Each type of visit service is defined by a set of outpatient revenue codes. See below. In addition, emergency room services must be associated with an ICD-10-CM diagnosis code. If the diagnosis code indicates a “true emergency”, the visit is paid at an emergency rate.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

The correct revenue code must be used for appropriate reimbursement.

- 450 - general
- 451 – EMTALA emergency medical screening services
- 452 – ER services beyond EMTALA screening
- 456 – urgent care
- 459 - other

Payment for drugs and supplies used in conjunction with an ED visit are included in the flat rate payment. The following revenue codes identified as drugs/supplies will be denied as they are inclusive:

Revenue Code	Description
250	General Pharmacy
251	Generic drugs
252	Non-generic drugs
253	Take-home drugs
254	Drugs incident to other diagnostic services
255	Drugs incident to radiology
257	Nonprescription
258	IV solutions
259	Other pharmacy
260	IV therapy -general

261	Infusion Pump
262	IV therapy/pharmacy services
263	IV therapy/drug /supply delivery
279	Other supplies devices
343	Diagnostic radiopharmaceuticals
344	Therapeutic radiopharmaceuticals
264	IV therapy/supplies
273	Take home supplies
621	Supplies incident to radiology
622	Supplies incident to other diagnostic services
623	Surgical dressing
631	Single source drug
632	Multiple source drugs
633	Restrictive prescription
636	Drugs requiring detailed coding
637	Self-administered drugs

Definitions

EMTALA
The Emergency Medical Treatment & Labor Act (EMTALA) ensures public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

Evaluation and Management
Evaluation and management (E/M) codes represent services by a physician (or other health care professional) in which the provider is either evaluating or managing a patient’s health. Procedures such as diagnostic tests, radiology, surgery and other particular therapies are not considered evaluation and management services.

Facility Evaluation and Management Coding
CMS requires each hospital to establish its own facility billing guidelines for emergency department services. The level of service billed must be based on the intervention(s) that are performed in relationship to the medical care required by the presenting symptoms and resulting in diagnosis of the patient.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. The National Correct Coding Initiative (NCCI).
V. https://medicaidpublications.dhss.delaware.gov/docs/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1284&language=en-US&PortalId=0&TabId=94
VI. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-C/section-438.114.

Attachments

N/A

Associated Policies

RPC.0066.7100 Evaluation and Management

Policy History

11/2025	Reimbursement Policy Committee Approval
06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas Delaware from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section