

Fighting Managed Care Denials in the Emergency Department

ACEP Reimbursement Committee 1999

Beginning in the 1970s, employers became increasingly concerned about the rising cost of health insurance premiums for their employees. By the late 1980s, double-digit premium inflation was becoming commonplace. Throughout those two decades, and into the 1990s, employers began to modify the health care benefits they offered to their employees in response to rising costs. Traditional indemnity insurance simply had become too expensive for most businesses. Health care policies that provided first dollar coverage or very low co-payments and deductibles were replaced with managed care plans that promised affordability, cost controls, and quality health care.

By definition, most forms of managed care tend to be in conflict with emergency medicine's core mission and federal mandate to see all patients regardless of insurance type or socioeconomic status. For enrollees in managed care plans, unrestricted access to emergency departments runs counter to managed care's business model, which is designed to decrease health care utilization while enhancing profitability. To that end, most managed care organizations (MCOs) have discouraged access to emergency department services by erecting various administrative barriers. These administrative hurdles frequently involve retrospective denials, pre-authorization requirements, random down-coding, modification of accepted CPT theory, prolonged payment of "clean" claims, and disregard for the prudent layperson definition of what constitutes an emergency condition. Although 26 states have enacted legislation to address these tactics, problems still exist.

To combat these and other MCO strategies, emergency physicians must work through a maze of MCO internal bureaucracy and an entanglement of federal and state laws. This article will review appurtenant

regulations and laws affecting managed care reimbursement and will serve as a resource to help emergency physicians with managed care claim denials.

Federal Law

Employee Retirement Income Security Act of 1974

According to the National Association of Insurance Commissioners, one third of people who have health insurance are covered by Medicare or Medicaid, another third by a health insurance policy that is regulated by state laws, and the remaining third by a health plan regulated by the US Department of Labor under the Employee Retirement Income Security Act of 1974 (ERISA). Before 1974, most employers bought health coverage primarily from indemnity insurance companies. Only a small percentage purchased health coverage from health maintenance organizations (HMOs). Concerned about the nation's shaky private pension system and looting of employees' pension benefits by shady employers, Congress passed ERISA to provide federal protection for employee retirement and welfare benefits. Almost as an afterthought, Congress included group health insurance and other employee benefit plans under the law's protection. Now most health benefit plans offered through large private employers are governed by ERISA.

ERISA plans have proved to be financially stable and have demonstrated significant cost savings for businesses. ERISA preempts state regulation of HMOs administered by self-insured employee benefit plans. This preemption provision has been broadly interpreted by the courts to include any state laws, regulations, or court decisions that "relate to" an employee benefit plan, such as laws mandating prudent layperson coverage or mental health coverage. Until recently, courts have also interpreted the ERISA preemption clause to include exemption from malpractice and negligence lawsuits.

The ERISA preemption clause creates an incentive for employers to self-fund their plans and thus falls under ERISA protection. Because ERISA plans are exempt from state mandates and regulations, they do not

need to be as comprehensive in their coverage as plans that fall under state jurisdiction. It is easier for such plans to deny care because state law protection for patients are unavailable and federal remedies for the wrongful denial of claims are limited to compensatory damages. In addition, federal enforcement of ERISA has been less than rigorous. Although few states have adopted laws designed to improve the way emergency coverage is provided, self-funded or ERISA plans are exempt from these state regulations. Government employees, participants in health plans sponsored by churches and individuals who purchase their own health coverage are not subject to ERISA preemption.

Self-funded plans have succeeded in containing costs for employers while maintaining an adequate level of satisfaction among employees. For example, the employer in an ERISA plan has no fiduciary responsibility to its employees. Therefore, if an employee develops an illness such as AIDS, it is perfectly legal under ERISA for the employer to subsequently amend the plan to eliminate coverage for this or any other disease. ERISA plans also are able to avoid the administrative and solvency costs associated with state insurance regulation by self-funding. As a result, they are able to operate without the minimum net worth and deposit requirements that apply to other health insurers. Finally, businesses are generally able to predict with great accuracy-95% to 98%-the amounts of health benefit payments in a given year. For all these reasons, ERISA plans are now the health insurance of choice among large employers.

The conversion of employee health benefit plans from indemnity insurance to self funding represents a dramatic shift in health care funding, one that has largely gone unnoticed by both the public and, until now, health care providers. In most cases, a self-funded plan hires an insurance company or a third-party administrator to manage the plan. When an insurance company administers a plan, it is called an "administrative and services only" arrangement. The administrator generally makes all the arrangements with providers, performs utilization review, and pays claims made for employees' medical services. Patients and providers deal directly with an insurance company that is acting on behalf of the employer and are frequently unaware that the insurer is functioning in an administrative capacity only.

A patient who challenges the denial of benefits in a self-funded plan must bring a claim under ERISA. When this happens, all state law remedies are preempted. Several steps must be followed to successfully challenge an ERISA denial.

Internal Plan Remedies. All ERISA plans contain provisions that allow for internal review of initial claim denials. When the plan administrator denies coverage, there are prescribed steps the claimant must follow to seek review of the decision. The claimant must be adequately informed of the denial, the basis for the denial, and the review procedure. The claimant must first exhaust any internal review or administrative remedies offered by the plan.

Court Jurisdiction. Once internal plan remedies have been exhausted, an ERISA claim can be filed in either state or federal court. Most claimants file in state courts, which tend to move faster than federal courts.

Standard of Review. The standard of review was established by *Firestone Tire & Rubber Co v Bruch* (103 L Ed 2d 80 [1989]). In this case, the Supreme Court confirmed that a challenge to a denial of benefits is to be given de novo review unless the benefit plan has given the plan administrator discretion in determining eligibility for benefits in interpreting terms of the plan.

This ERISA preemption clearly favors defendant insurance companies and plan administrators. Claimants must fight against a heightened standard of review, with a severely curtailed opportunity to present evidence and cross-examine adverse witnesses. Prevailing claimants can only recover payment of benefits (compensatory damages) to the extent allowed by the plan, and perhaps attorney fees. Recently, federal courts have begun offering a more liberal view of ERISA regulations that have favored claimants.

Prudent Layperson Standard

In 1994, the Board of Directors of the American College of Emergency Physicians (ACEP) adopted the following definition of an emergency service:

Emergency services are those health care services provided to evaluate and treat medical conditions of recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that urgent and/or unscheduled medical care is required.

An emergency condition is any medical condition of recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions or
- Serious dysfunction of any bodily organ or part

This prudent layperson standard addresses issues such as prior authorization and denials of coverage for emergency care, and discourages health plans from developing their own lists of "appropriate" emergency medical conditions. The prudent layperson standard defends the rights of patients to have access to emergency department care when they believe their symptoms warrant it. Patients, who conclude they have emergency medical conditions, belong in an emergency department, not sparring with a health plan over access to care.

Kaiser Permanente was one of the first MCOs to endorse the prudent layperson standard. Working with ACEP, Kaiser developed its own consumer protection principles in 1996, which included the prudent layperson standard. Kaiser has also worked with ACEP to support federal prudent layperson standards.

Federal legislation that incorporates the prudent layperson standard has been introduced in the 106th Congress (see section on National Healthcare Reform). Several states also have adopted prudent layperson standards.

Balanced Budget Act of 1997

The Balanced Budget Act of 1997 includes changes to the Medicare and Medicaid programs that directly affect emergency physicians. One of the most significant changes was the implementation of a new program of private health care coverage choices called Medicare+Choice, also known as Medicare Part C. In this new program, expanded health care coverage options include HMOs, preferred provider organizations, provider-sponsored organizations, and private fee-for-service. With these new programs, it was the government's intention to move the majority of older persons into managed care products.

The Balanced Budget Act mandates Medicare and Medicaid and their respective MCO variants (e.g., Medicaid HMOs) to follow the prudent layperson standard. The Balanced Budget Act definition of prudent layperson specifically includes severe pain. Because the Balanced Budget Act unequivocally encompasses managed care entities, the argument that federal regulation of emergency services applies only to fee-for-service has been eliminated.

The law also specifically prohibits prior authorization mandates for emergency services. Prior authorization is especially problematic for emergency department personnel. Consent for reimbursement is frequently approved or denied by MCO personnel who make decisions about the urgency of a patient's condition over the telephone without benefit of a hands-on examination, and generally without the training to make such judgments. Most legal experts agree that pre-authorization in the emergency department results in unnecessary delays and constitutes a violation of the Emergency Medical Treatment and Active Labor Act, or EMTALA.

Despite the clear prohibition of prior authorization by the Balanced Budget Act, several Medicaid HMOs continued to insist on prior authorization for emergency department patients. To address this illegal practice, Sally K. Richardson, director of the Center for Medicaid and State Operations, reconfirmed in a letter of guidance published in May 1998 that Medicare and Medicaid managed care plans are not to require prior authorization as well as mandates payment for prudent layperson emergencies. This letter can be downloaded from the Health Care Financing Administration (HCFA) web site:

(<http://www.hcfa.gov/medicaid/bba5698.htm>)

The Balanced Budget Act has expanded the scope of services that are to be covered as emergency services to inpatients as well as outpatients. Medical services must be provided by qualified providers and are to be “needed to evaluate or stabilize an emergency medical condition.” This standard applies to both a recipient and to an unborn child of a recipient, which means that it covers emergencies that could endanger a fetus. In addition, the new standard directly addresses MCOs’ obligations to pay for post-stabilization care. Previously, advocates had to argue that managed care plans should cover costs associated with hospitals’ obligation to comply with EMTALA, which requires that hospital emergency departments screen and stabilize emergency department patients and transfer them to other facilities only with informed consent. These refinements of the scope of emergency services are more comprehensive than that in previous federal regulations.

The law also requires that all managed care entities comply with guidelines regarding “the efficient and timely coordination of appropriate maintenance and post-stabilization care.” Although the guidelines on post-stabilization care are to apply to Medicaid managed care plans after the guidelines are developed; nothing in the BBA actually requires the government to establish these guidelines.

The Balanced Budget Act extends existing protections against balance billing (i.e., charging Medicaid recipients the difference between amounts paid by the Medicaid program and the provider’s usual charges)

to Medicaid MCOs and their subcontracting, referral, and other providers. This means that MCOs and their participating providers will receive only those amounts specified in their contracts and cannot bill beneficiaries any additional charges.

Existing statutes and regulations prohibit Medicaid HMO enrollees from being held liable if a health plan becomes insolvent. Under the Balanced Budget Act, a new provision extends this requirement to individual providers in the managed care network. Enrollees also are not responsible for costs of services provided if the state fails to pay the MCO or if the state or MCO fails to pay a subcontracting or referral provider. By prohibiting providers from seeking payments from beneficiaries, the Balanced Budget Act provides an important new protection against collection actions in cases in which a state, an MCO, and/or a provider is at odds over payment. In addition, enrollees are not to be charged by contracting or referral providers for payments that are in excess of the amount that would be owed by the individual if the organization had directly provided their services. States can allow MCOs to impose cost sharing in MCOs to the same extent that it is allowed in fee-for-service.

Medicaid MCOs must provide payments to health care providers on a timely basis consistent with the claims payment procedures required of the state unless the health care provider and the organization agree to an alternative payment schedule. Federal claims payment procedures require the MCO to pay 90% of claims (for which no further written information is required) within 30 days to receipt and 99% of such claims within 90 days. Nonetheless, because of the option to “agree to an alternative payment schedule,” the standards for timeliness could have little force.

<http://www.ACEP.org/MEMBERS/AN970901.HTM>

Emergency Medical Treatment and Active Labor Act (EMTALA)

EMTALA also known as “COBRA” because it was passed as part of the Comprehensive Omnibus Budget Reconciliation Act of 1986, mandates that all persons who present to emergency departments of Medicare-participating hospitals, seeking medical care receive a medical screening examination regardless of their ability to pay. The law also requires emergency departments to provide stabilizing care to any of these patients who are determined (by the screening examination) to have an emergency medical condition. MCOs recurrently have tried to “game” EMTALA by applying a restrictively narrow definition of an emergency medical condition, or by claiming that a condition was not a true emergency. Many MCOs have required pre-authorization before agreeing to pay for emergency care. As a result, emergency departments are obligated to provide services to MCO patients even when their managed care plans refuse to pay.

In November 1998, HCFA sent to its regional offices and state survey agencies revised EMTALA enforcement guidelines. In this revision, the US Office of the Inspector General (OIG) announced its intention to augment enforcement of EMTALA, emphasizing the prohibition against pre-authorization or any delay in treatment based on payer status. <http://www.dhhs.gov/progorg/oig/frdalrt/patientdump.htm>

As of July 14, 1998, these revised guidelines went into effect and will be used by the OIG to enforce EMTALA. These new guidelines provide the following clarifications:

- A clearer definition of the scope of the medical screening examination.
- That the determination of whether an emergency medical condition exists is made by the examining physician actually caring for the patient at the treating facility, not the managed care plan.
- Expanded definition of "to stabilize," setting out criteria for patients who are "stable for transfer" and those who are "stable for discharge."
- That the determination of a patient being "stable for transfer" or "stable for discharge" does not require the final resolution of the emergency medical condition.

- In case of a disagreement over whether a patient is stable for transfer, the medical judgment of the treating physician should take precedence over that of an off-site physician.
- Identifies best practices
- No prior authorization before screening or stabilization.
- No financial responsibility or advanced beneficiary notification forms prior to performing an appropriate medical screening examination

The advisory bulletin raises concerns about dual staffing arrangements, in which a hospital permits an MCO to station its own physicians in the hospital's emergency department. In this arrangement, the MCO physician is present in the emergency department specifically to screen and treat MCO patients who request emergency services. As a result, two separate physician groups are providing care using different policies and protocols, performing different procedures, and using different referral practices and drug formularies, relying on different on-call physicians, and having different credentials. Historically, HCFA has suggested that it considers this inherently unequal care, that exists only for the purpose of removing managed care patients from the emergency department and putting them back into the managed care system.

HCFA and the OIG have shown no reluctance in enforcing EMTALA regulations. In 1996, 127 violations were recorded, 44% related to the medical screening examination and 49% related to transfer violations. An estimated one third of hospitals in the United States have been investigated for alleged EMTALA violations.

<http://www.ACEP.org/policy/rs980715.htm>

Medical Necessity

"Lack of medical necessity" is often cited as a reason for claim denial. This can happen even if an inpatient admission was pre-certified or a primary care physician approved an emergency department visit before the patient arrived. Benefit plans are notorious for raising issues after the fact regarding patient's claim, basing

the denials on lists of ICD-9 based “not medically necessary” diagnoses. When these ICD-9 diagnoses are noted on a claim form or “seen” electronically, the payer’s computer may automatically deny payment. However, when properly reviewed, these claims are generally covered under the precise terms and conditions of the patient’s benefit plan.

To address the issue of, who decides what medical care is required, the American Medical Association (AMA) has adopted its own definition of medical necessity as follows:

Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate in terms of type, frequency, extent, site, and duration
- Not primarily for the convenience of the patient, physician, or other health care provider

The AMA contends that physicians need a legal guarantee that cost-conscious HMOs will not deny patients needed care. Insurance companies and businesses argue that physicians just want a blank check for what may or may not be the best treatment available. HMOs are committed to defeating any federal legislation on medical necessity provisions that require plans to cover treatment that is consistent with “generally accepted principles” or “prevailing standards” of medicine. Most health insurance contracts specifically give MCOs sole discretion to determine whether care is medically necessary.

In states where insurance payers are required to pay for emergency department screening examinations, “not medically necessary” denials are inappropriate. These claims should be resubmitted with an explanatory letter citing state statute language. In states that do not mandate payment for screening examinations, emergency department claims should include symptoms that reflect the patient’s chief complaint and services provided. Because the payer’s denial screens are based on ICD-9 diagnosis codes, adding ICD-9

codes based on presenting symptoms may be helpful in obtaining appropriate payment. This is a key concept for emergency physicians; many coders are trained to assign ICD-9 codes according to the final diagnosis. As a result, a claim for a patient who presents to the emergency department with chest pain and receives an appropriate cardiac work-up but whose final diagnosis is gastritis is likely to be denied.

Other ways to resolve medical necessity denials are as follows:

- Challenge the payer to add the final diagnosis in question to its “medically necessary” list.
- Advise the patient of the company’s payment denial on the grounds that it was not medically necessary. Consider asking the patient to help convince the payer to reimburse for the services. Make it clear that the patient is responsible for payment of this denied claim.
- If the patient does not respond, write off accounts receivable as uncollectable.
- Hand the account over to collections to pursue the patient more aggressively. Put the patient in a position to help force the payer to not only reimburse for this particular claim but update their medically necessary diagnosis list to pay for similar services provided in the future.
- If enough claims are inappropriately denied, contact the state regulatory agencies (e.g., insurance commission). Provide them with hard copy examples to help them review the claims, determine their legitimacy, and force the company to change its claims adjudication practices.

Internal versus External Review

All managed care companies have some form of internal review process to address disputed claims.

Although it is impossible for individual physicians to track specific plan benefits, appeals processes, and reimbursement rates for every plan, someone needs to be designated as the managed care “expert” within the

emergency department organization. Frequently this responsibility is entrusted to a billing company or hospital personnel if the hospital is the billing entity. A formal process within the billing organization must be in place to track, record, and review all denied claims. Billing personnel must be capable of sending claims electronically and must be completely correct according to the MCOs' specifications. When contacting payers, a log must be kept identifying names and dates as well as responses. Before appealing to an MCO, make sure that the service provided was documented correctly, coded accurately, and submitted to the appropriate plan. In addition, be aware that the denied service provided may fall under state or federal regulations such as the prudent layperson definition of an emergency condition.

Billing personnel should not hesitate to get patients and employers involved. Payers tend to listen to patients and to their employers who foot the insurance bills. A certified letter may also be effective and should reference the appropriate contractual language or state and federal regulations. Do not wait to demand a face-to-face meeting with the offending payer. Depending on the situation, local and state medical societies or the state insurance commissioner should be notified as well. Depending on the terms of the HMO contract, direct billing or out-of-pocket payments may be acceptable options.

As of mid-1999, 22 states had laws on external review. An external review allows denied claims to be adjudicated by a panel independent of the MCO. External reviews are decided in favor of the patient in 33% to 60% of cases, according to a November 1998 survey* prepared for the Kaiser Family Foundation by the Institute for Health Care Research and Policy at Georgetown University. Surveys* from New Jersey report that insurers have won two thirds of external review appeals in that state. Another study* also sponsored by the Kaiser Family Foundation concluded that state-mandated external review systems are underutilized. This under-utilization is attributed to consumers, not being aware that external review options exist and that patients find the appeals process difficult to understand. Unfortunately, state regulations often fall short for emergency service coverage. For example, although New York recently enacted external review legislation, the law only applies to denials of specific types of coverage. Other types of denials, such as access to

specialists or policies on emergency department visits, must still be handled by MCOs' internal review processes.

The rules governing external review vary considerably among states. Some state regulations mandate who can request a review (i.e. the patient, the diagnosing provider, the enrollee physician, or a legal representative), and some dictate what type of denial decisions are eligible for review. Some states limit external review to medical necessity, others to denial of covered services and experimental treatment.

Definitions of medical necessity vary from state to state as well. Some states require consumers to contribute to the cost of the review. These contribution range from \$100 to \$1,000 per claim.

The American Association of Health Plans recently began urging its members to develop external review programs voluntarily. One managed care company, U.S. Healthcare, declared that it would be the first national MCO to provide for external review of denied claims voluntarily. The California Association of Health Plans agreed to external reviews after state legislators failed to pass laws during 1998. These private initiatives differ from proposed federal legislation on issues such as who pays for external appeals, who picks the external panel, timeliness of reviews, and what medical services are covered. Although voluntary external review programs help MCOs promote consumer confidence, managed care proponents are also hopeful that these voluntary external review policies will satisfy critics who are pushing for more aggressive patient protection laws.

Problems with Medicare Managed Care

Medicare HMOs are becoming a popular alternative to fee-for-service Medicare. Although only about 13% of the Medicare population are currently enrolled in an HMO, it is estimated that 100,000 beneficiaries per month are enrolling in some form of a Medicare managed care program. With the creation of the Medicare+Choice program, HMO enrollments have more than doubled since 1993.

Although Medicare has a five-step appeal process for denied claims, a report issued by the OIG in December pointed out serious problems with Medicare's appeal system. These problems include the following:

- Beneficiaries were not fully aware of the appeals process.
- HMOs were failing to provide enrollees with proper notice when care was denied.
- The appeals process was very lengthy and had no provision for expedited review when delays could have resulted in harm to the enrollee.
- HMOs were not fully complying with HCFA directives on how to distinguish between a Medicare appeal and a grievance.
- HCFA had failed to enforce appeal and notice requirements.

In 1993, a study of coverage denial disputes between Medicare beneficiaries and HMOs demonstrated that more than one third of disputed cases from 1989 to 1991 were improperly denied, totaling \$13 million in benefits. Retrospective denial was the number one complaint cited in the study.

In March 1997, an Arizona federal district court issued an injunction that forced changes in HCFA's regulation of Medicare HMOs. This injunction was issued following a 3 year-old class action lawsuit (*Grijalva v. Shalala*) challenging the appeal rights of Medicare beneficiaries enrolled in an HMO. The court decreed due process for Medicare beneficiaries by requiring Medicare HMOs and comprehensive medical plans to follow up on denials, and reduction or termination of coverage for requested medical care. The injunction also mandated that Medicare HMOs must provide written notification of any adverse coverage determination within 5 working days of a request in a "clear, readable form." The notification must explain in lay terms the governing coverage rule, describe the appeal process, and provide information on how and when to submit supporting documentation. Medicare HMOs must also provide an administrative appeal process that includes an informal first level appeal, which involves in-person communication with the reconsideration decision-maker, and an expedited appeal process when services are needed urgently. The

expedited process mandates that a decision be made within 3 working days from the date reconsideration is requested and, for any adverse reconsideration decisions, reviews by a HCFA independent review agency.

The judge also ordered HCFA to monitor and investigate the compliance of its contracting HMOs with the notice and hearing requirements. Retaliation or reprisal by an HMO against a plan physician who provides documentation to support an enrollee's request for reconsideration is expressly prohibited. If a contracting HMO fails to substantially comply with the new notice and hearing requirements or retaliates against a physician, HCFA is prohibited from renewing its contract or entering into a new contract with the offending HMO.

State Regulatory Efforts

According to the Blue Cross and Blue Shield Association, state legislators passed 55 patient rights bills during 1998. Several states have adopted key consumer HMO protections related to the provision of emergency services. These include the following:

- Requiring HMOs to use a prudent layperson definition of an emergency condition.
- Requiring payment for initial screening and stabilizing treatment in an emergency department.
- Prohibiting HMOs from requiring payment authorization prior to the delivery of emergency services.
- Establishing a procedure for ensuring that emergency patients receive follow-up specialty care in the emergency department.

Currently, 25 states and the District of Columbia have an effective prudent layperson standard for access to emergency medical care. However, enforcement problems have arisen in some states. In 1993, Maryland became the first state to adopt the prudent layperson standard. In May 1998, the Maryland chapter of ACEP and the Maryland Hospital Association filed a complaint with the Maryland State Insurance Commissioner,

claiming that HMOs were “engaging in a pattern of reimbursement denial that is detrimental to patient health and contrary to Maryland law.” Maryland ACEP collected data from 13 of the 48 emergency departments in the state and found that there was widespread violation of the prudent layperson standard, disregard for Maryland’s prohibition of pre-authorization, and continued nonpayment for medical screening services that is prohibited by state law. The state insurance commissioner is currently investigating the complaints.

Unfortunately, passing prudent layperson legislation does not necessarily mean that MCOs will live by the rules. As with the Maryland experience, several other states are finding that simply legislating the prudent layperson standard is not enough. In Michigan, after the passage of the prudent layperson law, the Michigan chapter of ACEP worked with state representatives and members of the governor's office in an attempt to educate the managed care industry about its responsibilities under the law. Although the law went into effect April 1, 1998, to date, there has been no noticeable change in payment by the HMO industry. Prudent layperson legislation is ineffective unless it is properly enforced with the possibility of penalties for noncompliance.

At least eight states prohibit plans from requiring prior authorization for payment for the delivery of emergency services. For example, the Arkansas law reads as follows:

“Once a person qualifying for emergency medical care presents to an emergency department, that person shall be evaluated by medical personnel. This evaluation may include diagnostic testing to assess the extent of the condition, sickness, or injury and radiographic procedures and interpretations by a radiologist. Appropriate intervention may be initiated by medical personnel to stabilize any condition presenting under this act prior to receiving authorization for such treatment by an insurer, health maintenance organization, hospital medical service corporation, or health benefit plan.

The state of Washington recently announced that it will crack down on MCO emergency department abuses. State investigators looked at more than 700 emergency department denials by four major health carriers during the first four months of 1998. The investigation revealed that more than half of the emergency department denials were unlawful although Washington State law mandates a prudent layperson standard for emergency services. The state's insurance commissioner reported that investigators found a clear pattern of claim denials and delays for emergency services. In denying emergency department claims, carriers often contended that "the emergency room situation was not a true emergency, the consumer did not get a referral from his or her primary care provider, the consumer was out of the service area at the time the emergency occurred." The claims also included coding errors and minor paperwork mistakes. All of these are unlawful reasons to deny emergency services. The investigation determined that 66% of the denials issued during that period by the largest health carrier in the state were in violation of state law. In addition, as of October 1998, none of the major carriers had made any substantial changes in how they handled emergency department claims. The inquiry also found that the carrier's own handbooks offered illegal guidance. For example, "In case of life threatening emergency, go to your nearest participating provider." According to the commissioner the next step is to give the four carriers a chance to respond to the allegations.

<http://www.wa.gov/ins/>

Four states (Arizona, Florida, Maryland, and Texas) require MCOs to pay for initial screening and stabilizing treatment in emergency departments. Texas law, for example, reads as follows:

Pay for emergency care services performed by non-networks physicians, dentists or other providers at the negotiated or usual and customary rate. Any medical screening examination or other evaluation required by state or federal law, which is necessary to determine whether an emergency medical condition exists, will be provided to covered enrollees in the emergency department of a hospital.

Several states have addressed provider due process. These regulations focus on the relationship between MCOs and health care providers and often provide for grievance procedures for payment and other disputes. Texas was the first state to enact laws to hold managed care companies liable for their medical decisions. Several states are considering medical directors legislation which would give the state board power to impose fines and other sanctions on anyone who harms a patient by denying coverage for treatment an insurer deems not medically necessary.

Timely payment for services has also been a subject of state regulation. A 1997 review conducted in Pennsylvania found that the average time for payment was 77.5 days, with a range of 21 to 235 days. This has prompted Pennsylvania legislators to pass a bill requiring payment in 45 days. California has a similar time requirement for payment of services, but payment delays frequently range from 90 to 120 days. Presently, more than 30 states have laws on timely claims payment.

In 1996, the state of Oregon fined the PacifiCare HMO and Qual-Med for systematically denying payment of emergency claims. In New York, the state insurance commissioner has levied fines against 12 health insurers and HMOs for violating the state's prompt pay law, which requires payment within 45 days for undisputed claims. Delayed payment is such a widespread problem that the AMA through its Advocacy Resource Center, is currently developing and promoting state surveys to determine the extent of delayed payments.

Unfortunately, Oregon and New York are the exceptions and not the rule. Most states have only been marginally effective at fighting MCO abuses. Moreover, enforcement of these state statutes has been disappointing. In Florida, two medical associations and a 30 member obstetrics-gynecology group had to file a class action lawsuit to stop Prudential Health Care Plan Inc. from allegedly denying and delaying payments on large claims or losing claims. The lawsuit aims to recover interest on the claims and damages that may exceed \$10 million.

The issues expected to generate the most attention at the state level during 1999 and beyond include HMO liability, mental health parity, and mandated benefit. State laws, no matter how prolific, do not apply to the more than 50 million US residents who are covered by ERISA plans.

Managed Care Contractual Issues

One of the essential elements of managed care participation is the contract. Contractual issues include participation agreements, covered services, claims reporting requirements, and administrative procedures. .

Participation agreements are the first concern for emergency physicians. A hospital will often enter into contractual agreements on the physicians' behalf without involving them in the negotiations. In many situations, physicians have to comply with preexisting contracts when they join a hospital's medical staff. . In either case, be sure to review the credentialing requirements. Look for clauses that require board certification or "merit badge" certification. It is equally important to know how to terminate contractual obligations and the extent and time frame of the responsibilities if managed care plan fails.

Covered services are perhaps the single largest concern to practicing emergency physicians. Typically, a managed care plan requires that services be medically necessary in order to be considered covered. Although this sounds reasonable, it is the definition of medical necessity that causes problems. ACEP prefers the prudent layperson definition as applied to medical necessity. Managed care plans however, historically have used lists of approved diagnoses to determine medical necessity. These lists are problematic in the emergency department because a final diagnosis often is determined only after diagnostic testing rules out a more emergent condition. Diagnosis lists that do not consider presenting symptoms are a significant factor in retrospective denials; the MCOs' arguments will be that the patient did not have a medical emergency and should not have sought care in the emergency department. Other services are denied based on claims that diagnostic tests ordered were not medically necessary because they did not confirm an

emergency condition. EMTALA regulations require emergency physicians to provide a medical screening examination to determine the presence of an emergency medical condition or active labor. If such a condition is present, the patient's condition must be stabilized before discharge or transfer. Verify that the managed care plan will compensate the emergency physician for complying with the EMTALA mandate.

Depending on the evolution of managed care in a given area, reimbursement will be determined by a discounted fee-for-service basis or a capitated arrangement. Contractual issues related to reimbursement include claim filing deadlines, approved reporting formats, payer-specific payment policy, and precise risk-sharing arrangements. Negotiate for standard use of the HCFA-1500 claim form and CPT coding applications to report claims for payment. Try to keep payer-specific payment policies to a minimum, but get contractual agreement on issues such as using mid-level providers, payment for observation services, and considering presenting symptoms rather than final diagnosis only.

Emergency physicians must understand their contractual rights to balance bill managed care patients for services denied by managed care plans. Some MCOs forbid billing patients for non-covered services. EMTALA requires physicians to provide certain services as part of the screening examination that might retrospectively be deemed not medically necessary. Be sure to address this contractually to protect the emergency department physicians from being stuck with providing free services. In capitated or other risk-sharing arrangements, the negotiated maximum exposure must be clearly defined and based on historic utilization of services. Volume corridors can be added to a contract to address the capitation rate after so many visits above or below projected utilization. One contractual variation worth considering is conversion to a fee-for-service arrangement if utilization exceeds 10% projections.

Administrative procedures are another important contractual concern. Emergency physicians must understand what their obligations are in the areas of quality assurance and patient education. What are the

referral restrictions? How are out-of-network claims paid? Also of concern are conflict resolution, confidentiality, and standard general provisions.

ACEP has prepared a model managed care contract that is available to members on the Web site (<http://www.acep.org/MEMBERS/PDF/mcocontr.PDF>). This document is an excellent tool for analyzing or preparing a contract with an MCO.

National Managed Care Reform

Patients are becoming more vocal about their negative experiences with MCOs. During his 1999 State of the Union address, President Clinton promised to push for his “Patient Bill of Rights” during the 1999-2000 legislative session. The Republican “Patient Protection Act of 1999” was introduced earlier this year, with House Speaker Dennis Hastert (R-Ill.) as one of its cosponsors. Hastert currently remains opposed to any provisions that allow patients to sue their health plans. Rep. Cardin (D-Md) and Rep. Roukema (R-NJ) have also reintroduced their prudent layperson emergency care legislation. The Cardin bill contains provisions that would prevent health plans from denying patients coverage for legitimate emergency services. A companion bill was introduced in the Senate by Sen. Graham (D-Fl) and Sen. Chafee (R- R I). Organizations such as Quality Care and numerous other consumer groups are actively lobbying for HMO reform legislation and the right to sue their HMOs. Although the 105th Congress failed to enact reform legislation in 1998, 1999 has already seen some action. The remainder of the 106th Congress will undoubtedly be active with health care reform legislation.

Providers, patients, and lawyers are becoming more creative in holding MCOs accountable. The Pennsylvania Supreme Court recently ruled to limit HMOs from claiming ERISA preemption to avoid medical malpractice liability. The ruling was in connection with Pappas v Asbell, in which U.S. Healthcare allegedly was negligent in providing care by delaying a patient’s transfer to a university hospital for treatment of a neurologic emergency (epidural abscess), which allegedly resulted in permanent quadriplegia.

The court's opinion rejected U S Healthcare's argument that the federal ERISA statute protected it from being sued in a malpractice case and allows the case to move forward. In another case, the U S Supreme Court recently ruled that health insurance companies might be sued for fraud under the Federal Racketeering Influenced and Corrupt Organizations (RICO) Act. The ruling stemmed from a case in Nevada in which the plaintiff alleged that Humana violated RICO by accepting large discounts on hospital charges from a hospital it owned, resulting in higher charges to Humana subscribers for managed care coverage.

In California, a unique partnership has been formed between physicians and lawyers called the Legal Foundation for Healthcare Rights. Initially funded by the California chapter of ACEP, which provided \$10,000 in start-up money, this organization is dedicated to serving both provider and consumer interests by helping those who have been harmed by managed care. It is estimated that approximately 20,000 to 30,000 appeals have not been acted on, and state regulations have been ineffective. In addition, the foundation will serve as a resource to help regulatory agencies improve their ability to protect consumers and physicians from managed care abuses. The foundation has recently been successful in convincing California's Legislative Audit Committee to start investigating delayed authorizations, late payments, and denials.

Texas, Colorado, and now Florida have implemented "hassle factor logs", which track physician payment problems statewide. The goal of the hassle log is not only to document payer problems but also proactively work with their MCOs. Texas was the first state to start such a log in 1991. Originally designed to track Medicare and Medicaid issues, the Texas hassle log quickly expanded to address managed care complaints. After accumulating and organizing the complaints, the Texas Medical Association (TMA) schedules meetings with problem insurers. This state association also has formed the Council on Socioeconomics to meet regularly with Medicare, insurers, and managed care companies. The five most common complaints recorded by Texas physicians included delays in payment, claim denials, numerous telephone calls needed to resolve a single issue, telephone hold time, and chronic late payments from the same insurer. Each "hassle" was estimated to cost physicians and their staffs 4.2 hours to make telephone calls, resubmit claims,

and write letters detailing the treatment provided. Although the day-to-day operation of recording complaints is very labor intensive, most agree that hassle logs are a worthwhile mechanism.

Conclusion

To mount a competent defensive against managed care plan denials of emergency department services clearly entails a comprehensive knowledge of federal and state regulations. It is doubtful that a lone physician or physician group will be successful in fighting a problematic MCO without support from other physicians. “Show us your data” will be the mantra needed to wage a sufficient debate against the MCOs' no pay/low pay/slow pay manner of doing business. To win the public relations debate with Congress and patients, emergency physicians will need to link their reimbursement difficulties with patient rights and quality of care.

When President Ford signed the ERISA law on September 2, 1974, he did not say anything about exempting MCOs from malpractice or reimbursement abuses. By offering ERISA protections to employers, this law was intended to encourage more employers to provide pensions and health coverage for their employees. Although federal reform appears likely in the upcoming year, any reform will undoubtedly provide some relief for providers as well as the risk for unintended consequences.

April 10, 1999
Dear Sir or Madam HMO,

ABC Emergency Department
Somewhere Street
Somewhere, USA

This courtesy letter will result in our organization filing a complaint with the state insurance commissioner's office in 30 days if payment of the attached claims is not received within 30 days.

ABC Emergency Physicians have filed the attached claims and have received a denial due to your company's prior authorization not being met.

Florida State Law states the following:

Florida Statutes
Title XXXVII Insurance
Chapter 641. Health Care Service Programs
Part III. Health Care Services
641.513 Emergency services and care

"In providing for emergency services and care as a covered service, a health maintenance organization may not:

d) Deny payment based on the subscriber's failure to notify the health maintenance organization in advance of seeking treatment or within a certain period of time after the care is given."

The attached claims were filed for emergency services that your organization denied due to your organization's prior-authorization requirements. This does not exonerate you from your responsibility to reimburse the physician for the visit under Florida law.

Sincerely,

ABC Emergency Physicians

ABC Emergency Department
Somewhere Street
Somewhere, USA

April 10, 1999

Dear HMO Claims Review Department,

Sixty days ago ABC Emergency Physicians filed the attached claims with your company. To date, we have not received adjudication for these services.

You are now in violation of the following state regulations:

Title XXXVII Insurance

Chapter 627. Insurance Rates and Contracts

627.513 Time of payment of Claims

“Health insurers shall reimburse all claims within 45 days after receipt of the claim by the health insurer. A health insurer upon receipt of the additional information requested for the insured or the insured assignees shall pay or deny the contested claim or portion of the contested claim, within 60 days. All overdue payments shall bear simple interest at the rate of 10 percent per year.”

We will forward this listing to the state insurance commissioner with the said violation if adjudication is not received within 15 days.

Sincerely,

ABC Emergency Physicians

Suggested Readings

1. Karpel M. Managed Care in Emergency Medicine: Understanding the New Economics and Opportunities. Dallas, Tex: The American College of Emergency Physicians; 1995
2. American College of Emergency Physicians Strategic Plan and Environmental Assessment 1998-1999, Dallas, Tex: American College of Emergency Physicians; 1998
3. American College of Emergency Physicians, Federal Government Affairs Committee. Summary of Balanced Budget Act of 1997. August 11, 1997.
4. The Top Five Complaints about HMOs. Available at www.patientadvocacy.org/main/insurance/complaint.html.
5. Managed Care Reform Legislation. (Center for Patient Advocacy). Available at www.patientadvocacy.org/main/managedcare.
6. President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Quality First: Better Health Care for All Americans. Final Report to the President of the United States, February 20, 1999.
7. Highlights of Reports of Five Agencies' Record of Compliance with Consumer Bill of Rights in Implementation of Federal Health Programs. Forwarded from Vice-President Gore to President Clinton. The Washington, DC: Bureau of National Affairs Inc.: February 23, 1998.
8. David L. Coleman, JD. Will health plans keep their ERISA shield? Managed Care Magazine. May 1997.