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DOCTORS



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A Letter from the Chair of the Board

Proposed EMTALA Changes Impact the Medical Staff

Dear Colleague:

A number of proposed changes are being considered for the Emergency Medical Treatment and Active Labor Act (EMTALA). It is important that you understand what those changes are because the day-to-day business of carrying out the duties and responsibilities underlying the EMTALA regulations falls on you, whether you are a physician in an Emergency Department or an independent physician seeing patients in an on-call situation. This issue of the newsletter will walk you through those changes and their impact upon you so that you can comply with these regulations and limit your liability exposure.

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Chair of the Board

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If what is proposed is finalized, certain problem regulations governing the Emergency Medical Treatment and Active Labor Act (EMTALA) will change. The proposals are part of the proposed hospital inpatient prospective payment rule published on May 9, 2002 in the *Federal Register*; 67 Fed. Reg. 31,402. Staff of the Centers for Medicare and Medicaid Services ("CMS") of the U. S. Department of Health and Human Services says that the final rules should be out sometime this summer. A number of the hot spots to be addressed in the final rules have implications for the hospital's medical staff.

- **Meaning of "Comes to the Emergency Department."** In the proposed rule, CMS clarifies that a hospital is required to provide a medical screening examination and stabilizing treatment to any individual who presents to a "Dedicated Emergency Department" seeking examination or treatment for *any* medical condition. Those presenting elsewhere in the hospital or on hospital property only trigger EMTALA if they are seeking medical treatment for what they -- or a prudent layperson observer -- perceive to be an emergency medical condition. The proposed rule defines a "Dedicated Emergency Department" as "a specially equipped and staffed area of the hospital that is used a significant portion of the time for the initial evaluation and treatment of outpatients for emergency medical conditions," whether or not the area is on the main hospital campus or off that campus but treated by Medicare as a department of the hospital (under the provider-based payment rules). *Id.* at 31,506 (to be codified at 42 C.F.R. § 489.24(b)). CMS notes that such "Dedicated Emergency Departments" include not only a hospital's

Continued on next page



“emergency room” but also its labor and delivery department and any psychiatric unit that provides emergency services, as well as other departments held out to the public as places to come for urgent care on a non-appointment basis.

- **Import:** If an attending physician refers his/her patient to the Emergency Department because the physician's office is closed, that patient will be seeking examination or treatment and must be provided with a medical screening examination and any stabilizing treatment that is required. The patient will be required to wait until an appropriate medical screening examination can be performed and will incur an emergency department charge. It may be little comfort to the patient that the “appropriate” medical screening examination consists of no more than brief questioning by qualified medical personnel to establish that an emergency medical condition does not exist. The medical screening can be provided by the patient's attending physician if the hospital has named all of its attending staff as “qualified medical persons” under EMTALA. In that event, the attending physician should also know EMTALA's requirements for an appropriate transfer in order to deal with patients requiring resources that the transferring hospital cannot provide.
- **Import:** If the attending physician sends his/her patient to the Emergency Department for suture removal, that patient will be seeking treatment and must be provided with a medical screening examination and any necessary stabilizing treatment unless the patient signs a waiver of the EMTALA screening and treatment. A qualified medical person will need to examine the wound, determine that it is healing well and that the patient is not experiencing discomfort before either removing the sutures or referring the patient for follow up to an outpatient clinic for a condition that is not an emergency. Again, emergency room charges will generally be assessed for emergency room services provided.
- **Later-developed emergencies.** If the proposed rules become final, EMTALA obligations to screen and treat will no longer

attach to patients who arrive at the hospital for a previously scheduled outpatient appointment and experience what may be a medical emergency after the start of their visit. Likewise, if a patient is admitted as an inpatient for elective treatment, EMTALA obligations will not attach if the patient later experiences an emergency. Finally, once a patient suffering from an emergency medical condition and admitted for stabilization becomes stable, EMTALA obligations no longer apply and will not revive if the patient develops an emergency medical condition prior to discharge.

- **Import:** An attending physician need not be concerned with meeting EMTALA requirements for the transfer of an unstable patient in any of the above instances. In particular, the attending physician need not certify in writing the anticipated risks and benefits of transfer or secure the patient's acknowledgement, by signature, that those risks and benefits have been explained. To transfer unstable patients, EMTALA also requires that the transferring facility do all it can to minimize the risks of transfer, ascertain that the receiving facility has the needed equipment and personnel and is willing to accept the patient, send the patient's medical record and test results to the receiving facility, and arrange for the transport of the patient utilizing appropriate equipment and accompanying personnel. These requirements however, arguably represent good medical practice. To that end, the proposed rules stress, that, even in the absence of EMTALA requirements, the Medicare Conditions of Participation apply and require that later-arising emergencies be treated in accordance with accepted standards of practice. Note, too, that the attending physician's legal, licensing, and professional obligations to provide appropriate emergency care continue to pertain.
- **Non-hospital entities on campus.** Under the rules expected to be finalized, EMTALA obligations will not apply to provider-based entities that are on the hospital campus but are not considered hospital departments under Medicare's provider-based rules.



- **Import:** If a patient is brought to a physician office located within 250 yards of the hospital but not operated under the Medicare provider number of the hospital, the only obligation on that physician's office is to call for emergency medical assistance and provide what care the office can until emergency medical personnel arrive.

- **Physician on-call requirements.** Here, the proposed rules provide less guidance than is needed. The proposed rule states that a hospital may maintain its on-call list “in a manner that best meets the needs of its patients.” There is no predetermined number of days of on-call coverage a hospital must provide based on the number and type of specialists on its medical staff, but hospitals must have policies and procedures in place to cover situations when a particular specialty is not available. Finally, the proposed rules recognize that senior medical staff physicians may, under the medical staff bylaws, be exempt from on-call service without “necessarily violat[ing] EMTALA.”
- **Import:** If the proposed rule is finalized, CMS will not enforce any rigid formula in assessing the adequacy of on-call coverage (such as three physicians in a specialty requiring coverage twenty-four hours a day, seven days a week). Instead, CMS will consider all relevant factors, including the following: the number of physicians on staff; other demands on these physicians; the frequency with which the hospital's patients typically require services of the on-call specialists; and provisions the hospital has made to cover situations where a specialist is not available or the on-call physician is unable to respond because of circumstances beyond his/her control. Thus, an attending physician that is the only physician on the staff in a particular specialty --- or one of a very few physicians in that specialty -- may ask the hospital to make alternative arrangements for those days beyond the physician's reasonable on-call obligation. When on call, however, the physician may not refuse or fail to appear within a reasonable period of time. Otherwise, both the on-call physician and the hospital may be found in violation of EMTALA. Neither CMS nor the Office of the Inspector General has defined what constitutes a “reasonable response time.”

Other liability pitfalls also exist. For example, a physician on-call for Hospital A who responds to Hospital A's ER while he/she is located at Hospital B may not direct Hospital A's ER to transfer the patient to Hospital B so he/she can stabilize the patient's emergency medical condition. Only if Hospital A lacks the capability or capacity to treat the patient even if the on-call physician comes to Hospital A to screen the patient, could Hospital A transfer the patient to Hospital B for stabilizing treatment.

For the physician on-call simultaneously at two hospitals, appropriate back-up arrangements must be in place at both hospitals. These may consist of “second call” arrangements where more than one physician in a specialty is on the staff of the hospital. The ER is directed to contact the second on-call physician when the primary on-call physician is already medically engaged and cannot handle a medical

emergency. In contrast, when Hospital A has only one physician in a needed specialty on its medical staff and that physician is engaged, the back-up arrangement must be to transfer the patient requiring the specialty services to Hospital B where the needed physician specialist is available. In such situations, Dr. Jones on call at Hospital B is effectively on call for Hospital A as well.

- **Prior Authorization.** The proposed rule reinforces the current CMS position that a hospital violates EMTALA if it seeks authorization from a managed care plan before a patient is screened and stabilized. Information not relating to payment may be sought from the patient's regular physician, however, provided the consultation does not delay screening and stabilization.
- **Import:** Here the attending physician can be of great help to the hospital seeking to cope with EMTALA's prohibition against prior authorizations. When the attending knows his/her patient's insurance does not cover care at the hospital that is providing the emergency medical treatment, he/she should not request transfer of the patient to a participating hospital until the treating hospital determines that the patient is stable for transfer.

Complying with EMTALA is extremely important for both physicians and hospitals. The good news is that EMTALA is not a federal malpractice statute. A patient cannot, for example, bring an action against an examining physician for failing to detect a serious condition. Indeed, a patient cannot sue the physician for failing to provide any medical screening examination at all (although the patient can bring such an action against the hospital for having violated EMTALA). The bad news is that the government may impose civil monetary penalties on both hospitals and physicians of up to \$50,000 for each EMTALA violation. Even more, serious EMTALA violations can result in exclusion from participation in the Medicare and Medicaid programs – economic death to most health care providers. Happily, the means for avoiding such horrific consequences are at hand. These five steps remain valid whether or not the proposed EMTALA regulations are finalized:

- Know EMTALA's requirements. It is impossible to comply with the law unless you know what the law requires.
- Maintain a climate of mutual cooperation. When a hospital and its medical staff fail to hang together in meeting the demands of the law, they too often hang separately.
- Be consistent in how you screen patients for emergency medical conditions and in the stabilizing treatment you provide. Treat all who present with similar symptoms similarly. Turn a blind eye to patient finances, cleanliness – to all irrelevant factors.
- Above all, “do the right thing” for the patient. If in doubt about the law's requirements, put the patient first. More often than not, such action will be in accord with the law. When it is not, then you will be well positioned to defend your action.
- Document everything. Only by documenting can you prove you knew the law and did all the law required.

Doctors RX

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Numbers you should know!

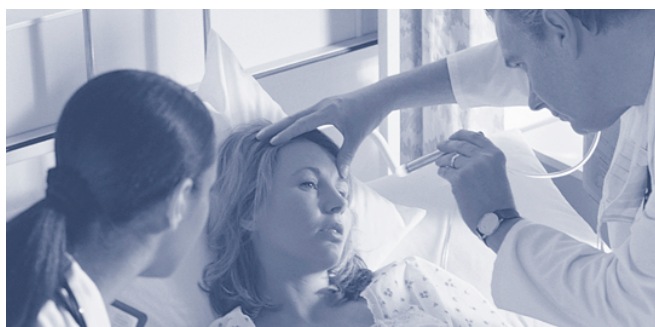
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CME Test Questions

Instructions for CME Participation

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Instructions — to receive credit, please follow these instructions:

1. Read the articles contained in the newsletter and then answer the test questions.
2. Mail or fax your completed answers for grading to the address or fax number provided below:
Med•Lantic Management Services, Inc.
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4. Completion Deadline: October 31, 2003
5. Upon completion of the test and evaluation form, a certificate of credit will be mailed to you. Please allow three weeks to receive your certificate.

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| <p>1. The EMTALA requirements do not have a definition for what constitutes a "reasonable response time."</p> <p style="text-align: center;">A. True B. False</p> | <p>6. A patient's attending physician can provide a medical screening exam if the hospital has designated all of its attending staff as "qualified medical persons."</p> <p style="text-align: center;">A. True B. False</p> |
| <p>2. If you are seeing patients at one hospital and on-call at another, you can have those patient you've been contacted to screen transferred to the hospital you're at.</p> <p style="text-align: center;">A. True B. False</p> | <p>7. Physicians can be sued for medical malpractice under EMTALA.</p> <p style="text-align: center;">A. True B. False</p> |
| <p>3. Physicians may not be on-call at two hospitals at the same time.</p> <p style="text-align: center;">A. True B. False</p> | <p>8. The proposed rule maintains that a hospital may not seek authorization from a managed care plan before screening and stabilizing a patient.</p> <p style="text-align: center;">A. True B. False</p> |
| <p>4. Physicians must be on-call for at least 60 days to comply with EMTALA.</p> <p style="text-align: center;">A. True B. False</p> | <p>9. A hospital emergency room is the only department that falls under the definition of "Dedicated Emergency Department."</p> <p style="text-align: center;">A. True B. False</p> |
| <p>5. The proposed rule clarifies what it means by "comes to the emergency department."</p> <p style="text-align: center;">A. True B. False</p> | <p>10. Even in the absence of EMTALA requirements, the Medicare Conditions of Participation still apply.</p> <p style="text-align: center;">A. True B. False</p> |



CME Evaluation Form

Statement of Educational Purpose

"Doctors RX" is a newsletter sent three times each year to the insured physicians of MEDICAL MUTUAL/Professionals Advocate. Its mission and educational purpose is to identify current health care related risk management issues and provide physicians with educational information that will enable them to reduce their malpractice liability risk.

Readers of the newsletter should be able to obtain the following educational objectives:

- 1) gain information on topics of particular importance to them as physicians,
- 2) assess the newsletter's value to them as practicing physicians, and
- 3) assess how this information may influence their own practices.

CME Objectives for Proposed EMTALA Changes Impact the Medical Staff:

Educational Objective: To provide information regarding the proposed changes to the Emergency Medical Treatment and Active Labor Act as well as assistance in understanding what is expected of physicians to ensure compliance.

Strongly Agree	5	4	3	2	1	Strongly Disagree
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Part I. Educational Value:

I learned something new that was important.

I verified some important information.

I plan to seek more information on this topic.

This information is likely to have an impact on my practice.

Part 2. Commitment to Change: What change(s) (if any) do you plan to make in your practice as a result of reading this newsletter?

Part 3. Statement of Completion: I attest to having completed the CME activity.

Signature: _____ Date: _____

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