

DEPARTMENT OF COMMUNITY HEALTH

GEORGIA FAMILIES

**REPORT #19: EMERGENCY ROOM
CLAIM PROCESSES ANALYSIS**

**MEDICAID CARE MANAGEMENT ORGANIZATION
ACT COMPLIANCE MONITORING**

JULY 28, 2012

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REPORT GLOSSARY

The following listing of terminology and references may be used throughout this report:

- **Adjudicate** – A determination by the Care Management Organization of the outcome of a health care claim submitted by a health care provider. Claims may pay, deny, or in some cases have an alternative adjudication outcome.
- **Appeal** – A formal process whereby a health care provider requests that a payor review the outcome of a claim previously submitted to the payor for reimbursement. This term is typically reserved for claims that were originally denied for payment or paid at a lower amount by the payor, and the provider believes a payment should be made or paid at a higher amount.
- **Autopayable (“Autopay” or “Presumptive”) List** – A list of diagnosis or procedure codes that, when submitted on a claim by a provider to a payor, are automatically paid at a specified level. For purposes of this report, the term is typically utilized when discussing reimbursement for emergency room services.
- **Care Management Organization (CMO)** – An organization that has entered into a risk-based contractual arrangement with the Department to obtain and finance care for enrolled Medicaid and PeachCare for Kids[®] members. CMOs receive a per capita or capitation claim payment from the Department for each enrolled member. Three Care Management Organizations currently operate in Georgia. These organizations include AMERIGROUP Community Care (AMERIGROUP), Peach State Health Plan (PSHP), and WellCare of Georgia (WellCare).
- **Centers for Medicare and Medicaid Services 1500 (CMS-1500 or “1500”) Claim Form** – Document most often required by payors to be utilized by physicians and other non-institutional providers for submission of a claim request for reimbursement to the health care payor.
- **Claims Processing System** – A computer system or set of systems that determine the reimbursement amount for services billed by the health care provider.
- **Current Procedural Terminology (CPT) Codes** – A listing of five character alphanumeric codes for use in reporting medical services and procedures performed by health care providers. CPT codes generally begin with a numeric character.

- **Department of Community Health (DCH or Department)** – The Department within the state of Georgia that oversees and administers the Medicaid and PeachCare for Kids® programs.
- **Denied Claim** – A claim submitted by a health care provider for reimbursement that is deemed by the payor to be ineligible for payment under the terms of the contract between the health care provider and payor.
- **Emergency Medical Condition (EMC)** – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An Emergency Medical Condition shall not be defined on the basis of lists of diagnoses or symptoms.
- **Emergency Medical Treatment and Active Labor Act (EMTALA)** – As it pertains to this report, a portion of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA '86) statute that outlines the patient's rights and guidelines to prevent denial of emergency treatment.
- **Emergency Services (ES)** – Covered inpatient and outpatient services furnished by a qualified Provider that are needed to evaluate or stabilize an Emergency Medical Condition that is found to exist using the prudent layperson standard.
- **Encounter** – A distinct set of health care services provided to a Medicaid or PeachCare for Kids® Member enrolled with a Contractor on the dates that the services were delivered.
- **Encounter Data** – Health Care Encounter Data include: (i) All data captured during the course of a single Health Care encounter that specify the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the Member receiving services during the Encounter; (ii) The identification of the Member receiving and the Provider(s) delivering the Health Care services during the single Encounter; and, (iii) A unique, i.e. unduplicated, identifier for the single Encounter.
- **Fiscal Agent Contractor (FAC)** – The entity contracted with the Department to process Medicaid and PeachCare for Kids® claim and other non-claim specific payments.
- **Georgia Families** – The risk-based managed care delivery program for Medicaid and PeachCare for Kids® where the Department contracts with Care Management

Organizations to manage and finance the care of eligible members.

- **Health Care** – Health Care means care, services, or supplies related to the health of an individual. Health Care includes, but is not limited to, the following: (i) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and (ii) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.
- **Health Care Professional** – A physician or other Health Care Professional, including but not limited to podiatrists, optometrists, chiropractors, psychologists, dentists, physician’s assistants, physical or occupational therapists and therapists assistants, speech-language pathologists, audiologists, registered or licensed practical nurses (including nurse practitioners, clinical nurse specialist, certified registered nurse anesthetists, and certified nurse midwives), licensed certified social workers, registered respiratory therapists, and certified respiratory therapy technicians licensed in the State of Georgia.
- **ICD-9-CM (ICD-9) Codes** – The International Classification of Diseases, Clinical Modification, 9th Revision is used to code and classify morbidity data from the inpatient and outpatient records, physician offices, and hospitals onto claims to submit to a health plan. Codes are classified as either diagnosis-specific or procedure-specific.
- **In-Network Provider** – A Provider that has entered into a Provider Contract with the Contractor to provide services.
- **Inpatient Facility** – Hospital or clinic for treatment that requires at least one overnight stay.
- **Medicaid Care Management Organizations Act** – O.C.G.A. 33-21-1, et seq MEDICAID CARE MANAGEMENT ORGANIZATIONS ACT. A bill passed by the Georgia General Assembly, signed into law by the Governor, and effective July 1, 2008 which speaks to several administrative requirements for the administrators of the Medicaid Managed Care plan, Georgia Families, to comply. Some of the requirements include dental provider networks; emergency room claims payment requirements, eligibility verification, and others.
- **Medicaid Management Information System (MMIS)** – Claims processing system used by the Department’s fiscal agent claims processing vendor to process

Georgia Medicaid and PeachCare for Kids[®] FFS claims and capitation claims.

- **Medical Records** – The complete, comprehensive records of a Member including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the Member’s participating Primary Care physician or Provider, that document all medical services received by the Member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable DCH rules and regulations, and signed by the medical professional rendering the services.
- **Medical Screening** – An examination: (i.) provided on hospital property, and provided for that patient for whom it is requested or required, (ii.) Performed within the capabilities of the hospital’s emergency room (ER) (including ancillary services routinely available to its ER), (iii.) The purpose of which is to determine if the patient has an Emergency Medical Condition, and (iv.) Performed by a physician (M.D. or D.O.) and/or by a nurse practitioner, or physician assistant as permitted by State statutes and regulations and hospital bylaws.
- **Medically Necessary Services** – Definition is from Section 4.5 of the Amended and Restated Contract between the Georgia Department of Community Health and the Care Management Companies. Based upon generally accepted medical practices in light of Conditions at the time of treatment, Medically Necessary services are those that are:
 - Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the eligible Member’s medical Condition;
 - Compatible with the standards of acceptable medical practice in the community;
 - Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
 - Not provided solely for the convenience of the Member or the convenience of the Health Care Provider or hospital;Not primarily custodial care unless custodial care is a covered service or benefit under the Members evidence of coverage.
- **Member** – An individual who is eligible for Medicaid or PeachCare for Kids[®] benefits. An individual who is eligible for Medicaid or PeachCare for Kids[®] benefits might also be eligible to participate in the Georgia Families program.
- **Model Contract** – A contract between a state agency and contractor(s) that does not indicate any specific contractor, specific financial terms, and/or any other addendums that may exist between the state agency and any individual contractor.
- **Out-of-Network Provider** – A Provider of services that does not have a Provider contract with the Contractor. Also referred to in the report as a “non-participating provider”.

- **Payor** – An entity that reimburses a health care provider a portion or the entire health care expenses of a patient for whom the entity is financially responsible.
- **Paid Claim** – A claim submitted by a health care provider for reimbursement that is deemed by the payor to be eligible for payment under the terms of the contract between the health care provider and payor.
- **PeachCare for Kids[®] Program (PCK)** – The Children’s Health Insurance Program (CHIP) funded by Title XXI of the Social Security Act, as amended.
- **Post-Stabilization Services** – Covered Services, related to an Emergency Medical Condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member’s condition.
- **Professional Services Claim (Professional Claim)** – A health care claim for reimbursement of services provided by a physician or other non-institutional provider.
- **Presumptive List** – See “Autopayable List”.
- **Prior Authorization (Authorization, PA, or Pre-Certification)** – An approval given by a health care payor to a health care provider before a health care service is performed, that allows the provider to perform a specific health care service for a patient who is the financial responsibility of the payor with the understanding that the payor will reimburse the provider for the service.
- **Provider** – Any physician, hospital, facility, or other Health Care Professional who is licensed or otherwise authorized to provide Health Care services in the State or jurisdiction in which they are furnished.
- **Provider Contract** – Any written contract between the Contractor and a Provider that requires the Provider to perform specific parts of the Contractor’s obligations for the provision of Health Care services under this Contract.
- **Provider Handbook** – A document created by a health care payor that describes the coverage and payment policies for health care providers that provide health care services to patients covered by the payor.
- **Provider Number (or Provider Billing Number)** – An alphanumeric code utilized by health care payors to identify providers for billing, payment, and reporting purposes.
- **Prudent Layperson** – A person with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that could cause:

- 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.

- **Revenue Codes** – A listing of three digit numeric codes utilized by institutional health care providers to report a specific room (e.g. emergency room), service (e.g. therapy), or location of a service (e.g. clinic).

- **Traditional Medicaid and PeachCare for Kids[®]** – For purposes of this analysis, the portion of the Medicaid and PeachCare for Kids[®] program that provides benefits to eligible members who are not participants in the Georgia Families program.

- **Triage** – The process of reviewing a patient's condition to determine the medical priority and the need for emergency treatment.

- **Triage Rate** – The reimbursement rate paid to a provider when a patient enters the emergency room but is deemed to not be in need of emergency care.

- **Uniform Billing (UB or UB-92 or UB04) Claim Form** – Document most often required by payors to be utilized by hospitals and other institutional providers for submission of a claim request for reimbursement to the health care payor. The UB-92 version of the claim form was replaced by the UB04 version in 2007. CMS refers to the UB-92/UB04 claim form as the CMS 1450 claim form.

EXECUTIVE SUMMARY

Objective of Initiative

The purpose of this analysis and the associated monitoring activity is to confirm that the Care Management Organizations (CMOs) under contract with the Georgia Department of Community Health are in compliance with the provisions relating to the processing of Emergency Room (ER) claims as mandated in the contract between the Department of Community Health (DCH) and the CMOs, as well as, the Medicaid Care Management Organizations Act (“The Act”). The analytical activities of this initiative included a point-in-time comparative analysis between the CMO-stated ER claims processing practices as of March 2008 (as previously reported in Report #3 “Comparative Analysis Policies and Procedures of Georgia Care Management Organizations”) and their stated practices as of March 2011.

Methodology

Myers and Stauffer performed numerous analyses in order to report on the above-stated objective¹. The detailed methodology for each of these analyses can be found in the Detailed Analyses and Findings section of this report.

Limitations

1. Some of the Emergency Room encounter data, as provided by the CMOs, did not contain an indication of the Level of Care (Emergency Room Evaluation and Management, or “E&M” code).
2. In attempting to identify instances where a CMO paid a provider a triage payment for an ER visit, certain claims may potentially not be identified because of reduced reimbursement resulting from the application of co-payments or increased reimbursement due to the addition of interest or any combination of the two.
3. Our analyses and any resulting findings were based on documentation provided by the CMOs or obtained from public sources. There may be other information regarding the CMOs’ policies and practices that was not provided in response to our requests for information. Additionally, we did not perform on-site assessments to inspect or confirm that the CMO’s operational practices were consistent with the data and documentation provided.
4. Monthly encounter reconciliation reports indicate that the encounter claims data provided by the CMOs may be less than 100 percent complete. As of the date the data used in our analysis was extracted, the completion rate for the

¹ The analyses and associated activities described herein were performed under the American Institute of Certified Public Accountants (AICPA) code of professional conduct for consulting engagements.

encounter claims was 99 percent for both Peach State and WellCare. The completion rate for AMGP was 100 percent. Although the completion rates indicate the encounter data is nearly complete in the aggregate, completion rates for certain services reflected in the encounter data may have more variation, which could have an impact on our analyses. However we believe that any potentially missing encounters would have a negligible impact on the findings.

Summary of Findings and Recommendations

Myers and Stauffer performed seven multiple stage analyses. Below is a listing of the key findings and related recommendations. Please refer to the subsequent sections of this report for additional details. Additionally, upon request of the CMO, Myers and Stauffer will provide example claims for the findings below to facilitate review, confirmation, and correction activities.

Each CMO was given an opportunity to review the initial draft of this report. CMO responses to Key Findings can be found throughout the Executive Summary and Detailed Analyses and Findings section of the report as applicable. As a result of our findings, the CMOs have provided a plan of action to DCH detailing how the issue will be addressed. If the Department wishes, Myers and Stauffer can follow-up with the CMOs to determine if their stated objectives have been achieved by the CMO-provided date.

- **Analysis One** – *Analysis of contractual changes related to emergency room provisions after the implementation of the Act in the model contract between the Department and the CMOs, as well as, the contracts between each CMO and their contracted hospital providers.*

Key Finding: Language inaccuracy was identified within the Emergency Medical Condition definition (Provision 4.6.1.2.) in the DCH-CMO Model Contract.

Recommendation: We recommend that the Department update Provision 4.6.1.2 to match the language in 42 CFR 489.24 by changing the word “adequate” to “inadequate”.

Update: This information was shared with DCH prior to this draft report. We believe that this recommendation has since been implemented.

Key Finding: Upon analysis of the DCH-CMO contract it was noted that there were two separate sections related to Emergency Room care and services.

Recommendation: The Department may wish to consider for future revisions of the DCH-CMO contract combining Section 4.6.1 and Section 4.16.5 so all provisions related to Emergency Room care and services can be found in the same section of the contract.

Key Finding: Language stating that the primary diagnosis code billed on the claim is used to make an Emergency Medical Condition (EMC) determination was found in 95 percent of the PSHP facility contracts. This language was not

found in any of the AMERIGROUP contracts and in just one percent of the WellCare facility contracts.

Recommendation: We recommend that PSHP and WellCare update their provider contracts to be in compliance with provisions of the Act by removing language stating that the primary diagnosis code billed on the claim is used to make an Emergency Medical Condition (EMC) determination. Because provider contracts likely include differing terms, we recommend that each CMO provide to DCH a schedule that reflects the timeline necessary to update each contract.

PSHP response: “We believe Peach State is in compliance with the Act as the Plan distributed a state approved notice (Important Provider Notice - House Bill 1234 dated 7/15/08) to all network providers after the implementation of the Act. The notice is also posted as a banner message on Peach State's provider web portal. In addition, Peach State will incorporate this language in the Provider Manual and distribute a product attachment to serve as an addendum to all existing provider contracts to include language specific to the Acts' requirements.”

WellCare response: “It was noted that approximately 1% of facility contracts reviewed under this project contained language indicating the primary diagnosis code billed on the claim is used to make an Emergency Medical Condition (EMC) determination. We acknowledge that our facility contracts include language that may have been appropriate at the time the contract was executed. However, please note that all providers received a contract addendum in September 2008, which notified providers of changes to their contracts that were the direct result of H.B. 1234. This contract addendum had not been provided to Myers and Stauffer (M&S) prior to the release of this draft report. This oversight has now been corrected through our submission of this contract addendum to the M&S secure ftp site on September 29, 2011.”

Key Finding: Only a small number of the facilities with CMO contracts revised on or after July 2008 contained part or all of the Act language.

Table 1: Number of Facilities with Act language in their CMO contract

	AMERIGROUP	PSHP	WellCare
Number of facilities with amended contracts on or after July 2008	20	42	20
Act language found in amended contract	8	13	5

Recommendation: We recommend that the CMOs amend provider contracts to include all of the Act language related to the processing of ER claims.

AMERIGROUP response: “AGP has reviewed the key findings and will request a meeting with DCH to seek clarity around the ER claims processing procedures. Upon receiving that clarity, we will amend our

standard contract template with the Act language within 30 days, and will work with DCH to put an action plan into place to amend all existing contracts with an estimated completion date of 3/31/12.”

PSHP response: “We believe Peach State is in compliance with the Act as the Plan distributed a state approved notice (Important Provider Notice - House Bill 1234 dated 7/15/08) to all network providers after the implementation of the Act. The notice is accessible via Peach State’s website. Provider contracts specifically incorporate the PSHP Policies and Procedures by reference. Policies and Procedures have been updated since July 2008 to reflect all of the Act language related to the processing of ER claims. Also, Peach State will distribute a product attachment to serve as an addendum to all existing provider contracts to include language specific to the Acts requirements.”

WellCare response: “M&S identified 20 WellCare facilities with amended contracts on or after July 2008, with five of these contracts having been updated to include H.B. 1234 language. All providers received a contract addendum in September 2008, which notified providers of changes to their contracts that were the direct result of H.B. 1234. This contract addendum had not been provided to Myers and Stauffer (M&S) prior to the release of this draft report. This oversight has now been corrected through our submission of this contract addendum to the M&S secure ftp site on September 29, 2011.”

- **Analysis Two** – *Analyses of the definition of an Emergency Medical Condition (EMC) used in CMO-issued provider handbooks and CMO-provider contracts to determine if they are equivalent to DCH’s EMC definition. Any variations among the different sources were noted.*

Key Finding: Analysis found that each CMO has multiple EMC definitions within their respective contracts with hospital providers. Additionally, none of the CMO-provider contracts that were analyzed contained an EMC definition that matched all elements of DCH’s EMC definition as written in the DCH-CMO model contract. Please refer to Table 2 below as well as Analysis one in the Detailed Analyses later in this report.

Table 2: Summary of the EMC definition analysis of CMO-Facility contracts

CMO	Number of contracts analyzed	Total number of distinct EMC definitions identified in CMO-provider contracts	Number of contracts where EMC definition matches DCH definition
AMERIGROUP	124	3	0
PSHP	128	8	0
WellCare	165	7	0

Recommendation: DCH may wish to consider requiring each CMO to use the same definition of an Emergency Medical Condition as was included in the DCH-CMO model contract. This common definition should be used consistently in all contracts, provider handbooks, subcontractor agreements and update bulletins, as applicable. DCH may also wish to require a corrective action plan from each CMO in order to track the anticipated changes and provide an estimated completion date.

AMERIGROUP response: “AGP has reviewed the finding assigned and is in agreement.”

PSHP response: “Peach State’s policies which are incorporated into the provider contracts by reference are reviewed and updated annually or as needed. The policy that governs emergency services was updated on 9/28/2011. As an added measure, Peach State will distribute a product attachment to serve as an addendum to all existing provider contracts to include language specific to the Acts requirements.”

WellCare response: “It was noted that, of the 165 WellCare contracts analyzed, M&S located seven different EMC definitions. Please be aware the Georgia Department of Community Health (DCH) approved a new WellCare Provider Contract template on June 10, 2011. Within Attachment B, Section 3i of this contract template, WellCare documents the definition of an EMC as:

“Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An Emergency Medical Condition shall not be defined on the basis of lists of diagnoses or symptoms.”

We request that M&S recognize WellCare’s approved contract template as an appropriate action in meeting the intent of this analysis.”

Myers and Stauffer response to WellCare request: This analysis was performed evaluating the current contracts between WellCare and its hospital providers nor had WellCare provided the provider contract template referenced above to Myers and Stauffer. Upon analysis of the above Emergency Medical Condition definition, it is noted key language, which is included in DCH’s definition of an Emergency Medical Condition, remains missing. The following language relating to mental health and when a pregnant woman is having contractions is not included above:

- *Serious harm to self or others due to an alcohol or drug abuse emergency;*
- *Injury to self or bodily harm to others; or*
- *With respect to a pregnant woman having contractions:*
 - (i) *That there is adequate time to affect a safe transfer to*

another hospital before delivery, or (ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.

Myers and Stauffer's finding for this analysis and subsequent recommendation remain the same.

- **Analysis Three** – *Analyses of facility and provider ER claims with dates of services prior to implementation of the Act and after implementation of the Act. Analyses include any trends identified, as well as, a cross-claim comparison to corresponding professional services claims.*

AMERIGROUP response: “AGP has reviewed the key findings assigned and provides responses below. Clarity for non-participating reimbursement of ER would be welcome. For example, Page 44 & 45 of the report indicates that there is inconsistency between the Act and the DCH contract. It would be helpful to clarify the methodology DCH wants the CMO's to employ for non-participating providers for ER (100% of Medicaid vs. 90% of Medicaid).”

Key Finding: Analysis found that for all the CMOs, the physician billed a higher Level of Care than the facility for the same episode of care in at least 79 percent of the time².

Recommendation: Myers and Stauffer recommends each CMO consider performing additional analyses to identify and recoup claims where the level of procedures and services billed cannot be justified. CMOs should also consider educational opportunities, and special handling of claims from providers that represent the greatest share of the potentially upcoded claims. DCH may wish to monitor this situation closely, including guidance to the CMOs as well as analyses to review claims from the same providers in the fee-for-service delivery system.

AMERIGROUP response: “AGP will pursue education opportunities, and will perform additional analysis, including special handling, to identify and recoup claims that might have paid at an inappropriate rate by 11/30/11. In order to execute, we may seek further clarification to understand the scope of recoupment timeframes.”

Key Finding: The largest percentage of denials for the AMERIGROUP provider (CMS1500) claims were for eligibility issues, representing 48 percent of all the denials.

Recommendation: We recommend that AMERIGROUP analyze these eligibility-related denials to identify and correct any potential issues. Because of the multi-faceted nature of member enrollment, once potential issues have been confirmed, convening a conference with all of the

² It is important to note that this initiative did not include collection and analysis of medical records from the providers in question. In order to confirm the potential upcoded claims, it may be necessary for the CMOs and/or DCH to review medical records or other financial information on file with providers.

entities involved with enrollment would assist in facilitating corrective actions.

AMERIGROUP response: “AGP will complete the analysis by 12/31/11.”

Key Finding: “No Reason Provided” or “Reason Not Clear” (e.g. “Reduced Allowable”, “Claim level Disallow”) accounted for the largest percentage, 26 percent, of facility (UB04) denials for AMERIGROUP.

Recommendation: We recommend that AMERIGROUP provide further clarification of Explanation of Payment (EOP) codes such as “Reduced Allowable” and “Claim level Disallow”, including communicating additional information on these codes to providers. The CMO should provide a corrective action plan for reducing denied claims for these EOPs.

AMERIGROUP response: “AGP will provide clarification to M&S and implement appropriate changes to our EOP by 10/31/11.”

Key Findings: Forty-four percent of PSHP’s denied CMS 1500 claims were due to timely filing issues and 60 percent of the UB04 claim denials were due to coordination of benefits issues.

Recommendation: We recommend that PSHP conduct an in-depth review of their filing time limit and coordination of benefit denials and provide a corrective action plan for reducing these types of denials, including a communication plan and/or provider education as appropriate.

PSHP response: “Upon review of the sample claims reviewed by Myers & Stauffer for COB, Peach State was able to determine that 100% of the Plan’s COB processing in the sample was accurate.

Peach State will develop an additional initiative to educate providers on timely filing and COB requirements as well as provide direction on how to confirm and validate other insurance for members related to COB processing. This additional initiative will be completed by November 1, 2011.”

Key Finding: Duplicate claim submissions represented the largest percentage of denials for both the WellCare CMS 1500 and UB04 claims.

Recommendation: The Department may consider requiring WellCare to develop an initiative where they work with providers in an effort to reduce duplicate submissions. Providers with the greatest share of these denials should be prioritized.

In the event that additional analysis by the CMOs identifies potential fraud, waste, or abuse, the CMOs should work with DCH to apply the appropriate sanctions or remedies to these providers.

WellCare response: “WellCare recognizes there is a large volume of duplicate claim denials for ER services. We will identify and educate the most frequent duplicate claim submitters.”

Key Finding: The Act and the Amended and Restated Model contract (Provision 4.8.19.2) appear to state two different requirements relative to the ER services

payment methodology for non-participating providers. The Act states the non-participating provider will be reimbursed an amount equal to what DCH would reimburse and the DCH Model contract allows the CMOs to reduce the reimbursement by ten percent of the applicable Medicaid rate.

Recommendation: DCH may wish to update the Model Contract to clarify the required payment methodology for non-participating providers.

Key Finding: It appears that a copayment was deducted for PSHP members who were under 21 years of age in 31 percent of the claims from non-participating providers in our sample.

Recommendation: We recommend that PSHP perform a comprehensive review of ER claims where the member is less than 21 years of age and a copayment was deducted from the provider's reimbursement. A corrective action plan should be provided to the Department detailing PSHP's findings and subsequent actions.

PSHP response: "Peach State conducted a review of the sample claims provided. Our findings revealed that the co-pay amount of \$6.00 was applied in error for a small number of manually processed claims. Upon discovering this error, we immediately took corrective action and reprocessed all claims which were impacted by this error resulting in 2,458 reprocessed claims with a payout of \$4,391.00."

Key Finding: Myers and Stauffer found claims within our sample where the facility or physician name was similar to the name of the corresponding CMO (e.g. "AMERIGROUP Hospital").

AMERIGROUP response: "Upon receipt of the information from M&S, AGP will review and correct any potential problems within 60 days."

Myers and Stauffer response to AMERIGROUP: A sample file of 14 claims was sent to AMERIGROUP on July 27, 2011 showing this issue. Claim examples were sent back to Myers and Stauffer on July 28, 2011 by AMERIGROUP with the name of the correct provider for each of the claims.

PSHP response: "As stated in our email dated 7/21/11 and as directed by DCH, for claims that were submitted by non participating out of state providers that did not have a Medicaid ID, Peach State used the State's generated "encounter dummy id" (Medicaid # 260075748M). Additionally, DCH and the State's CMOs recently held two meetings related to the use of "encounter dummy id's" as it relates to out of state providers."

Recommendation: Based on the responses received from the CMOs, Myers and Stauffer recommends the Department implement a policy which mandates the handling of claims received from providers without valid NPI numbers or from providers which are not found within the CMO's claims processing system. Policy should be in compliance with HIPAA requirements.

Key Finding: Myers and Stauffer found examples where the EOP code descriptions did not provide a reasonably clear explanation for the denial.

Recommendation: DCH may wish to require the CMOs to work with providers to identify EOP code and descriptions that are most problematic. CMOs should also consider making tools available to providers to facilitate their understanding of EOPs to reduce denials.

PSHP response: “Peach State provides an EOP Explanation code guide that explains the Explanation codes to our network providers via the web portal. Peach State's Provider Services representatives also provide education to network providers in relation to this code guide and the code guide is updated as needed.”

- **Analysis Four** – *Analysis of emergency room policies in each CMO's provider handbook to determine if the policies are in compliance with applicable contractual requirements related to ER processes as listed in the contract between DCH and the CMOs.*

Key Finding: The current revised DCH-CMO contract contains only one provision specifically related to ER in Section 4.9.2, entitled “Provider Handbook”.

Recommendation: We recommend the Department add a requirement to their contract stating the CMOs must describe all emergency room processes and appeals processes in their provider handbooks. This would assist in ensuring the CMOs' procedures for processing ER claims and any subsequent appeals are transparent to providers.

Key Findings: Documentation regarding the processing of ER claims within AMERIGROUP and Peach State Health Plan's individual provider handbooks appears to be contradictory to provisions in the contract between the Department and the CMOs. Specifically,

- AMERIGROUP's provider handbook states they will compare the admission and discharge (principal) diagnosis codes to the DCH approved diagnosis code list to determine reimbursement of the ER claim. Based on this statement, it appears that AMERIGROUP is not in compliance with their contract with DCH which mandates that several factors as listed in Section 4.16.5 be considered in the processing of ER claims.
- PSHP's provider handbook states “All requests for reconsideration of an ED claim paid at the triage rate must be submitted in writing to the following address along with the medical records and other clinical rationale (i.e., presenting symptoms, patient age, date, and time of arrival) that supports overturning the triage rate.” This statement appears to conflict with the Act which mandates that at the time the claim is submitted criteria such as patient age, severity and nature of presenting symptoms etc. be considered.

Recommendation: We recommend that the CMOs submit a corrective action plan to modify their provider handbooks such that they are in compliance their respective contracts with DCH.

AMERIGROUP response: “AGP has reviewed the key finding assigned.

We convened a workgroup in early September to review our Provider Manual and this workgroup will immediately review this concern to make sure consistency exists no later than 11/30/11 and make any required changes no later than 12/31/11.”

PSHP response: “Peach State's Provider Manual provides that the criteria established by the Act will be considered when the claim is initially submitted as well as when the claim is submitted for reconsideration. Certain conditions that are universally accepted as emergent – e.g., cardiac arrest; skull fracture with hemorrhage and coma – are paid at the providers' contracted rates without further review. Claims submitted with medical records are reviewed by a Prudent Lay person based on the Act's ED requirements. Claims which a hospital contends were not reimbursed appropriately can be re-submitted through a written "reconsideration" request and must include the medical records and other clinical rationale. Omission by the provider of information sufficient to satisfy the criteria specified in the Act precludes consideration of that same information in the adjudication of the claim.”

- **Analysis Five** – *Analysis of CMO policies and procedures in effect after the implementation of the ER-related provisions of the Act to determine if policies are in compliance with DCH-CMO Contract.*

Key Findings: Policies and procedures supplied by the CMOs do not contain all of the provisions related to ER services found in the DCH-CMO contract. The findings are as follows:

- 50 percent or six of the 12 provisions were found within the AMERIGROUP policies and procedures.
- Of the 12 ER provisions, Myers and Stauffer located seven or 58 percent within the policies and procedures supplied by PSHP.
- Ten of the 12 provisions, or 83 percent, were located within the policies and procedures supplied by WellCare.

Recommendation: We recommend that the CMOs modify their policies and procedures to include the specific ER provisions found in the DCH-CMO contract.

AMERIGROUP response: “AGP has reviewed the key findings assigned and will request a meeting with DCH to seek clarity around the ER claims processing procedures. Once clarification is received, AGP will conduct an internal review by 11/30/11 and implement required changes by 1/31/12.”

PSHP response: “Peach States' DCH approved policy GA.UM.12, the policy which governs Emergency Services, contains the provisions as identified in 4.6.1 of the contract between DCH and Peach State. The policy has been annotated to identify each contract provision located within the policy.”

Myers and Stauffer response to PSHP: We agree and have updated the report to show that all provisions from 4.6.1 were found

within your policies and procedures. Please consider also adding the remaining five ER provisions in section 4.16.5 of your contract with Department.

WellCare response: “M&S reviewed four WellCare policies and noted that 10 of the 12 ER related provisions could be located within these policies.

- In April 2011, WellCare approved an updated and consolidated version of these policies, which are now captured under policy # C7UM MD 6.1 Emergency and Post Stabilization Services. A copy of this updated policy is included with this letter. WellCare believes this updated policy does cover provision 4.6.1.7 and we respectfully request M&S reconsider this finding.
- In September 2008, WellCare updated our automated claims processing system to consider those elements required under Section 4.16.5.3. Our proprietary and confidential methodology for meeting this provision is attached to this letter under Attachment A. We respectfully request M&S reconsider this finding based upon this information.”

Myers and Stauffer response to WellCare request: Upon analysis of the updated WellCare policy C7UM MD 6.1 Emergency and Post Stabilization Services updated 04/11/11, Myers and Stauffer did find additional language was added regarding the coverage of post-stabilization services, however was not able to locate language expressly relating to provision 4.6.1.7 which is in regards to emergency services rather than post-stabilization services.

Myers and Stauffer conducted a teleconference with WellCare on October 4, 2011 to discuss updates WellCare made to their system in September 2008 in response to the implementation of the Act. While it appears WellCare has made some claims processing changes, there were still some remaining requirements of the Act which were not addressed by the system change made by WellCare. System changes implemented by WellCare are proprietary and therefore not included in this report.

Based on the analysis of the additional documentation provided by WellCare, Myers and Stauffer’s findings for this analysis and subsequent recommendations remain the same.

- **Analysis Six** – *Comparison of CMO emergency room coverage and payment policies after implementation of the ER-related provisions of the Act and in relation to our prior findings and recommendations previous to the Act, included in Report #3³.*

³ This report is dated July 17, 2008 and is available on-line at <http://dch.georgia.gov>.

Table 3: CMO stated Claim Payment Processes Prior to and After the Act

	Report #3	Current	Report #3	Current	Report #3	Current
	AMERIGROUP		PSHP		WellCare	
ICD-9/ CPT code list used to make ER payment determination		√	√	√	√	√
Differential payments (e.g., Triage and full payments)	√	√	√	√	√	√
ER Payment Determination Factors (Time/ Day of week/ Age of patient etc.)		√	√	√		√
ER Payment Determination Factor- Prudent Layperson Criteria		√	√	√		√

Key Findings: Based on the documentation provided by each CMO, it does not appear that the CMO’s current ER claims processing procedures are in full compliance with the Act.

AMERIGROUP

- AMERIGROUP indicated that they currently use an ER diagnosis list, considering factors such as age of patient, severity and nature of the presenting symptoms and patient’s initial and final diagnosis and apply prudent layperson criteria. AMERIGROUP stated, however, that they do not consider time and day of the week as mandated by the Act.
- Two different payment methodologies were located within AMERIGROUP’s policies and procedures: (1) reimbursement of participating providers at a negotiated rate, and (2) the adjudication of ER claims based on primary or admitting diagnosis code and place of service.
- AMERIGROUP policy states that for claims reimbursed at a triage rate, the provider may file an appeal and submit medical records for review.

Recommendations:

- Because AMERIGROUP’s written policies and their responses to questions posed by Myers and Stauffer outlined different methodologies, we recommend that AMERIGROUP review and clarify their ER claims processes.
- We recommend that AMERIGROUP provide an analysis that supports that their policies and procedures are in compliance with the Act. Because AMERIGROUP responded that they do not consider “time and day of the week patient presented to ER” when processing ER claims, it appears as though modifications to policies are required. Time and day of the week the patient presented to the ER is one of the criteria required by the Act.
- DCH may wish to require AMERIGROUP to describe how they apply the Act criteria since AMERIGROUP omitted a response to Myers and Stauffer regarding this question. Additionally, AMERIGROUP should

also clarify the point in time during the claims adjudication process that the criteria are applied, if applicable.

- We recommend that AMERIGROUP further clarify the point during the review of ER claims that medical records are requested from the provider and reviewed.

AMERIGROUP response: “AGP has reviewed the key findings assigned and will request a meeting with DCH to seek clarity around the ER claims processing procedures. Once clarification is received, AGP will conduct an internal review by 11/30/11 and implement required changes by 1/31/12.”

Peach State Health Plan (PSHP)

- PSHP described two processes for adjudicating claims in March of 2008: an automated process and non-automated process. The automated process allows for providers to get reimbursed more quickly based on an ICD-9 code billed, either a full-contracted rate or administrative fee. Providers who choose the non-automated process will be asked to submit medical records for claims that do not contain a specified ICD-9 code. Upon analysis of PSHP’S current documentation relating to the process for adjudicating ER claims it is not clear if PSHP continues to have a practice of having “automated” and “non-automated” claims processes.
- In March 2011, PSHP acknowledged using an “autopay” index of ICD-9 diagnosis codes. However, when asked whether this list of diagnosis codes was developed by PSHP or if they utilized the list used by the Department, PSHP responded “Not applicable”.
- PSHP responded that currently they consider all criteria listed in the Act; however, PSHP did not address how they apply the final diagnosis in processing claims for emergency health care services.
- Within PSHP’s existing policies and procedures, it states that non-participating provider ER claims will be reviewed by a physician reviewer who will look at the presenting symptoms and the discharge diagnosis when making a coverage decision.

Recommendations: We recommend that PSHP to provide the following:

- Clarify whether there are two separate ER claims processes utilized by PSHP.
- State if, and when, PSHP takes into consideration final diagnosis when processing ER claims as required by the Act.
- Provide an explanation regarding their usage of an “autopay” diagnosis index and how this index differs from the diagnosis code list utilized by DCH.
- Explain at what point in the ER claims process PSHP considers prudent layperson and other criteria of the Act. Specifically, if criteria is considered at the time when the claim is submitted or only at the time of a reconsideration or an appeal.

- Outline the process for reviewing ER claims from non-participating providers and explain how this differs from the participating provider process.
- Provide an analysis that supports PSHP policies and procedures to be in full compliance with the provisions of the Act.

PSHP response: “Peach State uses a two-tier ED review and claims adjudication process that consists of two separate courses of action that work together to process ED claims. Certain conditions that are universally accepted as emergent – e.g., cardiac arrest; skull fracture with hemorrhage and coma – are paid at the providers' contracted rates without further review. This process applies to conditions that are objectively considered to be emergent as that term is understood within and outside of medical circles (in other words, conditions which all reasonable persons – without exception - would consider to be an emergency). Secondary review is not required for these claims.

Because claims coding alone is not always sufficient to determine whether a visit is truly emergent, Peach State applies the Prudent Layperson standard to those claims that fall outside of what could be considered universally accepted emergent services. In these cases, the Prudent Layperson standard determines whether a condition was emergent by applying the criteria (as required by HB1234) referenced below to the medical claim and, if available, supporting documentation to determine the appropriateness of the place of service for that particular medical condition at that particular time.

In these cases, the Prudent Layperson staff reviews the medical records provided with the initial claims submission to determine whether the patient could have reasonably expected the absence of immediate medical attention to result in a serious threat to his or her health. The staff takes into consideration:

- The patient's age;
- The time and day of the week the patient presented to the ED;
- The severity and nature of the patient's presenting symptoms;
- The patient's initial and final diagnosis; and
- Other pertinent information that may have affected the patient's decision to seek services in the ED.

The persons conducting the review are not clinical staff. If the review process determines that the condition was emergent, the claim will pay at the contracted rate. If the review process determines that the condition was not emergent, the claim will pay at the triage or administrative rate. Providers who disagree with the findings may appeal the decision and are free to submit additional documentation to support the existence of a true

emergency. Again, this process is consistent with the process followed by the Department of Community Health for the claims it pays directly.

The above process is applicable to participating and non - participating providers.”

WellCare

- WellCare stated that when an ER claim is received they take into account all criteria as mandated by the Act (e.g. age of patient, patient’s initial and final diagnosis etc.).
- In March 2011, when asked how they apply prudent layperson criteria, WellCare provided an EMC definition and stated that a physician or other appropriate practitioner reviews the presenting symptoms and discharge diagnosis.
- In response to a Myers and Stauffer question regarding the processing of ER claims, WellCare stated they have “enhanced our automated presumptive list of DX codes that does not limit what will be considered an emergent condition, but instead presumptively or automatically treats certain claims as emergency condition by taking in to account the criteria as per HB1234.”

Recommendations:

- We recommend that WellCare provide detailed documentation regarding how WellCare considers the Act criteria at the time the claim is submitted. This should include indicating whether the process is manual or automated and outlining each step in the process.
- WellCare should further clarify how they apply prudent layperson criteria.
- In response to WellCare’s statement that they have “enhanced” their automated presumptive list of diagnosis codes, we recommend that WellCare describe the enhancements were implemented and how these enhancements take into account the Act criteria.
- Provide an analysis that supports WellCare policies and procedures to be in full compliance with the provisions of the Act.

WellCare response: *“Table 3, within Analysis Six, appears to document WellCare as meeting all four ER Claims Processing procedures for this current review. Yet, the Key Findings indicate that “...it does not appear that the CMO’s current ER claims processing procedures are in full compliance with the Act.” We request M&S clarify this statement as it appears to be in conflict with Table 3.”*

Myers and Stauffer response to WellCare request: Myers and Stauffer responded to WellCare via email on October 5, 2011 stating “...As noted at the beginning of Analysis six, findings for this analysis are based on questions Myers and Stauffer asked each CMO and their responses to these questions. Table 3 provided a comparison of each CMO’s stated claims payment processes prior to and after the effective date of the Act and was not intended to indicate whether

each respective CMO was in compliance with the provisions of the Act.

The statement “Based on the documentation provided by each CMO, it does not appear that the CMO’s current ER claims processing procedures are in full compliance with the Act” refers to the following finding as listed in Analysis six:

Myers and Stauffer Question: Please describe how WellCare applies prudent layperson criteria when adjudicating claims. Please describe the staff resources and qualifications used in this process.

WellCare Response:

WellCare of Georgia’s Prudent Layperson Standard is defined as, “An Emergency or Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- a. placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;*
- b. serious impairment to bodily functions;*
- c. serious dysfunction of any bodily organ or part;*
- d. serious harm to self or others due to an alcohol or drug abuse emergency;*
- e. injury to self or bodily harm to others; or*
- f. with respect to a pregnant woman having contractions;*
- i. that there is adequate time to effect a safe transfer to another hospital before delivery, or*
- ii. that transfer may pose a threat to the health or safety of the woman or the unborn child.*

A physician or other appropriate practitioner reviews presenting symptoms as well as the discharge diagnosis for emergency services. WellCare of Georgia has three (3) nurses, three (3) coordinators/support staff and 2 (two) Medical Doctors staffed for this review process.

The contract between DCH and the CMOs Provision 4.6.1.4 mandates:

The Contractor shall base coverage decisions for Emergency Services on the severity of the symptoms at the time of presentation and shall cover Emergency Services when the presenting symptoms are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a prudent layperson.

Additionally, the Act states that at the time that a claim is submitted, at a minimum the

following criteria must be considered:

- (1) The age of the patient;
- (2) The time and day of the week the patient presented for services;
- (3) The severity and nature of the presenting symptoms;
- (4) The patient's initial and final diagnosis; and
- (5) Any other criteria prescribed by the Department of Community Health, including criteria specific to patients under 18 years of age.

WellCare's statement that the "physician or other appropriate practitioner reviews presenting symptoms as well as the discharge diagnosis for emergency services" does not appear to meet the Provision of 4.6.1.2, which states the coverage decision in the judgment of a prudent layperson should be based on the severity of the symptoms at the time of presentation.

It should be noted also that the above WellCare response appears to contradict WellCare's "Emergency Room and Urgent Care Services" policy with a revision date on 01/27/11 as this policy includes Provision 4.6.1.4. This policy was provided to Myers and Stauffer by WellCare in March 2011."

Additional consideration relating to the Act

The Act requires the following when adjudicating ER claims:

(a) In particular, but without limitation, a care management organization shall not:

(1) Deny or inappropriately reduce payment to a provider of emergency healthcare services for any evaluation, diagnostic testing, or treatment provided to a recipient of medical assistance for an emergency condition; or

(2) Make payment for emergency health care services contingent on the recipient or provider of emergency health care services providing any notification, either before or after receiving emergency health care services.

(b) In processing claims for emergency health care services, a care management organization shall consider, at the time that a claim is submitted, at least the following criteria:

- (1) The age of the patient;*
- (2) The time and day of the week the patient presented for services;*
- (3) The severity and nature of the presenting symptoms;*
- (4) The patient's initial and final diagnosis; and*
- (5) Any other criteria prescribed by the Department of Community Health, including criteria specific to patients under 18 years of age.*

A care management organization shall configure or program its automated claims processing system to consider at least the conditions and criteria described in this subsection for claims presented for emergency health care services. The Department of Community Health may develop and publish a list of additional standards to be used by care management organizations to maximize the identification and accurate payment of claims for emergency health care services.

(c) If a provider that has not entered into a contract with a care management organization provides emergency health care services or post-stabilization services to that care management organization's member, the care management organization shall reimburse the noncontracted provider for such emergency health care services and post-stabilization services at a rate equal to the rate paid by the Department of Community Health for Medicaid claims that it reimburses directly.

Based on our experience with Medicaid claims adjudication, certain elements of the Act may be problematic for both DCH and the CMOs. In particular, the UB04 claim form does not include designated "initial" or "discharge" diagnosis fields. Additionally, the time (admission hour field) is not a required field for outpatient services on the UB04 claim form. This situation causes a potential conflict between the Act and the feasibility of implementing and following the provisions of the Act as written. Therefore, we recommend that DCH consider support for an amendment to the Act to provide DCH with discretion to determine what set of criteria the CMOs are mandated to follow.

- **Analysis Seven** – *The Act states that a CMO shall configure its automated claims processing system to consider criteria and conditions as listed in the Act. This analysis contains our findings regarding how the CMOs have programmed their respective claims processing services and if it appears the CMOs are in compliance with this provision of the Act.*

Key Findings: Based on the documentation provided by each CMO, it does not appear that the CMOs are in compliance with this provision of the Act. Specifically:

- AMERIGROUP stated that their claims system "determines the nature of the Emergency based on diagnosis. If it is considered a non-emergent diagnosis the Triage rate will be reimbursed, else contracted ER Level rates will apply."
- PSHP indicated they have configured their system to identify emergency related diagnosis codes.
- WellCare indicated they have a multi-step review process (1) review using presumptive diagnosis list, (2) system auto adjudicates claim based on criteria listed on the claim. Medical records are used to review additional information not found on the provider claim form.

Recommendation: We recommend that the Department consider requiring each CMO to submit a comprehensive strategic assessment of the requirements that would be needed to configure their claims

adjudication systems to fully consider the criteria of the Act at the time of adjudication.

AMERIGROUP response: “AGP has reviewed the key findings assigned and will request a meeting with DCH to seek clarity around the ER claims processing procedures. Once clarification is received, AGP will conduct an internal review by 11/30/11 and implement required changes by 1/31/12.”

PSHP response: “In terms of the criteria specified in the Act, the Federally mandated UB Claim Form is deficient with regards to the inclusion of minimally required information. The Peach State claims processing system is configured to consider all specified criteria when submitted, typically through supplemental documentation. In the absence of supplemental documentation, a claim payment may be reduced to the triage rate due to insufficient medical information.”

WellCare response: “Within the Key Findings under Analysis Seven, M&S states “Based on the documentation provided by each CMO, it does not appear that the CMOs are in compliance with this provision of the Act.” As noted in our response to Analysis Six, WellCare did not provide our proprietary and confidential ER claim editing methodology to M&S. We are doing so at this time, as a proprietary and confidential attachment to this letter.”

Myers and Stauffer response to WellCare: Our response in Analysis Six is also applicable to this issue as well.

Also of note in Myers and Stauffer’s Report #3 “Comparative Analysis Policies and Procedures of Georgia Care Management Organizations”, Exhibit F, Krieg DeVault, made the following statement: “It appears from the ER Process – Summary flow chart provided by CMO #1, that CMO #1 pays all Emergency Medical Services claims at either the triage rate or the “Full ER Payment”; consequently, we equate payment at the triage rate as the same as or equivalent to a denial of the emergency medical services claim.” We understand that the Department was evaluating the use of the triage payment to determine if this practice is in compliance with Federal and State law, however we are not aware of any action taken as a result of this evaluation at this time.

PROJECT BACKGROUND AND OBJECTIVE

In July 2008, Myers and Stauffer provided to the Department Report #3 “Comparative Analysis Policies and Procedures of Georgia Care Management Organizations”.¹ Within this report was an analysis of each Care Management Organization’s (CMO) policies and procedures, as well as, their responses to a series of questions relating to the handling of emergency room (ER) claims. One of our findings in that report was that each of the CMOs utilized different methodologies in the processing of ER claims. Myers and Stauffer recommended standardizing the approach for reimbursing emergency department claims using one of the following approaches:

- “CPT” list approach: all emergency department claims would be treated as true emergent situations that meet the prudent layperson standard. Hospital providers would code the appropriate procedure code considering all conditions and factors consistent with standard coding principles, HB 1234, and their contract with the CMOs. Medical charts would not be required to be submitted to or reviewed by the CMOs. CMOs could utilize post payment review to confirm correct coding by hospitals.
- “Diagnosis” list approach: all claims using a diagnosis on the list would represent a presumed emergent condition. DCH would provide a minimum list of presumed emergent conditions. CMOs could add additional diagnosis codes to the minimum list. Claims with a diagnosis on the presumed emergent list would automatically be paid as a true emergency. For any diagnosis not on the presumed list, the hospital would be required to submit medical charts at the time of the claim submission. The CMOs would be required to complete a prudent layperson review of the claim, considering all necessary factors and conditions in compliance with HB 1234 and the DCH contract, and determine reimbursement either at the true emergency rate or the triage rate. Additionally, CMOs would use the definition of emergency health care services described in the DCH model contract. The same definition would be used by each CMO and CMO/provider contract.

Since the period covered by Report #3, the Medicaid Care Management Organizations Act (“the Act”) which was signed into law and became effective July 1, 2008. Section 33-21A-4 of the Act states the following in regards to emergency healthcare services:

- (a) *In particular, but without limitation, a care management organization shall not:*
- (1) *Deny or inappropriately reduce payment to a provider of emergency healthcare services for any evaluation, diagnostic testing, or treatment provided to a recipient of medical assistance for an emergency condition;*
 - or
 - (2) *Make payment for emergency health care services contingent on the recipient or provider of emergency health care services providing any notification, either before or after receiving emergency health care services.*

1-This report is available online at <http://dch.georgia.gov>.

(b) In processing claims for emergency health care services, a care management organization shall consider, at the time that a claim is submitted, at least the following criteria:

- (1) The age of the patient;*
- (2) The time and day of the week the patient presented for services;*
- (3) The severity and nature of the presenting symptoms;*
- (4) The patient's initial and final diagnosis; and*
- (5) Any other criteria prescribed by the Department of Community Health, including criteria specific to patients under 18 years of age.*

A care management organization shall configure or program its automated claims processing system to consider at least the conditions and criteria described in this subsection for claims presented for emergency health care services. The Department of Community Health may develop and publish a list of additional standards to be used by care management organizations to maximize the identification and accurate payment of claims for emergency health care services.

(c) If a provider that has not entered into a contract with a care management organization provides emergency health care services or post-stabilization services to that care management organization's member, the care management organization shall reimburse the noncontracted provider for such emergency health care services and post-stabilization services at a rate equal to the rate paid by the Department of Community Health for Medicaid claims that it reimburses directly.

In addition to the Act, the CMOs are also required to comply with Federal Regulations such as 42 CFR 438.114 and 42 CFR 489.24 which contain specific provisions regarding emergency care services. Federal Regulations 42 CFR 438.114 and 42 CFR 489.24 can be found attached to this report as Exhibits A and B, respectively.

Report Objective

The objective of this report is to confirm whether the Georgia Care Management Organizations (CMOs) are in compliance with the provisions relating to the processing of Emergency Room (ER) claims as mandated in the contract between the Department of Community Health (DCH) and the CMOs, as well as, the Medicaid Care Management Organizations Act ("The Act"). In addition to the stated objective above, Myers and Stauffer also performed 1) a point-in-time comparison between the CMO ER claims processing practices as of March 2008 and their stated practices as of March 2011; and 2) analysis of contractual changes related to emergency room provisions after the implementation of the Act in the model contract between the Department and the CMOs, as well as, the contracts between each CMO and their contracted hospital providers.

DETAILED ANALYSES AND FINDINGS

This section contains our detailed analytical methodologies and any related findings for Analyses One through Seven. There is a “Summary of Findings” section located at the end of each analysis.

Analysis One

- *Analysis of contractual changes related to emergency room provisions after the implementation of the Act in the model contract between the Department and the CMOs, as well as, the contracts between each CMO and their contracted hospital providers.*

DCH-CMO Model Contract Analysis

In order to complete this analysis, Myers and Stauffer studied the Amended and Restated Model DCH-CMO Contract dated September 3, 2008 and the current Amended and Restated Model DCH-CMO Contract dated July 1, 2010. Myers and Stauffer was able to locate Act language related to ER services in both of the aforementioned contracts.

This analysis examines the contractual changes related to emergency room processes after the execution of the Act in the model contract between the Department and the CMOs, as well as, the contracts between the CMOs and their respective hospital providers.

CMO and Hospital Provider Contract Analysis

In order to determine what provider contracts were needed from each CMO, we developed a list of facilities from two sources: a unique list of providers derived from each CMO’s respective claims data and CMO-Provider contracts received from previous supplemental data requests. Using these source materials, we were able to compile a distinct list of participating facilities for each CMO. Any contracts not previously received were requested from each CMO, as applicable.

Additional Data and Documentation Requirements for Analysis One

- CMO resource materials available to providers, as applicable
- Federal Regulations 42 CFR 438.114 and 42 CFR 489.24
- DCH CMO Model Contract dated July 14, 2007
- Amended and Restated DCH CMO Model Contract dated September 8, 2008
- Amended and Restated DCH CMO Model Contract effective July 10, 2010
- Myers and Stauffer report “Comparative Analysis Policies and Procedures of Georgia Care Management Organizations” issued July 17, 2008
- CMO – Provider contracts

Assumptions, Limitations and Notes Relevant to Analysis One

1. The data provided by the CMOs is presumed to be complete and accurate. The CMOs attest to the truthfulness, completeness and accuracy of all data and documentation submitted.
2. Myers and Stauffer analyzed and provided findings based on the documentation either provided by the three CMOs or documentation obtained on-line to confirm whether their policies and procedures appeared to meet the contractual requirements set forth in the Georgia Families model contract. There may be other information, regarding the CMOs' practices, that was not provided or available to us. Additionally, our assessment did not include confirmation of the CMO's operational practice with the procedures as written.
3. Provider contracts received from the CMOs were considered the comprehensive participating provider list for each CMO. Contracts have been requested on numerous occasions and with each supplemental data request. Additionally, contracts and/ or contract amendments that were received at the time of the analysis were considered the current contract in effect.
4. Any contract that did not appear to be a hospital facility based on analysis of the contract or results from an internet search was not included in any of the analyses.

DCH-CMO Model Contract Analysis

Myers and Stauffer identified a potential issue the Department may wish to consider addressing in future updates to the contract between the Department and the CMOs. Section 4.6.1 of the contract between DCH and the CMOs provides a basis for emergency services coverage and reimbursement requirements for the CMOs. The provisions of the contract closely correlate to the Federal Regulations defining an emergency medical condition as in 42 CFR 438.114(Exhibit A) and 42 CFR 489.24(Exhibit B). However, the current DCH-CMO contract Provision 4.6.1.2 defines an Emergency Medical Condition as:

An Emergency Medical Condition shall not be defined or limited based on a list of diagnoses or symptoms. An Emergency Medical Condition is a medical or mental health Condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- *Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;*
- *Serious impairment to bodily functions;*
- *Serious dysfunction of any bodily organ or part;*
- *Serious harm to self or others due to an alcohol or drug abuse emergency;*
- *Injury to self or bodily harm to others; or*

- *With respect to a pregnant woman having contractions:*
(i) That there is adequate time to effect a safe transfer to another hospital before delivery, or (ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.

Provision 4.6.1.2(i), “With respect to a pregnant woman having contractions: (i) that there is adequate time to effect a safe transfer to another hospital before delivery, or...” is not in agreement with the language found in 42 CFR 489.24 which states in the definition of an Emergency Medical Condition under (2) (i) “... that there is inadequate time to effect a safe transfer to another hospital before delivery, or...”. The discrepancy between this language and the language found in 4.6.1.2(i) of the DCH-CMO contract is the word “adequate” (i.e., missing “in”). This issue was identified in the Myers and Stauffer “Comparative Analysis Policies and Procedures of Georgia Care Management Organizations dated July 17, 2008 as well.

CMO and Hospital Provider Contract Analysis

Contractual provisions related to Emergency Services in effect prior to July 1, 2008 between the CMOs and their participating hospital providers were analyzed as well as any updated versions dated July 1, 2008 and thereafter.

Results are shown on Table 4 and the corresponding narrative below.

Table 4: Number of Amended Contracts and Updated Payment Methodology

	AMERIGROUP	PSHP	WellCare
Total Number of Facilities contracted with CMO	124	128	165
Number of Facilities with Amended Contracts on or after 7/1/08	20	42	20
Number of facilities where payment methodology changed	11	2	10
Act language found in CMO-facility contract	8	13	5

AMERIGROUP

- Of the 124 facilities contracted with AMERIGROUP, 20 facilities or 16 percent of the facilities have an updated or amended contract with AMERIGROUP on or after July 1, 2008.
- A change in ER claim payment methodology was seen in 55 percent of the amended contracts. Forty percent contained language from the Act.

Peach State Health Plan (PSHP)

- Of the 128 facilities contracted with PSHP, 42 facilities, or 33 percent, had amended contracts on or after July 1, 2008.
- Two of the 42 facilities with an amended contract had a different payment methodology for ER claims, while 13 facilities, or 31 percent, contained language from the Act.

WellCare

- Of the 165 facilities contracted with WellCare, 20 facilities, or 12 percent, had a contract amended on or after July 1, 2008.
- Of the facilities with amended contracts, 10, or 50 percent, contained changes in payment methodology for ER claims and five, or 25 percent, included language from the Act.

The number of facility contracts which were amended after the Act was implemented was relatively low. This may be due to the following:

1. The CMOs may have employed different means to communicate any changes in their payment methodologies or ER claims determination processes such as an update to their provider manual or provider newsletter or bulletin.
2. The CMOs may plan to update the contract language as they are negotiating amendments with each entity.

It is important to note, as shown on Table 4 above, that not all of the amended contracts in effect after the implementation date of the Act contain the Act language.

Based on the Act language stating that the CMOs cannot "...deny or inappropriately reduce payment to a provider of emergency healthcare services for any evaluation, diagnostic testing, or treatment provided to a recipient of medical assistance for an emergency condition...", it does not appear that the use of a triage rate can be considered in compliance with the Act if it is not combined with the other applicable criteria for determining the emergent status of the claim. Table 5 below provides a count of facilities which have a triage rate listed in their current contract with the CMO. Additionally, Myers and Stauffer included a count of facilities where the triage rate was removed from their contract with the CMO.

Table 5: Count of Triage Rates per CMO

	AMERIGROUP	PSHP	WellCare
Number of facilities including triage rates in current contract	0	126	129
Number of facilities where triage rate was removed	0	2	11

- Of the contracts provided to Myers and Stauffer, none of the AMERIGROUP facility contracts contain language associated with triage rates or administrative fees. It appears AMERIGROUP reimburses hospital providers based on the level of care billed by the provider.

- All but two of PSHP’s hospital provider contracts contain triage rate information. The remaining two appear to have been updated to remove that language.
- The majority (78 percent) of WellCare facility contracts contain a triage rate payment methodology. Myers and Stauffer found 11 updated contracts where it appears this language was removed from the contract.
- In contracts identified as including a triage rate as part of the reimbursement methodology for ER claims, the triage rate listed was equal to or greater than the administrative fee DCH reimburses for ER services not determined to be true emergencies.

Table 6 provides a count of each CMO-Facility contract which contains language stating that the Emergency Medical Condition (EMC) is determined by the primary diagnosis code billed or mentions the use of the DCH diagnosis code list.

Table 6: Emergency Medical Condition Determination per CMO

	AMERIGROUP	PSHP	WellCare
EMC Determination by Primary Diagnosis (by facility)	0	121	2
Contract mentions DCH Diagnosis code list (by facility)	32	123	3

For this analysis, we examined the contract language to assess if the determination of an emergency medical condition was dependent upon the placement of the diagnosis code on the claim (e.g. primary, etc.). We noted the following:

- We were unable to locate language indicating that the determination of an EMC is based on the primary diagnosis code within the available AMERIGROUP - facility contracts.
- Nearly all (95 percent) of the PSHP facility contracts contain language stating the primary diagnosis code is used to make an emergency medical condition determination.
- Only two (One percent) of the WellCare facility contracts mention utilizing the primary diagnosis when making coverage decisions for ER claims.

The Act states that DCH may develop other tools for the CMOs for ER claims payment. Myers and Stauffer analyzed contracts for language stating the CMO would utilize the DCH diagnosis code list when making an emergency medical condition determination. AMERIGROUP has 32 (26 percent) facilities whose contract mention DCH’s diagnosis list, PSHP has 123 (96 percent), and WellCare has three (two percent).

Summary of Findings

- Language inaccuracy was identified within the Emergency Medical Condition definition (Provision 4.6.1.2.) in the DCH-CMO Model Contract.
- Upon analysis of the DCH-CMO contract it was noted that there were two separate sections related to Emergency Room care and services.

- Only a small number of the facilities with CMO contracts revised on or after July 2008 contained part or all of the Act language. Specifically, 16 percent for AMERIGROUP, 32 percent for Peach State Health Plan and 12 percent for WellCare.
- A change in the ER claim payment methodology was seen in 55 percent of the amended contracts between the facility and AMERIGROUP. Forty percent (40 percent) contained language from the Act.
- Two, or four percent, of the 42 facilities with an amended Peach State Health Plan contract had a different payment methodology for ER claims, while eight, or 19 percent, contained language from the Act.
- Of the facilities with amended contracts with WellCare, 50 percent contained changes in the payment methodology for ER claims and 25 percent included language from the Act.
- In terms of triage language within the contract between the facility and the individual CMO, AMERIGROUP had none, Peach State Health Plan had 126 (98 percent) and WellCare had 129 (78 percent) contracts, respectively, which contained that type of language.
- Language stating that the primary diagnosis code billed on the claim is used to make an Emergency Medical Condition (EMC) determination was found in 95 percent of the PSHP facility contracts. This language was not found in any of the AMERIGROUP contracts and in one percent of the WellCare facility contracts.
- Regarding the use of the DCH diagnosis code list in making an emergency medical condition determination, AMERIGROUP has 32 (26 percent) facilities whose contract mentions DCH's diagnosis list, PSHP has 123 (96 percent), and WellCare has three (two percent).
- A small number of the facilities with updated CMO contracts on or after July 2008 had at least part or all of the Act language in their contract with the CMO.

Based on these findings, we recommend the following:

- Update Provision 4.6.1.2 to match the language in 42 CFR 489.24 by changing the word "adequate" to "inadequate".
- Consider for future revisions of the DCH-CMO contract combining Section 4.6.1 and Section 4.16.5 so all provisions related to Emergency Room care and services can be found in the same section of the contract.
- Require the CMOs to amend provider contracts to include the Act language related to the processing of ER claims.
- Peach State Health Plan and WellCare to update their provider contracts to be in compliance with the provisions of the Act by removing language stating that the primary diagnosis code billed on the claim is used to make an Emergency Medical Condition (EMC) determination. Because provider contracts likely include differing terms, we recommend that each CMO provide to DCH a schedule that reflects the timeline necessary to update each contract.

Analysis Two

- *Analyses of the definition of an Emergency Medical Condition (EMC) used in CMO issued provider handbooks and CMO-Provider contracts to determine if they are equivalent to DCH's EMC definition. Any variations among the different sources are noted.*

The purpose of Analysis two was to evaluate the Emergency Medical Condition (EMC) definition used in each CMO's provider handbook, as well as, within each CMO's provider contract, noting if the definition matches the EMC definition in the DCH-CMO model contract. Additionally, Myers and Stauffer noted any variation in the definition used among these different sources in this analysis.

In order to complete Analysis two, Myers and Stauffer utilized various versions of the model contract between DCH and the CMOs, as well as, CMO and hospital provider contracts.

With the purpose of determining what provider contracts were needed from each CMO, we developed a list of facilities from two sources: each CMO's respective claims data and CMO-provider contracts received from previous supplemental data requests. Using these initial findings, we were able to define a distinct list of participating facilities for each CMO. Any contracts not previously provided were sent to each CMO for follow up, as applicable.

In addition to the CMO-provider contracts, Myers and Stauffer also utilized each CMO's most current Provider Handbook (at the time this report was written) in order to complete Analysis two. Myers and Stauffer was able to obtain Provider Handbooks for both PSHP and WellCare on-line. PSHP's most recent Provider Handbook was dated February 22, 2011, while the on-line WellCare Provider Handbook was dated April 2010. Myers and Stauffer requested and received AMERIGROUP's most recent Provider Handbook dated February 4, 2011 on March 22, 2011.

Additional Data and Documentation Requirements for Analysis Two

- CMO resource materials available to providers, as applicable
- Federal Regulations 42 CFR 438.114 and 42 CFR 489.24
- DCH CMO Model Contract dated July 14, 2007
- Amended and Restated DCH CMO Model Contract dated September 8, 2008
- Amended and Restated DCH CMO Model Contract effective July 10, 2010
- Myers and Stauffer report "Comparative Analysis Policies and Procedures of Georgia Care Management Organizations" issued July 17, 2008

Assumptions, Limitations and Notes Relevant to Analysis Two

1. The data provided by the CMOs is presumed to be complete and accurate.
2. Myers and Stauffer analyzed and provided findings based on the documentation either provided by the three CMOs or documentation obtained on-line to confirm if their policies and procedures appeared to meet the contractual requirements set forth in the Georgia Families model contract. There may be other

information, regarding the CMOs' practices, that was not available to us. Additionally, our assessment did not include confirmation of the CMO's operational practice with the procedures as written.

3. Provider contracts received from the CMOs were considered the comprehensive participating provider list for each CMO. Contracts have been requested on numerous occasions and with each supplemental data request. Additionally, contracts and/ or contract amendments that were received at the time of the analysis were considered the current contract in effect.
4. Any listing that did not appear to be a facility based on analysis of the contract or results from an internet search was not included in any of the analyses.

In Myers and Stauffer's Report #3, we noted that "It appears that each of the CMOs are using a different definition for 'Emergency Medical Services' in their contracts with the providers and that the definitions used by the CMOs in their contracts with providers are not the same as the definition in the DCH-CMO model contract. These variations in definition could allow the CMOs to more narrowly or broadly define emergency services for providers."

For all three Georgia CMOs, Myers and Stauffer found each respective CMO's provider handbook included an EMC definition that was in agreement with the definition in the current DCH-CMO contract with the exception of the wording issue identified in Analysis one.

Myers and Stauffer also evaluated the EMC definition included in each CMO's contract with their respective behavioral health subcontractor, if applicable.

For the analysis of the CMO-provider contracts, Myers and Stauffer divided the Department's EMC definition into eight different elements (Figure 1, below) in order to illustrate what language from the definition was or was not included. A summary of our findings can be found on Table 7.

Figure 1: DCH EMC definition divided into Elements

Element A	An Emergency Medical Condition shall not be defined or limited based on a list of diagnoses or symptoms.
Element B	An Emergency Medical Condition is a medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
Element C	• Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
Element D	• Serious impairment to bodily functions;
Element E	• Serious dysfunction of any bodily organ or part;
Element F	• Serious harm to self or others due to an alcohol or drug abuse emergency;
Element G	• Injury to self or bodily harm to others; or
Element H	• With respect to a pregnant woman having contractions:
Element H(i)	That there is adequate time to affect a safe transfer to another hospital before delivery, or
Element H(ii)	That transfer may pose a threat to the health or safety of the woman or the unborn child.

Table 7: Comparison of the EMC definition in each CMO-hospital provider contract with DCH EMC definition

CMO	Total # of Contracts	Total # of Contracts where EMC definition matches	Contract EMC language omitted by Element									
			Element A	Element B	Element C	Element D	Element E	Element F	Element G	Element H	Element H(i)	Element H(ii)
AMERIGROUP	124	0	15	120	124	1	1	124	124	124	124	124
PSHP	128	0	128	125	128	0	0	3	3	3	3	3
WellCare	165	0	165	165	160	0	0	161	161	161	161	161

Notes:

1. All elements were analyzed for language content with the exception of Element H(i) since this element contains an inaccuracy in the DCH contract. However, if

Element H(i) was missing in its entirety in the EMC definition between the CMO and hospital provider, this was noted.

2. *For instances where the language was only partially located and the missing language potentially impacted the meaning of the element, the element was considered omitted.*

AMERIGROUP

- Myers and Stauffer was unable to locate Element A in 15, or 12 percent, of the contracts.
- In comparison with the Department's definition for Element B, AMERIGROUP's definition states an EMC "is a medical condition..." omitting the word *mental* in 97 percent of the contracts analyzed.
- In 100 percent of AMERIGROUP'S contracts, Element C did not state "Placing the physical or mental health of the individual ..."; rather Element C read "placing the health...", excluding the words *physical* and *mental*.
- One AMERIGROUP contract did not contain a definition of an EMC.
- Language for Elements F-H(ii) were not found in any of the AMERIGROUP contracts analyzed.
- AMERIGROUP manages the behavioral health benefits for its members, and therefore, there was not a contract for Myers and Stauffer to analyze.

Peach State Health Plan (PSHP)

- Element A did not match the DCH Element A language in any of the PSHP hospital provider contracts. While some contracts did not include Element A in its entirety, other contracts stated an EMC shall not be defined on a list of diagnoses or symptoms, rather than an EMC shall not be defined *or limited* based on a list of diagnoses or symptoms.
- In 125, or 98 percent, of the contracts, an EMC is defined as "a medical condition..." for Element B. This definition does not match the DCH definition which states an EMC "is a medical *or mental* health condition..."
- For Element C, PSHP stated in all of the contracts analyzed "placing the health of the individual..." while the DCH definition more clearly defines this statement by stating "Placing the *physical* or *mental* health of the individual..."
- It appeared PSHP did not include any of the language for Elements F-H(ii) in three, or two percent, of their contracts with hospital providers.
- Although the EMC definition in PSHP's provider handbook matches DCH's definition, their contract with Cenpatico Behavioral Health LLC contains two different EMC definitions, neither matching the definition used by the Department.

WellCare

- Element A, as listed in WellCare's provider contracts, did not match DCH's Element A in any of the contracts analyzed. Element A was either missing in its entirety or stated an EMC shall not be defined on a list of diagnoses or symptoms, rather than an EMC shall not be defined *or limited* based on a list of diagnoses or symptoms.

- Of WellCare’s 165 contracts, none contained the same language for Element B as found in DCH’s definition. Specifically, WellCare listed an EMC as “a medical condition...” rather than a medical *or mental* health condition as defined by the Department
- In 97 percent of WellCare’s contracts, Element C states “Placing the health of the individual ...” excluding the words *physical* and *mental* which are listed in DCH’s definition.
- Myers and Stauffer was unable to locate Elements F-H (ii) in 98 percent of the WellCare contracts.
- The EMC definition used by WellCare in their agreement with their behavioral health subcontractor, Magellan Health Services, matches the EMC definition in the DCH-CMO contract.

Summary of Findings

This analysis found that each CMO has multiple EMC definitions within their respective contracts with hospital providers. Specifically, Myers and Stauffer located three distinct definitions for AMERIGROUP, eight for PSHP and seven for WellCare. Additionally, none of the CMO-provider contracts that were analyzed contained an EMC definition that matched all elements of DCH’s EMC definition as written in the DCH-CMO model contract.

DCH may wish to consider requiring each CMO to use the same definition of an Emergency Medical Condition as that included in the DCH-CMO model contract. This common definition should be used consistently in all contracts, provider handbooks, subcontractor agreements and update bulletins, as applicable.

Analysis Three

- *Analyses of facility and provider ER claims with dates of services prior to implementation of the Act and after implementation of the Act. Analyses include any trends identified, as well as, a cross-claim comparison to corresponding professional services claims.*

Myers and Stauffer performed several different analyses of ER claims with dates of services previous to the Act and after implementation of the Act. Paid and denied claims are included in these analyses. Our analysis identified, by CMO, all ER facility and ER practitioner claims with dates of service April 1, 2008 to June 30, 2008, April 1, 2009 to June 30, 2009 and April 1, 2010 to June 30, 2010. The dates of service for 2009 were selected to ensure that CMOs have had ample time to implement the provisions of the Act. The date ranges chosen for 2008 and 2010 were selected to be consistent with the 2009 date range.

Myers and Stauffer has developed a data warehouse that includes encounter data from each CMO, as well as Traditional Medicaid and PeachCare for Kids® data from the fiscal agent contractor (FAC). The FAC provides Myers and Stauffer with updated member eligibility, encounter data, and claims data monthly in a standardized extract. The paid and denied claims utilized in these analyses were extracted from our data warehouse.

When necessary, additional data was requested from the CMOs to supplement the data available in the data warehouse. Quality Assurance (QA) procedures were performed to identify any potential data quality issues.

In consultation with the Department, we analyzed the data and documentation received from the CMOs, and we did not independently validate or verify the information. Each CMO attested and warranted that the information they provided was “accurate, complete, and truthful, and consistent with the ethics statements and policies of DCH”.

Additional Data and Documentation Requirements for Analysis Three

- Member Eligibility files
- Provider files
- CMO Encounter Data
- Supplementary data to the encounter data, as required
- CMO Policies and Procedures related to Emergency Room Claims, as needed
- DCH Model CMO Contract Revised Contract Amendment dated July 10, 2010
- Supplemental documentation related to CMO policy and procedures
- CMO-Hospital Provider Contracts

Assumptions, Limitations and Notes Relevant to Analysis Three

1. Monthly reconciliation reports indicate that the encounter data provided by the CMOs is less than 100 percent complete. As of the date the sample was determined, the completion rate for the encounter claims was 99 percent for both Peach State and WellCare. The completion rate for AMGP was 100 percent. Although the rates indicate the encounter data is nearly complete, because the analyses were performed on a less than 100 percent complete set of encounter claims, there is a potential that the findings resulting from these analyses may reflect slightly inaccurate results. We do not anticipate that the less than complete encounter data will significantly impact the findings, if any.
2. The data provided by the CMOs is presumed to be complete and accurate.
3. The data provided by the FAC is presumed to be complete and accurate.
4. The denial rates will only reflect “back end” denials as the CMOs are not required to submit denials for duplicate claim submissions, eligibility and EDI front end denials.
5. Some of the Emergency Room encounter data, as provided by the CMOs, did not contain a Level of Care (Emergency Room Evaluation and Management Code).
6. In attempting to identify instances where a CMO paid a provider a triage payment for an ER visit, certain claims may potentially not be identified because of reduced reimbursement due to the deduction of co-payments or increased reimbursement due to the addition of interest or a combination of the two.
7. Changes to provider contracts from paying for emergency services at triage and emergency rates to instead include terms for reimbursement of emergency services at a negotiated rate based on level of care, will impact any trending analyses related to frequency of triage payments.

8. Practitioner or facility ER claims in which G0380-G0384 was billed instead of one of the ER Evaluation and Management codes (99281-99285,99291-99292) were excluded from our analyses as it does not appear that these codes are covered by Medicaid.

In an April 2000 letter to State Medicaid Directors, CMS described Emergency Room Evaluation and Management CPT code range as CPT code 99281 ("Straightforward medical decision making") to CPT code 99285 ("Medical decision making of high complexity"). Within this letter, CMS also advised that absent provider up-coding, CPT codes 99283 - 99285 "very likely" meet the federal prudent layperson standard of a true "emergency".

In addition to the above ER Evaluation and Management Codes, Myers and Stauffer also included code 99291(Evaluation and Management of the critically ill or injured patient; first 30-74 minutes) and 99292(Evaluation and Management of the critically ill or injured patient; every additional 30 minutes) in the claims analyses.

Within this analysis, Myers and Stauffer uses the term "Level of Care" when denoting the ER Evaluation and Management Code billed. Figure 2 below provides an explanation to which CPT Code each level of care will equate.

Figure 2: Level of Care and Corresponding CPT Code

Level of Care	Corresponding CPT Code
Level One	99281
Level Two	99282
Level Three	99283
Level Four	99284
Level Five	99285
Trauma Level One	99291
Trauma Level Two	99292

ER Facility and ER Practitioner Claim Trends

ER facility and practitioner claims were analyzed to determine if the ER facility claim and corresponding ER practitioner claims were processed in a similar manner. In order to complete this analysis, Myers and Stauffer linked the ER practitioner claim to the corresponding facility claim using the member identification number and date of service. These trending analyses include counts of the following occurrences:

- A. Paid Claims**
- B. Denied Claims**
- C. Facility claim was paid and ER physician claim was denied**
- D. ER Physician claim was paid and the facility claim was denied**
- E. ER Facility Claims Originally Paid at Triage Rate but Later Paid as Emergency**
- F. Emergency Room Services Provided at Non-Participating Facilities**
- G. Other Findings**

A summary for each of the analyses is listed within this section.

A. Paid Claims Analysis

Table 8 provides a count, by level of care, of ER encounter claims where both the facility and physician, having billed the same ER Level of Care for the same episode of care, were both paid. Additionally, Myers and Stauffer included the average paid per facility encounter. As noted in Table 8 below, AMERIGROUP had 42,266 encounters that met these criteria. AMERIGROUP’s average amount paid per facility encounter was \$227.14. Peach State Health Plan had a total of 51,113 encounters and an average facility encounter paid amount of \$191.60. 100,538 paid encounters were determined for WellCare. The WellCare average facility encounter paid amount was \$170.73. As expected, the average paid amount for each encounter level of care generally increased as the level of care increased. Also of note, instances where both the provider and the facility billed a CPT code of 99283 or Level of Care Three counted for 64 percent or greater of the claims for each CMO. The next largest instance was when both the facility and provider billed a Level of Care Four or CPT code of 99284 which accounted for 16 to 18 percent among the CMOs.

Table 8: Paid ER Encounters with Same Level of Care on Facility and ER Physician Encounter

Level of Care	AMERIGROUP			Peach State Health Plan			WellCare		
	Count of Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Count of Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Count of Encounters	Total Facility Payment	Average Paid Per Facility Encounter
Level One	113	\$6,537.64	\$57.86	1,000	\$75,157.28	\$75.16	578	\$35,844.29	\$62.01
Level Two	3,583	\$347,091.91	\$96.87	7,051	\$595,653.49	\$84.48	10,303	\$798,780.20	\$77.53
Level Three	28,933	\$4,692,501.14	\$162.19	32,953	\$4,643,427.47	\$140.91	67,768	\$8,123,199.01	\$119.87
Level Four	7,727	\$2,736,558.71	\$354.16	7,960	\$2,480,615.05	\$311.64	17,874	\$4,696,336.28	\$262.75
Level Five	1,844	\$1,714,240.73	\$929.63	2,070	\$1,852,235.88	\$894.80	3,898	\$3,341,295.63	\$857.18
Trauma Level One	66	\$103,371.20	\$1,566.23	78	\$144,366.43	\$1,850.85	117	\$169,445.42	\$1,448.25
Trauma Level Two	0	\$0.00	\$0.00	1	\$1,829.84	\$1,829.84	0	\$0.00	\$0.00
	42,266	\$9,600,301.33	\$227.14	51,113	\$9,793,285.44	\$191.60	100,538	\$17,164,900.83	\$170.73

Myers and Stauffer also analyzed instances where both the facility encounter and physician ER encounter where the Level of Care billed by the facility and the corresponding physician claim differed. Although, the facility and physician billed different Levels of Care for the same date of service, both claims were paid by the CMO. It is noted that the majority of these instances occurred when the provider billed a higher Level of Care than billed by the facility. Analysis found that for all the CMOs, the

physician billed a higher Level of Care than the facility for the same episode of care in at least 79 percent of the time.

Myers and Stauffer recommends each CMO consider performing additional analysis to identify and recoup claims where the level of procedures and services billed cannot be justified. CMOs should also consider educational opportunities, and special handling of claims from providers that represent the greatest share of the potentially upcoded claims. DCH may wish to monitor this situation closely, including guidance to the CMOs as well as analyses to review claims from the same providers in the fee-for-service delivery system.

Table 9 provides a count of the largest number of occurrences for paid facility and physician ER encounters where the Level of Care billed by the facility and the corresponding physician claim did not match. As shown on Table 9, the largest occurrence for all three CMOs was where the facility billed a Level of Care Two and the physician billed a Level of Care Three.

Table 9: Count and Percentage of largest occurrences for paid ER encounters with Different Level of Care on Facility and ER Physician Encounters

CMO	Total Count of Encounters	Facility Level of Care	Physician Level of Care	Count of Encounters	% of total
AMERIGROUP	54,654	Level Two	Level Three	18,847	34%
PSHP	69,275	Level Two	Level Three	22,920	33%
WellCare	152,822	Level Two	Level Three	52,006	34%

Additional detail for Table 9 can be found in Exhibit C of this report.

Summary of Findings

Based on the findings of the paid ER claims where the Level of Care was the same, the data shows the largest Level of Care billed was 99283, which accounted for 64 percent or greater of the claims for each CMO.

The paid claim analyses of different Levels of Care billed by the facility and the physician show the largest percentage for all CMOs was when the facility billed Level of Care Two, 99282, and corresponding physician claim billed Level of Care Three, 99283. Additionally it was noted that across all three CMOs in greater than 79 percent of these occurrences, the physician billed a higher Level of Care than the facility. There are a variety of reasons in which this could occur, for instance, the quality assurance process differences between the facility and physician billing offices.

Myers and Stauffer recommends each CMO consider performing additional analyses to identify and recoup claims where the level of procedures and services billed cannot be justified. CMOs should also consider educational opportunities, and special handling of claims from providers that represent the greatest share of the potentially upcoded claims. DCH may wish to monitor this situation closely, including guidance to the

CMOs as well as analyses to review claims from the same providers in the fee-for-service delivery system.

B. Denied Claims Analysis

This section provides two different analyses: (1) a count of occurrences where both the facility and corresponding physician claim were both denied (2) identification of all denied claims, within our sample time periods, that were denied or paid zero and a count of the denial reasoning.

Both Facility and Corresponding Physician Claims Denied

Myers and Stauffer performed a claims analysis to determine the number of occurrences by CMO, where both the physician and facility claim for the same episode of care were denied. Also listed are the two largest instances of denials per CMO. Our findings are as follows:

- A total of 1,209 occurrences for AMERIGROUP were identified
 - Twenty-seven percent (27 percent) occurred when both the facility and physician billed a Level of Care Three or 99283
 - The second highest instance, or sixteen percent, occurred when the facility billed a Level of Care Two and the physician billed a Level of Care Three
- 2,001 instances where both the facility and physician claim were denied for Peach State Health Plan
 - Instances where the facility and physician both billed a Level of Care Three or 99283 accounted for 29 percent of these counts
 - Seventeen percent, or the second highest occurrence, was when the facility billed a Level of Care Two and the physician billed a Level of Care Three
- A total of 5,495 instances for WellCare
 - A Level of Care Three or 99283 billed by both the facility and physician, accounted for 27 percent of the WellCare total
 - The facility billed Level of Care Two and the physician billed a Level of Care Three accounted for nineteen percent

For further detailed information regarding this analysis, including counts by Level of Care, please see Exhibit D.

Based on the paid and denied claim analyses (where both facility and physician claims had the same adjudication status), Level of Care Three, or 99283, was billed most often.

Denial Reasoning Analysis

Myers and Stauffer identified all ER facility claims and ER physician claims with a date of service from April 1, 2008 to June 30, 2008, April 1, 2009 to June 30, 2009 or April 1, 2010 to June 30, 2010 where the paid amount is zero or where the claim denied. In addition to providing a total count below, Myers and Stauffer also provides the

associated explanation of payment (EOP) codes for these claims, when available. The EOP codes were placed into categories, as determined by Myers and Stauffer, by issue type. The results were summarized by CMO below. Figure 3 below provides a summary of the Categories created and utilized for this analysis.

Figure 3: Listing of Categories including Description

Category #	Category	Category Description
1	Medical Management Denial	May include: Medical Necessity Denials and request for Medical Records submission
2	Coordination of Benefits	May include: Request for other carrier's information, Rebill to primary carrier
3	Contracted Rate Issue	May contain any of the following: Write-off amounts or Late charges
4	Timely Filing	Timely Filing date not met
5	Miscellaneous Denial	May contain any of the following: Submission of claims to a different payor, Certification Form missing, Duplicates, Processing Error, Non Covered Benefit.
6	Billing Issue	May contain: invalid code(s) on claim, submitted on incorrect claim form
7	Eligibility Issue	Issues regarding member eligibility
8	No Reason Provided or Reason Not Clear	EOP code description not provided or not clear

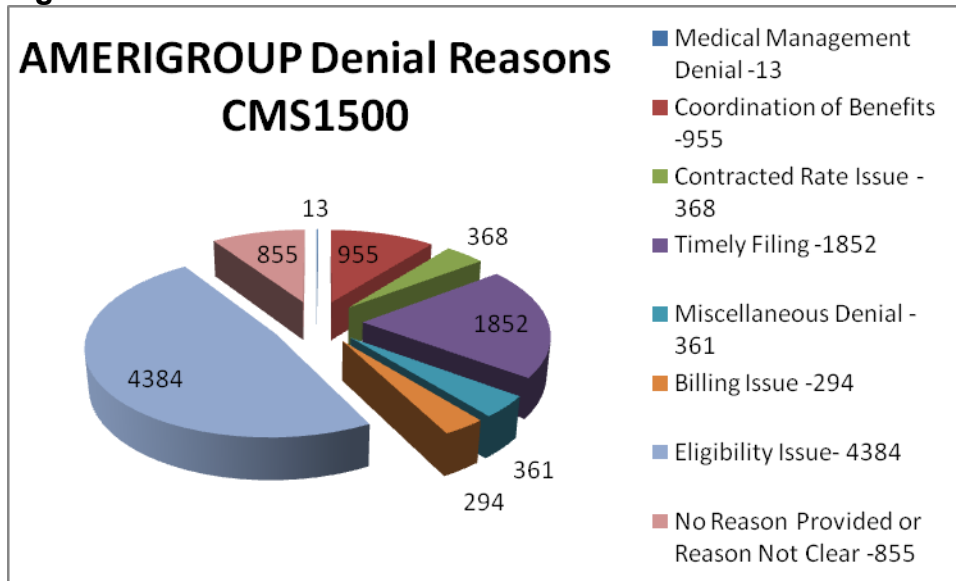
AMERIGROUP

A total of 13,487 claims were identified for AMERIGROUP. Of the 13,487 claims, 9,082 were billed on a CMS 1500 and 4,405 on a UB04 claim form.

As shown on Figure 4 below, of the 9,082 claims billed on a CMS 1500:

- 48 percent included a denial reason related to an Eligibility issue
- 20 percent included a Timely Filing denial reason
- Less than .2 percent included a denial reason related to a Medical Management issue

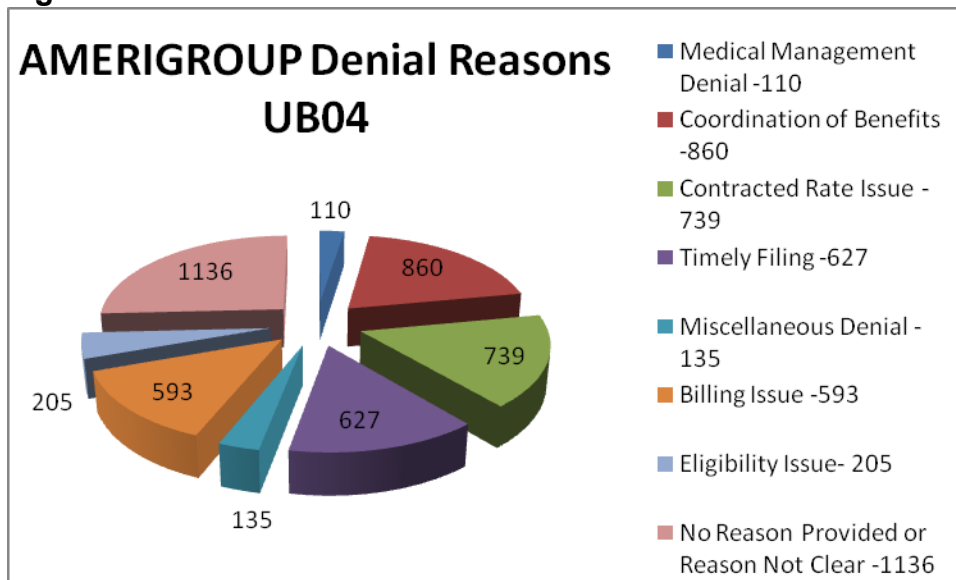
Figure 4: AMERIGROUP Denial Reasons CMS 1500



Of the 4,405 AMERIGROUP UB04 claims located on Figure 5:

- No Reason Provided or Reason Not Clear accounted for the largest percentage, 26 percent, of denial reasons included on the claims
- Twenty percent of the claims included Coordination of Benefits denial reasons
- Two percent of the claims were related to Medical Management issues

Figure 5: AMERIGROUP Denial Reasons UB04



Based on the analysis of the denials reasons for AMERIGROUP we recommend:

- AMERIGROUP analyze these eligibility-related denials to determine the accuracy and to identify any potential issues. Because of the multi-faceted nature of

member enrollment, once potential issues have been confirmed, convening a conference with all of the entities involved with enrollment would assist in facilitating corrective actions.

- AMERIGROUP provide further clarification of Explanation of Payment (EOP) codes such as “Reduced Allowable” and “Claim level Disallow”, including communicating additional information on these codes to providers. The CMO should provide a plan for reducing denied claims for these EOPs.

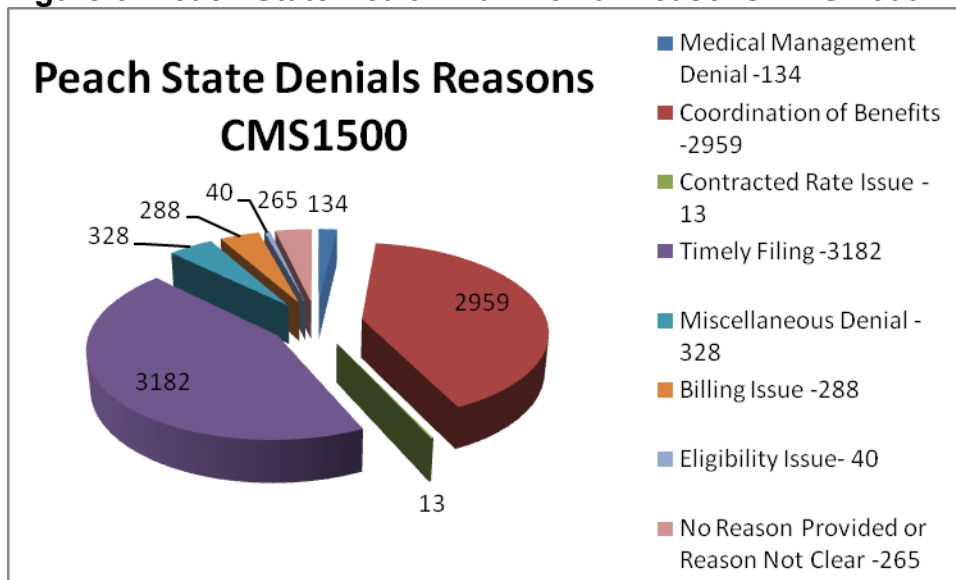
Peach State Health Plan (PSHP)

Myers and Stauffer identified 10,942 Peach State Health Plan denied claims. 7,209 of these claims were submitted on a CMS 1500 form, while 3,733 were submitted on a UB04.

Figure 6 below shows all the denial reasons for PSHP ER claims billed on a CMS 1500. Of these claims, 7,209 in total, Myers and Stauffer found the following :

- The largest percentage of the denied claims, 44 percent, included a Timely Filing denial
- A Coordination of Benefits denial was included on 41 percent of the denied claims
- Contracted Rate issues, as well as, Eligibility issues each were included on less an 1% of the denied claims

Figure 6: Peach State Health Plan Denial Reasons CMS 1500

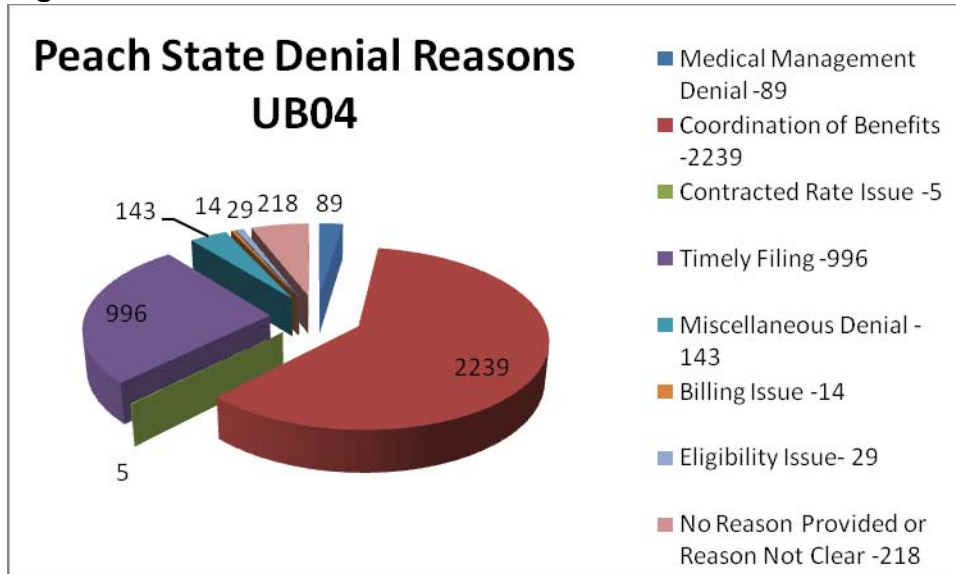


For the remaining 3,733 UB04 claims, as seen on Figure 7 below, Myers and Stauffer noted the following:

- Sixty percent (60 percent) of the denied claims included a denial reason related to Coordination of Benefits
- 27 percent of the denied claims included Timely Filing denial

- Less than .3 percent of the denied claims included a Billing Issue as the denial reason

Figure 7: Peach State Health Plan Denial Reasons UB04



We recommend that PSHP conduct an in-depth review of their filing time limit and coordination of benefit denials and provide a plan for reducing these types of denials, including a communication plan and/or provider education as appropriate.

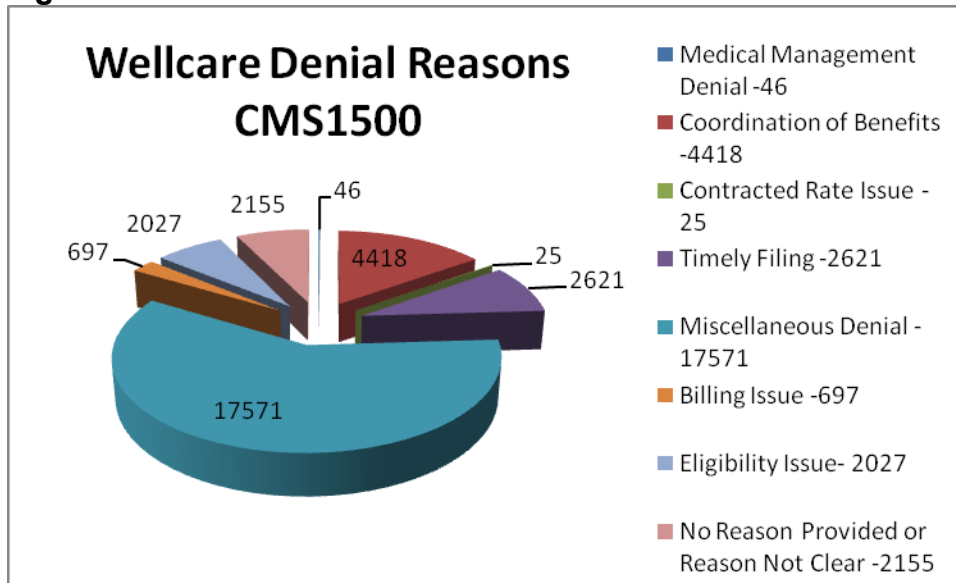
WellCare

Myers and Stauffer identified 50,426 WellCare claims where the claim was denied or paid at zero. There were 29,560 of these claims billed on a CMS 1500 claim form. The total number of UB04 claims identified was 20,866.

Of the 29,560 CMS 1500 claims identified for WellCare:

- Fifty-nine percent (59 percent) of the denied claims included a denial reason classified within the Miscellaneous category. The majority of these denials are related to duplicate claims submissions.
- Fifteen percent (15 percent) of the denied claims included a Coordination of Benefits denial
- Less than .2 percent of the denied claims included a denial reason either due to a Medical Management issue or Contracted Rate issue

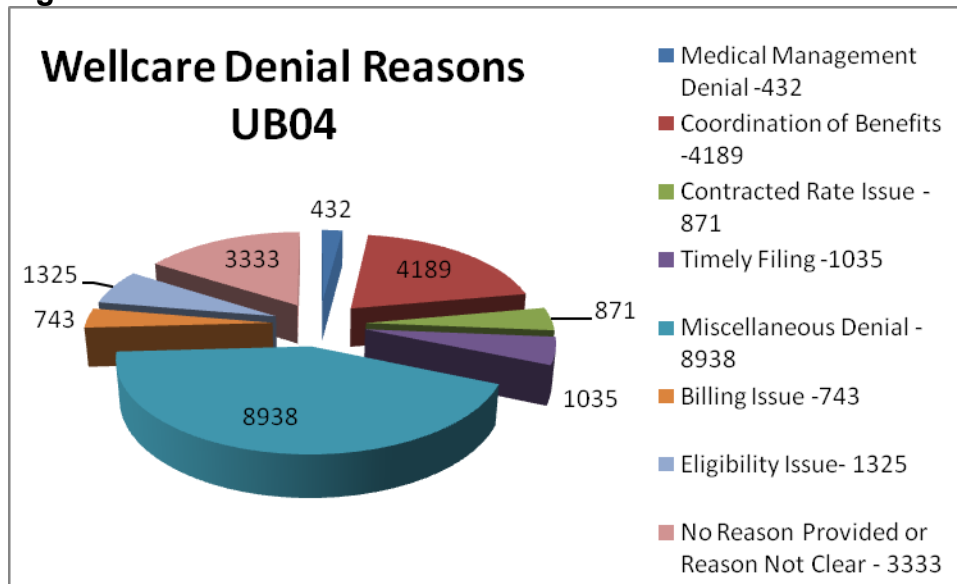
Figure 8: WellCare Denial Reasons CMS 1500



Myers and Stauffer found that for the 20,866 UB04 claims identified:

- Forty-three percent (43 percent) of the denied claims included a denial reason classified within the Miscellaneous Denial category. Over half of the denials included in this category were related to duplicate claim submissions.
- Coordination of Benefits denial reasons were included on 20 percent of the denied claims
- Medical Management denials reasons were included on two percent of the denied claims

Figure 9: WellCare Denial Reasons UB04



The Department may consider requiring WellCare to develop an initiative where they work with providers in an effort to reduce duplicate submissions. Providers with the greatest share of these denials should be prioritized.

In the event that additional analysis by the CMOs identifies potential fraud, waste, or abuse, the CMOs should work with DCH to apply the appropriate sanctions or remedies to these providers.

C. Facility claim was paid and ER physician claim was denied

For this claims analysis, Myers and Stauffer analyzed claims, grouped by level of care, where the facility claim was paid, but the corresponding physician claim was denied. A summary of our findings is listed below on Table 10.

The most frequent instances of a paid facility claim and a denied physician claim for all CMOs occurred when both claims included a Level of Care Three (CPT code 99283)

The second most frequent occurrence for all the CMOs was when the facility billed a Level of Care of Two (ER Evaluation and Management code 99282) and the physician claim which was billed as a Level Three.

A possible explanation for these occurrences could be different ICD-9 diagnosis codes billed on each respective claim, resulting in one claim paying and the other denying. Additional detail for Table 10 can be found in Exhibit E of this report.

Table 10: Most frequent occurrences where the ER physician claim was denied and the corresponding facility was paid

Facility Level of Care	Physician Level of Care	AMERIGROUP Count of Encounters	% of total	Peach State Health Plan Count of Encounters	% of total	WellCare Count of Encounters	% of total
Level Two	Level Three	643	24%	428	17%	897	19%
Level Three	Level Three	677	25%	662	26%	1209	25%
Claim Totals		2,676		2,574		4,753	

D. ER Physician claim was paid and the facility claim was denied

Myers and Stauffer identified the instances where the ER physician claim was paid, but the corresponding facility claim was denied. Table 11 below contains a summary of our findings. The largest percentage of the denials for AMERIGROUP, PSHP, and WellCare was seen when both the facility and physician billed an ER Evaluation and Management of 99283. One possible reason for the denials may be due to different ICD-9 Diagnosis codes billed on each claim.

The second largest group of denials occurred was when the facility billed an ER Evaluation and Management code of 99282 and physician billed ER Evaluation and Management code on 99283. As stated above, one possible explanation may be due to the ICD-9 Diagnosis codes or other data elements billed on each claim. Additional detail for Table 11 can be found in Exhibit F of this report.

Table 11: Highest occurrences where the ER physician claim was paid and the corresponding facility was denied

Facility Level of Care	Physician Level of Care	AMERIGROUP Count of Encounters	% of total	Peach State Health Plan Count of Encounters	% of total	WellCare Count of Encounters	% of total
Level Two	Level Three	260	13%	121	13%	1369	17%
Level Three	Level Three	396	20%	167	17%	1907	24%
Claim Totals		2,022		930		7,914	

E. ER Facility Claims Originally Paid at Triage Rate but Later Paid as Emergency

Myers and Stauffer identified claims which were paid a triage fee and subsequently were adjusted to pay at a higher emergency rate. The focus of this analysis was on instances where the adjusted claim was reimbursed at a higher level of payment than the original claim, but the billed level of care did not change. We excluded claims with no procedure code or level of care, as well as claims that included providers other than facilities.

Table 12: Claims originally paid at triage rate which were adjusted to pay an emergency rate

CMO	Number of Triage Claims	Number of Adjusted Claims	% of Triage Claims Adjusted
AMERIGROUP	363	290	80%
PSHP	2,893	133	4%
WellCare	2,807	1,277	46%

The most common claim adjustment reasons we found when performing this analysis are as follows:

- Updated Contract Reimbursement Terms
- Processing Errors
- Corrected Claim Submissions
- Interest Due to Provider
- Medical Review

Because of the inaccuracies of the CMOs' interest data, we could not determine if interest was involved in the cases where the claims were adjusted to pay more than the original paid amount, but were less than \$10.00.

AMERIGROUP

AMERIGROUP had 290 claims where the level of care did not change and the claims were adjusted and paid greater than the original amount. It appears 41 percent of the 290 claims paid at an amount which would be consistent with a full ER payment for that provider.

Peach State Health Plan (PSHP)

PSHP had a small percentage of claims in which the adjusted claim's level of care matched the original claim's level of care. Four percent (4 percent) of the adjusted claims were paid at a higher amount than the original claim.

WellCare

For WellCare, nearly half of their adjusted claims' level of care matched the level of care on the original claims and all paid more than the original claims. It appears 11 percent of the 2,807 claims paid at an amount which would be consistent with a full ER payment for those providers.

F. Emergency Room Services Provided at Non-Participating Facilities

Myers and Stauffer analyzed emergency room claims submitted by non-participating (out-of-network) providers to determine if each CMO is in compliance with the Act which states:

If a provider that has not entered into a contract with a care management organization provides emergency health care services or post-stabilization services to that care management organization's member, the care management organization shall reimburse the noncontracted provider for such emergency health care services and post-stabilization services at a rate equal to the rate

paid by the Department of Community Health for Medicaid claims that it reimburses directly.

The DCH Model Contract with the CMOs states in 4.8.19.2, bullet 3:

If the service is available from an In-Network Provider, but the service meets the Emergency Medical Condition standard, and the Contractor has three (3) Documented Attempts to contract with the Provider, the Contractor is not required to pay more than Medicaid FFS rates for the applicable service, less ten percent (10%).

It appears the payment methodology is not clear as to which is applicable to non-participating providers for ER services because the Act states the non-participating provider will be reimbursed an amount equal to what DCH would reimburse and the DCH Model contract allows the CMOs to reduce the reimbursement by ten percent of the applicable Medicaid rate.

DCH may wish to update the Model Contract to clarify the required payment methodology for non-participating providers.

Myers and Stauffer first determined the appropriate rate that would have been paid by the Department of Community Health for Medicaid claims for emergency health and post-stabilization services to non-participating providers by reviewing available Medicaid resources.

Per analysis, of the Georgia Medicaid Hospital Manuals, for claims with dates of service April 1, 2008 to June 30, 2008, and April 1, 2009 to June 30, 2009 and April 1, 2010 to June 30, 2010 the reimbursement rate for emergency services not found to be a true medical emergency is a flat rate of \$50.00. ER claims found to be emergent in nature are reimbursed at the Georgia Medicaid Interim Outpatient Rate (IOR) for any provider which participates in Georgia Medicaid's Fee For Service (FFS) program. We also utilized the Georgia Medicaid out of state guidelines for outpatient reimbursement, which says for providers which are within 50 miles of Georgia's state line, 65 percent of covered charges was used. We used 45 percent of covered charges for all other out of state providers.

ER Facility encounters were analyzed to identify the number of non-participating facilities reimbursed at a rate equal to, less than, or greater than the rate that would have been paid by the DCH for Medicaid claims that it reimburses directly.

It is important to note that this analysis was not intended to provide any findings related to the appropriateness of reimbursement of a triage or administrative fee versus a full ER payment. The purpose of this analysis was to first determine the level of reimbursement the claim was paid at (triage or full payment) and what payment rate the Department would have reimbursed the claim. For example, if it appears the CMO paid

the full ER rate, Myers and Stauffer attempted to determine the rate the Department would have paid for this claim and did a comparison of the two reimbursement rates.

AMERIGROUP

Only seven percent of the claims identified in the emergency room sample in which the provider is considered non-participating paid less than the Georgia Medicaid triage fee of \$50.00. The analysis shows the majority (84 percent) of the claims, which paid less than \$50.00, paid 90 percent of the Georgia Medicaid triage fee. Myers and Stauffer asked AMERIGROUP about the reduction from the allowed amount of \$50.00 to \$45.00 and \$39.00 and sent a small sample of the claims in question for their review. Their response, received on August 5, 2011, is as follows:

The reduction would be as a result of a co-payment. For example, if the allowed amount is \$45 - \$6 copay = \$39. Claims showing paid amount \$44.00 because according to the provider's contract effective 12/1/2008 All ER claims will be priced at \$50.00 (\$50.00 - \$6 copay = \$44.00).

Peach State Health Plan (PSHP)

For PSHP, eight percent of the claims identified in the sample with a non-participating provider paid less than the Georgia Medicaid triage fee. Of the eight percent, there is a considerable amount (60 percent) which paid \$44.00. Myers and Stauffer asked PSHP about the reduction from the allowed amount of \$50.00 to \$44.00 and sent a small sample of the claims in question to PSHP for their review. Their response, received on July 29, 2011, is as follows:

In response to your request, please be advised that Peach State's Director of Reimbursement reviewed the claims examples and has confirmed that for all six episodes Peach State paid the \$50 triage fee for non-emergent services, and subtracted a \$6 co-pay paid by the member.

While a copayment is allowed for non-emergent services, it appears that a copayment was taken for members who are under 21 years of age in 31 percent of the non-participating claims in our sample when \$44.00 was the CMO paid amount. The dates of service range from 2009 through 2010.

In follow up to the above response from Peach State Health Plan, Myers and Stauffer asked the following question: "*Based on your response, we have noted that for the claim in question, there were copayments taken on members under the age of 21. Can you provide us with an explanation as to why co-payments were deducted for members under the age of 21?*" Donna McIntosh, Director of Compliance at PSHP, provided the following response via email on August 2, 2011:

In follow up to your question below and to provide further clarification, Peach State conducted an in-depth review of the sample claims provided. As we know, a co-pay is not applicable for members under age 21. Our findings revealed that the co-pay amount of \$6.00 was applied in error by one of our Claims

Processors. We are in the process of identifying claims that were processed in error with plans to reprocess the affected claims.

We recommend that PSHP perform a comprehensive review of ER claims where the member is less than 21 years of age and a copayment was deducted from the provider's reimbursement. A corrective action plan should be provided to the Department detailing PSHP's findings and subsequent actions.

WellCare

WellCare had 24 percent of non-participating provider claims in the sample which paid less than \$50.00. Of the 24 percent which paid less than the triage fee, there are 44 percent which paid 90 percent of the Georgia Medicaid triage fee or \$45.00. Myers and Stauffer asked WellCare about the reduction from the allowed amount of \$50.00 to \$45.00 and \$44.00 and sent a small sample of the claims in question for their review. Their response, received on August 3, 2011, was as follows:

*In response to your request below regarding ER Claims payment;
The claims that were paid prior to July 1, 2008 were paid at a rate of 90% of the Medicaid allowable (100%), therefore, ER triage would be paid at \$45. However, after HB1234, CMOs were mandated to reimburse ER at a rate equal to the Department, minus any applicable co-pays, which explains the \$44.00 payments;
\$50 Triage (100%) - \$6 co-pay = \$44.*

G. Other Findings

Ambiguous Provider Name on Claim

Myers and Stauffer found claims within our sample where the facility or physician name was similar to the name of the corresponding CMO. For AMERIGROUP, we found claims with a provider name of AMERIGROUP HOSPITAL (402876121H) or AMERIGROUP PHYSICIAN (402876121M). Instances were found where Peach State Health Plan claims were identified with a facility provider name of "PEACH STATE HOSPITAL". Claims with a provider listed as "WELLCARE OF GA HOSPITAL" were found in the WellCare data. Myers and Stauffer asked each individual CMO for an explanation as to why there are instances of this issue found in the claims sample. Below are responses from each CMO regarding this issue.

Rachelle Whitacre, AMERIGROUP, replied on August 5, 2011, as follows:

402876121M and 402876121H are not AGP provider IDs. They appear to us to be Medicaid IDs, yet we are unable to identify these as Medicaid IDs in facets.

Donna McIntosh, Director, Compliance, Peach State Health Plan responded on July 21, 2011 that:

Peach State's research identified from the claims sample provided that the claims were from early 2008. During this time, the Medicaid ID was the primary identifier used to adjudicate claims. Because these claims were submitted by out of state hospitals/facilities who were non participants of the GA Medicaid program (non-participating) and did not have a Medicaid ID, Peach State used the State's generated 'encounter dummy id' (Medicaid #260075748M) to identify and process those claims submitted by an out of state hospital. This ensured claims processing, encounter reconciliation and plan reconciliation to identify claims processed by an out of state provider. Please note that although this Medicaid ID was tied to 'PEACH STATE HOSPITAL' (listed in the 7400 file), claims were processed to the applicable out of state hospital.

Joshua Luft, Manager, Reporting & Analytics at WellCare responded to our question on July 29, 2011 as follows:

"...the claims identified in your sample file failed our internal NPI association edits. As a result we incorporated the Medicaid ID 644551483M into the logic for these claims, identifying them as GA Hospital claims. This allowed the claims to pass our Xengine and reapplied the submitting information once they were through the system. At the point in the system they were pulled and submitted to Myers and Stauffer, the "WELLCARE OF GA Hospital" name was still on the record."

We recommend that the CMOs and the state fiscal agent contractor (FAC) meet to determine what processes are being utilized when the provider on an encounter received from a CMO is not in the Medicaid Management Information System (MMIS). Utilizing an ambiguous provider name could cause numerous issues with reporting, data analyses and rate-setting activities. Myers and Stauffer will provide information to both the CMOs and the FAC to facilitate the review and correction of this issue.

Explanation of Payment Codes Clarification

Myers and Stauffer identified two Explanation of Payment (EOP) code descriptions where we needed additional information from the CMO to determine when the EOP code would be assigned to a claim. One was an AMERIGROUP EOP code, while the other was an EOP code used by Peach State Health Plan.

For AMERIGROUP, we requested that they explain to us when EOP code GA7 "GA Triage ER Pricing" would be assigned to a claim. The following is AMERIGROUP's response:

Email from Rachelle Whitacre on July 19, 2011 *"Explanation code GA7 is assigned to claims where the service was provided in the emergency room of a hospital but do not appear to be emergent. These claims are paid at a triage rate and providers are asked to submit medical records if they feel the service was truly emergent."*

For Peach State Health Plan, we requested an explanation regarding when EOP code 40 "DENY: CHARGES DO NOT MEET QUALIFICATIONS FOR EMERGENCY

CARE OUT OF AREA " would be assigned to a claim. Below is Peach State's response:

Donna McIntosh, Director, Compliance, Peach State Health Plan responded via email on July 21, 2011 that *"It should be noted that this code was retired by Peach State on July 1, 2008 and has not been used by the Plan since that time. The code was assigned to emergency room (ER) claims, submitted by non-participating out of the area (OOA) providers, which did not meet the criteria for an emergent condition. Pursuant to the payment policy which existed at the time, ER claims (emergent and non-emergent) submitted by participating Georgia providers would be paid in accordance with the provider's contract or the Georgia Medicaid fee schedule. ER claims (emergent and non-emergent) submitted by OOA providers would be paid in accordance with the Georgia Medicaid fee schedule or the provider's billed charges, based on the number of previous attempts by Peach State to contract with the provider. The code at issue was intended to pend the claim for determination of the applicable triage rate. However, it was retired when a system error cancelled payments associated with the code."*

DCH may wish to require the CMOs to work with providers to identify EOP code and descriptions that are most problematic. CMOs should also consider making tools available to providers to facilitate their understanding of EOPs to reduce denials.

Analysis Four

- *Analysis of emergency room policies in each CMO's provider handbook to determine if each is in compliance with applicable contractual requirements related to ER processes as listed in the contract between DCH and the CMOs.*

For Analysis four, Myers and Stauffer examined each CMO's provider handbook for language relating to ER processes and procedures as required by the contract between DCH and the CMOs.

Additional Data and Documentation Requirements for Analyses Four

- AMERIGROUP Provider Handbook dated February 4, 2011
- Peach State Health Plan Provider Handbook dated February 22, 2011
- WellCare Provider Handbook dated April 2010
- DCH CMO Model Contract dated July 14, 2007
- DCH CMO Model Contract Revised Contract Amendment dated July 10, 2010
- Myers and Stauffer report "Comparative Analysis Policies and Procedures of Georgia Care Management Organizations" issued July 17, 2008

Assumptions, Limitations and Notes Relevant to Analyses Four

1. The data provided by the CMOs is presumed to be complete and accurate.
2. Myers and Stauffer analyzed and provided findings based on the documentation either provided by the three CMOs or documentation obtained via the Internet to confirm whether their policies and procedures appeared to meet the contractual requirements set forth in the Georgia Families model contract. There may be other information, regarding the CMOs' practices, that was not available to us.

Additionally, our assessment did not include confirmation of the CMO's operational practice with the procedures as written.

Per the current DCH and CMO contract, each CMO provider handbook must contain several pieces of information as outlined in provision 4.9.2.1. For the purposes of this analysis, Myers and Stauffer only included the provider handbook requirement directly related to ER processes and procedures. As shown in Table 15 below, all three CMOs met the requirement of listing the Emergency Services responsibilities of the provider in their individual Provider Handbooks.

Table 15: DCH contract provision related to Provider Handbook requirements as located within each CMOs Provider Handbook

DCH Contract Provisions	AMGP	PSHP	WellCare
4.9.2 Provider Handbook			
4.9.2.1 At a minimum, the Provider Handbook shall include the following information: <ul style="list-style-type: none"> Emergency Service responsibilities; 	√	√	√

The second part of this analysis was to determine if the documentation each CMO supplied in their respective provider handbooks regarding the ER claims processes was in compliance with provisions as listed in the DCH-CMO contract. A summary of findings for each CMO is listed below.

AMERIGROUP

In the AMERIGROUP Provider Handbook effective February 2011, in the Emergency Room Appeals Process section, AMERIGROUP states the following:

Emergency Room (ER) claims review compares the admission and discharge diagnosis codes on the claim against the Department of Community Health (DCH) approved diagnosis code list for outpatient hospital claims. If the admission or discharge (principal) diagnosis codes match a diagnosis code on the DCH list, then the claim will process for reimbursement per the hospital's contract. If the admission or discharge diagnosis codes do not match a diagnosis code on the DCH list, then the claim will process for reimbursement at the current ER triage rate of \$50. An Explanation of Payment (EOP) will indicate the triage rate, including an explanation code with the option to appeal within 30 calendar days by completing a Provider Payment Dispute and Correspondence Submission Form and submitting the medical records. Medical records should not be submitted with the initial claim.

In the statement above, AMERIGROUP notes that they will compare the admission and discharge (principal) diagnosis codes against the DCH approved diagnosis code list to determine reimbursement of the ER claim. This statement is not in compliance with the DCH-CMO contract which states a CMO should take into account, when a claim is submitted, no less than: patient age, the time and day of the week the patient presented for services, severity and nature of the presenting symptoms, initial and final diagnosis, as well as, any additional criteria stipulated by DCH.

Based on analysis of the DCH-CMO contract, it appears that the process outlined in the AMERIGROUP Provider Handbook is not taking into account all of the criteria in provision 4.16.5.3.

Peach State Health Plan (PSHP)

The PSHP February 2011 Provider Handbook has a section entitled “Emergency Department Hospital Claims Adjudication Process” which describes the processes in place for the adjudication of emergency room claims. Within this section, it states “ED claims coded with a diagnosis that represents certain diagnoses or conditions (e.g., status asthmaticus or fractured femur) that are recognized as a medical emergency will result in the claims being treated and reimbursed as an emergency based on the rate negotiated with the hospital. Claims for emergency services submitted with a diagnosis that represents a disease or condition that is not recognized as an emergency situation (e.g., upper respiratory infection), will be reimbursed at the triage rate or the hospital’s contracted rate, whichever is applicable.”

PSHP process does not list the required criteria from section 4.16.5. of the DCH-CMO contract that is to be considered when processing ER claims. Furthermore, the PSHP Provider Handbook states “All requests for reconsideration of an ED claim paid at the triage rate must be submitted in writing to the following address along with the medical records and other clinical rationale (i.e., presenting symptoms, patient age, date, and time of arrival) that supports overturning the triage rate” This statement conflicts with provision 4.16.5.3 of the DCH-CMO contract which mandates at the time the claim is submitted criteria such as patient age, severity and nature of presenting symptoms etc. be considered.

WellCare

WellCare has a provider handbook and a hospital handbook listed in their website. The WellCare Provider Handbook, Section 4, Member Services, dated January 2011 includes a definition of an Emergency Medical Condition and a listing of the criteria as listed in provision 4.16.5.3 of the DCH-CMO contract which WellCare states it considers when processing an emergency room claim. Myers and Stauffer did not find any additional language regarding the processing of the emergency room claims.

The WellCare Hospital Handbook, Section 7 Scope of Services, dated January 2009 also included the language found in the Provider Handbook with additional language regarding the processing of ER claims as listed in the DCH-CMO contract.

Summary of Findings

- The current revised DCH-CMO contract contains only one provision specifically related to ER in Section 4.9.2 “Provider Handbook”. All three CMO’s include this provision in their individual provider handbooks.
- AMERIGROUP’s provider handbook states they will compare the admission and discharge (principal) diagnosis codes to the DCH approved diagnosis code list to determine reimbursement of the ER claim. Based on this statement, it appears

that AMERIGROUP is not in compliance with their contract with the Department which mandates several factors be considered in the processing of ER claims.

- PSHP's provider handbook states "All requests for reconsideration of an ED claim paid at the triage rate must be submitted in writing to the following address along with the medical records and other clinical rationale (i.e., presenting symptoms, patient age, date, and time of arrival) that supports overturning the triage rate." This statement appears to conflict with PSHP's contract with the Department which mandates that at the time the claim is submitted criteria such as patient age, severity and nature of presenting symptoms etc. be considered.
- Myers and Stauffer found only a small amount of documentation regarding ER services, including the criteria used in the processing of ER claims and the definition of an EMC in the WellCare Provider Handbook. It is noted that WellCare's Hospital Handbook contained additional documentation on ER claims processing not found in the WellCare Provider Handbook.

We recommend the Department add a requirement to their contract stating the CMOs must describe all emergency room processes and appeals processes in their provider handbooks. This would assist in ensuring the CMOs' procedures for processing ER claims and any subsequent appeals are transparent to providers.

We also recommend that the CMOs submit a corrective action plan to modify their provider handbooks such that they are in compliance with the provisions listed in Section 4.16.5 of their respective contracts with the Department

Analysis Five

- *Analysis of CMO policies and procedures in effect after the implementation of the ER-related provisions of the Act to determine if policies are in compliance with DCH-CMO Contract.*

In order to complete Analysis five, on March 15, 2011, Myers and Stauffer sent each CMO a listing of the ER policies and procedures which had been received from the CMO with the policy's effective date. We requested each CMO submit any updated policies based on the list provided, as well as, any additional current policies related to the processing of Emergency Room claims. The request included any ER claims policies/procedures and configuration documentation specific to each CMO's claims system.

Additional Data and Documentation Requirements for Analysis Five

- AMERIGROUP Provider Handbook dated February 4, 2011
- Peach State Health Plan Provider Handbook dated February 22, 2011
- WellCare Provider Handbook dated April 2010
- DCH CMO Model Contract dated July 14, 2007
- DCH CMO Model Contract Revised Contract Amendment dated July 10, 2010
- Myers and Stauffer report "Comparative Analysis Policies and Procedures of Georgia Care Management Organizations" issued July 17, 2008

Assumptions, Limitations and Notes Relevant to Analysis Five

1. The data provided by the CMOs is presumed to be complete and accurate.
2. Myers and Stauffer analyzed and provided findings based on the documentation either provided by the three CMOs or documentation obtained via the Internet to confirm whether their policies and procedures appeared to meet the contractual requirements set forth in the Georgia Families model contract. There may be other information, regarding the CMOs’ practices, that was not available to us. Additionally, our assessment did not include confirmation of the CMO’s operational practice with the procedures as written.

In Report # 3, Myers and Stauffer chose select contract provisions related to ER in the DCH-CMO contract and analyzed each CMO’s policies and procedures for inclusion of these provisions. Myers and Stauffer performed this analysis again in this report to determine if these same provisions are included within the current policies and procedures for each CMO. Table 16, below, includes our findings as detailed in Report #3 and our current findings, as well as, narrative proceeding the Table. Table 17 includes all the Act ER provisions and an indicator of whether we were able to locate this language within each CMO’s current policies and procedures. Language found within a CMO’s policies and procedures is denoted with a “√” as it appears the requirement was met; language partially found or not found at all is denoted with a “U” - unable to determine if requirement met.

It is important to note that while Myers and Stauffer may have been able to locate specific contractual provisions within the CMO’s policies and procedures, we did not verify that the CMO is, in fact, applying its own policies and procedures in its day-to-day operations. Additionally, if we indicate that we could not confirm that a CMO met the contractual requirement, the CMO may have additional information that if obtained, would have yielded a different conclusion.

Table 16: DCH contract ER provisions located within CMOs policies and procedures

DCH Contract Provisions	AMGP	AMGP	PSHP	PSHP	WellCare	WellCare
4.6.1 Emergency Services	Report #3	Current	Report #3	Current	Report #3	Current
4.6.1.1 Emergency Services (ES) shall be available twenty-four (24) hours a day, seven (7) Days a week to treat an Emergency Medical Condition.	√	√	√	√	√	√

DCH Contract Provisions	AMGP	AMGP	PSHP	PSHP	WellCare	WellCare
<p>4.6.1.2 An Emergency Medical Condition (EMC) shall not be defined or limited based on a list of diagnoses or symptoms. An Emergency Medical Condition is a medical or mental health Condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:</p> <ul style="list-style-type: none"> • Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; • Serious dysfunction of any bodily organ or part; • Serious harm to self or others due to an alcohol or drug abuse emergency; • Injury to self or bodily harm to others; or • With respect to a pregnant woman having contractions: <ul style="list-style-type: none"> (i) That there is adequate time to affect a safe transfer to another hospital before delivery, or (ii) That transfer may pose a threat to the health or safety of the woman or the unborn child. 	✓	✓	✓	✓	✓	✓
<p>4.6.1.3 The Contractor shall provide payment for Emergency Services when furnished by a qualified Provider, regardless of whether that Provider is in the Contractor's network. These services shall not be subject to prior authorization requirements. The Contractor shall be required to pay for all Emergency Services that are Medically Necessary until the Member is stabilized. The Contractor shall also pay for any screening examination services conducted to determine whether an Emergency Medical Condition exists</p>	✓	✓	✓	✓	✓	✓
<p>4.6.1.4 The Contractor shall base coverage decisions for Emergency Services on the severity of the symptoms at the time of presentation and shall cover Emergency Services when the presenting symptoms are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a prudent layperson.</p>	U	U	✓	✓	U	✓
<p>4.6.1.6 The Contractor shall not retroactively deny a Claim for an emergency screening examination because the Condition, which appeared to be an EMC under the prudent layperson standard, turned out to be non-emergency in nature. If an emergency screening examination leads to a clinical determination by the examining physician that an actual EMC does not exist, then the determining factor for payment liability shall be whether the Member had acute symptoms of sufficient severity at the time of presentation. In this case, the Contractor shall pay for all screening and care services provided. Payment shall be at either the rate negotiated under the Provider Contract, or the rate paid by DCH under the Fee for Service Medicaid program.</p>	✓	U	✓	✓	✓	✓
<p>4.6.1.7 The Contractor may establish guidelines and timelines for submittal of notification regarding provision of Emergency Services, but, the Contractor shall not refuse to cover an Emergency Service based on the emergency room Provider, hospital, or fiscal agent's failure to notify the Member's PCP, CMO plan representative, or DCH of the Member's screening and treatment within said timeframes.</p>	U	U	U	✓	U	U
<p>4.6.1.8 When a representative of the Contractor instructs the Member to seek ES the Contractor shall be responsible for payment for the Medical Screening examination and for other Medically Necessary ES, without regard to whether the Condition meets the prudent layperson standard.</p>	✓	✓	✓	✓	U	✓

AMERIGROUP

- Four of the seven ER provisions were located within the current policies and procedures supplied by AMERIGROUP.

- Provisions 4.6.1.4 and 4.6.1.7 were not located with AMERIGROUP’s current policies.
- Provision 4.6.1.6 was found within AMERIGROUP’s policies and procedures at the time Report #3 was completed, but not found within their current policies and procedures.

Peach State Health Plan (PSHP)

- All seven provisions listed on Table 16 were located within PSHP policies and procedures.
- Provision 4.6.1.7 was not found in PSHP’s policies and procedures for Report #3; however this language was found within PSHP’s current policies and procedures.

WellCare

- Myers and Stauffer was able to locate six of the seven provisions within the policies and procedures provided by WellCare.
- While provisions 4.6.1.4 and 4.6.1.8 were not found in WellCare policies and procedures in Report #3, these provisions were located within the current WellCare policies and procedures.
- Myers and Stauffer was unable to locate provision 4.6.1.7 within the current WellCare policies and procedures. This provision was also not found in our policy and procedure analysis performed for Report #3 which was issued July 2008.

Table 17: The Act ER provisions located within each CMO’s policies and procedures

DCH Contract Provisions	AMGP	PSHP	WellCare
4.16.5 Emergency Health Care Services			
4.16.5.1 The Contractor shall not deny or inappropriately reduce payment to a provider of emergency health care services for any evaluation, diagnostic testing, or treatment provided to a recipient of medical assistance for an emergency condition; or	U	U	√
4.16.5.2 Make payment for emergency health care services contingent on the recipient or provider of emergency health care services providing any notification, either before or after receiving emergency health care services.	U	U	√
4.16.5.3 In processing claims for emergency health care services, a care management organization shall consider, at the time that a claim is submitted, at least the following criteria: <ul style="list-style-type: none"> • The age of the patient; • The time and day of the week the patient presented for services; • The severity and nature of the presenting symptoms; 	U	U	√

<ul style="list-style-type: none"> • The patient’s initial and final diagnosis; and • Any other criteria prescribed by DCH, including criteria specific to patients less than 18 years of age. 			
4.16.5.4 The Contractor shall configure or program its automated claims processing system to consider at least the conditions and criteria described in this subsection for claims presented for emergency health care services.	U	U	U
4.16.5.5 If a provider that has not entered into a contract with a care management organization provides emergency health care services or post-stabilization services to that care management organization’s member, the care management organization shall reimburse the non contracted provider for such emergency health care services and post-stabilization services at a rate equal to the rate paid by DCH for Medicaid claims that it reimburses directly.	√	U	√

AMERIGROUP

- Only comprehensive language from one of the five provisions was found within the policies and procedures supplied by AMERIGROUP. Only partial language was located for the remaining four provisions.

Peach State Health Plan (PSHP)

- Myers and Stauffer was not able to locate any of the five provisions as listed on Table 17 within the PSHP policies and procedures.

WellCare

- Myers and Stauffer located four of the five provisions within the WellCare policies and procedures.

Summary of Findings

- Of the total 12 ER provisions analyzed, Myers and Stauffer located six or 50 percent within the policies and procedures supplied by AMERIGROUP.
- Provisions 4.6.1.4 and 4.6.1.7 were not located with AMERIGROUP’s policies and procedures for Report #3 or currently.
- Provision 4.6.1.6 was found within AMERIGROUP’s policies and procedures at the time Report #3 was issued; this provision was not located within their current policies and procedures.
- Myers and Stauffer identified seven of the 12 provisions or 58 percent within PSHP’s policies and procedures.
- Provision 4.6.1.7 was not found within PSHP’s policies and procedures when Myers and Stauffer issued Report #3; however this language was found within PSHP’s current policies and procedures.
- Ten of the 12 provisions, or 83 percent, were located within the policies and procedures supplied by WellCare.
- While provisions 4.6.1.4 and 4.6.1.8 were not found in WellCare policies and procedures in Report #3, these provisions were located within the current WellCare policies and procedures.
- Myers and Stauffer was unable to locate provision 4.6.1.7 within the current WellCare policies and procedures; this provision was also not found in our policy and procedure analysis performed for Report #3 which was issued in July 2008.

We recommend that the CMOs modify their policies and procedures to include the specific provisions found in the DCH-CMO contract.

Analysis Six

- *Comparison of CMO emergency room coverage and payment policies after implementation of the ER-related provisions of the Act and in relation to our prior findings and recommendations previous to the Act, included in Report #3.*

Analysis six contains two sections: ER policies prior to the Act and ER policies in effect after implementation of the Act. In March 2011, Myers and Stauffer requested that each CMO provide responses to six questions related to their processing of ER claims. This analysis includes a comparison of each CMO's stated emergency room coverage and payment policies as of March 2008. This analysis differs from Analysis five in that Analysis five is an analysis of each CMO's policies and procedures, while for Analysis six, Myers and Stauffer asked each CMO the same set of ER claims processing question and includes their responses to these questions.

Additional Data and Documentation Requirements for Analysis Six

- AMERIGROUP Provider Handbook dated February 4, 2011
- Peach State Health Plan Provider Handbook dated February 22, 2011
- WellCare Provider Handbook dated April 2010
- DCH CMO Model Contract dated July 14, 2007
- DCH CMO Model Contract Revised Contract Amendment dated July 10, 2010
- Myers and Stauffer report "Comparative Analysis Policies and Procedures of Georgia Care Management Organizations" issued July 17, 2008

Assumptions, Limitations and Notes Relevant to Analysis Six

1. The data provided by the CMOs is presumed to be complete and accurate.
2. Myers and Stauffer analyzed and provided findings based on the documentation either provided by the three CMOs or documentation obtained via the Internet to confirm whether their policies and procedures appeared to meet the contractual requirements set forth in the Georgia Families model contract. There may be other information, regarding the CMOs' practices, that was not available to us. Additionally, our assessment did not include confirmation of the CMO's operational practice with the procedures as written.

As part of Report #3, Myers and Stauffer asked each CMO a series of questions related to their processing of ER claims. These questions, as well as, each CMO's responses can be found in each section titled "ER policies previous to the Act". Myers and Stauffer asked each CMO similar questions regarding their ER claims processing procedures on March 2011. Each CMO's responses to these questions can be found in the "ER policies in effect after implementation of the Act" section of this analysis. Also included in this section are Myers and Stauffer's analysis of each CMO's current policies and procedures related to ER.

The “Summary of Findings” section at the end of this analysis contains a summary of each CMO’s current ER claims processing procedures, comparison of these procedures with those as reported in Report #3 and a synopsis of any relevant documentation found within each CMO’s current policies and procedures.

AMERIGROUP

ER Policies previous to the Act

From Report #3:

Myers and Stauffer requested that AMGP describe their emergency room coverage and payment policies. Per information received from AMGP on 03/26/08:

“If the provider is billing only ER and no other higher level of care (99281-99285) then the claim pays based on the CPT code billed per the provider contract. If the provider is billing ER and Observation, then the higher level of care would pay and the ER would not pay per AMGP policies and provider contract. In this scenario, [AMGP] would pay the observation rate.”

Health plans were also asked if they use a list of diagnoses or symptoms to identify emergent conditions for payment purposes. According to AMGP’s response received via email on 03/26/08:

“[AMGP] does not use a diagnosis or symptoms listing to identify emergent conditions for claims payment. [AMGP] pays based on CPT code and revenue code billed by provider.”

Myers and Stauffer asked, in instances when an ER claim does not have an “autopayable” diagnosis, what is process for determining whether the claim should pay at the triage rate, or does the claim pend/deny for medical records?

AMGP responded on 3/26/08 that this is not applicable to them as their payment is based on the CPT code billed unless a higher level of care applies, then payment would be at the higher level of care and not the emergency room rate.

AMGP was also asked whether the time of day or day of the week, as well as the age of the patient, is a factor in determining payment for emergency room claims. AMGP responded on 3/26/08 that this question did not apply to them due to their payment policies.

Additionally, AMGP was asked to describe their process for applying the prudent layperson standards and the qualifications of personnel involved in this process.

The response received on 3/26/08 from AMGP stated that this process was not applicable to the CMO.

ER Policies after implementation of the Act

Myers and Stauffer analyzed policies and procedures relating to ER supplied by AMERIGROUP that had an effective on or after July 1, 2008. Of note in AMERIGROUP’s policies was the statement that participating providers are reimbursed according to their contracts and reimbursement is either based on the assigned interim outpatient rate (IOR) or the Emergency Room level of care billed. This statement appears to contradict AMERIGROUP’s responses received on March 22, 2011.

Myers and Stauffer asked AMERIGROUP a series of questions related to their ER claims processes and procedures. Below on Figure 10 are AMERIGROUP's responses which were received electronically on March 22, 2011. A copy of the letter with each CMO's responses can be found in Exhibit G.

Figure 10: Myers and Stauffer Questions-AMERIGROUP responses

<p>Myers and Stauffer Question: Describe each step in the process for an ER claim once it is received by AMERIGROUP.</p>	<p>AMERIGROUP response: Any outpatient hospital claim we receive with Revenue Code 450 is auto-adjudicated based on diagnosis. If the diagnosis is not on our approved ER diagnosis list then claim is paid at triage rate and plan will request the provider to submit medical records for further review. If it does have a diagnosis that matches our diagnosis list then claim is paid at contracted rate.</p>
<p>Myers and Stauffer Question: Does AMERIGROUP use a list of diagnoses or symptoms to identify emergent conditions for payment purposes?</p>	<p>AMERIGROUP response: YES</p>
<p>Myers and Stauffer Question: If so, are you using DCH's version or your own?</p>	<p>AMERIGROUP response: Amerigroup uses a DCH approved diagnosis list</p>
<p>Myers and Stauffer Question: Are there CPT codes on the list?</p>	<p>AMERIGROUP response: NO, ICD-9 Codes only</p>
<p>Myers and Stauffer Question: For a claim that does not have an "autopayable" diagnosis, what process does the claim go through?</p>	<p>AMERIGROUP response: We do not pend ER claims for review.</p>
<p>Myers and Stauffer Question: Please describe how AMERIGROUP applies prudent layperson criteria when adjudicating claims. Please describe the staff resources and qualifications used in this process.</p>	<p>AMERIGROUP response: These claims are reviewed by Nurse Reviewers and/or Medical Director based on medical records submitted by the hospital, clinical protocols and as directed in our DCH contract.</p>
<p>Myers and Stauffer Question: In processing claims for emergency health care services, do you consider the following criteria:</p>	
<p>(1) The age of the patient;</p>	<p>AMERIGROUP response: YES</p>
<p>(2) The time and day of the week the patient presented for services;</p>	<p>AMERIGROUP response: NO</p>
<p>(3) The severity and nature of the presenting symptoms;</p>	<p>AMERIGROUP response: YES</p>
<p>(4) The patient's initial and final diagnosis;</p>	<p>AMERIGROUP response: YES</p>
<p>(5) Any other criteria prescribed by the Department of Community Health, including criteria specific to patients under 18 years of age.</p>	<p>AMERIGROUP response: YES</p>
<p>Myers and Stauffer Question: If so, please describe how AMERIGROUP applies the above listed criteria when adjudicating claims.</p>	<p>No response was provided by AMERIGROUP to this question.</p>

<p>Myers and Stauffer Question: Please describe your policy for processing ER claims where the emergency health care services or post-stabilization services were provided by a noncontracted provider.</p>	<p>AMERIGROUP response: Amerigroup will reimburse Non-par providers based on the same clinical criteria and DCH Reimbursement rate.</p>
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**Peach State Health Plan (PSHP)
ER Policies previous to the Act**

Myers and Stauffer received the following information on 03/28/08 regarding PSHP’s emergency claim payment processes. As reported in Report #3:

PSHP pays emergency room (ER) claims using two (2) different methods, an automated process and a non-automated process. At the time of contracting with PSHP, each hospital makes an independent decision based on its own preference as to which process it prefers for the adjudication of ER claims.

The automated process addresses the concerns of providers who want to be paid sooner and also relieves them from the time and expense involved in gathering and submitting medical records and other supporting documentation. Under the automated process and to facilitate administrative simplicity, PSHP has established specific ICD-9 codes that are automatically approved for payment. The provider manual explains the process for billing under the automated process. Emergency room claims are not denied under the automated process. Under this process all claims are paid at the full-negotiated rate for ER services or a lower emergency administrative fee. In addition, the provider has the ability to appeal claims paid at the emergency administrative fee rate.

For non-contracted providers and contracted provider who elect not to participate in the automated process, claims are paid at the full emergency services rate (i.e., network or non-network rate), an emergency administrative fee or denied. Consistent with the automated process, the non-automated process pays claims that have the specified ICD-9 codes in the primary diagnosis field at the applicable emergency services rate. For claims not coded with one of the specified ICD-9 codes, the hospital is sent a request for applicable medical records and supporting documentation. This information enables PSHP to perform a manual, prudent lay person review to determine eligibility for coverage, the applicable payment rate or if the claim should be denied.

PSHP also confirmed that they are using DCH’s version of the diagnosis code list for reimbursement of emergency room claims, however they do not deny an emergency room claim based on the diagnosis code list. There are no CPT codes on this list. PSHP also confirmed that the time of day, day of the week and/or age of the patient are taken into consideration when making a determination regarding an emergent condition either in the claims adjudication or the appeal process.

Myers and Stauffer asked PSHP to describe how they apply the prudent layperson criteria when adjudicating claims and also to provide a description of staff resources and qualifications used in this process. The PSHP response received on 03/28/08 is as follows:

The claim is reviewed by a non-clinical CCM analyst. The CCM analyst reviews the ED record, specifically evaluating the member’s presenting symptoms (at the time of triage in the ER) and whether or not they meet the PLP definition of an emergency as defined in the contract agreement between Georgia DCH and PSHP. The CCM analyst works under the supervision of a registered nurse in order to ensure correct interpretation of the medical record and facilitate the decision with respect to the presence or absence of an obvious medical emergency.

ER Policies after implementation of the Act

The following are the responses received from PSHP to the questions posed by Myers and Stauffer in March 2011.

Figure 11: Myers and Stauffer Questions-PSHP responses

<p>Myers and Stauffer Question: Describe each step in the process for an ER claim once it is received by Peach State Health Plan.</p>	<p>PSHP response: When Peach State Health Plan (Peach State) receives the claims, they are entered into the Plan’s claims data system (Amisys). After they are entered, the ER claims are reviewed according to the Plan’s established policies (see attached – CC.CLMS.07.86, CC.UM.12.03 and CC.UM.12.05). If the claim(s) meet emergent ER criteria, the claim will be processed according to the fee schedule or contracted rate. If the claim(s) does not meet emergent ER criteria, the claim will be processed at the triage rate.</p>
<p>Myers and Stauffer Question: Does Peach State Health Plan use a list of diagnoses or symptoms to identify emergent conditions for payment purposes?</p>	<p>PSHP response: Peach State Health Plan uses an “autopay” index of ICD-9 diagnosis codes that are always considered to be emergent to identify emergent conditions for payment purposes. Medical records are also reviewed when submitted by the provider.</p>
<p>Myers and Stauffer Question: If so, are you using DCH’s version or your own?</p>	<p>PSHP response: Not applicable</p>
<p>Myers and Stauffer Question: Are there CPT codes on the list?</p>	<p>PSHP response: Not applicable</p>

<p>Myers and Stauffer Question: For a claim that does not have an “autopayable” diagnosis, what process does the claim go through?</p>	<p>PSHP response: For claims that do not have an “autopayable” diagnosis, Peach State will review medical records in conjunction with the Prudent Lay Person Standard, set forth in Peach State’s contract with DCH, to determine whether the case meets emergent ER criteria. If the diagnoses contained on the claim are not emergent and if medical records were not received, the claim will be processed at the triage rate.</p>
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<p>Myers and Stauffer Question: Please describe how Peach State Health Plan applies prudent layperson criteria when adjudicating claims. Please describe the staff resources and qualifications used in this process.</p>	<p>PSHP response: Five (5) designated associates within Peach State’s Medical Review Unit (MRU) who possess an average knowledge of health and medicine are responsible for applying the prudent layperson (PLP) criteria to ER claims. The PLP process and the claims process are coordinated processes between the MRU and Claims departments to allow for claim adjudication. The responsibilities of the MRU for PLP review of ED claims include:</p> <ol style="list-style-type: none"> a. Review of the submitted ED record to determine severity of symptoms at time of presentation. b. Application of the PLP Definition of Emergency c. Making a determination of whether the PLP Definition of Emergency has been met d. Communication of PLP determination to the Claims department e. Issuance of any letters associated with the PLP determination of “not met” <p>Please see policy CC.UM.12.03 for an outline of the detailed process. GA ED PLP HB1234 language: ‘Emergency services’ or ‘Emergency care’ means those health services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:</p> <ol style="list-style-type: none"> (A) Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy. (B) Serious impairment to bodily functions; or (C) Serious dysfunction of any bodily organ or part <p>Other emergency situations as stated in the Medicaid managed care contract include:</p> <ul style="list-style-type: none"> • Serious harm to self or others due to alcohol or drug abuse emergency; • Injury to self or bodily harm to others; • With respect to pregnant woman having contractions: <ol style="list-style-type: none"> (i) That there is adequate time to affect a safe transfer to another hospital before delivery; or (ii) That transfer may pose a threat to the health or safety of the woman or unborn child
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<p>Myers and Stauffer Question: In processing claims for emergency health care services, do you consider the following criteria:</p> <ul style="list-style-type: none"> (1) The age of the patient; (2) The time and day of the week the patient presented for services; (3) The severity and nature of the presenting symptoms; (4) The patient's initial and final diagnosis; (5) Any other criteria prescribed by the Department of Community Health, including criteria specific to patients under 18 years of age. 	<p>PSHP response: Yes, Peach State considers all of the above mentioned criteria in the processing of claims for emergency health care services.</p>
<p>Myers and Stauffer Question: If so, please describe how Peach State Health Plan applies the above listed criteria when adjudicating claims.</p>	<p>PSHP response: In accordance with MRU Analyst Process F (see policy CC.UM.12.03), the MRU Analyst will review the claim with consideration of the 1) time the patient was presented at the ER, 2) the day the patient was presented at the ER (weekday or weekend), 3) the age of the patient, 4) the patient's chief complaint, 5) the onset of the symptoms and 6) the severity of the patient's symptoms. After reviewing these facts, the MRU Analyst will make a PLP determination. Based on that determination, the analyst selects Pay or Deny. Pay should be selected if the reviewer feels the provided information meets the PLP definition of an emergency or urgent medical problem. Deny should be selected if the reviewer feels that, based on the provided information, the definition of PLP has not been met.</p>
<p>Myers and Stauffer Question: Please describe your policy for processing ER claims where the emergency health care services or post-stabilization services were provided by a noncontracted provider.</p>	<p>PSHP response: Non-participating providers are subject to the same process as participating providers.</p>

WellCare ER Policies previous to the Act

As stated in Report #3:

Regarding the use of a “presumptive emergency or autopayable” list, WellCare stated the following on 3/27/08:

As independently validated by the FourThought Group, ‘Specifically, WellCare does not use a fixed list of diagnosis (DX) codes to determine what is considered an emergent versus non-emergent condition’ (FourThought Group, Emergency Room Claims Monitoring, pg 14).

Additionally, when asked if the presumptive emergency or autopayable list is identical to the list utilized by DCH for traditional Medicaid or a list of their own development and if the list includes CPT codes, their response was “N/A”.

Myers and Stauffer asked WellCare the following question “For an ER claim that does not have an “autopayable” diagnosis, what process does the claim go through? Is the claim paid at the triage rate or does the claim pend/ deny for medical records?” The following response was provided by WellCare on 3/27/08:

WellCare has developed an automated ‘presumptive’ list of DX codes that does not limit what will be considered an emergent condition, but instead, ‘presumptively’ or automatically treats certain claims as an emergency condition. This facilitates automated, systematic payment of a claim at the ER rate.’ (FourThought Group, Emergency Room Claims Monitoring, pg. 12) ‘Hospitals billing non-emergent DX codes in the admitting, primary, secondary and tertiary diagnosis fields which may have been considered emergencies under the Medicaid FFS program...are not specific enough to warrant an emergency determination in the WellCare system’ ‘These claims would need to be resubmitted via the reconsideration process, with additional documentation, in order to be further classified as emergency claims’ (FourThought Group, Emergency Room Claims Monitoring, p. 12-13). Claims not considered as an emergency condition are adjudicated and paid at the individual contracted rate for non-emergent claims.

WellCare was also asked whether the time of day, day of the week or the age of patient is a factor in determining payment for emergency room claims. The response provided by WellCare on 3/27/08 is below:

The WellCare System does not currently consider day of the week (weekend vs. weekday, time of day of presentation to the ER, or member age’ (FourThought Group, Emergency Room Claims Monitoring, p 13), during the claim adjudication process, unless the medical records are provided with the initial claim submission. These factors are taken into consideration when medical records and documents are submitted during the ER reconsideration and appeals process, but can not be considered as a sole determining factor when assessing the condition.

Finally, WellCare was asked to describe their process for applying prudent layperson criteria and the qualifications of personnel involved in this

process. The response received on 3/27/08 from WellCare stated: “WellCare has developed an automated ‘presumptive’ list of DX codes that does not limit what will be considered an emergent condition, but instead, ‘presumptively’ or automatically treats certain claims as an emergency condition. This facilitates automated, systematic payment of a claim at the ER rate.’ (FourThought Group, Emergency Room Claims Monitoring, p.12) ‘Hospitals billing non-emergent DX codes in the admitting, primary, secondary and tertiary diagnosis fields which may have been considered emergencies under the Medicaid FFS program are not specific enough to warrant an emergency determination in the WellCare system’ ‘These claims would need to be resubmitted via the reconsideration process, with additional documentation, in order to be further classified as emergency claims.’ (FourThought Group, Emergency Room Claims Monitoring, p.12-13). Claims not considered as an emergency condition are adjudicated and paid at the individual contracted rate for non-emergent claims.”

ER Policies after implementation of the Act

Figure 12 below contains a series of questions asked by Myers and Stauffer and WellCare’s response to each.

Figure 12: Myers and Stauffer Questions-WellCare responses

<p>Myers and Stauffer Question: Describe each step in the process for an ER claim once it is received by WellCare.</p>	<p>WellCare response: As cited from WellCare of GA’s P&P for Emergency Room & Urgent Care Services: “In processing claims for emergency health care services, WellCare of GA shall consider, at the time that a claim is submitted, at least the following criteria: a. The age of the patient b. The time and day of the week the patient presented for services c. The severity and nature of the presenting symptoms d. The patient’s initial and final diagnosis; e. Any other criteria prescribed by DCH, including criteria specific to patients less than 18 years of age.”</p>
<p>Myers and Stauffer Question: Does WellCare use a list of diagnoses or symptoms to identify emergent conditions for payment purposes? a) If so, are you using DCH’s version or your own? b) Are there CPT codes on the list? c) For a claim that does not have an “autopayable” diagnosis, what process does the claim go through?</p>	<p>WellCare response: WellCare has developed an automated presumptive list of DX codes that does not limit what will be considered an emergent condition, but instead presumptively or automatically treats certain claims as an emergency condition. This facilitates automated, systematic payment of a claim at the ER rate. Without using a listing of DX codes, there will always be claims that are truly emergent in nature, as defined by the PLP standard, that the system cannot determine as such given the parameters submitted by the provider on the claim.</p>

<p>Myers and Stauffer Question: Please describe how WellCare applies prudent layperson criteria when adjudicating claims. Please describe the staff resources and qualifications used in this process.</p>	<p>WellCare response: WellCare of Georgia’s Prudent Layperson Standard is defined as, “An Emergency or Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a. placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; b. serious impairment to bodily functions; c. serious dysfunction of any bodily organ or part; d. serious harm to self or others due to an alcohol or drug abuse emergency; e. injury to self or bodily harm to others; or f. with respect to a pregnant woman having contractions; i. that there is adequate time to effect a safe transfer to another hospital before delivery, or ii. that transfer may pose a threat to the health or safety of the woman or the unborn child.</p> <p>A physician or other appropriate practitioner reviews presenting symptoms as well as the discharge diagnosis for emergency services. WellCare of Georgia has three (3) nurses, three (3) coordinators/support staff and 2 (two) Medical Doctors staffed for this review process.</p>
<p>Myers and Stauffer Question: In processing claims for emergency health care services, do you consider the following criteria: (1) The age of the patient; (2) The time and day of the week the patient presented for services; (3) The severity and nature of the presenting symptoms; (4) The patient’s initial and final diagnosis; (5) Any other criteria prescribed by DCH, including criteria specific to patients under 18 years of age. If so, please describe how WellCare applies the above listed criteria when adjudicating claims.</p>	<p>WellCare response: In the adjudication of claims, including reconsideration, WellCare considers all the criteria listed above. WellCare has enhanced our automated presumptive list of DX codes that does not limit what will be considered an emergent condition, but instead presumptively or automatically treats certain claims as emergency condition by taking in to account the criteria as per HB1234.</p>

<p>Myers and Stauffer Question: Please describe your policy for processing ER claims where the emergency health care services or post-stabilization services were provided by a noncontracted provider.</p>	<p>WellCare response: It is the policy of WellCare Health Plans, Inc. (the “Company”) that a member has post stabilization services available, without authorization up to the point where the Company is notified that the member is stable, regardless of whether the member obtains the service within or outside of the Company’s network. Please refer to WellCare’s policy “Coverage of Post-Stabilization Services”, Policy Number C7UM MD-6.2 for further detail regarding post-stabilization services.</p>
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Summary of Findings

Table 18, below, offers a summary of CMO stated claims payment processes previous to (Report #3) and following implementation of the Act. This table is not intended to indicate whether each respective CMO was in compliance with the provisions of the Act. Any noted variances or areas where it appears there may be a compliance issue is noted in the narrative below by CMO.

Table 18: CMO stated Claims Payment Processes Prior to and After the Act, by CMO

	Report #3	Current	Report #3	Current	Report #3	Current
	AMERIGROUP		PSHP		WellCare	
ICD-9/ CPT code list used to make ER payment determination		√	√	√	√	√
Differential payments (e.g., Triage and full payments)	√	√	√	√	√	√
ER Payment Determination Factors (Time/ Day of week/ Age of patient etc.)		√	√	√		√
ER Payment Determination Factor- Prudent Layperson Criteria		√	√	√		√

AMERIGROUP

- The ER claims payment methodology reported by AMERIGROUP has changed from March 2008 to March 2011
- March 2008 payment methodology:

- Pay ER claims based on the CPT code billed per provider contract
 - No use of a diagnosis code list
 - No application of prudent layperson standards
 - No application of factors such as time of day
- March 2011 payment methodology
 - ER Claims with a 450 revenue code are auto-adjudicated using diagnosis codes
 - Use an ER diagnosis list
 - Consideration of age of patient, severity and nature of the presenting symptoms and patient's initial and final diagnosis ; AMERIGROUP stated they do not consider "time and day of the week"
 - Application of prudent layperson standards
- Current payment methodology per AMERIGROUP policy and procedure
 - Two different payment methodologies listed:
 - Reimbursement of participating providers based on their negotiated rate
 - Auto-pay of ER claims by place of service and admitting and/or primary diagnosis code. If the admitting and/or primary diagnosis code is on the Emergent Diagnosis Code list, the claim will pay the full rate, if diagnosis code(s) is not on the Code list, claim will reimburse the triage rate.
 - AMERIGROUP policy states that for claims reimbursed at a triage rate, the provider may file an appeal and submit medical records for review.

Peach State Health Plan (PSHP)

- PSHP described two processes for adjudicating claims in March of 2008: an automated process and non-automated process. The automated process allows for providers to get reimbursed more quickly with providers being reimbursed, based on ICD-9 code billed, either a full-contracted rate or administrative fee. Providers who choose the non-automated process will be asked to submit medical records for claims that do not contain a specified ICD-9 code. Upon analysis of PSHP'S current documentation relating to the process for adjudicating ER claims it is not clear if PSHP continues to have a practice of having "automated" and "non-automated" claims processes.
- One current PSHP policy referenced claims from non-automated provider are manually reviewed. Another PSHP policy stated that providers who take part in the CMO's "ED Program" may not file an appeal regarding the reimbursement of their ER claims. However, in their response to Myers and Stauffer's question to describe their ER claims processing procedures, PSHP did not differentiate between two separate claims processes for providers.
- In March 2011, PSHP acknowledged using an "autopay" index of ICD-9 diagnosis codes. However, when asked whether this list of a diagnosis codes was developed by PSHP or if they utilized the list used by the Department, PSHP responded "Not applicable".
- PSHP responded that currently they consider all criteria listed in the Act; however, PSHP did not address how they apply final diagnosis in processing claims for emergency health care services.

- Within PSHP's existing policies and procedures, it states that non-participating provider ER claims will be reviewed by a physician reviewer who will look at the presenting symptoms and the discharge diagnosis when making a coverage decision.

WellCare

- In March 2008, WellCare indicated their system was not set-up to consider factors such as time of day, day of the week and age of patient on an ER claim. These factors were considered if medical records were received.
- In March 2011, WellCare stated when an ER claim is received they take into account all criteria as mandated by the Act (e.g. age of patient, patient's initial and final diagnosis etc.)
- In a response to a Myers and Stauffer question regarding the processing of ER claims, WellCare stated they have "enhanced our automated presumptive list of DX codes that does not limit what will be considered an emergent condition, but instead presumptively or automatically treats certain claims as emergency condition by taking in to account the criteria as per HB1234."
- When asked to describe their process for applying prudent layperson criteria in March 2008, WellCare indicated they use an automated 'presumptive' list of diagnosis codes.
- In March 2011, when asked how they apply prudent layperson criteria, WellCare provided an EMC definition and stated a physician or other appropriate practitioner reviews the presenting symptoms and discharge diagnosis.

Based on the findings from this analysis, Myers and Stauffer has several recommendations. Our recommendations, by CMO, are listed below.

AMERIGROUP

- Because AMERIGROUP's written policies and their responses to questions posed by Myers and Stauffer outlined different methodologies, we recommend that AMERIGROUP review and clarify their ER claims processes.
- We recommend that AMERIGROUP provide a analysis that supports that their policies and procedures are in compliance with the Act. Because AMERIGROUP responded that they do not consider "time and day of the week patient presented to ER" when processing ER claims, it appears as though modifications to policies are required. Time and day of the week the patient presented to the ER is one of the criteria required by the Act.
- DCH may wish to require AMERIGROUP to describe how they apply the Act criteria since AMERIGROUP omitted a response to Myers and Stauffer regarding this question. Additionally, AMERIGROUP should also clarify the point in time during the claims adjudication process that the criteria are applied, if applicable.
- We recommend that AMERIGROUP further clarify the point during the review of ER claims that medical records are requested from the provider and reviewed.

Peach State Health Plan

- Clarify whether there are two separate ER claims processes utilized by PSHP.

- State if, and when, PSHP takes into consideration final diagnosis when processing ER claims as required by the Act.
- Provide an explanation regarding their usage of an “autopay” diagnosis index and how this index differs from the diagnosis code list utilized by DCH.
- Explain at what point in the ER claims process PSHP considers prudent layperson and other criteria of the Act. Specifically, if criteria is considered at the time when the claim is submitted or only at the time of a reconsideration or an appeal.
- Outline the process for reviewing ER claims from non-participating providers and explain how this differs from the participating provider process.
- Provide a analysis that supports PSHP policies and procedures to be in full compliance with the provisions of the Act.

WellCare

- We recommend that WellCare provide detailed documentation regarding how WellCare considers the Act criteria at the time the claim is submitted. This should include indicating whether the process is manual or automated and outlining each step in the process.
- WellCare should further clarify how they apply prudent layperson criteria.
- In response to WellCare’s statement that they have “enhanced” their automated presumptive list of diagnosis codes, we recommend that WellCare describe the enhancements were implemented and how these enhancements take into account the Act criteria.
- Provide a analysis that supports WellCare policies and procedures to be in full compliance with the provisions of the Act.

Analysis Seven

- *The Act states that a CMO shall configure its automated claims processing system to consider criteria and conditions as listed in the Act. This analysis contains our findings regarding how the CMOs have programmed their respective claims processing services and if it appears the CMOs are in compliance with this provision of the Act.*

Analysis seven provides an assessment of the three CMOs’ respective automated claims processing systems and how each system has been configured or programmed to consider the criteria listed within the Act.

Assumptions, Limitations and Notes Relevant to Analysis Seven

1. The data provided by the CMOs is presumed to be complete and accurate.
2. Myers and Stauffer analyzed and provided findings based on the documentation either provided by the three CMOs or documentation obtained via the Internet to confirm whether their policies and procedures appeared to meet the contractual requirements set forth in the Georgia Families model contract. There may be other information, regarding the CMOs’ practices, that was not available to us. Additionally, our assessment did not include confirmation of the CMO’s operational practice with the procedures as written.

In order to perform this analysis, Myers and Stauffer requested two pieces of documentation from each of the CMOs. First, Myers and Stauffer requested each policies and procedures related to the configuration documentation specific to each CMO's respective claims system in respect to ER claims. Secondly, Myers and Stauffer asked each CMO to explain how their claims system is programmed to consider any of the following criteria as listed in the Act:

- (1) The age of the patient;
- (2) The time and day of the week the patient presented for services;
- (3) The severity and nature of the presenting symptoms;
- (4) The patient's initial and final diagnosis;
- (5) Any other criteria prescribed by the Department of Community Health, including criteria specific to patients under 18 years of age.

AMERIGROUP

AMERIGROUP responded to our question on how their system is programmed by stating "Our system determines the nature of the Emergency based on diagnosis. If it is considered a non-emergent diagnosis the Triage rate will be reimbursed, else contracted ER Level rates will apply."

Myers and Stauffer located an AMERIGROUP policy where they stated they have programmed their claims system to auto-pay Emergency Room claims for both practitioners and facilities if the place of service is for emergency room services and primary and/or admitting diagnosis code is on AMERIGROUP's Emergent Diagnosis Code list. Furthermore, their policy states for claims where the admitting or primary diagnosis code is not on the diagnosis code list, the claim will reimburse a triage amount. Myers and Stauffer did not find any further documentation within the policies and procedures supplied by AMERIGROUP which included an indication that AMERIGROUP has programmed their claims systems to account of the criteria as listed in the Act.

Peach State Health Plan (PSHP)

In response to our question on how their claims system is programmed to consider any of the following criteria as listed in the Act, PSHP stated "Peach State's system is configured to recognize emergency related diagnosis codes and will process claims according to the applicable fee schedule or contracted rate. Claims which have non-emergency related diagnosis codes require diagnosis review to determine if the PLP criteria have been met."

Myers and Stauffer was unable to locate any language in the PSHP policies and procedure that addressed how their system is programmed to consider any of the criteria as listed in the Act.

WellCare

WellCare gave the following response to Myers and Stauffer's question above: "Claims are first reviewed based on the presumptive list, considering criteria listed above. Our system auto adjudicates based on the criteria presented on the claim and can be reviewed retrospectively based on supporting documentation from the medical record. Medical records submitted by the provider are used to consider additional detail not captured on the submitted claim."

Myers and Stauffer was not able to find language which stated how WellCare's claims processing system was programmed to account for the Act criteria when processing ER claims.

Summary of Findings

Based on the documentation provided and the responses to our questions, it does not appear that any of the CMOs are in compliance with the Act which states that "A care management organization shall configure or program its automated claims processing system to consider at least the conditions and criteria described in this subsection for claims presented for emergency health care services."

Based on these findings, the Department may consider having a discussion with each CMO regarding the feasibility of configuring their systems to consider the criteria of the Act.

RECOMMENDATIONS

DCH may wish to:

- Update Provision 4.6.1.2 to match the language in 42 CFR 489.24 by changing the word “adequate” to “inadequate”.
- Consider for future revisions of the DCH-CMO contract combining Section 4.6.1 and Section 4.16.5 so all provisions related to Emergency Room care and services can be found in the same section of the contract.
- Consider requiring each CMO to use the same definition of an Emergency Medical Condition as that included in the DCH-CMO model contract. This common definition should be used consistently in all contracts, provider handbooks, subcontractor agreements and update bulletins, as applicable.
- Add a requirement to their contract stating the CMOs must describe all emergency room processes and appeals processes in their provider handbooks. This would assist in ensuring the CMOs’ procedures for processing ER claims and any subsequent appeals are transparent to providers.
- Create a policy which mandates the handling of claims received from providers without valid NPI numbers or from providers which are not found within the CMO’s claims processing system. Policy should be in compliance with HIPAA requirements.
- Require WellCare to develop an initiative where they work with providers in an effort to reduce duplicate submissions. Providers with the greatest share of these denials should be prioritized. In the event that additional analysis by the CMOs identifies potential fraud, waste, or abuse, the CMOs should work with DCH to apply the appropriate sanctions or remedies to these providers.
- Update the Model Contract to clarify the required payment methodology for non-participating providers.
- Require AMERIGROUP to research and address the following potential issues relating to the processing of ER claims:
 - State how they apply the Act criteria since AMERIGROUP did not provide a response to Myers and Stauffer regarding this question. Additionally, AMERIGROUP should also clarify when during the claims adjudication process the criteria are applied, if applicable.
- Require the CMOs to work with providers to identify EOP code and descriptions that are most problematic. CMOs should also consider making tools available to providers to facilitate their understanding of EOPs to reduce denials.
- Require AMERIGROUP to describe how they apply the Act criteria since AMERIGROUP omitted a response to Myers and Stauffer regarding this question. Additionally, AMERIGROUP should also clarify the point in time during the claims adjudication process that the criteria are applied, if applicable.
- Consider support for an amendment to the Act to provide DCH with discretion to determine what set of criteria the CMOs are mandated to follow.
- Require each CMO to submit a comprehensive strategic assessment of the requirements that would be needed to configure their claims adjudication systems to fully consider the criteria of the Act at the time of adjudication.

CMO Recommendations

Myers and Stauffer recommends:

- Peach State Health Plan and WellCare to update their provider contracts to be in compliance with the provisions of the Act by removing language stating that the primary diagnosis code billed on the claim is used to make an Emergency Medical Condition (EMC) determination. Because provider contracts likely include differing terms, we recommend that each CMO provide to DCH a schedule that reflects the timeline necessary to update each contract.
- Each CMO consider performing additional analysis to identify and recoup claims where the level of procedures and services billed cannot be justified. CMOs should also consider educational opportunities, and special handling of claims from providers that represent the greatest share of the potentially upcoded claims. DCH may wish to monitor this situation closely, including guidance to the CMOs as well as analyses to review claims from the same providers in the fee-for-service delivery system.
- The CMOs to amend their provider contracts to include the Act language related to the processing of ER claims.
- AMERIGROUP to analyze eligibility-related denials to determine the accuracy and to identify any potential issues. Because of the multi-faceted nature of member enrollment, once potential issues have been confirmed, convening a conference with all of the entities involved with enrollment would assist in facilitating corrective actions.
- AMERIGROUP provide further clarification of Explanation of Payment (EOP) codes such as “Reduced Allowable” and “Claim level Disallow”, including communicating additional information on these codes to providers. The CMO should provide a plan for reducing denied claims for these EOPs.
- PSHP conduct an in-depth review of their filing time limit and coordination of benefit denials and provide a plan for reducing these types of denials, including a communication plan and/or provider education as appropriate.
- PSHP perform a comprehensive review of ER claims where the member is less than 21 years of age and a copayment was deducted from the provider’s reimbursement. A corrective action plan should be provided to the Department detailing PSHP’s findings and subsequent actions.
- The CMOs and the state fiscal agent contractor (FAC) meet to determine what processes are being utilized when the provider on an encounter received from a CMO is not in the Medicaid Management Information System (MMIS). Utilizing an ambiguous provider name could cause numerous issues with reporting, data analyses and rate-setting activities. Myers and Stauffer will provide information to both the CMOs and the FAC to facilitate the review and correction of this issue.
- The CMOs submit a corrective action plan to modify their provider handbooks such that they are in compliance with the Act.
- We recommend that the CMOs modify their policies and procedures to include the specific ER provisions found in the DCH-CMO contract.

- Because AMERIGROUP’s written policies and their responses to questions posed by Myers and Stauffer outlined different methodologies, we recommend that AMERIGROUP review and clarify their ER claims processes
- AMERIGROUP provide a analysis that supports that their policies and procedures are in compliance with the Act. Because AMERIGROUP responded that they do not consider “time and day of the week patient presented to ER” when processing ER claims, it appears as though modifications to policies are required. Time and day of the week the patient presented to the ER is one of the criteria required by the Act.
- AMERIGROUP further clarify the point during the review of ER claims that medical records are requested from the provider and reviewed.
- We recommend PSHP provide the following:
 - Clarify whether there are two separate ER claims processes utilized by PSHP.
 - State if, and when, PSHP takes into consideration final diagnosis when processing ER claims as required by the Act.
 - Provide an explanation regarding their usage of an “autopay” diagnosis index and how this index differs from the diagnosis code list utilized by DCH.
 - Explain at what point in the ER claims process PSHP considers prudent layperson and other criteria of the Act. Specifically, if criteria is considered at the time when the claim is submitted or only at the time of a reconsideration or an appeal.
 - Outline the process for reviewing ER claims from non-participating providers and explain how this differs from the participating provider process.
 - A analysis that supports PSHP policies and procedures to be in full compliance with the provisions of the Act.
- WellCare provide detailed documentation regarding how WellCare considers the Act criteria at the time the claim is submitted. This should include indicating whether the process is manual or automated and outlining each step in the process.
- WellCare further clarify how they apply prudent layperson criteria.
- In response to WellCare’s statement that they have “enhanced” their automated presumptive list of diagnosis codes, we recommend that WellCare describe the enhancements were implemented and how these enhancements take into account the Act criteria.
- WellCare provide a analysis that supports WellCare policies and procedures to be in full compliance with the provisions of the Act.

EXHIBIT A

438.114 Emergency and poststabilization services.

(a) *Definitions.* As used in this section—

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- (2) Serious impairment to bodily functions.
- (3) Serious dysfunction of any bodily organ or part.

Emergency services means covered inpatient and outpatient services that are as follows:

- (1) Furnished by a provider that is qualified to furnish these services under this title.
- (2) Needed to evaluate or stabilize an emergency medical condition.

Poststabilization care services means 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 (e) of this section, to improve or resolve the enrollee's condition.

(b) *Coverage and payment: General rule.* The following entities are responsible for coverage and payment of emergency services and poststabilization care services.

- (1) The MCO, PIHP, or PAHP.
- (2) The PCCM that has a risk contract that covers these services.
- (3) The State, in the case of a PCCM that has a fee-for-service contract.

(c) *Coverage and payment: Emergency services.*

(1) The entities identified in paragraph (b) of this section—

- (i) Must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO, PIHP, PAHP, or PCCM; and
- (ii) May not deny payment for treatment obtained under either of the following circumstances:

(A) 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 paragraphs (1), (2), and (3) of the definition of *emergency medical condition* in paragraph (a) of this section.

(B) A representative of the MCO, PIHP, PAHP, or PCCM instructs the enrollee to seek emergency services.

(2) A PCCM must—

- (i) Allow enrollees to obtain emergency services outside the primary care case management system regardless of whether the case manager referred the enrollee to the provider that furnishes the services; and
 - (ii) Pay for the services if the manager's contract is a risk contract that covers those services.
- (d) *Additional rules for emergency services.*
- (1) The entities specified in paragraph (b) of this section may not—
 - (i) Limit what constitutes an emergency medical condition with reference to paragraph (a) of this section, on the basis of lists of diagnoses or symptoms;
 - and
 - (ii) Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, MCO, or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.
 - (2) An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
 - (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.
- (e) *Coverage and payment: Poststabilization care services.*
- Poststabilization 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 "M+C organization" must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section.
- (f) *Applicability to PIHPs and PAHPs.*
- To the extent that services required to treat an emergency medical condition fall within the scope of the services for which the PIHP or PAHP is responsible, the rules under this section apply.

Centers for Medicare & Medicaid Services, HHS. § 438.114.(2002). Retrieved May 9, 2011, from <http://edocket.access.gpo.gov>

EXHIBIT B

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

(a) *Applicability of provisions of this section.*

- (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) “comes to the emergency department”, as defined in paragraph (b) of this section, the hospital must—
 - (i) Provide an appropriate medical screening examination within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of § 482.55 of this chapter concerning emergency services personnel and direction; and
 - (ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital’s obligation under this section ends, as specified in paragraph (d)(2) of this section.
- (2)(i) When a waiver has been issued in accordance with section 1135 of the Act that includes a waiver under section 1135(b)(3) of the Act, sanctions under this section for an inappropriate transfer or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department if the following conditions are met:
 - (A) The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period.
 - (B) The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan.
 - (C) The hospital does not discriminate on the basis of an individual’s source of payment or ability to pay.
 - (D) The hospital is located in an emergency area during an emergency period, as those terms are defined in section 1135(g)(1) of the Act.
 - (E) There has been a determination that a waiver of sanctions is necessary.
- (ii) A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the

applicable declaration of a public health emergency, as provided under section 1135(e)(1)(B) of the Act.

(b) *Definitions.* As used in this subpart—

Capacity means the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses such things as numbers and availability of qualified staff, beds and equipment and the hospital's past practices of accommodating additional patients in excess of its occupancy limits.

Comes to the emergency department means, with respect to an individual who is not a patient (as defined in this section), the individual—

- (1) Has presented at a hospital's dedicated emergency department, as defined in this section, and requests examination or treatment for a medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition;
- (2) Has presented on hospital property, as defined in this section, other than the dedicated emergency department, and requests examination or treatment for what may be an emergency medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs emergency examination or treatment;
- (3) Is in a ground or air ambulance owned and operated by the hospital for purposes of examination and treatment for a medical condition at a hospital's dedicated emergency department, even if the ambulance is not on hospital grounds. However, an individual in an ambulance owned and operated by the hospital is not considered to have "come to the hospital's emergency department" if—
 - (i) The ambulance is operated under communitywide emergency medical service (EMS) protocols that direct it to transport the individual to a hospital other than the hospital that owns the ambulance; for example, to the closest appropriate facility. In this case, the individual is considered to have come to the emergency department of the hospital to which the individual is transported, at the time the individual is brought onto hospital property;
 - (ii) The ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance;
- (4) Is in a ground or air nonhospital-owned ambulance on hospital property for presentation for examination and treatment for a medical condition at a hospital's dedicated emergency department. However, an individual in a nonhospital-owned ambulance off hospital property is not considered to have come to the hospital's emergency department, even if a member of the ambulance staff contacts the hospital by telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and treatment. The hospital may direct the ambulance to another facility if it is in

“diversionary status,” that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregards the hospital’s diversion instructions and transports the individual onto hospital property, the individual is considered to have come to the emergency department.

Dedicated emergency department means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus that meets at least one of the following requirements:

- (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;
- (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
- (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

Emergency medical condition means—

- (1) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in—
 - (i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
 - (ii) Serious impairment to bodily functions; or
 - (iii) Serious dysfunction of any bodily organ or part; or
- (2) With respect to a pregnant woman who is having contractions—
 - (i) That there is inadequate time to effect a safe transfer to another hospital before delivery; or
 - (ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.

Hospital includes a critical access hospital as defined in section 1861(mm)(1) of the Act.

Hospital property means the entire main hospital campus as defined in § 413.65(b) of this chapter, including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the hospital’s main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities.

Hospital with an emergency department means a hospital with a dedicated emergency department as defined in this paragraph (b).

Inpatient means an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services as described in § 409.10(a) of this chapter with the expectation that he or she will remain at least

overnight and occupy a bed even though the situation later develops that the individual can be discharged or transferred to another hospital and does not actually use a hospital bed overnight.

Labor means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor.

Participating hospital means (1) a hospital or (2) a critical access hospital as defined in section 1861(mm)(1) of the Act that has entered into a Medicare provider agreement under section 1866 of the Act.

Patient means—

- (1) An individual who has begun to receive outpatient services as part of an encounter, as defined in § 410.2 of this chapter, other than an encounter that the hospital is obligated by this section to provide;
- (2) An individual who has been admitted as an inpatient, as defined in this section.

Stabilized means, with respect to an “emergency medical condition” as defined in this section under paragraph (1) of that definition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to an “emergency medical condition” as defined in this section under paragraph (2) of that definition, that the woman has delivered the child and the placenta.

To stabilize means, with respect to an “emergency medical condition” as defined in this section under paragraph (1) of that definition, to provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility or that, with respect to an “emergency medical condition” as defined in this section under paragraph (2) of that definition, the woman has delivered the child and the placenta.

Transfer means the movement (including the discharge) of an individual outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (i) has been declared dead, or (ii) leaves the facility without the permission of any such person.

- (c) *Use of dedicated emergency department for nonemergency services.* If an individual comes to a hospital’s dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.

(d) *Necessary stabilizing treatment for emergency medical conditions—*

(1) *General.*

Subject to the provisions of paragraph (d)(2) of this section, if any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

- (i) Within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition.
- (ii) For transfer of the individual to another medical facility in accordance with paragraph (e) of this section.

(2) *Exception: Application to inpatients.*

- (i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual.
- (ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment.
- (iii) A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation.

(3) *Refusal to consent to treatment.* A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual's behalf) does not consent to the examination or treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both.

(4) *Delay in examination or treatment.*

- (i) A participating hospital may not delay providing an appropriate medical screening examination required under paragraph (a) of this section or further medical examination and treatment required under paragraph (d)(1) of this section in order to inquire about the individual's method of payment or insurance status.
- (ii) A participating hospital may not seek, or direct an individual to seek, authorization from the individual's insurance company for screening or stabilization services to be furnished by a hospital, physician, or non-physician practitioner to an individual until after the hospital has provided

the appropriate medical screening examination required under paragraph (a) of this section, and initiated any further medical examination and treatment that may be required to stabilize the emergency medical condition under paragraph (d)(1) of this section.

(iii) An emergency physician or non-physician practitioner is not precluded from contacting the individual's physician at any time to seek advice regarding the individual's medical history and needs that may be relevant to the medical treatment and screening of the patient, as long as this consultation does not inappropriately delay services required under paragraph (a) or paragraphs (d)(1) and (d)(2) of this section.

(iv) Hospitals may follow reasonable registration processes for individuals for whom examination or treatment is required by this section, including asking whether an individual is insured and, if so, what that insurance is, as long as that inquiry does not delay screening or treatment. Reasonable registration processes may not unduly discourage individuals from remaining for further evaluation.

(5) *Refusal to consent to transfer.*

A hospital meets the requirements of paragraph (d)(1)(ii) of this section with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with paragraph (e) of this section and informs the individual (or a person acting on his or her behalf) of the risks and benefits to the individual of the transfer, but the individual (or a person acting on the individual's behalf) does not consent to the transfer. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of a person acting on his or her behalf). The written document must indicate the person has been informed of the risks and benefits of the transfer and state the reasons for the individual's refusal. The medical record must contain a description of the proposed transfer that was refused by or on behalf of the individual.

(e) *Restricting transfer until the individual is stabilized—*

(1) *General.* If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless—

(i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and

(ii)(A) The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer;

(B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the

- woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or
- (C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.
- (2) A transfer to another medical facility will be appropriate only in those cases in which—
- (i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;
 - (ii) The receiving facility— (A) Has available space and qualified personnel for the treatment of the individual; and (B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment;
 - (iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer; and
 - (iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.
- (3) A participating hospital may not penalize or take adverse action against a physician or a qualified medical person described in paragraph (e)(1)(ii)(C) of this section because the physician or qualified medical person refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized, or against any hospital employee because the employee reports a violation of a requirement of this section.
- (f) *Recipient hospital responsibilities.* A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or, with respect to rural areas, regional referral centers (which, for purposes of this subpart, mean hospitals

meeting the requirements of referral centers found at § 412.96 of this chapter)) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

- (1) The provisions of this paragraph (f) apply to any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.
 - (2) The provisions of this paragraph (f) do not apply to an individual who has been admitted to a referring hospital under the provisions of paragraph (d)(2)(i) of this section.
- (g) *Termination of provider agreement.* If a hospital fails to meet the requirements of paragraph (a) through (f) of this section, CMS may terminate the provider agreement in accordance with § 489.53.
- (h) *Consultation with Quality Improvement Organizations (QIOs)*—
- (1) *General.* Except as provided in paragraph (h)(3) of this section, in cases where a medical opinion is necessary to determine a physician's or hospital's liability under section 1867(d)(1) of the Act, CMS requests the appropriate QIO (with a contract under Part B of title XI of the Act) to review the alleged section 1867(d) violation and provide a report on its findings in accordance with paragraph (h)(2)(iv) and (v) of this section. CMS provides to the QIO all information relevant to the case and within its possession or control. CMS, in consultation with the OIG, also provides to the QIO a list of relevant questions to which the QIO must respond in its report.
 - (2) *Notice of review and opportunity for discussion and additional information.* The QIO shall provide the physician and hospital reasonable notice of its review, a reasonable opportunity for discussion, and an opportunity for the physician and hospital to submit additional information before issuing its report. When a QIO receives a request for consultation under paragraph (h) (1) of this section, the following provisions apply—
 - (i) The QIO reviews the case before the 15th calendar day and makes its tentative findings.
 - (ii) Within 15 calendar days of receiving the case, the QIO gives written notice, sent by certified mail, return receipt requested, to the physician or the hospital (or both if applicable).
 - (iii)(A) The written notice must contain the following information:
 - (1) The name of each individual who may have been the subject of the alleged violation.
 - (2) The date on which each alleged violation occurred.
 - (3) An invitation to meet, either by telephone or in person, to discuss the case with the QIO, and to submit additional information to the QIO within 30 calendar days of receipt of the notice, and a statement that these rights will be waived if the invitation is not accepted. The QIO must receive the information and hold the meeting within the 30-day period.
 - (4) A copy of the regulations at 42 CFR 489.24.

- (B) For purposes of paragraph (h)(2)(iii)(A) of this section, the date of receipt is presumed to be 5 days after the certified mail date on the notice, unless there is a reasonable showing to the contrary.
- (iv) The physician or hospital (or both where applicable) may request a meeting with the QIO. This meeting is not designed to be a formal adversarial hearing or a mechanism for discovery by the physician or hospital. The meeting is intended to afford the physician and/or the hospital a full and fair opportunity to present the views of the physician and/or hospital regarding the case. The following provisions apply to that meeting:
- (A) The physician and/or hospital has the right to have legal counsel present during that meeting. However, the QIO may control the scope, extent, and manner of any questioning or any other presentation by the attorney. The QIO may also have legal counsel present.
- (B) The QIO makes arrangements so that, if requested by CMS or the OIG, a verbatim transcript of the meeting may be generated. If CMS or OIG requests a transcript, the affected physician and/or the affected hospital may request that CMS provide a copy of the transcript.
- (C) The QIO affords the physician and/or the hospital an opportunity to present, with the assistance of counsel, expert testimony in either oral or written form on the medical issues presented. However, the QIO may reasonably limit the number of witnesses and length of such testimony if such testimony is irrelevant or repetitive. The physician and/or hospital, directly or through counsel, may disclose patient records to potential expert witnesses without violating any non-disclosure requirements set forth in part 476 of this chapter.
- (D) The QIO is not obligated to consider any additional information provided by the physician and/or the hospital after the meeting, unless, before the end of the meeting, the QIO requests that the physician and/or hospital submit additional information to support the claims. The QIO then allows the physician and/or the hospital an additional period of time, not to exceed 5 calendar days from the meeting, to submit the relevant information to the QIO.
- (v) Within 60 calendar days of receiving the case, the QIO must submit to CMS a report on the QIO's findings. CMS provides copies to the OIG and to the affected physician and/or the affected hospital. The report must contain the name of the physician and/or the hospital; the name of the individual, and the dates and times the individual arrived at and was transferred (or discharged) from the hospital. The report provides expert medical opinion regarding whether the individual involved had an emergency medical condition, whether the individual's emergency medical condition was stabilized, whether the individual was transferred appropriately, and whether there were any medical utilization or quality of care issues involved in the case.

- (vi) The report required under paragraph (h)(2)(v) of this section should not state an opinion or conclusion as to whether section 1867 of the Act or § 489.24 has been violated.
- (3) If a delay would jeopardize the health or safety of individuals or when there was no screening examination, the QIO review described in this section is not required before the OIG may impose civil monetary penalties or an exclusion in accordance with section 1867(d)(1) of the Act and 42 CFR part 1003 of this title.
- (4) If the QIO determines after a preliminary review that there was an appropriate medical screening examination and the individual did not have an emergency medical condition, as defined by paragraph (b) of this section, then the QIO may, at its discretion, return the case to CMS and not meet the requirements of paragraph (h) except for those in paragraph (h)(2)(v).
 - (i) *Release of QIO assessments.* Upon request, CMS may release a QIO assessment to the physician and/or hospital, or the affected individual, or his or her representative. The QIO physician's identity is confidential unless he or she consents to its release. (See §§ 476.132 and 476.133 of this chapter.)
- (j) *Availability of on-call physicians.* In accordance with the on-call list requirements specified in § 489.20(r)(2), a hospital must have written policies and procedures in place—
 - (1) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control; and
 - (2) To provide that emergency services are available to meet the needs of individuals with emergency medical conditions if a hospital elects to—
 - (i) Permit on-call physicians to schedule elective surgery during the time that they are on call;
 - (ii) Permit on-call physicians to have simultaneous on-call duties; and
 - (iii) Participate in a formal community call plan. Notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to conduct appropriate transfers. The formal community plan must include the following elements:
 - (A) A clear delineation of on-call coverage responsibilities; that is, when each hospital participating in the plan is responsible for on-call coverage.
 - (B) A description of the specific geographic area to which the plan applies.
 - (C) A signature by an appropriate representative of each hospital participating in the plan.
 - (D) Assurances that any local and regional EMS system protocol formally includes information on community on-call arrangements.
 - (E) A statement specifying that even if an individual arrives at a hospital that is not designated as the on-call hospital, that hospital still has an obligation under § 489.24 to provide a medical screening examination and stabilizing treatment within its capability, and that hospitals participating in the community call plan must abide by the regulations under § 489.24 governing appropriate transfers.

(F) An annual assessment of the community call plan by the participating hospitals.

[59 FR 32120, June 22, 1994, as amended at 62 FR 46037, Aug. 29, 1997; 65 FR 18548, Apr. 7, 2000; 65 FR 59748, Oct. 6, 2000; 66 FR 1599, Jan. 9, 2001; 66 FR 59923, Nov. 30, 2001; 68 FR 53262, Sept. 9, 2003; 71 FR 48143, Aug. 18, 2006; 72 FR 47413, Aug. 22, 2007; 73 FR 48758, Aug. 19, 2008; 74 FR 44001, Aug. 27, 2009]
EFFECTIVE DATE NOTE: At 59 FR 32120, June 22, 1994, § 489.24 was added.
Paragraphs (d) and (g) contain information collection and recordkeeping requirements and will not become effective until approval has been given by the Office of Management and Budget.

Centers for Medicare & Medicaid Services, HHS. § 489.24.(2010). Retrieved May 9, 2011, from <http://edocket.access.gpo.gov>

EXHIBIT C

Detailed data showing paid ER Encounters with Different Level of Care on Facility and ER Physician Encounter

Facility Level of Care	Physician Level of Care	AMERIGROUP			Peach State Health Plan			WellCare		
		Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Encounters	Total Facility Payment	Average Paid Per Facility Encounter
Level One	Level Two	1,287	\$78,479.99	\$60.98	2,808	\$152,035.52	\$54.14	4,371	\$278,501.53	\$63.72
Level One	Level Three	4,511	\$261,025.49	\$57.86	5,804	\$339,718.85	\$58.53	14,281	\$1,030,015.19	\$72.12
Level One	Level Four	646	\$37,042.14	\$57.34	877	\$94,482.03	\$107.73	2,278	\$215,505.46	\$94.60
Level One	Level Five	48	\$6,747.91	\$140.58	81	\$16,672.32	\$205.83	164	\$25,765.00	\$157.10
Level One	Trauma Level One	1	\$50.00	\$50.00	3	\$457.19	\$152.40	5	\$1,181.27	\$236.25
Level One	Trauma Level Two	0	\$0.00	\$0.00	1	\$50.00	\$50.00	2	\$102.88	\$51.44
Level Two	Level One	102	\$8,775.01	\$86.03	276	\$19,153.71	\$69.40	480	\$32,495.99	\$67.70
Level Two	Level Three	18,847	\$1,614,848.82	\$85.68	22,920	\$1,697,683.38	\$74.07	52,006	\$3,832,989.21	\$73.70
Level Two	Level Four	4,195	\$534,157.65	\$127.33	4,910	\$639,258.18	\$130.20	13,165	\$1,390,953.32	\$105.66
Level Two	Level Five	366	\$88,138.85	\$240.82	459	\$135,030.37	\$294.18	1,262	\$281,751.85	\$223.26
Level Two	Trauma Level One	7	\$1,185.57	\$169.37	14	\$3,242.03	\$231.57	27	\$4,352.30	\$161.20
Level Two	Trauma Level Two	0	\$0.00	\$0.00	1	\$1,865.17	\$1,865.17	3	\$169.00	\$56.33
Level Three	Level One	59	\$8,161.82	\$138.34	298	\$29,018.07	\$97.38	349	\$33,863.49	\$97.03
Level Three	Level Two	1,560	\$226,992.65	\$145.51	3,311	\$391,846.91	\$118.35	5,481	\$613,961.96	\$112.02
Level Three	Level Four	11,009	\$2,313,051.18	\$210.11	11,830	\$1,929,638.38	\$163.11	28,020	\$4,001,556.77	\$142.81

Detailed data showing paid ER Encounters with Different Level of Care on Facility and ER Physician Encounter

Facility Level of Care	Physician Level of Care	AMERIGROUP			Peach State Health Plan			WellCare		
		Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Encounters	Total Facility Payment	Average Paid Per Facility Encounter
Level Three	Level Five	1,479	\$562,534.35	\$380.35	1,747	\$638,072.70	\$365.24	4,454	\$1,148,366.39	\$257.83
Level Three	Trauma Level One	35	\$15,152.73	\$432.94	35	\$18,691.16	\$534.03	64	\$18,832.03	\$294.25
Level Three	Trauma Level Two	1	\$1,166.44	\$1,166.44	4	\$606.57	\$151.64	3	\$381.39	\$127.13
Level Four	Level One	33	\$7,223.89	\$218.91	106	\$20,416	\$193	117	\$19,235.65	\$164.41
Level Four	Level Two	256	\$72,941.59	\$284.93	691	\$170,048	\$246	1,066	\$220,902.52	\$207.23
Level Four	Level Three	3,927	\$1,048,698.81	\$267.05	4,962	\$1,254,527	\$253	9,641	\$1,792,379.23	\$185.91
Level Four	Level Five	2,816	\$1,514,046.99	\$537.66	2,966	\$1,394,220	\$470	7,716	\$3,069,846.75	\$397.85
Level Four	Trauma Level One	68	\$46,219.32	\$679.70	71	\$47,834	\$674	182	\$87,532.53	\$480.95
Level Four	Trauma Level Two	3	\$1,410.41	\$470.14	0	\$0	\$0	8	\$6,364.85	\$795.61
Level Five	Level One	4	\$1,899.08	\$474.77	9	\$3,360.53	\$373.39	17	\$6,245.32	\$367.37
Level Five	Level Two	62	\$32,244.85	\$520.08	124	\$56,061.03	\$452.11	248	\$91,381.36	\$368.47
Level Five	Level Three	610	\$369,460.35	\$605.67	870	\$514,659.71	\$591.56	1,504	\$542,475.25	\$360.69
Trauma Level One	Level One	0	\$0.00	\$0.00	0	\$0.00	\$0.00	1	\$1,090.04	\$1,090.04

Detailed data showing paid ER Encounters with Different Level of Care on Facility and ER Physician Encounter

Facility Level of Care	Physician Level of Care	AMERIGROUP			Peach State Health Plan			WellCare		
		Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Encounters	Total Facility Payment	Average Paid Per Facility Encounter
Trauma Level One	Level Two	1	\$276.18	\$276.18	4	\$4,139.71	\$1,034.93	6	\$4,462.10	\$743.68
Trauma Level One	Level Three	22	\$28,696.54	\$1,304.39	27	\$34,266.58	\$1,269.13	48	\$49,816.18	\$1,037.84
Trauma Level One	Level Four	47	\$67,987.36	\$1,446.54	48	\$66,846.78	\$1,392.64	146	\$142,096.04	\$973.26
Trauma Level One	Level Five	67	\$95,599.95	\$1,426.86	64	\$115,491.69	\$1,804.56	122	\$153,827.28	\$1,260.88
Trauma Level One	Trauma Level Two	0	\$0.00	\$0.00	0	\$0.00	\$0.00	0	\$0.00	\$0.00
Trauma Level Two	Level One	0	\$0.00	\$0.00	0	\$0.00	\$0.00	0	\$0.00	\$0.00
Trauma Level Two	Level Two	0	\$0.00	\$0.00	0	\$0.00	\$0.00	0	\$0.00	\$0.00
Trauma Level Two	Level Three	1	\$20.03	\$20.03	1	\$0.00	\$0.00	0	\$0.00	\$0.00
Trauma Level Two	Level Four	0	\$0.00	\$0.00	1	\$1,324.04	\$1,324.04	1	\$235.00	\$235.00
Trauma Level Two	Level Five	0	\$0.00	\$0.00	0	\$0.00	\$0.00	0	\$0.00	\$0.00
Trauma Level Two	Trauma Level One	1	\$245.51	\$245.51	1	\$5,422.21	\$5,422.21	1	\$2,624.32	\$2,624.32

Detailed data showing paid ER Encounters with Different Level of Care on Facility and ER Physician Encounter

Facility Level of Care	Physician Level of Care	AMERIGROUP			Peach State Health Plan			WellCare		
		Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Encounters	Total Facility Payment	Average Paid Per Facility Encounter
No Level of Care Provided	Level One	2	\$314.26	\$157.13	122	\$6,138.20	\$50.31	13	\$1,746.31	\$134.33
No Level of Care Provided	Level Two	84	\$19,772.36	\$235.39	246	\$37,376.87	\$151.94	252	\$50,890.98	\$201.95
No Level of Care Provided	Level Three	474	\$83,466.16	\$176.09	876	\$142,774.99	\$162.99	785	\$135,134.01	\$172.15
No Level of Care Provided	Level Four	183	\$40,121.48	\$219.24	484	\$93,674.05	\$193.54	336	\$80,708.03	\$240.20
No Level of Care Provided	Level Five	31	\$18,670.64	\$602.28	84	\$66,134.64	\$787.32	69	\$72,870.72	\$1,056.10
No Level of Care Provided	Trauma Level One	7	\$1,701.73	\$243.10	3	\$2,436.19	\$812.06	7	\$5,334.65	\$762.09
No Level of Care Provided	Trauma Level Two	0	\$0.00	\$0.00	0	\$0.00	\$0.00	1	\$165.00	\$165.00
Totals		54,654	\$10,336,911.84	\$189.13	69,275	\$11,384,135.77	\$164.33	152,822	\$21,181,655.88	\$138.60

EXHIBIT D

Both Facility and Corresponding Physician Claims Denied

Facility Level of Care	Physician Level of Care	Peach State		
		AMERIGROUP Encounters	Health Plan Encounters	WellCare Encounters
Level One	Level One	2	46	24
Level One	Level Two	16	47	77
Level One	Level Three	52	73	316
Level One	Level Four	9	3	55
Level One	Level Five	3	2	3
Level One	Trauma Level One	0	0	0
Level One	Trauma Level Two	0	0	0
Level Two	Level One	3	8	18
Level Two	Level Two	38	169	243
Level Two	Level Three	195	347	1,038
Level Two	Level Four	71	62	270
Level Two	Level Five	8	4	45
Level Two	Trauma Level One	0	0	1
Level Two	Trauma Level Two	0	0	0
Level Three	Level One	3	14	3

Both Facility and Corresponding Physician Claims Denied

Facility Level of Care	Physician Level of Care	Peach State		
		AMERIGROUP Encounters	Health Plan Encounters	WellCare Encounters
Level Three	Level Two	15	50	110
Level Three	Level Three	321	579	1,476
Level Three	Level Four	143	181	578
Level Three	Level Five	16	21	108
Level Three	Trauma Level One	2	0	2
Level One	Trauma Level Two	0	0	0
Level Four	Level One	0	6	3
Level Four	Level Two	7	9	25
Level Four	Level Three	51	68	212
Level Four	Level Four	108	153	404
Level Four	Level Five	43	49	146
Level Four	Trauma Level One	0	0	2
Level Two	Trauma Level Two	0	0	0
Level Five	Level One	0	0	0
Level Five	Level Two	6	1	10
Level Five	Level Three	11	10	51

Both Facility and Corresponding Physician Claims Denied

Facility Level of Care	Physician Level of Care	Peach State		
		AMERIGROUP Encounters	Health Plan Encounters	WellCare Encounters
Level Five	Level Four	13	25	106
Level Five	Level Five	32	31	99
Level Five	Trauma Level One	1	0	5
Level Five	Trauma Level Two	0	1	3
Trauma Level One	Level One	0	0	0
Trauma Level One	Level Two	0	0	0
Trauma Level One	Level Three	1	0	4
Trauma Level One	Level Four	2	0	4
Trauma Level One	Level Five	1	0	5
Trauma Level One	Trauma Level One	0	2	3
Trauma Level One	Trauma Level Two	0	0	0
Trauma Level Two	Level One	0	0	0
Trauma Level Two	Level Two	0	0	0
Trauma Level Two	Level Three	0	0	0
Trauma Level Two	Level Four	0	0	0

Both Facility and Corresponding Physician Claims Denied

Facility Level of Care	Physician Level of Care	Peach State		
		AMERIGROUP Encounters	Health Plan Encounters	WellCare Encounters
Trauma Level Two	Level Five	0	0	0
Trauma Level Two	Trauma Level One	0	0	0
Trauma Level Two	Trauma Level Two	0	0	0
No Level of Care Provided	Level One	3	4	0
No Level of Care Provided	Level Two	22	4	10
No Level of Care Provided	Level Three	8	22	26
No Level of Care Provided	Level Four	3	9	10
No Level of Care Provided	Level Five	0	1	0
No Level of Care Provided	Trauma Level One	0	0	0
No Level of Care Provided	Trauma Level Two	0	0	0
Totals:		1,209	2,001	5,495

EXHIBIT E

Detailed data on Denied Physician Encounters with Paid Facility Encounters

Facility Level of Care	Physician Level of Care	AMERIGROUP			Peach State Health Plan			WellCare		
		Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Encounters	Total Facility Payment	Average Paid Per Facility Encounter
Level One	Level One	6	330	55.00	87	\$3,261.84	\$37.49	24	\$1,445.17	\$60.22
Level One	Level Two	51	\$4,073.78	\$79.88	68	\$3,652.21	\$53.71	113	\$8,564.99	\$75.80
Level One	Level Three	140	\$10,510.45	\$75.07	140	\$8,355.90	\$59.69	246	\$16,669.12	\$67.76
Level One	Level Four	9	\$605.90	\$67.32	18	\$2,622.02	\$145.67	42	\$2,532.81	\$60.31
Level One	Level Five	3	\$130.17	\$43.39	1	\$44.00	\$44.00	0	\$0.00	\$0.00
Level One	Trauma Level One	0	\$0.00	\$0.00	0	\$0.00	\$0.00	0	\$0.00	\$0.00
Level One	Trauma Level Two	0	\$0.00	\$0.00	1	\$50.00	\$50.00	0	\$0.00	\$0.00
Level Two	Level One	8	\$1,214.91	\$151.86	9	\$721.37	\$80.15	17	\$1,371.93	\$80.70

Detailed data on Denied Physician Encounters with Paid Facility Encounters

Facility Level of Care	Physician Level of Care	AMERIGROUP			Peach State Health Plan			WellCare		
		Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Encounters	Total Facility Payment	Average Paid Per Facility Encounter
Level Two	Level Two	137	\$13,204.03	\$96.38	220	\$21,279.75	\$96.73	288	\$27,345.62	\$94.95
Level Two	Level Three	643	\$61,176.17	\$95.14	428	\$34,589.39	\$80.82	897	\$69,831.71	\$77.85
Level Two	Level Four	129	\$15,893.05	\$123.20	107	\$15,489.49	\$144.76	247	\$26,858.15	\$108.74
Level Two	Level Five	12	\$1,861.00	\$155.08	12	\$5,381.19	\$448.43	24	\$4,234.53	\$176.44
Level Two	Trauma Level One	0	\$0.00	\$0.00	0	\$0.00	\$0.00	0	\$0.00	\$0.00
Level Two	Trauma Level Two	0	\$0.00	\$0.00	0	\$0.00	\$0.00	2	\$100.00	\$50.00
Level Three	Level One	2	\$667.13	\$333.57	4	\$519.97	\$129.99	12	\$1,193.24	\$99.44
Level Three	Level Two	38	\$5,702.12	\$150.06	64	\$10,904.43	\$170.38	157	\$20,852.58	\$132.82
Level Three	Level Three	677	\$112,961.14	\$166.86	662	\$88,342.09	\$133.45	1,209	\$154,075.91	\$127.44

Detailed data on Denied Physician Encounters with Paid Facility Encounters

Facility Level of Care	Physician Level of Care	AMERIGROUP			Peach State Health Plan			WellCare		
		Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Encounters	Total Facility Payment	Average Paid Per Facility Encounter
Level Three	Level Four	289	\$73,177.89	\$253.21	263	\$48,606.66	\$184.82	503	\$76,372.76	\$151.83
Level Three	Level Five	47	\$17,252.74	\$367.08	36	\$14,634.58	\$406.52	84	\$24,944.72	\$296.96
Level Three	Trauma Level One	0	\$0.00	\$0.00	1	\$50.00	\$50.00	2	\$415.43	\$207.72
Level Three	Trauma Level Two	0	\$0.00	\$0.00	0	\$0.00	\$0.00	0	\$0.00	\$0.00
Level Four	Level One	0	\$0.00	\$0.00	2	\$186.20	\$93.10	1	\$84.97	\$84.97
Level Four	Level Two	11	\$3,100.51	\$281.86	3	\$643.04	\$214.35	28	\$9,359.48	\$334.27
Level Four	Level Three	91	\$24,464.87	\$268.84	56	\$16,783.88	\$299.71	154	\$29,554.43	\$191.91
Level Four	Level Four	197	\$77,983.16	\$395.85	194	\$67,549.11	\$348.19	276	\$71,537.86	\$259.20
Level Four	Level Five	76	\$50,038.06	\$658.40	57	\$32,214.75	\$565.17	122	\$67,329.20	\$551.88
Level Four	Trauma Level One	2	\$1,094.36	\$547.18	2	\$1,130.37	\$565.19	5	\$1,040.78	\$208.16

Detailed data on Denied Physician Encounters with Paid Facility Encounters

Facility Level of Care	Physician Level of Care	AMERIGROUP			Peach State Health Plan			WellCare		
		Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Encounters	Total Facility Payment	Average Paid Per Facility Encounter
Level Four	Trauma Level Two	0	\$0.00	\$0.00	0	\$0.00	\$0.00	0	\$0.00	\$0.00
Level Five	Level One	0	\$0.00	\$0.00	0	\$0.00	\$0.00	0	\$0.00	\$0.00
Level Five	Level Two	0	\$0.00	\$0.00	1	\$250.22	\$250.22	5	\$1,330.21	\$266.04
Level Five	Level Three	9	\$4,186.20	\$465.13	6	\$3,564.91	\$594.15	34	\$14,651.51	\$430.93
Level Five	Level Four	19	\$11,046.81	\$581.41	20	\$11,852.44	\$592.62	60	\$23,493.80	\$391.56
Level Five	Level Five	37	\$23,075.96	\$623.67	35	\$24,050.61	\$687.16	59	\$39,371.09	\$667.31
Level Five	Trauma Level One	6	\$2,036.23	\$339.37	1	\$233.51	\$233.51	2	\$1,400.00	\$700.00
Level Five	Trauma Level Two	0	\$0.00	\$0.00	1	\$0.00	\$0.00	0	\$0.00	\$0.00
Trauma Level One	Level One	0	\$0.00	\$0.00	0	\$0.00	\$0.00	0	\$0.00	\$0.00

Detailed data on Denied Physician Encounters with Paid Facility Encounters

Facility Level of Care	Physician Level of Care	AMERIGROUP			Peach State Health Plan			WellCare		
		Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Encounters	Total Facility Payment	Average Paid Per Facility Encounter
Trauma Level One	Level Two	0	\$0.00	\$0.00	0	\$0.00	\$0.00	0	\$0.00	\$0.00
Trauma Level One	Level Three	1	\$1,396.50	\$1,396.50	0	\$0.00	\$0.00	4	\$4,208.78	\$1,052.20
Trauma Level One	Level Four	1	\$690.00	\$690.00	0	\$0.00	\$0.00	14	\$9,277.20	\$662.66
Trauma Level One	Level Five	1	\$2,992.05	\$2,992.05	1	\$1,852.36	\$1,852.36	5	\$1,521.82	\$304.36
Trauma Level One	Trauma Level One	0	\$0.00	\$0.00	0	\$0.00	\$0.00	1	\$1,473.14	\$1,473.14
Trauma Level One	Trauma Level Two	0	\$0.00	\$0.00	0	\$0.00	\$0.00	0	\$0.00	\$0.00
Trauma Level Two	Level One	0	\$0.00	\$0.00	0	\$0.00	\$0.00	0	\$0.00	\$0.00
Trauma Level Two	Level Two	0	\$0.00	\$0.00	0	\$0.00	\$0.00	0	\$0.00	\$0.00
Trauma Level Two	Level Three	0	\$0.00	\$0.00	0	\$0.00	\$0.00	0	\$0.00	\$0.00

Detailed data on Denied Physician Encounters with Paid Facility Encounters

Facility Level of Care	Physician Level of Care	AMERIGROUP			Peach State Health Plan			WellCare		
		Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Encounters	Total Facility Payment	Average Paid Per Facility Encounter	Encounters	Total Facility Payment	Average Paid Per Facility Encounter
Trauma Level Two	Level Four	0	\$0.00	\$0.00	0	\$0.00	\$0.00	0	\$0.00	\$0.00
Trauma Level Two	Level Five	0	\$0.00	\$0.00	0	\$0.00	\$0.00	0	\$0.00	\$0.00
Trauma Level Two	Trauma Level One	0	\$0.00	\$0.00	0	\$0.00	\$0.00	0	\$0.00	\$0.00
Trauma Level Two	Trauma Level Two	0	\$0.00	\$0.00	0	\$0.00	\$0.00	0	\$0.00	\$0.00
No Level of Care Provided	Level One	0	\$0.00	\$0.00	13	\$803.89	\$61.84	4	\$1,045.33	\$261.33
No Level of Care Provided	Level Two	6	\$1,369.11	\$228.19	13	\$2,944.52	\$226.50	29	\$6,565.81	\$226.41
No Level of Care Provided	Level Three	21	\$3,397.24	\$161.77	27	\$6,825.23	\$252.79	55	\$10,542.36	\$191.68
No Level of Care Provided	Level Four	5	\$2,108.13	\$421.63	17	\$3,213.71	\$189.04	23	\$6,364.87	\$276.73
No Level of Care Provided	Level Five	2	\$1,054.23	\$527.12	4	\$10,889.22	\$2,722.31	5	\$4,634.99	\$927.00
No Level of Care Provided	Trauma Level One	0	\$0.00	\$0.00	0	\$0.00	\$0.00	0	\$0.00	\$0.00
Totals:		2,676	\$528,793.90	\$197.61	2,574	\$443,492.86	\$172.30	4,753	\$741,596.30	\$156.03

EXHIBIT F

Detailed data showing where ER physician claim was paid and the corresponding facility was denied

Facility Level of Care	Physician Level of Care	AMERIGROUP Encounters	Peach State Health Plan Encounters	WellCare Encounters
Level One	Level One	3	13	11
Level One	Level Two	34	16	116
Level One	Level Three	107	49	394
Level One	Level Four	13	15	77
Level One	Level Five	1	0	8
Level One	Trauma Level One	0	0	0
Level One	Trauma Level Two	0	0	0
Level Two	Level One	5	1	15
Level Two	Level Two	58	44	300
Level Two	Level Three	260	121	1,369
Level Two	Level Four	66	47	396
Level Two	Level Five	11	8	53
Level Two	Trauma Level One	0	0	0
Level Two	Trauma Level Two	0	0	0
Level Three	Level One	1	2	10
Level Three	Level Two	18	18	140
Level Three	Level Three	396	167	1,907
Level Three	Level Four	178	92	893
Level Three	Level Five	42	19	181
Level Three	Trauma Level One	1	0	1
Level Three	Trauma Level Two	0	0	0

Detailed data showing where ER physician claim was paid and the corresponding facility was denied

Facility Level of Care	Physician Level of Care		AMERIGROUP Encounters	Peach State Health Plan Encounters	WellCare Encounters
Level Four	Level One		2	1	2
Level Four	Level Two		5	4	35
Level Four	Level Three		57	36	350
Level Four	Level Four		153	68	638
Level Four	Level Five		58	30	303
Level Four	Trauma Level One		4	0	8
Level Four	Trauma Level Two		0	0	1
Level Five	Level One		0	0	0
Level Five	Level Two		6	2	19
Level Five	Level Three		10	5	78
Level Five	Level Four		33	10	211
Level Five	Level Five		90	25	247
Level Five	Trauma Level One		12	3	14
Level Five	Trauma Level Two		0	1	0
Trauma Level One	Level One		0	0	0
Trauma Level One	Level Two		0	0	0
Trauma Level One	Level Three		0	0	0
Trauma Level One	Level Four		0	0	8
Trauma Level One	Level Five		1	0	11
Trauma Level One	Trauma Level One		5	3	9
Trauma Level One	Trauma Level Two		0	0	0
Trauma Level Two	Level One		0	0	0

Detailed data showing where ER physician claim was paid and the corresponding facility was denied

Facility Level of Care	Physician Level of Care		AMERIGROUP Encounters	Peach State Health Plan Encounters	WellCare Encounters
Trauma Level Two	Level Two		0	0	0
Trauma Level Two	Level Three		0	0	0
Trauma Level Two	Level Four		0	0	0
Trauma Level Two	Level Five		0	0	0
Trauma Level Two	Trauma Level One		0	0	0
Trauma Level Two	Trauma Level Two		0	0	0
No Level of Care Provided	Level One		1	3	2
No Level of Care Provided	Level Two		61	12	18
No Level of Care Provided	Level Three		170	82	43
No Level of Care Provided	Level Four		112	30	32
No Level of Care Provided	Level Five		46	3	14
No Level of Care Provided	Trauma Level One		2	0	0
No Level of Care Provided	Trauma Level Two		0	0	0
Totals			2,022	930	7,914

EXHIBIT G

AMERIGROUP's responses to Processing of Emergency Room Claims

Date: March 15, 2011

To: Jeanne Broudy
AVP, Regulatory Services
AMERIGROUP Corporation

From: Alicia Jansen

Copy: Beverly Kelly

Re: **Processing of Emergency Room Claims**

Jeanne – Please review the questions below and provide a detailed response for each. Thank you.

- 1) Describe each step in the process for an ER claim once it is received by AMERIGROUP. Any outpatient hospital claim we receive with Revenue Code 450 is auto-adjudicated based on diagnosis. If the diagnosis is not on our approved ER diagnosis list then claim is paid at triage rate and plan will request the provider to submit medical records for further review. If it does have a diagnosis that matches our diagnosis list then claim is paid at contracted rate.

- 2) Does AMERIGROUP use a list of diagnoses or symptoms to identify emergent conditions for payment purposes? YES
 - a) If so, are you using DCH's version or your own? Amerigroup uses a DCH approved diagnosis list

 - b) Are there CPT codes on the list? NO, ICD-9 Codes only

- c) For a claim that does not have an “autopayable” diagnosis, what process does the claim go through? We do not pend ER claims for review.
- 3) Please describe how AMERIGROUP applies prudent layperson criteria when adjudicating claims. Please describe the staff resources and qualifications used in this process. These claims are reviewed by Nurse Reviewers and/or Medical Director based on medical records submitted by the hospital, clinical protocols and as directed in our DCH contract.
- 4) In processing claims for emergency health care services, do you consider the following criteria:
- (1) The age of the patient; YES
 - (2) The time and day of the week the patient presented for services; NO
 - (3) The severity and nature of the presenting symptoms; YES
 - (4) The patient’s initial and final diagnosis; YES
 - (5) Any other criteria prescribed by the Department of Community Health, including criteria specific to patients under 18 years of age. YES

If so, please describe how AMERIGROUP applies the above listed criteria when adjudicating claims.

- 5) How is your claims system programmed to consider any of the above criteria listed in Question 4?

Our system determines the nature of the Emergency based on diagnosis. If it is considered a non-emergent diagnosis the Triage rate will be reimbursed, else contracted ER Level rates will apply.

- 6) Please describe your policy for processing ER claims where the emergency health care services or post-stabilization services were provided by a noncontracted provider.

Amerigroup will reimburse Non-par providers based on the same clinical criteria and DCH Reimbursement rate.

Peach State Health Plan's responses to Processing of Emergency Room Claims

Date: March 22, 2011

To: Alicia Jansen
Myers & Stauffer

From: Peach State Health Plan

Copy: Beverly Kelly

Re: Processing of Emergency Room Claims

Ms. Jansen,

Please find below a list of the questions posed in your letter dated March 15, 2011 and the corresponding answers.

1) Describe each step in the process for an ER claim once it is received by Peach State Health Plan.

When Peach State Health Plan (Peach State) receives the claims, they are entered into the Plan's claims data system (Amisys). After they are entered, the ER claims are reviewed according to the Plan's established policies (see attached – CC.CLMS.07.86, CC.UM.12.03 and CC.UM.12.05). If the claim(s) meet emergent ER criteria, the claim will be processed according to the fee schedule or contracted rate. If the claim(s) does not meet emergent ER criteria, the claim will be processed at the triage rate.

2) Does Peach State Health Plan use a list of diagnoses or symptoms to identify emergent conditions for payment purposes?

Peach State Health Plan uses an "autopay" index of ICD-9 diagnosis codes that are always considered to be emergent to identify emergent conditions for payment purposes. Medical records are also reviewed when submitted by the provider.

a) If so, are you using DCH's version or your own?

Not applicable

b) Are there CPT codes on the list?

Not applicable

c) For a claim that does not have an “autopayable” diagnosis, what process does the claim go through?

For claims that do not have an “autopayable” diagnosis, Peach State will review medical records in conjunction with the Prudent Lay Person Standard, set forth in Peach State’s contract with DCH, to determine whether the case meets emergent ER criteria. If the diagnoses contained on the claim are not emergent and if medical records were not received, the claim will be processed at the triage rate.

3) Please describe how Peach State Health Plan applies prudent layperson criteria when adjudicating claims. Please describe the staff resources and qualifications used in this process.

Five (5) designated associates within Peach State’s Medical Review Unit (MRU) who possess an average knowledge of health and medicine are responsible for applying the prudent layperson (PLP) criteria to ER claims. The PLP process and the claims process are coordinated processes between the MRU and Claims departments to allow for claim adjudication. The responsibilities of the MRU for PLP review of ED claims include:

- a. Review of the submitted ED record to determine severity of symptoms at time of presentation.
- b. Application of the PLP Definition of Emergency
- c. Making a determination of whether the PLP Definition of Emergency has been met
- d. Communication of PLP determination to the Claims department
- e. Issuance of any letters associated with the PLP determination of “not met”

Please see policy CC.UM.12.03 for an outline of the detailed process. GA ED PLP HB1234 language: 'Emergency services' or 'Emergency care' means those health services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

- (A) Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy.
- (B) Serious impairment to bodily functions; or
- (C) Serious dysfunction of any bodily organ or part

Other emergency situations as stated in the Medicaid managed care contract include:

- Serious harm to self or others due to alcohol or drug abuse emergency;
- Injury to self or bodily harm to others; or
- With respect to pregnant woman having contractions:
 - (i) That there is adequate time to affect a safe transfer to another hospital before delivery; or
 - (ii) That transfer may pose a threat to the health or safety of the woman or unborn child

4) In processing claims for emergency health care services, do you consider the following criteria:

- (1) The age of the patient;**
- (2) The time and day of the week the patient presented for services;**
- (3) The severity and nature of the presenting symptoms;**
- (4) The patient's initial and final diagnosis;**
- (5) Any other criteria prescribed by the Department of Community Health, including criteria specific to patients under 18 years of age.**

Yes, Peach State considers all of the above mentioned criteria in the processing of claims for emergency health care services.

If so, please describe how Peach State Health Plan applies the above listed criteria when adjudicating claims.

In accordance with MRU Analyst Process F (see policy CC.UM.12.03), the MRU Analyst will review the claim with consideration of the **1)** time the patient was presented at the ER, **2)** the day the patient was presented at the ER (weekday or weekend), **3)** the age of the patient, **4)** the patient's chief complaint, **5)** the onset of the symptoms and **6)** the severity of the patient's symptoms. After reviewing these facts, the MRU Analyst will make a PLP determination. Based on that determination, the analyst selects Pay or Deny. Pay should be selected if the reviewer feels the provided information meets the PLP definition of an emergency or urgent medical problem. Deny should be selected if the reviewer feels that, based on the provided information, the definition of PLP has not been met.

5) How is your claims system programmed to consider any of the above criteria listed in Question 4?

Peach State's system is configured to recognize emergency related diagnosis codes and will process claims according to the applicable fee schedule or contracted rate. Claims which have non-emergency related diagnosis codes require diagnosis review to determine if the PLP criteria have been met.

6) Please describe your policy for processing ER claims where the emergency health care services or post-stabilization services were provided by a noncontracted provider.

Non-participating providers are subject to the same process as participating providers.

WellCare's responses to Processing of Emergency Room Claims

Date: March 15, 2011

To: Joshua Luft

WellCare of Georgia

From: Alicia Jansen

Copy: Beverly Kelly

Re: Processing of Emergency Room Claims

Joshua – Please review the questions below and provide a detailed response for each. Thank you.

1) Describe each step in the process for an ER claim once it is received by WellCare.

As cited from WellCare of GA's P&P for Emergency Room & Urgent Care Services: "In processing claims for emergency health care services, WellCare of GA shall consider, at the time that a claim is submitted, at least the following criteria:

- a. The age of the patient
- b. The time and day of the week the patient presented for services
- c. The severity and nature of the presenting symptoms
- d. The patient's initial and final diagnosis;
- e. Any other criteria prescribed by DCH, including criteria specific to patients less than 18 years of age."

2) Does WellCare use a list of diagnoses or symptoms to identify emergent conditions for payment purposes?

a) If so, are you using DCH's version or your own?

b) Are there CPT codes on the list?

c) For a claim that does not have an "autopayable" diagnosis, what process does the claim go through?

WellCare has developed an automated presumptive list of DX codes that does not limit what will be considered an emergent condition, but instead presumptively or automatically treats certain claims as an emergency condition. This facilitates automated, systematic payment of a claim at the ER rate. Without using a listing of DX codes, there will always be claims that are truly emergent in nature, as defined by the PLP standard, that the system cannot determine as such given the parameters submitted by the provider on the claim.

- 3) Please describe how WellCare applies prudent layperson criteria when adjudicating claims. Please describe the staff resources and qualifications used in this process.

WellCare of Georgia's Prudent Layperson Standard is defined as, "An Emergency or Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- a. placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- b. serious impairment to bodily functions;
- c. serious dysfunction of any bodily organ or part;
- d. serious harm to self or others due to an alcohol or drug abuse emergency;
- e. injury to self or bodily harm to others; or
- f. with respect to a pregnant woman having contractions;
 - i. that there is adequate time to effect a safe transfer to another hospital before delivery, or
 - ii. that transfer may pose a threat to the health or safety of the woman or the unborn child.

A physician or other appropriate practitioner reviews presenting symptoms as well as the discharge diagnosis for emergency services. WellCare of Georgia has three (3) nurses, three (3) coordinators/support staff and 2 (two) Medical Doctors staffed for this review process.

- 4) In processing claims for emergency health care services, do you consider the following criteria:
- (1) The age of the patient;
 - (2) The time and day of the week the patient presented for services;
 - (3) The severity and nature of the presenting symptoms;

- (4) The patient's initial and final diagnosis;
- (5) Any other criteria prescribed by the Department of Community Health,
including criteria specific to patients under 18 years of age.

If so, please describe how WellCare applies the above listed criteria when adjudicating claims.

In the adjudication of claims, including reconsideration, WellCare considers all the criteria listed above. WellCare has enhanced our automated presumptive list of DX codes that does not limit what will be considered an emergent condition, but instead presumptively or automatically treats certain claims as emergency condition by taking in to account the criteria as per HB1234.

- 5) How is your claims system programmed to consider any of the above criteria listed in Question 4?

Claims are first reviewed based on the presumptive list, considering criteria listed above. Our system auto adjudicates based on the criteria presented on the claim and can be reviewed retrospectively based on supporting documentation from the medical record. Medical records submitted by the provider are used to consider additional detail not captured on the submitted claim.

- 6) Please describe your policy for processing ER claims where the emergency health care services or post-stabilization services were provided by a noncontracted provider.

It is the policy of WellCare Health Plans, Inc. (the "Company") that a member has post stabilization services available, without authorization up to the point where the Company is notified that the member is stable, regardless of whether the member obtains the service within or outside of the Company's network.

Please refer to WellCare's policy "Coverage of Post-Stabilization Services", Policy Number C7UM MD-6.2 for further detail regarding post-stabilization services.