

 Well - Tara Parker-Pope on Health

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The Costs of Emergency Room Cost-Cutting

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It was the dead of winter, high season for viral gastroenteritis, so it was with a certain degree of wariness that the harried doctor and nurse finally got around to seeing the patient, a man in his late 60s who had come to the emergency room complaining of belly discomfort.

“I think I’ve got the stomach bug,” he said when they approached.

The nurse moved him to a far corner of the emergency department reserved for less critical cases. The doctor’s plan was to infuse a liter of intravenous fluids then send the man home.

But a couple of hours later, mid-infusion, the patient suddenly turned blue, then gray and passed out.

The patient’s belly pain, it turned out, was the result of a life-threatening aneurysm, a ballooning of the abdominal aorta that had been leaking blood internally for several hours.

Thanks to emergency surgery, the patient survived. But his sudden downturn, his dramatic brush with death and the cavalier initial response of the staff were powerful reminders of an aphorism I had heard since my first weeks of internship; “Assume nothing.”

I remembered that patient after reading a new study that analyzed an assumption underlying a perennially popular cost-cutting measure: reduce emergency room visits for non-urgent care, which can cost up to five times more than care provided in a doctor’s office.

For close to 50 years, emergency rooms have been fingered as a major source of excessive health care costs. And while some newer research has challenged the idea that a large proportion of patients visit the emergency room for routine problems, many payers and policy makers continue to focus on these patients as a major source of wasteful spending.

Not long ago, for example, in an effort to cut back on Medicaid expenditures, several states zeroed in on these so-called “unwarranted visits” and proposed a policy so apparently logical that it was hard to resist the temptation to slap yourself on the forehead. The proposal was to reimburse for an emergency room visit based on the urgency of the discharge diagnosis.

Bills would be paid for true emergencies, like a heart attack or ruptured aneurysm. But payment would be reduced or denied for visits that turned out to be less serious, like heartburn, constipation or an insect bite.

It sounded like an obvious way to discourage unnecessary and expensive visits to the E.R.

But according to the new study, published in *The Journal of the American Medical Association*, such a policy relies on a huge, and erroneous, assumption: that patients can predict the urgency of their diagnosis based on initial symptoms alone.

Researchers reviewed the records from almost 35,000 patient visits to emergency departments across the country. In 6 percent of cases, the patient was discharged and could have been treated in a doctor's office.

The researchers then combed through the initial symptoms or complaints of these non-urgent cases and discovered that in nearly 90 percent of the other, more urgent cases, patients came to the emergency room with the same primary presenting symptoms, complaints like abdominal discomfort, chest pain or fever. In addition, more than 10 percent of these urgent patients ended up requiring hospital admission, surgery or intensive care.

In other words, basing reimbursement on discharge diagnoses is just Monday morning quarterbacking, health care policy style.

"Patients don't have their diagnosis taped to their forehead when they come into the emergency department," said Dr. Renee Y. Hsia, senior author of the study and an assistant professor of emergency medicine at the University of California, San Francisco. "They present with symptoms or complaints."

It is not the first time that limiting payments based on discharge diagnoses has been proposed. During the 1980s and '90s, private insurers imposed similar restrictions, requiring patients to obtain "pre-authorization" for emergency room visits, then denying payments to those whose discharge diagnosis turned out not to be an emergency. In response, several states at the time passed "prudent layperson mandates" requiring insurers to pay for the emergency room visit of any patient who presented with symptoms that an average person might consider urgent, even if the final diagnosis was not.

The mandates helped to ensure that patients could get care. But the recent interest in once again basing payment on discharge diagnosis could limit patient access. "It's easy to see why paying for non-urgent problems might make a policy maker's blood boil," Dr. Hsia said. "But is it right to make patients shoulder the entire burden and associated risk of figuring out whether their presenting complaint meets the payer's criteria for reimbursement?"

One state that did consider such a policy now appears to have found a different solution that, while complicated, does not assume that patients know the true seriousness of their

condition before they head to the hospital. Since July of last year, emergency departments in Washington state have established programs to educate patients on how to access care as well as other measures designed to improve care, including statewide guidelines on prescribing narcotics, shared electronic health and prescription information, and regularly updated reports on how emergency department resources are utilized. The policy has already resulted in significant changes and a projected savings of over \$31 million by the end of the fiscal year.

Dr. Hsia believes that the policy's success, as well as the degree of work and cooperation required, only confirm what her study showed: that when it comes to caring for patients, the best approaches are neither simple nor assumed.

"A policy that requires more coordination and more tailoring means more work than one that slashes benefits across the board," Dr. Hsia said. "But it's the right thing to do for patients."

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Comparison of presenting complaint vs discharge diagnosis for identifying "nonemergency" emergency department visits.

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Abstract

IMPORTANCE: Reduction in emergency department (ED) use is frequently viewed as a potential source for cost savings. One consideration has been to deny payment if the patient's diagnosis upon ED discharge appears to reflect a "nonemergency" condition. This approach does not incorporate other clinical factors such as chief complaint that may inform necessity for ED care.

OBJECTIVE: To determine whether ED presenting complaint and ED discharge diagnosis correspond sufficiently to support use of discharge diagnosis as the basis for policies discouraging ED use.

DESIGN, SETTING, AND PARTICIPANTS: The New York University emergency department algorithm has been commonly used to identify nonemergency ED visits. We applied the algorithm to publicly available ED visit data from the 2009 National Hospital Ambulatory Medical Care Survey (NHAMCS) for the purpose of identifying all "primary care-treatable" visits. The 2009 NHAMCS data set contains 34,942 records, each representing a unique ED visit. For each visit with a discharge diagnosis classified as primary care treatable, we identified the chief complaint. To determine whether these chief complaints correspond to nonemergency ED visits, we then examined all ED visits with this same group of chief complaints to ascertain the ED course, final disposition, and discharge diagnoses. **MAIN OUTCOMES AND MEASURES:** Patient demographics, clinical characteristics, and disposition associated with chief complaints related to nonemergency ED visits.

RESULTS: Although only 6.3% (95% CI, 5.8%-6.7%) of visits were determined to have primary care-treatable diagnoses based on discharge diagnosis and our modification of the algorithm, the chief complaints reported for these ED visits with primary care-treatable ED discharge diagnoses were the same chief complaints reported for 88.7% (95% CI, 88.1%-89.4%) of all ED visits. Of these visits, 11.1% (95% CI, 9.3%-13.0%) were identified at ED triage as needing immediate or emergency care; 12.5% (95% CI, 11.8%-14.3%) required hospital admission; and 3.4% (95% CI, 2.5%-4.3%) of admitted patients went directly from the ED to the operating room.

CONCLUSIONS AND RELEVANCE: Among ED visits with the same presenting complaint as those ultimately given a primary care-treatable diagnosis based on ED discharge diagnosis, a

substantial proportion required immediate emergency care or hospital admission. The limited concordance between presenting complaints and ED discharge diagnoses suggests that these discharge diagnoses are unable to accurately identify nonemergency ED visits.

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