# Emergency department: Level of Evaluation and Management Services

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These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement by Anthem Blue Cross (Anthem) Medicare Advantage if the service is covered by a member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a non-contracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem Medicare Advantage may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Anthem Medicare Advantage reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal, or Centers for Medicare and Medicaid Services (CMS) contracts and/or requirements. System logic or set up may prevent the loading of policies into the claims platforms in the same manner as described; however, Anthem Medicare Advantage strives to minimize these variations.
Anthem Medicare Advantage reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

## Policy

Anthem Medicare Advantage allows reimbursement for facility emergency department (ED) evaluation and management (E&M) services unless provider, federal or CMS contracts and/or requirements indicate otherwise. Reimbursement for facility ED services is based on the highest level E&M code for which a claim qualifies.
Anthem Medicare Advantage determines the appropriate level of ED E&M code by classification of intensity and/or complexity of resources or interventions a facility utilizes to furnish all services indicated on the claim. Providers must utilize appropriate CPT/HCPCS and revenue codes for all services rendered during the ED encounter.

Anthem Medicare Advantage classifies the intensity/complexity of facility interventions used for services with an E&M code level. E&M services will be reimbursed based on this classification at the highest E&M level supported on the claim.

## Exclusions

- ED visits resulting in observation status or inpatient admission
- Critical access hospital services
- Trauma or critical care services
- Surgical intensive care services

**Note:** Anthem Medicare Advantage adheres to the requirements of the Emergency Medical Treatment and Labor Act (EMTALA) and federal managed care regulations.

**URL:** https://providernews.anthem.com/california/article/emergency-department-level-of-evaluation-and-management-services

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