

Managed Care Organization Authorization Denials: Lack of Patient Knowledge and Timely Alternative Ambulatory Care

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Study objective: To assess patient knowledge of managed care organization (MCO) regulations, availability of alternative ambulatory care, and patient outcome after MCO insurance authorization denial for an emergency department visit.

Methods: A medical screening examination and a follow-up structured interview were conducted with patients denied authorization for ED visits. The study was conducted at a large urban hospital with 36,000 annual ED visits and 40% MCO patients.

Results: During a 7-month period, 151 patients did not receive MCO authorization for ED care. The interview response rate was 75% (104/138) with 13 patients excluded. Eighty-three percent (86/104) of respondents came to the ED because they believed their problem was an emergency. Four percent (4/104) of the respondents had been instructed to go to the ED but were later denied authorization, whereas 85.6% (89/104) did not know that the MCO could deny payment. Only 37% (38/104) of the respondents reported having received instruction on the MCO preauthorization process, whereas of the 19% who contacted their MCO as instructed, all resulted in scheduling difficulties. Although 57% (59/104) received follow-up within 24 hours, 11% (11/104) of the respondents had a subsequent return visit to the ED with a subsequent admission rate of 4% (4/104).

Conclusion: Few patients are aware of the need for MCO preauthorization for ED care, and almost half do not receive alternative care within 24 hours. A significant number of patients (11%) returned to the ED with an admission rate of 4%.

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INTRODUCTION

Managed health care is becoming increasingly common in this country. In an effort to contain costs, managed care organizations (MCOs) often implement a preauthorization process by which patients with nonemergency problems are "triaged out" of the emergency department. This is accomplished by "gatekeeping," whereby MCO personnel prospectively deny ED authorization for coverage if a patient does not have a problem deemed emergency in nature. Patients are then forced to choose between staying in the ED to receive care that will not be covered, or leaving to receive care at a designated alternative site. This practice may place patients at risk for adverse outcomes.¹ Furthermore, prior authorization requirements of MCOs have resulted in multiple Emergency Medical Treatment and Active Labor Act (EMTALA) citations for emergency departments and physicians.²

Despite EMTALA regulations, gatekeeping is frequently used by MCOs and may not be a safe practice.³ In one California study, Derlet and Young³ reported that of 516 patients denied authorization, 9 later returned to an ED with serious medical conditions (eg, pulmonary embolism and myocardial infarction).⁴ In a consecutive case series of patients denied preauthorization using previously published triage criteria,⁵ which allowed triage of patients from an ED over a 5-year period, 47% of patients were identified as being in potentially unstable condition.⁶

Studies of patient follow-up after denial of preauthorization are limited. One study revealed that one third of patients denied ED preauthorization who left the ED never saw a physician for their problem.⁷ A recent survey of health maintenance organization membership instructions specific to ED and 911 use found that these instructions varied widely and were often inconsistent.⁸ To date, there have been no studies examining patient knowledge of MCO regulations before the preauthorization process.

In this study, we investigated patient knowledge of MCO regulations, the availability of alternative ambulatory care, and the outcomes of patients denied payment for the ED visit by their MCO.

MATERIALS AND METHODS

This study was conducted at a 400-bed urban teaching hospital with 36,000 ED visits per year and was approved by the investigators' institutional review board. Approximately 42% of these visits were by MCO enrollees. Patients who were denied authorization and

subsequently left the ED without receiving care were identified during a 7-month study period from November 1, 1996, through May 30, 1997. A triage nurse assessed all patients presenting to the ED for severity of their condition. Patients with problems of higher severity were sent directly to the patient care area, whereas those with less severe problems were directed to the registration desk before being seen by a physician. Registration personnel contacted the patients' MCO for preapproval before physician evaluation. If authorization was denied, the patient was still offered the option of evaluation and treatment by an emergency physician. If despite encouragement the patient decided to leave, the patient was counseled about possible medical risks and the importance of follow-up care. Subjects were identified by registration information and the ED triage note.

Study investigators contacted patients by telephone within 1 to 8 weeks after their ED presentation. In addition, 2 follow-up letters were sent to those unable to be contacted by telephone. Patients were asked to give verbal consent for participation in the study. Those who consented were asked a series of questions to ascertain the reason for their ED visit, their knowledge of access to care, and of the preauthorization process. Subsequent questions identified alternate care offered and outcomes. The outcomes investigated were return ED visits or hospital admission for their original complaint. All questions were presented in a multiple-choice or yes/no format.

Respondents were also asked about the availability of MCO care before coming to the ED, and about the alternative care offered by the MCO at the time of authorization denial. The time and location (ie, clinic, ED) of subsequent evaluation were also noted, as well as whether their medical problem had required subsequent hospital admission. Respondents were asked whether their medical condition was better, unchanged, or worse at the time of the telephone interview.

RESULTS

During the 7-month study period, 151 patients were denied MCO authorization and chose to leave the ED without receiving care. Thirteen were not included in the study because of incorrect or incomplete registration (invalid telephone number and/or address). Of the remaining 138 patients, 104 (75%) were contacted by either telephone or letter and agreed to participate. Of the participants, 36% were female. The mean age was 30.1 years (range birth to 85 years).

Eighty-six (83%) of 104 respondents came to the ED because they believed their problem was an emergency.

Four percent of patients stated they were instructed to go to the ED by the MCO, then subsequently denied authorization. Eight percent reported that either their primary care physician was unavailable or they were unable to obtain an appointment with their MCO.

Sixty-three percent of the respondents stated they were not aware of the need for preauthorization. In addition, 86% of the respondents stated they were not aware that their MCO could deny payment for ED services. Eighty percent of patients did not try to make an appointment with their doctor before coming to the ED; however, all 20 patients who contacted the MCO as instructed encountered scheduling difficulties that prompted the ED visit (Table 1).

At the time of the telephone survey, 58% of respondents stated they did not understand why they were not seen in the ED. Seventy-eight percent of patients believed the payment authorization denial was inappropriate. A majority of patients were offered alternative care by the MCO; of those, 77% were offered appointments within 24 hours. Seventeen percent were given appointments 24 to 48 hours later, with the remainder (6%) receiving appointments after more than 48 hours. Twenty-six percent of patients stated the MCO provided no alternative care (Table 2).

A physician later evaluated most patients (95/104 [91%]). Of those, 71% were seen within 24 hours, 25% between 1 and 5 days, and 3% after more than 5 days. Most patients were seen at their MCO clinic. Nine percent of patients were never seen, and 11% returned to an ED for evaluation.

At the time of the survey, most patients reported an improvement in the condition that prompted the initial ED visit. Sixty-eight percent of respondents had complete resolution of their condition, 23% stated their condition was only somewhat improved, whereas 5% of patients reported there was no change in their condition. Two

patients stated their problem was worse. Four percent of patients required subsequent hospital admission.

DISCUSSION

Managed care is a method of financing and organizing the delivery of health care in an attempt to lower costs by controlling access to services, coordinating care in a network of providers at discounted rates, emphasizing preventive services, and monitoring outcomes to improve the efficiency of care.⁶ MCOs are becoming very common in this country; at the end of 1995, 23% of the US population had health coverage through MCOs.⁹ Weiner¹⁰ estimated that by the end of 2000, as many as 65% of all Americans would be enrolled in managed care plans.

The ED is historically seen as a costly location for delivering health care. EDs consume only about 2% of national health care expenditures,^{4,11} and reports focusing on high costs of nonurgent care in the ED¹² have been challenged with data that nonurgent care delivered in the ED is actually less expensive.¹³ Kerr¹⁴ found that the majority of MCOs use the terms "life-threatening" or "non-life-threatening" to determine policies regarding access and coverage for ED services. Unfortunately, an MCO's criterion for defining an emergency or life-threatening condition is often poorly defined, which may lead the enrollee to make the decision as to whether an emergency condition exists.⁸ Health plans frequently base claims decisions on a patient's eventual diagnosis instead of the presenting symptoms.¹⁵ Recent federal legislation mandates that claims decisions are to be based on the average person's or "prudent layperson" definition of an emergency for Medicaid and Medicare. Legislation extending the prudent layperson standard to all health plans has been

Table 1. Knowledge of MCO policy.

Variable	Yes	No
	No. (%)	No. (%)
Instructed to call before visit	38 (37)	66 (63)
Aware MCO could deny ED visit	15 (14)	89 (86)
Called before visit	20 (19)	84 (81)
Understand why not seen in ED	44 (43)	60 (58)
Believed ED visit refusal appropriate	23 (22)	81 (78)

Table 2. Follow-up and outcome.

Variable	No. (%)
Offered care elsewhere*	77 (74)
Immediately	59 (77)
1-2 d	13 (17)
3-5 d	4 (5)
Other	1 (1)
Never seen*	9 (9)
Outcome	
Recurrent ED visit	11 (11)
Admit to hospital	4 (4)

*N=104.

introduced in Congress. If passed, this may result in decreased authorization denials. Our results show that 83% of patients considered their problem to be an emergency, which could lead to coverage under the prudent layperson standard.

Although MCOs may deny payment, they do not deny care. Therefore, they cannot be fined under EMTALA regulations, which mandate a medical screening examination for everyone presenting to an ED, regardless of ability to pay. This disparity places the ED physician and the hospital at risk for potential violations.¹ Furthermore, gatekeeping uses no standardized triage criteria, with various personnel functioning as the gatekeeper. These inconsistencies could potentially lead to adverse outcomes when patients leave the ED without receiving care.

Previous studies have focused on the process and safety of triage of patients away from the ED. In an attempt to limit ED overcrowding, Derlet et al⁵ performed a 5-year prospective trial using specific triage criteria to refer "nonurgent" patients out of the ED. They reported only a small number of adverse outcomes. Other investigators were unable to prospectively validate their published criteria. Lowe et al¹⁶ found that 33% of patients were appropriate for treatment in the ED. Birnbaum et al¹⁷ had similar results using the criteria of Derlet et al. Later studies have examined the safety of triage away from the ED as it applies to the gatekeeping process.^{4,6,18-21} The results of these studies suggest that gatekeeping may lead to adverse medical outcomes. There is clearly a need for safe triage and gatekeeping practices.

Inherent in the gatekeeping process, MCOs typically provide alternate sites for health care at the time of payment denial. A few studies have examined alternative care provided by the MCOs when patients were denied payment authorization for ED care. Shaw et al¹⁸ found that 40% of children never saw a physician for alternative care. Lowe et al¹⁶ found that half of patients saw their primary care physician, whereas half never saw a physician. Straus et al²² found that only 34% of patients given referral to a clinic from the ED complied with the follow-up, whereas Abbuhl et al²³ found that 32% of all patients turned away by their MCO never saw a physician for their problem. However, a study by Chan et al²⁴ found that 90% of patients were offered alternative care but only 76% of those sought care as directed.

Our study found that although 74% of patients were offered alternative care while in the ED, 23% of patients were not given an appointment until more than 24 hours later, with 5% given appointments within 3 to 5 days. Most patients kept their appointments as directed. However,

11% of patients returned to an ED for further care because they believed their appointment was not timely enough. These results suggest that if given timely follow-up, patients often comply.

To date, there have been no studies examining patient knowledge of MCO policies and procedures regarding ED usage and preauthorization. A few studies have looked at patients' perceptions of the denial process and satisfaction with MCOs.

We discovered an overall lack of knowledge among enrollees of MCOs regarding the preauthorization process and MCO policies. The majority of patients stated they were never instructed to call the MCO before seeking care at an ED. Furthermore, all patients who attempted to make an appointment with their primary care physician before presenting to the ED encountered a problem with scheduling. Interestingly, we found that 4% of patients were instructed to go to the ED by the MCO, then were subsequently denied authorization while in the ED. Even after the denial process, 58% of patients still did not understand why they were not seen in the ED.

Few studies have looked at patients' perceptions regarding the denial process.^{24,25} These studies found that a large number of patients were unsatisfied with their MCOs. We found that 78% of patients considered their denial to be inappropriate. We did not ask the follow-up question as to whether, if given the same circumstances, the patient would return to the ED. However, Chan et al²⁴ found that half of the patients in their study were unsatisfied and would return to the ED if given the same circumstances.

Our study has a number of limitations. First, our survey population is relatively small and reflects a group of MCO patients at only one institution. In addition, the results may be biased because of our inability to gather data from nonresponders, who represented 25% of the study population. Finally, we only surveyed patients who were denied authorization and left the ED, not those who decided to stay and receive treatment in the ED. Future studies are needed to compare outcomes between these 2 patient populations.

In summary, few patients who are refused authorization for ED care are aware of the need for preauthorization for ED visits. For those nonapproved patients, almost half do not receive follow-up within 24 hours. A significant number of patients (11%) returned to the ED, and 4% were admitted.

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EDITOR'S NOTES:

These data highlight the information gap between insurers and patients regarding coverage for emergency services. The fact that only 14% of respondents in this sample were aware that their MCO could deny payment for an ED visit is discouraging. These data reflect the overall lack of agreement among patients, providers, and insurers

about how an emergency medical condition is defined. The timing of consequent care in this population is also interesting. Although most patients were offered care at an alternative location in a timely fashion, a concerning minority (4%) was admitted to a hospital. It is not clear whether these admissions could have been avoided if the patients had received care in the ED, nor did the authors present clinical data indicating poor outcomes. We still lack validated criteria for identifying patients at greatest risk for poor outcomes before the delivery of ED care. The most appropriate time to provide an alternative to ED care is before the patient arrives. If the information gap between insurers and plan enrollees is not narrowed, there is no reason to expect lower rates of ED utilization.

As the authors point out, the study has important limitations. The most significant limitation is the highly selected patient population. It is not surprising that patients who were denied authorization for ED care believed that this denial was inappropriate. Future studies of health plan policies for ED utilization should survey a representative sample of plan enrollees from a variety of insurance types. This sample would provide more definitive conclusions about the information gap between health plans and patients regarding coverage for emergency services.

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