

## National Coverage Provision

**Subject Name:**

Emergency Department Services

**Subject Number:**

PHYS-021

**Subject Type:**

An operational statement of national coverage policy.

**Indications and Limitations of Coverage and/or Medical Necessity**

- A. *Coverage for emergency department (ED) services under Part B is for the physician services provided. The services of the facility, auxiliary personnel, drugs and the supplies are considered to be a Part A benefit.*
- B. *ED services (CPT codes 99281-99285) are used to bill for services for patients that are registered in the ED of a hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention.*
1. *ED services are not covered in a site of service of office, outpatient, or any setting other than an ED. These codes should not be used for services provided in other areas of the hospital, or for observation care.*
  2. *ED services may be billed by physicians that are not assigned to the ED. Any physician that provides services in the ED may use these codes to report the services.*
  3. *ED services are covered regardless of whether the services were emergency service (e.g., non-emergency service). The only requirement for using the ED codes is that the patient is seen in the ED for an unanticipated service. Normally a lower level ED code would be reported for such a non-emergency condition*

**NOTE:** *If the physician asks the patient to meet him/her in the ED as an alternative to the physician's office, and the patient is not registered as a patient in the ED, the physician should bill the appropriate office/outpatient visit codes.*

4. *No distinction is made for new or established patients in the ED setting.*
5. *Physician service level of care should be considered similar to an office visit when determining the level of service provided.*
  - a. *A physician service includes obtaining the history, the physical exam, ordering and interpreting the x-rays, EKG, cardiac monitoring, laboratory tests, making an assessment, and ordering treatments.*
  - b. *Additional services should be listed as performed. For example, this would include suturing lacerations or applying a cast.*
6. *X-rays and EKGs Furnished to ED Patients As of January 1, 1996, Medicare allows payment for the interpretation of an x-ray or an EKG furnished in an ED setting by a hospital's radiologist or cardiologist, respectively, to either the specialist or the treating physician*

- a. *The professional component of a diagnostic procedure furnished to a beneficiary in a hospital includes an interpretation and written report for inclusion in the beneficiary's medical record maintained by the hospital.*
  - b. *There is a distinction between an "interpretation and report" of a x-ray or an EKG procedure and a "review" of the procedure. A professional component billing based on a review of the findings of these procedures, without a complete, written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for separate payment of the service since the review is already included in the ED evaluation and management (E/M) payment.*
    1. *For example, a notation in the medical records saying "fx-tibia" or EKG-normal would not suffice as a separately payable interpretation and report of the procedure and should be considered a review of the findings payable through the E/M code.*
    2. *An "interpretation and report" should address the findings, relevant clinical issues, and comparative data (when available).*
- C. *ED or Office/Outpatient services on the same day as a Nursing Facility admission. ED services are not separately covered on the same day as a comprehensive nursing facility assessment. Payment for evaluation and management services on the same date provided in sites other than the nursing facility are included in the payment for initial nursing facility care when performed on the same date as the nursing facility admission.*
- D. *Physician billing for ED services provided to a patient by both the patient's personal physician and the ED physician. When a physician advises his/her own patient to go to the ED of a hospital for care, and subsequently is asked by the ED physician to come to the hospital to evaluate the patient and to advise the ED physician as to whether the patient should be admitted to the hospital or be sent home, the physician should bill as follows:*
1. *If the patient is admitted to the hospital by the patient's personal physician, then the patient's regular physician should bill only the appropriate level of the initial hospital care (codes 99221-99223). All evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The ED physician who saw the patient in the emergency department should bill the appropriate level of ED codes.*
  2. *If the ED physician, based on the advice of the patient's personal physician who came to the ED to see the patient, sends the patient home, the ED physician should bill the appropriate level of ED service. The patient's personal physician should also bill the level of ED code that describes the service he/she provided in the ED. The patient's personal physician would not bill a consultation because he/she is not providing information to the ED physician for his/her use in treating the patient. If the patient's personal physician does not come to the hospital to see the patient, but only advises the ED physician by telephone, the patient's personal physician may not bill.*
- E. *Reporting of a visit when a patient is seen in the ED and the ED physician requests another physician to see the patient in the ED or office/outpatient setting.*
1. *If the ED physician requests that another physician evaluate a given patient, the other physician should bill a consultation if the criteria for consultation are met.*
  2. *If the criteria for a consultation are not met and the patient is discharged from the ED or admitted to the hospital by another physician, the physician contacted by the ED physician should bill an ED visit.*

3. *If the consulted physician admits the patient to the hospital and the criteria for a consultation are not met, he/she should bill an initial hospital care code.*
4. *If the service is furnished in the physician's office, an outpatient/office visit would be reported.*

**F. Physicians in Group Practice**

1. *Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.*
2. *Physicians in the same group practice but who are in different specialties must bill and be paid without regard to their membership in the same group practice.*

**G. Critical Care**

1. *If critical care is required upon the patient's presentation to the ED, only critical care codes 99291 - 99292 may be reported. ED codes will not be paid for the same day*
2. *If there is a hospital or office/outpatient evaluation and management service furnished early in the day and at that time the patient does not require critical care, but the patient requires critical care later in the day, both critical care and the evaluation and management service may be paid.*
3. *Submit documentation when critical care is billed on the same day as other evaluation and management services.*

**H. ED services (99281-99285) are considered included in radiation treatment management codes.**

**II. Coding Guidelines:**

1. List the appropriate CPT code; 99221,-99223; 99281-99288; or 99291-99292.
2. List the appropriate ICD-9 code that reflects the reason for the service. Documentation in the patient's progress notes must support medical necessity and be available upon request.
3. Submit documentation to support special situations such as when critical care is billed on the same day as other E&M services.

**CPT/ HCPCS Section & Benefit Category:**

Evaluation and Management Services

**CPT/HCPCS Codes**

99221-99223; 99281-99288; \*99291-99292

**ICD-9 Codes that Support Medical Necessity**

N/A

**Reasons for Non-Coverage:**

Non-coverage and medical necessity

**Documentation Requirements:**

See Indications and Limitations of Coverage.

**Other Comments:**

\*This NCP replaces Tri State PHYS-021 and becomes Quad State PHYS-021.

**Sources of Information:**

MCM §15504, 15505, 15507; MCM§ 15501.H, 15508 F, 15023, TR 1644.

Title XVIII of the Social Security Act §1862.

**AMA CPT Copyright Statement**

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