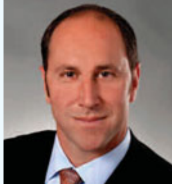
LETTER FROM THE EDITOR-IN-CHIEF

The ED Utilization Debate: Can a Shell-Game Redirect the Scrutiny?



You might not expect one of our most prestigious medical journals to be susceptible to scientific sleight of hand. But the *JAMA* editorial board apparently fell victim to just that in publishing the latest in a string of self-serving, extraordinarily biased "studies" supported by the American College of Emergency Physicians (ACEP), entitled "Comparison of Presenting Complaint vs Discharge Diagnosis for Identifying "Nonemergency" Emergency Department Visits." The study's objective was to determine if there is concordance between presenting complaint and discharge diagnosis for emergency department (ED) visits. If not, the authors would conclude that discharge diagnosis should not be used as a premise for reimbursement.

The study was a response to efforts by several state legislatures to control Medicaid costs by limiting coverage for inappropriate ED use. Federal agencies' use of "discharge diagnosis" as the basis for determining need for emergency services has led to the complaint that such a diagnosis is frequently discordant with the presenting complaint and should not be used to determine payment. Led by current and former "consultants" to ACEP, the *JAMA* authors designed a study with limited definitions that ensured that the results would support a predetermined agenda. How did they do that without catching the eye of peer reviewers and *JAMA*'s editorial board? By allowing for only two potential case outcomes: 100% primary care treatable or 100% appropriate for emergency care.

While there are allusions to things like x-rays, "testing" and hours, no specifics are given as to how a case was determined to be 100% primary care treatable. Similarly, no such definitions or alternatives were applied to the "Emergency Appropriate" group. For this study, patients were judged 100% ED appropriate if they had a problem that was not 100% primary care treatable (100% of the time) OR they presented with any complaint deemed emergency appropriate regardless of final diagnosis. Under the predetermined definitions, a case was ED-appropriate if the complaint was ED-reasonable or required x-rays, or "testing", or was not typically treated in a primary care setting (think lacerations), or there was zero likelihood that the problem could be treated in "primary care."

Urgent care was completely ignored, despite the fact that it is the most sensible comparison group given hours of operation, scope of services, and x-ray and lab capabilities. And let's not forget the specialty's national presence, representation in nearly every community, and provision of annual visits in numbers that approach those for emergency medicine (EM). The authors concluded that because more than 99% of ED visits are not "100% primary care treatable" and/or present with complaints deemed "emergency worthy" regardless of discharge diagnosis, then any attempt to reduce payment based on these factors is unfounded. Any self-respecting emergency physician would simply giggle at the thought that fewer than 1% of cases could be treated elsewhere in a more cost-effective way.

This is not the first time that data from the National Hospital Ambulatory Medical Care Survey (NHAMCS) have been manipulated for self-serving benefit. In the last year, several studies with ACEP connections have been published that interpret the NHAMCS data as demonstrating that EDs are appropriately used and no cost-savings would be realized with a policy of redirecting care to more cost-effective options. None of these studies have even mentioned "urgent care," but how can we have a reasonable and honest dialogue about alternative, more cost-effective acute care options *without* a discussion about urgent care's role?

I personally respect and support our EM colleagues and the critical work they do. I also feel quite strongly that they are underpaid for work that really matters and overpaid for care that can obviously be treated elsewhere more efficiently. To be honest about the issue of appropriate use and distribution of finite healthcare dollars, we must move away from protectionism and studies with predetermined outcomes. No one on this planet can say with a straight face that only 1% of ED visits can or should be treated elsewhere. ■

Lee A. Resnick, MD
Editor-in-Chief
JUCM, The Journal of Urgent Care Medicine