

Mastering Utilization Review and Patient Status

a NAHRI virtual event 

Emergency Hospital Admissions – Is Your UR Focus Askew?

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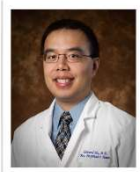
Chapel Hill, NC



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Presented By



Edward Hu, MD, CHCQM-PHYADV, FABQAURP, is a board-certified internal medicine physician and physician advisor. He received his medical degree from Washington University in St. Louis in 1999, followed by an internal medicine residency at Duke University Hospital completed in 2002. He practiced as a hospitalist at UNC Rex Hospital in Raleigh, NC, from 2002 through 2016. He co-founded the physician advisor program at UNC Rex in 2012. In 2016, he became the UNC Health system executive director of inpatient physician advisor services.

He served as the second President of the American College of Physician Advisors (ACPA) from 2016 through 2019, and served on its Board from 2014 through 2021. He has edited or developed numerous educational materials and presentations related to physician advisor work, including CME modules, presentations, and articles for organizations such as NAHRI, ACPA, ABQAURP, HFMA, and SHM.

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Learning Objectives

- At the completion of this educational activity, the learner will be able to:
 - Identify the statutory and regulatory protections built into Medicare Advantage and Managed Medicaid when beneficiaries present for emergency care
 - Describe the concept of stabilization of an emergency medical condition
 - Explain the distinction between care to stabilize an emergency medical conditions and post-stabilization care

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Traditional UR Decision Timeframes

Medicare Advantage (MA)

- “Organization Determination”
- As expeditiously as health condition requires
- Standard: 14 days
- Expedited: 72 hours
- Emergency services?
- Post-stabilization services?

Managed Medicaid

- “Benefit Determination”
- As expeditiously as condition requires
- Standard: 14 days
- Expedited: 72 hours
- Emergency services?
- Post-stabilization services?

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“Approving Obs” When Inpatient Requested = Denial

Medicare Advantage (MA)

- Actions that are organization determinations:
 - The MA organization’s refusal to provide or pay for services, in whole or in part, including the type or level of services

Managed Medicaid

- Adverse benefit determination means, in the case of a managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP):
 - The denial or limited authorization of a requested service including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit

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CMS Created Special Rules For Emergency Services

▼ Title 42 Public Health	Part / Section
▼ Chapter IV Centers for Medicare & Medicaid Services, Department of Health and Human Services	400 – 699
▼ Subchapter B Medicare Program	405 – 429
▼ Part 422 Medicare Advantage Program	422.1 – 422.2615
▼ Subpart C Benefits and Beneficiary Protections	422.100 – 422.136
§ 422.113 Special rules for ambulance services, emergency and urgently needed services, and maintenance and post-stabilization care services.	
▼ Title 42 Public Health	Part / Section
▼ Chapter IV Centers for Medicare & Medicaid Services, Department of Health and Human Services	400 – 699
▼ Subchapter C Medical Assistance Programs	430 – 456
▼ Part 438 Managed Care	438.1 – 438.930
▼ Subpart C Enrollee Rights and Protections	438.100 – 438.116
§ 438.114 Emergency and poststabilization services.	

<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C?toc=1>

<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-C?toc=1>

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Medicare Advantage

Emergency Services



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Statutory Basis

- Section 1852(d)(1)(E) of the Social Security Act
 - “[C]overage is provided for emergency services... without regard to prior authorization or the emergency care provider’s contractual relationship with the organization.”

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Definitions

- **Emergency medical condition**
 - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
 - Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
 - Serious impairment to bodily functions; or
 - Serious dysfunction of any bodily organ or part
- <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.113>

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Definitions

- **Emergency services**
 - Covered inpatient and outpatient services that are:
 - Furnished by a provider qualified to furnish emergency services; and
 - Needed to evaluate or stabilize an emergency medical condition
- <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.113>

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42 CFR § 422.113

MA organization financial responsibility

- The MA organization is financially responsible for emergency services –
 - Regardless of whether the services are obtained within or outside the MA organization;
 - Regardless of whether there is prior authorization for the services;
 - In accordance with the prudent layperson definition of emergency medical condition regardless of final diagnosis
- The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the MA organization
- <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.113>

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Example #1 Of EMC And Point Of Stabilization

- “A patient is brought to the emergency department with the preliminary diagnosis of a seizure. The patient is screened and receives services to stabilize his condition. Thus far, the services that the patient has received are emergency services under § 422.113(b). Once the emergency room physician considers the patient stabilized, the M+C organization is notified of the need to consult a neurologist in order to proceed with relevant diagnostic tests and to determine the cause of the seizures, and to treat the cause of the seizure definitively.” *Federal Register*, Vol.65, No.126, p.40202

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Example #2 Of EMC And Point Of Stabilization

- “I was the Emergency Department Physician who evaluated [the enrollee] when he presented to [redacted] Medical Center on [redacted]. The Chief Complaint upon presentation was Headache with an elevated blood pressure. Upon evaluation, I was advised by [the enrollee] that he ha[d] a pressure type frontal headache for two (2) days in duration. In addition, I was advised that he had terminated his hypertension medication. Upon evaluation, blood pressure was 161/86, pulse 74 and respirators 20. Following evaluation, my differential diagnosis included, but not limited to acute cephalgia and headache secondary to increased intracranial pressure secondary to CVA... [P]atient’s headache did not improve. In addition, the patient’s hypertension became problematic wherein it was elevated at 178/80. Given the foregoing, I was of the impression that the patient was unstable for transfer at the time of the admission on [redacted] due to the likelihood and/or potential of material deterioration. I discussed the case with admitting physician and the patient was ultimately admitted. I contemporaneously noted within the records that the patient was unstable for transfer at the time of admission due to my clinical assessment and based upon my training, experience, and education.” *Kaiser Foundation Health Plan v Burwell* (N.D.Cal. 2015)
- [Kaiser Foundation Health Plan, Inc. v. Burwell, 147 F. Supp. 3d 897 | Casetext Search + Citor](#)

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Example #2 Of EMC And Point Of Stabilization

- Kaiser argued “[t]hat point was nearly 24 hours before the hospital ultimately deemed him stable and sent him home.”
- Kaiser paid for emergency stabilization services but refused to pay for inpatient services, stating further care was post-stabilization care and the patient could have been safely transferred to a Kaiser facility.
- Medicare Appeals Council decision

 - MA plan must pay for enrollee’s care until her treating physician determined that she was stable and could safely be transferred.
 - Kaiser was responsible for the costs “based on the treating physician’s binding determination that the enrollee was not stable for transfer” until approximately 24 hours after the emergency department (ED) physician assessment, at which point the enrollee was discharged
- [Kaiser Foundation Health Plan, Inc. v. Burwell, 147 F. Supp. 3d 897 | Casetext Search + Citor](#)

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“Stabilization” For Transfer Or Discharge

- 1852(d)(2)
 - A Medicare + Choice plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.
- 1867(e)(3)(B) – EMTALA
 - The term “stabilized” means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during transfer of the individual from a facility.

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“Stabilization” For Transfer Or Discharge

- *State Operations Manual*, Appendix V, Interpretive Guidelines - EMTALA
 - To be considered stable the emergency medical condition that caused the individual to seek care in the dedicated ED must be resolved, although the underlying medical condition may persist.
 - An individual will be deemed stabilized if the treating physician or qualified medical person attending to the individual in the emergency department/hospital has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.
 - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

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EMTALA Not The Final Word On “Stabilization” For § 422.113

- Medicare Appeals Council M-2010-274 Decision
 - Admission to inpatient status does not indicate stabilization has been achieved
 - “CMS did not incorporate the EMTALA test of stability in the MA regulations at 42 CFR § 422.113, and any case law concerning EMTALA is not on point.”
 - **“When the doctors who are giving you Emergency Care say that your condition is Clinically Stable** and the emergency is over, what happens next is called ‘Post-stabilization Care.’ Post-stabilization care is the Services you **receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable.**” [emphasis original]
 - [In the Case of Desert Valley Hospital \(hhs.gov\)](https://www.hhs.gov/ohrt/decisions/2010-274)

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EMTALA Not The Final Word On “Stabilization” For § 422.113

- Kaiser Foundation Health Plan v. Burwell
 - “When **documented** in the contemporaneous medical records, the treating physician’s decision with respect to when the enrollee [is] stabilized for transfer or discharge **binds** both the MAO and subsequent adjudicators. **By definition**, post-stabilization care does not begin until after the treating physician decides the enrollee is stabilized for transfer or discharge.” [emphasis original]
 - “The regulation clearly indicates that the binding effect of the treating physician’s determination of stabilization applies to Kaiser’s financial obligation.”
 - [Kaiser Foundation Health Plan, Inc. v. Burwell, 147 F. Supp. 3d 897 | Casetext Search + Citor](https://www.casotext.com/casotext/casotextsearch/casotextsearch.asp?casotextsearch=Kaiser+Foundation+Health+Plan,+Inc.+v.+Burwell,+147+F.+Supp.+3d+897)

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Medicare Advantage

Post-stabilization Services



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Definition

- Post-stabilization care services
 - Covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in paragraph (c)(2)(iii) of this section, to improve or resolve the enrollee's condition.
- <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.113>

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MA Organization Financial Responsibility

- Is financially responsible (consistent with 422.214) for post-stabilization care services obtained within or outside the MA organization that are pre-approved by a plan provider or other MA organization representative
- Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain the enrollee's stabilized condition within one hour of a request to the MA organization for pre-approval of further post-stabilization care services
- Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain, improve, or resolve the enrollee's stabilized condition if:
 - The MA organization does not respond to a request for pre-approval within one hour;
 - The MA organization cannot be contacted, or
 - The MA organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the MA organization must give the treating physician the opportunity to consult with the plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in 422.113(c)(3) is met.
- <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.113>

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End Of MA Organization's Financial Responsibility

- For post-stabilization services occurs when:
 - A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care
 - A plan physician assumes responsibility for the enrollee's care through transfer
 - An MA organization representative and the treating physician reach an agreement concerning the enrollee's care
 - The enrollee is discharged.
- <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.113>

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CMS Reiteration Of Post-stabilization Responsibility

- “The requirements outlined in 42 *C.F.R.* § 422.113(c)(2)(iii) apply to both contracted and non-contracted facilities. A Medicare Advantage Organization (MAO) is financially responsible for post-stabilization care when the organization does not respond to a request for pre-approval within 1 hour or cannot be contacted. Plans are responsible for post-stabilization care designated by the emergency provider until the plan does respond and directs care. MAOs must take all actions necessary to ensure it meets its financial responsibility for post-stabilization care services provided by contracted and non-contracted providers. We also clarify that MAOs may not require prior authorization for emergency services per in 42 *C.F.R.* § 422.113(b)(2)(ii).”
- Correspondence with CMS Division of Policy, Analysis, and Planning (DPAP), November 2021, with permission to share

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Payments For Emergency And Post-stabilization Services

- Special rules for emergency services do not address payment directly
- Special rules for post-stabilization services for emergency medical conditions state that the payment rules for non-network providers at 422.214 will apply
 - i.e., fee-for-service (FFS) payment which requires using FFS status rules

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Post-stabilization Response Within One Hour

- “If the provider calls when the enrollee is stabilized, an organization which calls back within the hour should not need more time to make a decision. Therefore, we consider a response by the M+C organization to be when the M+C organization submits a decision to the provider about its request for post-stabilization care.”
- “When an M+C organization representative who is a non-physician and the treating physician cannot reach an agreement on a course of treatment, the M+C organization must allow the treating physician to speak with a plan physician.”

– *Federal Register*, Vol 65, No.126, p40201

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If The MAO Says “No” To Post-stabilization Services Within An Hour

- “[I]n order to be able to bill the beneficiary in circumstances where the plan is not liable for payment, the treating provider is expected to provide the stabilized patient with a notice of non-coverage, such as an Advance Beneficiary Notice.”
 - *Federal Register*, Vol 65, No. 126, p40202

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Appeals Related To Post-stabilization Services

- “The enrollee (or the provider if the provider agrees not to charge the enrollee) has the right to appeal any decision by an M+C organization to deny payment for post-stabilization services.”
- “A dispute over whether the conditions for M+C coverage for post-stabilization care services under 422.100 and 422.113 have been met could be resolved in an enrollee’s appeal of the M+C organization’s denial of payment for post-stabilization services, or an appeal by a provider if the provider agrees not to charge the enrollee. (We note that the rules governing payment for services furnished by noncontracting providers would apply in post-stabilization cases, as set forth in 422.214 and discussed in detail in section II.E of this preamble. We have made this explicit at 422.113(c)(2).)”

– *Federal Register*, Vol 65, No. 126, pp40203

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Reinforcement Of §422.113 Applicability In- And Out-of-network

- “In this final rule, general requirements for financial responsibility for service provided outside the M+C organization remain at § 422.100, while definitions and policies relating to all types of emergency episodes of care, including ambulance services, emergency services, urgently needed services, and post-stabilization care services have been consolidated at § 422.113.”

– *Federal Register*, Vol 65, No.126, p40199

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Managed Medicaid

Emergency Services and Post-Stabilization Care



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Statutory Basis

- Section 1932(b)(2)(A) of the Social Security Act
 - To provide coverage for emergency services without regard to prior authorization or the emergency care provider's contractual relationship with the organization or manager
 - To comply with guidelines established under section 1852(d)(2) (respecting coordination of post-stabilization care) in the same manner as such guidelines apply to Medicare + Choice plans offered under part C of title XVIII.

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Definitions

Mirror those of Medicare discussed above:

- Emergency medical condition
- Emergency services
- Post-stabilization care services

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42 CFR § 438.114 Emergency Services

- MCO, PIHP, PAHP, and the state (for primary care case management [PCCM] entities):
 - Must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO, PIHP, PAHP, PCCM, or PCCM entity; and
 - May not deny payment for treatment obtained under either of the following
 - An enrollee had an emergency medical condition including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition
 - A representative of the MCO, PIHP, PAHP, PCCM, or PCCM entity instructs the enrollee to seek emergency services
 - May not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms

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Stabilization- 42 CFR § 438.114(d)(3)

- The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment.

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Post-stabilization Services

- Post-stabilization care services are covered and paid for in accordance with provisions set forth at 422.113(c) of this chapter. In applying those provisions, reference to “MA organization” and “financially responsible” must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section, and payment rules governed by Title XIX of the Act and the states.
- <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-C/section-438.114>

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42 Cfr § 438.114 Emergency And Post-stabilization Services

- Differences from Medicare rules
 - Urgently needed services when network is unavailable is not addressed
 - PCCM, PIHP, PAHP delivery models are unique to Medicaid
 - Allows technical denials for payment if PCP is not notified within 10 business days

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Comparison of Level of Care Regulations

FFS Medicare (paraphrased)

- 42 CFR § 412.3(d) – Inpatient is generally appropriate when
 - Two-midnight expectation of medically necessary hospital care, or
 - Inpatient-only procedure, or
 - Case by case exception without a two-midnight expectation

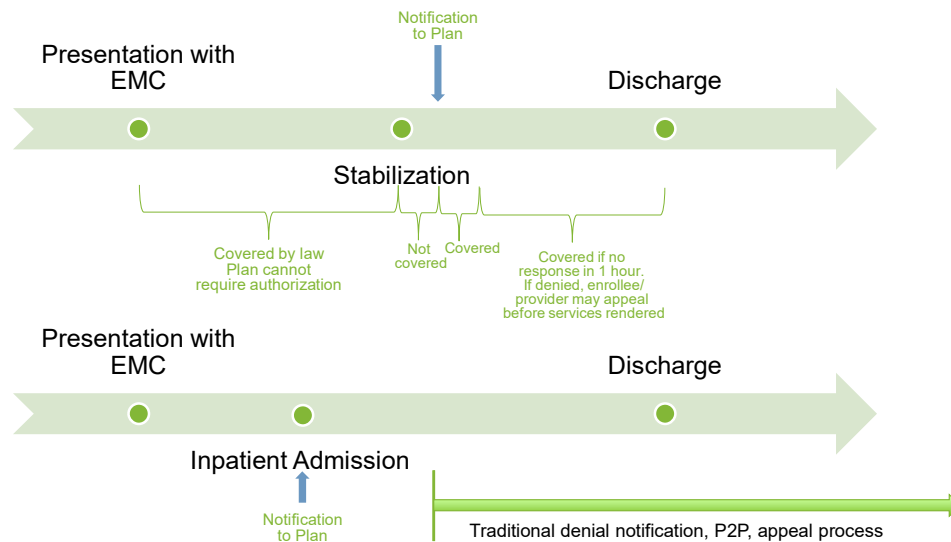
FFS Medicaid (paraphrased)

- 42 CFR § 440.2
 - Inpatient is appropriate when necessary hospital services are expected to meet or exceed 24 hours, or do end up meeting or exceeding 24 hours
 - Outpatient is appropriate when necessary hospital services are not expected to exceed 24 hours, and do not exceed 24 hours

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EMC Special Rules Revolve Around The Time Of Stabilization



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Summary

- CMS put into effect special rules for services related to emergency medical conditions, for both MA and Managed Medicaid, that date back to the beginnings of these programs.
- Emergency services prior to the point of stabilization cannot require prior authorization, or even notification to the plan.
- The treating provider decides when the patient's emergency medical condition is stabilized, and that decision is binding on the payer and subsequent adjudicators.
- Many providers do not use these regulations, allowing plans to apply regular UR rules. In part, this may be because providers may not always clearly document the point of stabilization of an emergency medical condition.

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