Payment Policy: Emergency Department Care

Reference Number: QCP.PP.040
Last Review Date: 07/1/2026

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

Effective Date:

a) This policy will apply to all services performed on or after the above revision date which will become the new effective date.
b) For all services referred to in this policy that were performed before the revision date, contact customer service for the rules that would apply.

1. The hospital emergency department setting is only intended to treat patients who are experiencing a medical or psychological emergency. Emergency Department care requires any medical condition of a recent onset and severity, leading a prudent layperson to believe that the condition is of such a nature where failure to seek immediate medical care could result in placing the person's health in serious jeopardy. An emergency situation is serious, arises quickly and threatens the life or welfare of a person.
2. Services rendered in the Emergency Department for non-emergent conditions are not covered.
3. Physician Extenders (licensed Advanced Practice Nurses (APN) and Physician Assistants (PA)) are not eligible for reimbursement of the highest level (level 5) E&M emergency department code, 99285. For this level of complexity, direct physician involvement is expected.

Medical Statement

1. Below are examples of conditions that are not considered medical emergencies and therefore are not covered in the Emergency Department setting:
    a. Common superficial skin conditions (fungal infections, lice, scabies) (B35.0 – B36.9, B85.0 – B86)
    b. Benign skin growths/nevi (D22.0 – D23.9)
    c. Intellectual disabilities (F70 – F79)
    d. Disorders of Refraction and Accommodation (H52.0 – H52.4, H52.6, H52.7)
    e. Dental disorders:
        i. Disorders of tooth development and eruption (K00.0 – K00.9)
        ii. Dental Caries or other non-traumatic diseases (K02.3 – K03.9)
        iii. Dental infections including periapical abscess (K04.2 – K04.99)
        iv. Gingival and periodontal diseases (K05.00 – K05.20, K06.010– K06.9)
        v. Other diseases and conditions of teeth and supporting structures (K08.0 – K08.409, K08.421 – K09.9, M27.3)
        vi. Dentofacial anomalies, including malocclusion (M26.00 – M26.59)
        vii. Dental alveolar anomalies (M26.70 – M26.9) f) Chronic skin conditions or growths (psoriasis, actinic keratosis, seborrheic keratosis, corns, g) Calluses (L40.0 – L40.9, L57.0 – L57.9, L82.1 – L84)
    f. Vaginitis and vulvovaginitis (N76.0 – N76.3, N77 – N77.1) if 7 years of age or older
    g. Aftercare for healing fractures or sequelae of healed fractures—as opposed to acute fractures

h. Generally, when some circumstance or problem is present which influences the person`s health status but is not in itself a current illness or injury (Z00 – Z99). This includes wound dressing changes, care for artificial openings and ostomies, postoperative care and removal of drains, and aftercare after explantation of prosthesis. However, the following 'Z' diagnosis code exceptions are covered:
    i. Immunizations (Z23) ONLY for Rabies vaccination (CPT 90675 – 90676) and Tetanus (CPT 90714 – 90715) in case of an injury
    ii. Childbirth and delivery (Z37.0 – Z38.9)
    iii. Persons with potential health hazards related to communicable diseases (Z20 – Z29)
    iv. Occupational exposure to risk factors (Z57.1 – Z57.6)
    v. Exposure to hazardous chemicals (Z77.01 – Z77.098) 2)

2. Constipation (K59.00- K59.09) will deny for medical record review. If review of medical records determines the presenting symptoms are consistent with an acute abdomen and requires ruling out of potentially serious conditions, coverage will be approved. On the other hand, if constipation is obvious with no symptoms suggestive of a potentially serious condition, coverage will be denied. In this situation the presenting symptoms are more relevant than the final diagnosis.

Application to Products

This policy applies to all health plans administered by QualChoice, both those insured by QualChoice and those that are self-funded by the sponsoring employer, unless there is indication in this policy otherwise or a stated exclusion in your medical plan booklet. Consult the individual plan sponsor Summary Plan Description (SPD) for self-insured plans or the specific Evidence of Coverage (EOC) for those plans insured by QualChoice. In the event of a discrepancy between this policy and a self-insured customer's SPD or the specific QualChoice EOC, the SPD or EOC, as applicable, will prevail. State and federal mandates will be followed as they apply.

Changes: QualChoice reserves the right to alter, amend, change or supplement benefit interpretations as needed

Important Reminder

This PAYMENT POLICY has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this PAYMENT POLICY; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this PAYMENT POLICY. This PAYMENT POLICY is consistent with standards of medical practice current at the time that this PAYMENT POLICY was approved. "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 of such health plan's affiliates, as applicable.

The purpose of this PAYMENT POLICY is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions 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 Health Plan-level administrative policies and procedures.

This PAYMENT POLICY is effective as of the date determined by the 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. The Health Plan retains the right to change, amend or withdraw this PAYMENT POLICY, and additional clinical 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 PAYMENT POLICY are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This PAYMENT POLICY is the property of the Health Plan. Unauthorized copying, use, and distribution of this PAYMENT POLICY or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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, LCDs, and Medicare Coverage Articles 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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