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MANAGED BY HOME STATE HEALTH



FROM



Provider Notice: Emergency Department Facility E/M Leveling Update

Effective Date: September 15, 2026

Line of Business: Home State Health, Show Me Healthy Kids, Ambetter from Home State Health, Wellcare, Wellcare by Allwell

Applies To: Hospital-based and Free-Standing Emergency Departments

Claim Type: Institutional Claims (UB-04 / 837I)

Summary

Home State Health is updating the vendor and methodology used to evaluate Emergency Department (ED) facility Evaluation and Management (E/M) levels. This update enhances an existing ED facility leveling process and does not introduce denials or remove appeal rights. The change is designed to increase transparency, consistency, and alignment with CMS guidance regarding facility resource utilization.

What Is Changing

Home State Health is transitioning its ED facility E/M leveling review from Policy CC.PP.064 (Optum EDC Analyzer) to Policy CC.PP.80 (Cotiviti Leveling of Care: Emergency Department E/M Over coding for Facility).

While ED facility leveling has been in place, this update introduces several material enhancements to how claims are evaluated:

- Updated Vendor: Cotiviti will replace Optum as the leveling vendor
- Pre-Payment Review: Claims are evaluated prior to payment rather than post-payment estimation- Clinical Review Integration: Incorporates nurse clinical review prior to final adjustment
- Level 3 Payment Floor: Claims will not be reduced below Level 3 (CPT 99283 / HCPCS G0382)



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What Is Not Changing

- Resource-Based Methodology: Review is still based on services and resources billed (e.g., labs, imaging, treatments), not diagnosis codes
- Enhanced Transparency: Clear alignment to facility resource consumption consistent with CMS guidance
- ED facility E/M services are not denied under this policy
- Claims may be adjusted downward only when the billed level exceeds what is supported
- Appeal rights remain unchanged
- The policy continues to apply only to facility E/M services (CPT 99281–99285; HCPCS G0380–G0384)
- No changes are made to physician professional E/M coding

How Claims Are Evaluated

Under CC.PP.80, ED facility E/M levels are determined using a resource-consumption model that evaluates:

- Diagnostic and treatment services billed
- Intensity and combination of services
- Historical claim patterns
- Overall facility resource utilization

Diagnosis codes are not used to determine facility E/M leveling.

Why This Update Is Being Made

This transition improves consistency, predictability, and provider transparency by:

- Aligning more closely with CMS guidance on ED facility resource consumption
- Standardizing review criteria across Medicaid programs
- Providing explicit provider-protective safeguards, including a Level 3 minimum payment floor



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Importantly, this update enhances an existing leveling program rather than introducing a new payment policy.

No immediate action is required. Providers should continue to submit ED facility claims using standard CMS-compliant coding and documentation practices that accurately reflect the services and resources provided.

Questions or Appeals

Providers may continue to exercise existing appeal rights according to their contract and standard claims appeal processes. For policy-related questions, please contact Provider Services.