American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

POLICY STATEMENT

Approved October 2020

Third-Party Payers and Emergency Medical Care

Revised October 2020, April 2014, June 2007 with current title, July 2000, January 1999 titled "Managed Health Care Organizations and Emergency Care", March 1993

Originally approved September 1987 titled "Managed Health Care Plans and Emergency Care"

The American College of Emergency Physicians (ACEP) believes that emergency medical care must be readily available to all persons requesting it regardless of their ability to pay or their health insurance status.

Individuals requesting medical care at an emergency department (ED) must be provided a medical screening examination (MSE) and any necessary stabilizing treatment as defined by federal law[1] and state law, as applicable. This requirement applies to all individuals and may not be superceded or pre-empted by any third-party payer policy or regulation.

Third-party payers[2] that actively practice demand management have a duty and responsibility to educate their members regarding emergency services, including appropriate access and use of emergency services, especially emergency medical services (EMS) 911 or other public emergency access telephone systems. All health care access information provided to members should clearly state that preauthorization for emergency care, as defined by the federal law and state law, as applicable, is not required. Any person who perceives that he or she is experiencing an emergency should call 911 without delay or go directly to the nearest ED without regard to the facility being in or out of network.

Emergency physicians should assume an active role in working with third-party payers to ensure that third-party payers do not interfere with the prompt availability and delivery of emergency services. Only appropriately qualified medical professionals, such as managed care organizations (MCO) medical advice line, participating physicians' offices, and demand management organizations, should respond to patient calls concerning the need for medical care. Such medical professionals should be specifically trained in history-taking, clinical judgment and assessment skills, triage categorization, liability issues, and appropriate utilization of the decision support tools. Triage decisions should be based on sound medical protocols under the policy direction and responsibility of a qualified physician. This physician should have the authority to implement and enforce these protocols as well as the authority to direct any necessary deviation from written protocols.

Innovative initiatives that are intended to direct patients to the most appropriate site of care should be done with qualified emergency physician input to ensure quality emergency care exists in the appropriate setting.

Assessment protocols and advice policies affecting ED access should be developed with emergency physician input and should address both adult and pediatric patients. The policies should address access to appropriate levels of service in appropriate time frames. Assessment protocols and advice policies should be subject to ongoing performance review to confirm validity.

ACEP Recommendations

To ensure access to emergency medical care by all individuals and to provide guidelines for emergency physicians when communicating with third-party payers, ACEP recommends the following:

- Emergency ambulance transportation to EDs, including transports by privately contracted ambulances, must be integrated into the local emergency medical services (EMS) systems.
- Copays and deductibles should not differ for in- or out-of-network care in the ED, and copays should not be so high as to circumvent the intent of the prudent layperson standard or potentially delay care in the event of a bonified emergency.
- If third-party payers have a system for post-stabilization case management, it must be readily accessible at all times (24/7) and provide a means for contemporaneous consultation with a physician representative who has knowledge and experience in the care of ED patients. The ability to confirm insurance coverage and to utilize case management resources should be available promptly, with a single telephone call to a plan representative.
- All initiatives that are designed to triage patients to the most appropriate site of care should have the input and oversight of qualified emergency physicians.
- In the event of a disagreement regarding the need for post-stabilization care, hospitalization, or discharge, the emergency physician who is physically evaluating the patient has the final authority to determine disposition of the patient. If appropriate, the emergency physician may consider transfer of post-stabilization care to a payer-assigned physician or transfer to a payer-contracted facility as long as the Emergency Medical Treatment & Labor Act (EMTALA) transfer and stabilization requirements are met. All such transfer decisions require the consent of the patient or their designee.
- All patient transfers, including those involving MCO members, should be consistent with ACEPs published guidelines.
- Emergency physicians should be fairly reimbursed for all services provided, regardless of in- or out-of-network status, including the provision of mandated EMTALA-related care. Claims should be processed expeditiously and on the basis of established billing and coding procedures. Claims should be adjudicated on the basis of the patient's presenting complaint and symptoms. An equitable and timely appeal and arbitration process should exist for disputes involving reimbursement.
- Recognizing that on-call specialty services may provide simultaneous coverage to several hospitals, third-party payers are expected to cover on-call specialty services when emergency physicians require access to hospital on-call panels in order to meet MSE and stabilization expectations as required by EMTALA regardless of network status.

- Emergency physicians should assume an active, positive role in any contract negotiations involving healthcare institutions and payers, especially where emergency services are included as part of a comprehensive program of services.

References

1. The Emergency Medical Treatment & Labor Act (EMTALA), as established under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 USC 1395 dd), Section 9121, as amended by the Omnibus Budget Reconciliation Acts (OBRA) of 1987, 1989, and 1990. Rules and regulations published. Federal Register June 22, 1994; 59:32086-32127. Amended September 9, 2003; 68:53221-53264.
2. Third-party payers include: Medicare, Medicaid, managed care organizations, indemnity insurers, and businesses that contract for services