

EMTALA And The On-Call Physician

presented by

Paul J. Giancola
Snell & Wilmer
One Arizona Center
Phoenix, AZ 85004-2202
602/382-6324
pgiancola@swlaw.com

HISTORY

- 1986 Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
 - 42 U.S.C. §§ 1395cc and 1395dd
 - Section 1867 of the Social Security Act (Medicare)
- 1994 Final Regulations (42 C.F.R. 489.24)

HISTORY *cont'd*

- 2000 Amended Regulations
- 2003 Revised Regulations
- CMS Interpretive Guidelines, 1995 and 1998, 2004
 - Instructions and Policy Interpretations
 - Issued by CMS to State Surveyors (how CMS interprets the law)

HISTORY *cont'd*

- 1999 CMS and OIG Special Advisory Bulletin
 - Dual staffing of ERs by managed care and non-managed care physicians
 - Prior authorization requirements under managed care
 - Use of advance beneficiary notices
 - Handling inquiries about financial liability
 - Voluntary withdrawal of treatment request

HISTORY *cont'd*

- November 10, 2003 EMTALA revisions
 - Outpatients
 - Physician On-Call Obligations
 - Hospital Owned Ambulances
 - Patient Location on Hospital Property
 - Contact between ER and Patient's Physician

HISTORY *cont'd*

- Non Emergency Services
- Managed Care Issues
 - Authorization for post-stabilization care services
- Revised Definitions
 - Comes to Emergency Department
 - Dedicated Emergency Department
 - Hospital Property
 - Hospital with an Emergency Department

THE FUTURE

- CMS to standardize EMTALA
 - Investigation
 - Reporting
 - Timely notification
 - Consistent enforcement policies
- Will court opinions become consistent
 - Inpatients

GOVERNMENT ENFORCEMENT

- HHS, CMS (regional offices)
- State Survey Agency
- HHS, OIG

ALSO KNOWN AS

- COBRA
- “Anti-Dumping” Act
- “Free Care Law”

PURPOSE

- Prevent ER “Dumping” of Indigent
 - Refusal to treat
 - Transferring before stable

APPLIES TO

- Hospitals
 - ER (offers emergency services)
 - Medicare provider
 - Ensure Compliance by Physicians and Employed Staff
- Physicians
 - On Staff (attending/on-call)
 - ER

COMES TO ER

- Hospital property
 - Dedicated ER
 - Main Campus
 - Hospital owned ambulance
 - Ambulance on hospital property
- Request for evaluation or treatment

COMES TO ER *cont'd*

- Does not apply to admitted inpatients/ outpatients
- May not delay exam screening or treatment to request insurance/prior authorization

WHAT ARE THE HOSPITAL'S OBLIGATIONS UNDER EMTALA?

- Medical screening exam: to determine if *emergency medical condition* (EMC) exists
- Stabilization: if EMC is found, individual must be *stabilized* within capability of hospital
- Transfer: if further stabilization is required, individual must be *transferred* to hospital with specialized capabilities

WHO SCREENS

- ER Physician
- Qualified medical person
 - Must be designated by hospital bylaws or rules and regulations
 - In consultation with a physician
 - Physician certification (responsibility)
 - Nurse practitioner

WHO SCREENS *cont'd*

- Qualified medical person *cont'd*
 - Physician's assistant
 - Registered nurses with specialized training (OB)
 - Within scope of practice and competent
 - Telephone consultation with physician

HOW FAST

- Reasonably Prompt
- May not delay to inquire about payment or insurance status
- Not a triage exam

MEDICAL SCREENING EXAM (MSE)

- "Appropriate"
 - To Determine the Presence or Absence of an EMC
 - Non-Discriminatory
- Within the ER "Capability"
 - Ancillary Services
 - On-Call Specialists

MSE *cont'd*

- “Within Reasonable Clinical Confidence”
- Does EMC exist
 - Acute symptoms of sufficient severity that absence of immediate medical attention, could be expected to result in:
 - Serious jeopardy of health
 - Serious impairment of bodily functions
 - Serious dysfunction of any organ or part

OBSTETRICS MSE

- Pregnant women with contractions
 - Inadequate time to safely transfer before delivery
 - Transfer may pose threat to health or safety of mom or baby
 - Contractions vs Labor

OTHER EMCs

- Severe pain
- Psychiatric disturbances
- Substance abuse symptoms

WHEN EMTALA OBLIGATIONS END


- No EMC after MSE
- EMC Resolved
- EMC Stabilized
- Admitted
- Refuses MSE in writing
- Appropriate transfer

STABILIZING TREATMENT FOR EMC

- Reasonable
 - Within capability
 - Includes services of on-call physician
 - CMS Review is not outcome based!


STABILIZATION FOR EMC *cont'd*

- Refusal of Treatment
 - Offer
 - Informed Refusal
 - Documented All Reasonable Steps Taken (AMA Form)



STABLE

- Medically Stable (underlying EMC) for **Discharge** with Follow-up Arranged by the Hospital
 - Instructions and follow-up plan
 - On-call obligation triggered if referral
 - Immediate for further stabilization
 - Prevent destabilization or provide definitive care
 - Routine follow-up
- Medically Stable for **Transfer** (still EMC)
 - Physician certification of no material deterioration of EMC



UNSTABLE

- Transfer
 - Patient Request
 - Informed of EMTALA obligation, risks and benefits
 - Physician Certification
 - Benefits outweigh risks
 - In patient's best interests (medical reason)
 - Not for physician convenience
 - Consultation with qualified medical person
- Transfer of unstable patients to equal or lesser facilities is potential violation




TRANSFEREE HOSPITAL

- Must accept if capable
 - Space
 - Personnel
 - To treat EMC and reasonably foreseeable complications
 - Duty to report improper transfer
- "Reverse dumping" prohibited




HOSPITAL PENALTIES

- Termination from Medicare
 - \$25,000 (small) per violation
 - \$50,000
- Civil suit by patient
- Receiving facility claim
- Licensure and Accreditation



PHYSICIAN PENALTIES

- Excluded from Medicare
 - Gross, flagrant, repeated standard
 - Unnecessarily place patient in high risk situation
- Up to \$50,000
 - Negligent standard
 - Examples
 - Knew or should have know Risks >Benefits
 - Misrepresents condition
 - Refuses or fails to appear in reasonable time
- Medical Board and hospital discipline



CHANGES TO ON-CALL

- Discretion of each hospital to maintain on-call list to best meet patient needs
- Reasonable amount of coverage
 - Given circumstances of
 - Hospital
 - Community

HOSPITAL OBLIGATIONS FOR ON-CALL PHYSICIANS

- Must maintain a list of physicians who agree to take call
 - Fair distribution
 - Available without delay
- Physicians on list must show up when called
- Capability of hospital
 - Services offered to public
 - Specialty must be available on-call
 - To provide:
 - Further Screening
 - Diagnosis
 - Treatment

HOSPITAL OBLIGATIONS *cont'd*

- Compliance with EMTALA
 - Medicare conditions of participation
 - Bylaws, rules, regs
 - Method for monitoring
 - Call list
 - Plan to manage unavailable referrals
 - Notice to public

PHYSICIAN OBLIGATIONS

- Come to hospital
 - Further screening EMC
 - Diagnosis EMC
 - Treatment to stabilize
- Timely and appropriate response
 - Time to call/arrive
 - Bylaws may define
 - Person attending determines if needed
 - May be telephonic (verbal consult)
- Not clinically competent is not an excuse

PHYSICIAN OBLIGATIONS *cont'd*

- Unavailability
 - Document reasons
 - Transfer in patient's best interests
- Accept transfers
- Agents of the hospital
- No transfers for convenience

PHYSICIAN OBLIGATIONS *cont'd*

- Report suspicious transfers or refusals
- Provide office follow-up
 - To further stabilize
 - Prevent de-stabilization of EMC

CHANGES TO PHYSICIAN OBLIGATIONS

- Not required:
 - Physicians are not required to take call nor are physicians required to be on-call at all times.
 - No "Rule of 3"
- Permitted
 - Simultaneous call
 - Performing surgery while on-call
 - If a suitable backup plan



HOW MUCH CALL IS ENOUGH?

- CMS: Flexibility
 - No rule linking extent of coverage with number of specialists
 - 1-2 specialists
 - Ad hoc
 - 7 to 10 days per month per specialist?
 - Scheduled gaps in coverage
 - Notice to public
 - Referral plan
 - 3 or more specialists



HOW MUCH CALL IS ENOUGH? *cont'd*

- CMS: Flexibility
 - Reasonable call schedule
 - Composition of medical staff
 - Number of physicians in a specialty
 - Scope of practice
 - Relationship with other hospitals



RECENT TRENDS

- Most common violations
 - Seeking prior authorization before providing MSE
 - On-call specialist failing to come to ER
- Lack of surgical subspecialties



ON-CALL COMPLAINTS

- Overworked
- Underpaid or no pay
- Asked to treat outside competence
- Malpractice risks
- “Undesirable patients”
- Disruption of practice/life style



PHYSICIAN RESPONSES

- Retire
- Resign from active staff
 - Courtesy or consulting
- Request payment for on-call
- Request hospital to help
- Specialty hospitals
- Extended care providers



HOSPITAL RESPONSES

- Demand evaluation even if not clinically competent
- Eliminate courtesy staff category
- General on-call schedules
 - Require MD to maintain sufficient competency
 - Require MD to obtain substitute
- Deny request to change privileges
 - Unless obtain substitute



HOSPITAL RESPONSES *cont'd*

- No longer provide a specialty service
- Pay for on-call service
- Limit services available
- Hospitalists
- Admit all patients to a PCP
- Exclusive contracting
- Refusal to exempt



SOLUTIONS ?

- Reduce uninsured
- On-call payment
- Reimbursement for ER at higher rates
- Change EMTALA



CONCLUSION

- Questions
- Comments
- Thank you