Payers Are Shoplifting in Your Emergency Department
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The attempt by Anthem and other payers nationwide to re-write the prudent layperson (PL) standard (1) is an industry changing event. It is being monitored and challenged by industry organizations including EDPMA.

Let’s walk back through history to understand why this attack is happening now.

The EMTALA obligation was established by Congress in 1986 to prevent patient dumping (cf. ED Patient Eugene Barnes and Congressman Peter Stark). As a result, when a patient presents to an emergency department, they will receive a medical screening exam (MSE).

The MSE in most hospitals is defined as the exam performed by the physician or APP in the ED, not the exam performed by a nurse in triage. If an emergency medical condition (EMC) is identified, EMTALA requires it be stabilized (at that hospital, or through transfer if the condition is beyond the hospital’s or provider’s skill set, etc.).

There are rare examples of systems in which the patients are currently “triaged-out” from the ED before being evaluated by a provider, but these typically have an established network of clinics or other sites where time sensitive primary care appointments can be arranged immediately. Most EDs cannot provide this and therefore must treat the patients.

After EMTALA was established payers began to deny payment for emergency services based on “not an emergency” or other similar language. Patients were aware of these denials and would not present for care if they were unsure whether they were having an emergency or would delay care while they made attempts to get prior authorization from the payer before seeking care. Care was delayed or not provided and several cases made public headlines.
ACEP and other interested parties worked with Congress and in 1997 the Balance Budget Act established the “prudent layperson” standard, first for Medicaid, then Medicare.

Here are some excerpts from a letter Timothy Westmoreland, Director of HCFA in the late 1990s and early 2000s, wrote to State Medicaid Directors and their respective MCOs (managed care organizations) in April, 2000, regarding the PL standard and its intended purpose.

*The BBA addresses emergency services using a prudent layperson standard. It defines an "emergency medical condition" as:*

> a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

*The BBA requires that a Medicaid beneficiary be permitted to obtain emergency services immediately at the nearest provider when the need arises. When the prudent layperson standard is met, no restriction may be placed on access to emergency care. Limits on the number of visits are not allowed.*

Note that payers may not deny coverage solely on the basis of ICD-9 codes. Payers are also barred from denying coverage on the basis of ICD-9 codes and then requiring resubmission of the claim as part of an appeals process. This bar applies even if the process is not labeled as an appeal. Whenever a payer (whether an MCO or a State) denies coverage or modifies a claim for payment, the determination of whether the prudent layperson standard has been met must be based on all pertinent documentation, must be focused on the presenting symptoms (and not on the final diagnosis), and must take into account that the decision to seek emergency services was made by a prudent layperson (rather than a medical professional).

States over time enacted PL standards forcing commercial payers into this payment standard as well. However, ERISA plans (Employee Retirement Income Security Act, 1974), provide coverage for about 50% of all non-governmentally insured patients, through self-insured employers, and are not subject to any state-specific PL standard. ERISA is governed at the federal level and has no PL standard in its law.

Seema Verma, the designer of the “Healthy Indiana” Medicaid plan, is the newly appointed Administrator of CMS. The current Indiana Medicaid expansion plan requires emergency department providers to assess if an EMC exists. If the ED provider feels that the PL standard is not met the provider, “may collect the copayment at the point of service.” This suggests that we are in for more of these programs that inappropriately move the patient away from ED care.

The ACA brought into focus the fact that healthcare costs simply must be reduced and a reduction in emergency department visits was part of the formula. Self-insured employers are actively working to keep costs down (2) and are not obligated to follow a PL standard for claims payment. State budgets are stretched and their Medicaid costs continue to rise.
Claims denial or the threat of nonpayment for PL is now an easy and popular target for the media, state governors and the insurers. What we know is that multiple studies have shown no concordance between discharge diagnosis and the existence of an EMC or appropriate use of the ED. (3,4) The Billings, Parikh, et.al. study at NYU was a test of access to basic primary care but is repeatedly misused by payers. (5)

Payment policy now is returning ED use to the mid-1990s making patients fear using the ED, lest a financially motivated third party decides incorrectly on discharge diagnosis that the PL was not met. With medical bills now being the biggest cause of bankruptcies in America, patients have reason to fear (6) seeking care in the ED.

Currently the Emergency Department Practice Management Association (EDPMA) is reaching out to payers and other industry organizations to monitor this issue. We believe that patients seeking ED treatment under the belief that they have good insurance should not get “surprise” bills when the payer believes that they know better than the physician what is good for them. We must stop this payer theft of ED services.

We have distributed the “no-pay” list to the committees and billing companies for monitoring. Our hope is to move this discussion back to the federal level and avoid a state-by-state, payer-by-payer fight.

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