

# Washington State Health Care Authority

## Emergency Rooms and Medical Necessity

**Questions and Answers from the Health Care Authority on limiting payment for “not medically necessary” in the Emergency Room setting.**

*These are questions and answers from a conversation between WSHA and our physician partners and the Washington State Health Care Authority regarding the state’s new policy on payments for Emergency Department visits made by Medicaid clients.*

**Question:** How is the HCA process going to work?

**Answer:** *HCA plans to stop paying for hospital Emergency Department visits for Medicaid clients when it deems those visits “not medically necessary in the ER setting.” HCA will continue to pay for visits to the Emergency Department when it determines the Emergency Room setting was the medically necessary place of service for the care. If the ER decides that care is not appropriate for the Emergency Room setting and should be triaged to the primary care office through an EMTALA screening, the HCA managed care plans will pay a screening fee.*

*HCA fee-for-service and managed care will only purchase care that is medically necessary, and in this case, medically necessary care includes care provided in the appropriate setting. It has been a struggle to develop an exclusive list or set number of visits to provide access to quality/affordable health care. Instead, the new standard will be based solely on medical necessity of the visit to that place of service.*

*An extensive set of examples has been provided to the associations, and there will be ongoing dialogue regarding appropriate coding for payment of emergency services as we transition care to primary care providers and change coding from ICD9 to ICD10.*

*The HCA will determine when a visit is medically necessary or not. The HCA plans to use diagnosis codes for most clients and will conduct chart reviews for those clients who are chronic users of the Emergency Department. The HCA has asked WSHA and our physician partners provide for feedback on the codes that are proposed for use and the best process to ensure access to quality services at an affordable cost. As always, the HCA will continue to meet with association representatives on a bimonthly basis to discuss our efforts.*

*Based upon conversations with the Centers for Medicare & Medicaid Services and other health plans across the country, HCA believes this change in payment can be made within the current Medicaid state plan and WACs.*

*HCA is tentatively planning for an effective date of April 1, 2012, for the new policy.*

**Question:** Will there be an expedited prior authorization (EPA) process for this policy?

*Answer: No, there will not be an expedited prior authorization process for purposes of reviewing the medical necessity of Emergency Room visits.*

**Question:** Who will decide what is medically necessary?

*Answer: The Health Care Authority will use sound evidence and a collaborative process in determining what constitutes medically necessary care in an Emergency Room setting.*

**Question:** Given an original estimate of savings from a composite approach, the number was \$21 million and is now proposed at \$51 million. Where is the extra \$30 million in savings going to come from?

*Answer: The savings estimate is based upon the elimination of payments for Emergency Department visits that are deemed not medically necessary. This initial estimate is based upon a list of non-emergency codes provided by Washington ACEP and California's MediCal program; however, there is no static list. Medical necessity will continue to be evaluated based upon diagnosis and chart review for clients with multiple Emergency Department visits.*

**Question:** Will this change in payment and review for medical necessity delay payment to physicians or hospitals?

*Answer: The impact will be felt in direct proportion to the number of clients that receive non-medically necessary care in an Emergency Room.*

**Question:** How will this change impact payments for children who visit the Emergency Department?

*Answer: This policy impacts all Medicaid clients, regardless of age. Children will be included in the non-payment if Emergency Department visits are not medically necessary. However, the savings related to children in Washington is expected to be small.*

**Question:** What mechanism will there be to bill Medicaid patients for non-covered visits?

**Answer:** *Under Medicaid law, hospitals and physicians may not balance bill the client for covered services. Emergency Rooms and physicians may bill and will be paid for covered services that are medically necessary. Non-medically necessary services that are received in the Emergency Room are covered services but not paid, and as such the client cannot be billed. Patients can only be billed for non-covered services, regardless of care setting. Therefore Emergency Rooms and hospitals should make every effort to triage, per EMTALA rules, non-emergent conditions to the PCP office where they are medically necessary and can be paid.*

**Question:** Will there be a review process?

**Answer:** *Yes, there will be the usual option to resubmit the claim with supporting documentation. However, Emergency Rooms should note that in addition to the medical records, the Prescription Monitoring Program (PMP), the Emergency Department Information Exchange (EDIE) and case management systems may be used to assess medical necessity.*

**Question:** Is there an exception or exclusion process?

**Answer:** *No, because these conditions are treatable in the PCP office, there will be no need for exceptions. These conditions existing alone should never result in an inpatient admission, outpatient surgery, transfer or death.*

**Question:** Will hospital and physicians' payment be impacted if the Medicaid client does not have a primary care physician in a reasonable distance for their transportation needs, if the provider had no open appointments, or if the office is closed on evenings and weekends?

**Answer:** *Yes, payment will be impacted. We need to work with the community to get primary physicians to see these clients. WSHA and the HCA are leading a quality assessment effort that can bring dollar incentives to hospital systems that "reduce community non-emergent ER services." It is our hope that communities will take advantage of these incentives to provide access to better quality care that is more affordable.*

**Question:** What will the EMTALA screening fee be for hospitals and physicians?

**Answer:** *The EMTALA screening payment will only be made by managed care plans for managed care clients. There will be no EMTALA screening payment for clients covered by the fee-for-service program.*

**Question:** How will HCA determine medical necessity? Will it be chart reviews or based on coding?

**Answer:** *The state will look at diagnosis codes billed on the claim. If the principal diagnosis code does not require the Emergency Room setting for treatment, the claim will deny. The process will evolve based upon provider feedback and changes in coding (ICD-10). However, the state will do chart reviews for Patient Requiring Coordination (PRC) clients with a focus on those clients that abuse the Emergency Room and narcotics benefit.*

**Question:** Are you talking to primary care physicians about what diagnostic functions primary care will be doing in their offices? Some of the diagnoses may require diagnostic equipment like X-rays or other diagnostic tests to rule out more serious issues that they may not have the capability to provide in their offices. Will those be taken off the list or how will that be handled?

**Answer:** *There will be no changes in what is determined to be medically necessary. The state will work with primary care physicians on more appropriate coding and care processes to improve access to quality services at more affordable rate.*

**Question:** What is happening with the rulemaking process related to the three-visit limit?

**Answer:** *The rulemaking process for that WAC will not move forward. This new process requires no change to rules or the State Plan. Medical necessity is a longstanding process that has applied to many types of services and will now apply to Emergency Room services.*

**Question:** Will payment be made immediately for Emergency Department visits or will it be withheld until each case is evaluated for necessity?

**Answer:** *It will be a mix. Payment will be processed as usual and denied if obviously medically unnecessary. (Examples from Washington ACEP and MediCal were distributed on December 23, 2011). For other denials related to PRC clients, payment may be retroactively denied – especially if we can show that prescriptions for narcotics or similar services were rendered in other Emergency Rooms outside an acceptable time period or in cases when the community does not implement better primary care referral processes (e.g., placing care management instructions in EDIE or case management processes).*

**Question:** Will lists of PRC clients be made available for hospitals and Emergency Rooms?

**Answer:** *Yes, a monthly list of PRC clients and their PCPs is available on request through the PRC program. The HCA will work with Washington ACEP and WSHA on processes to share the PRC list in HIPAA transmission. In addition, HCA would like to team with local providers on “how to” file treatment plans for frequent Emergency Room users (e.g., narcotic refills and chronic lower back pain, etc.)*

**Question:** Is there liability protection for Emergency Room physicians and primary care physicians willing to see these patients when care may be delayed? (Example: Patient is diabetic and has a splinter . These patients are more likely to get infected if not treated right away in the Emergency Room and sent to the primary care physician instead.)

**Answer:** *There are provisions in Washington law to use "decision aids" to better inform clients of risk and reduce liability for providers. The state will work with associations to set community care standards, explore the use of "decision aids" and to communicate with clients/communities on appropriate Emergency Room use.*

**Question:** Does the state language on prudent layperson apply to Medicaid?

**Answer:** *State and federal prudent layperson statutes apply to managed care and Primary Care Case Management (PCCM) programs, but not to fee-for-service. Medicaid will instruct managed care plans to use the "prudent layperson" standard for EMTALA screening exams per their professional and provider contracts. Medical necessity will apply in all programs for Emergency Room services.*

**Question:** How will the HCA monitor for upcoding and ensure quality services are rendered?

**Answer:** *HCA has a retrospective review and audit program that will review Emergency Room claims for upcoding or other efforts to bypass our management of this policy. Also, the state will work with associations, communities, provider groups, plans and other interested parties on feedback reports to monitor coding practices as well a quality of care in the communities. The HCA intends to meet with the above-mentioned groups to review these metrics on an ongoing basis to ensure access to quality and affordable care.*

**FOR ADDITIONAL INFORMATION:**

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