Revised Emergency Department (ED) Outpatient Facility Evaluation and Management (E/M) Coding Policies

Dear Community Health Choice Provider,

As part of our continued efforts to reinforce accurate coding practices, Community Health Choice has revised the current Emergency Department (ED) outpatient facility Evaluation and Management (E/M) coding reimbursement policy and procedure. This revision applies to the following plans as of the dates shown below:

- Medicaid, Medicare, Market Place Plans, effective February 1, 2026

The policy focuses on outpatient facility ED claims that are submitted with level 1 (99281, G0380), level 2 (99282, G0381), level 3 (99283, G0382), level 4 (99284, G0383), or level 5 (99285, G0384) E/M codes. The policy was developed to address inconsistencies in coding accuracy. They are based on the E/M coding principles created by the Centers for Medicare and Medicaid Services (CMS) that require hospital ED facility E/M coding guidelines to follow the intent of CPT® code descriptions and reasonably relate to hospital resource use.

The policy will apply to all facilities, including freestanding facilities, which submit ED claims with level 1, 2, 3, 4, or 5 E/M codes for members of the affected plans, regardless of whether they are under contract to participate in our network.

As part of the implementation of these policies and procedures, we will begin using the Optum Emergency Department Claim (EDC) Analyzer tool, which determines appropriate E/M coding levels based on data from the patient's claim including the following:

- Presenting problem
- Diagnostic services performed during the visit.
- Any patient complicating conditions

To learn more about the EDC Analyzer™ tool, please visit Emergency Department Claim (EDC) Analyzer | Optum Business

Facilities submitting claims for ED E/M codes may experience adjustments to level 1, 2, 3, 4, or 5 E/M codes to reflect an appropriate level E/M code or may receive a denial, based on the reimbursement structure within their contracts with Community Health Choice. Facilities may submit a reconsideration or appeal request to validate a higher-level E/M code in accordance with the terms of their contract. If a reconsideration or appeal request is submitted, medical records are required. If medical records are not submitted with the request, the original determination will be upheld for lack of supporting documentation.

Criteria that may exclude outpatient facility claims from level adjustment include, but not limited to:

- Claims for patients who were admitted from the emergency department or transferred to another health care setting (Skilled Nursing Facility, Long Term Care Hospital, etc.)
- Claims for patients who received critical care services (99291, 99292)
- Claims for patients who are under the age of 2 years.

- Claims with certain diagnosis codes that when treated in the ED most often necessitate greater than average resource usage, such as significant nursing time.
- Claims for patients who expired in the ED.

If you need further information, please contact your Network Representative at ProviderWebInquiries@CommunityHealthChoice.org or 713-295-2295.