



PROFESSION

New ED drama? Hospitals demand upfront fee for nonemergencies

More are charging patients up to \$180 for problems deemed nonemergent. Some doctors say the policy could backfire and harm patients.

By **KEVIN B. O'REILLY**, *amednews staff*. *Posted Dec. 3, 2012.*

Physicians who take after-hours calls from patients often face a difficult decision: Which symptoms can wait for an office visit, and which ones require a trip to the emergency department? Now doctors find these decisions complicated by a troubling, rising trend: Will a trip to the ED mean an upfront charge for a patient if the problem is deemed nonemergent?

At least half of hospitals are making efforts to collect patient co-pays, deductibles or other charges at the time of service in the emergency department, said Richard Gundling, vice president of health care financial practices at the Healthcare Financial Management Assn. The organization has 39,000 members, including chief financial officers and other professionals in health care financing.

Gundling said a smaller but growing number of hospitals give patients whose problems are deemed nonemergent a choice: Pay an initial fee to get the problem treated in the ED, or seek care elsewhere. The fees range from \$100 to \$180 for uninsured patients, or the relevant co-pay or deductible for insured patients. He said it is unclear how many hospitals are charging ED patients up front for nonemergency care, but he added that hospitals financially squeezed by uncompensated care increasingly are opting for this collections model.

"That's getting to be more and more common," Gundling said, "because of overcrowding, and because hospitals tend to be filled with people who are using ERs as a regular physician office. It's better to tell the patient up front that they have to pay a \$150 fee than billing them at the end, when they may not have realized the difference in cost."

Yet many doctors interviewed for this article found the growing trend alarming. They said it unfairly targets patients with poor access to primary care and is unlikely to alleviate ED crowding because nonurgent problems make up less than 10% of visits. Emergency physicians added that the policy could result in tragedy, because some seemingly nonemergent conditions quickly worsen, and because some patients with life-threatening problems may wrongly decide to steer clear of the ED to avoid pay-first fees.

80,000 walk away from HCA

A Houston hospital that is part of Nashville, Tenn.-based HCA adopted the payment policy in 2004, and it has since spread to nearly half of the chain's 163 hospitals, said company spokesman Ed Fishbough. Of 6 million ED visits to HCA hospitals in 2011, 80,000 patients with nonemergent problems left without treatment to avoid paying the upfront fee, Fishbough said.

"It has been a successful part of helping to reduce crowding in emergency rooms and to encourage appropriate use of scarce resources," he added. "This helps ensure that the sickest patients get treated quickly and those who do not have an emergency have access to more efficient, less-costly care settings."

In November, the Newton Medical Center in Covington, Ga., announced that it would charge \$150 to uninsured patients who want treatment for nonemergent conditions and would collect co-pays or deductibles from insured patients. Two other nearby hospitals in Georgia — Clearview Regional Medical Center in Monroe and Rockdale Medical Center in Conyers — have adopted similar policies, a local news report said.

Hospitals implementing the pay-first policy say it complies with the Emergency Medical Treatment and Active Labor Act because all patients receive the federally required medical screening regardless of ability to pay. It is only after a patient's condition is deemed nonemergent that upfront payment for further treatment in the ED is discussed. Fishbough said HCA hospitals exempt patients who are pregnant or who are younger than 5 or older than 65. He said HCA hospitals typically have a triage nurse and a physician make the determination that a patient's condition is not emergent.

Fear of unintended consequences

Some physicians, however, object to the idea. The pay trend is severely misguided, said Arthur L. Kellermann, MD, MPH, who served on an Institute of Medicine emergency care panel and now is a health policy researcher at the RAND Corp., an independent nonprofit think tank.

"People don't go the ER as a recreational event," he said. "If you tell me you have an urgent care clinic or walk-in clinic or other places where these people can go straight to, then OK. But to tell someone to just go away if you don't have \$150, you have to be ignoring the fact that if they had somewhere to go they wouldn't be there in the first place. And you have to be damn sure that this patient doesn't have a more serious problem.

"This is putting a Band-Aid on a gunshot wound."

Andrew E. Sama, MD, president of the American College of Emergency Physicians, also expressed reservations about the upfront-charge policy.

“What I’m worried about is that people are going to have second thoughts about getting serious symptoms evaluated, and that to me is a real compromise,” said Dr. Sama, senior vice president of emergency services at North Shore-Long Island Jewish Health System in Manhasset, N.Y. The hospital does not charge ED patients up front for nonemergent care.

Emergency medicine researchers said charging first for nonurgent care is unlikely to cut wait times significantly or reduce crowding. According to the most recent data from the Centers for Disease Control and Prevention, only 7.7% of ED visits are classified as “nonurgent,” meaning patients would not be harmed by waiting to receive treatment within two to 24 hours for their problems. Meanwhile, a June 20 *Annals of Emergency Medicine* study found that ED visits rose 15% between 2001 and 2008 and outpaced population growth by 60%. The time spent in the ED — one way to measure crowding — jumped 30%. But that rise was driven by a 23% growth in high-acuity patients who spent 41% more time in the ED undergoing tests and procedures. The number of low-acuity patients grew by only 6%, the study said.

Patrick O’Malley, MD, an emergency physician in a suburb of Columbia, S.C., said he is sympathetic to the broader notion of trying to discourage misuse of the ED.

“The idea of it is great, because we all get barraged with patients who come in for the refills on their Percocet for chronic pain, and it’s inappropriate,” Dr. O’Malley said. “No, we shouldn’t have to fill our waiting room and keep other people waiting for that type of thing.”

But Dr. O’Malley also sees a potential downside.

“There are truly people who come to the ED with something very benign, and it ends up being a major medical issue,” he said. “Determining who those patients are right at the front door is difficult.”

For example, he said, a patient with lingering back pain may be better off visiting a primary care doctor, yet a neurological exam could reveal an epidural abscess that requires emergent management. He said research should be conducted to track patient outcomes at EDs with pay-first policies before widespread implementation of the concept.

Primary care physicians interviewed for this article also saw drawbacks to the pay policy.

“It could very well have the unintended consequence of scaring patients away,” said Sandra A. Fryhofer, MD, an Atlanta internist. “The ideal situation would be for the patient to call his or her physician before going to the ED, but they may not be able to get in touch with that doctor. ... This puts a lot of stress on patients. If someone is having chest pains, you know, it could be a heart attack or just a sore muscle.”

Hospitals implementing these policies should inform physicians in the area so they can tell patients about the possibility of upfront charges for nonemergent care, Dr. Fryhofer said.

The pay-first policy appears to be aimed at discouraging uninsured patients from visiting the ED, said Leora Horwitz, MD, assistant professor of general internal medicine at Yale University School of Medicine in Connecticut.

“A much better solution to this kind of problem would be to incentivize primary care doctors to provide the care that’s needed, to have evening hours, weekend hours, and to have more urgent care centers,” Dr. Horwitz said. “There are many ways to improve access for patients without barring the door of the ER as your solution.”

ADDITIONAL INFORMATION:

How often do patients visit the ED for nonurgent problems?

In an effort to reduce crowding, some hospitals charge patients up front for treatment that is deemed to be better handled outside the emergency department. Relatively few patients, even among the uninsured, visit the ED for problems that could wait a day before being treated.

Triage acuity of visit	Percentage of overall visits	Percentage for uninsured patients
Immediate	1.8%	1.3%
Emergent (0-14 minutes)	10.2%	8.5%
Urgent (15-60 minutes)	41.6%	40.4%
Semi-urgent (1-2 hours)	35.1%	38.7%
Nonurgent (2-24 hours)	7.7%	8.4%

Note: Percentages do not add up to 100 because some visits occurred at hospitals that do not conduct nursing triage.

Source: “National Hospital Ambulatory Medical Care Survey: 2009 Emergency Department Summary Tables,” Centers for Disease Control and Prevention (cdc.gov/nchs/data/ahcd/nhamcs_emergency/2009_ed_web_tables.pdf)

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“National Trends in Emergency Department Occupancy, 2001 to 2008: Effect of Inpatient Admissions Versus Emergency Department Practice Intensity,” *Annals of Emergency Medicine*, June 20 (www.ncbi.nlm.nih.gov/pubmed/22727201)

“National Hospital Ambulatory Medical Care Survey: 2009 Emergency Department Summary Tables,” Centers for Disease Control and Prevention (www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2009_ed_web_tables.pdf)

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