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

- 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