
HALL
RENDER
KILLIAN HEATH & LYMAN
Illinois
State
Medical
Society
EMTALA and Call Coverage
MEDICAL STAFF
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HEALTH LAW IS OUR BUSINESS.

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Presenter Info

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EMTALA Overview

- EMTALA Triggers
- Medical Screening Examination
- Emergency Medical Condition
- Qualified Medical Personnel
- Appropriate Stabilizing Treatment/Transfer
- On-Call Obligations

Hospital's EMTALA Duty

- **Emergency Medical Treatment and Active Labor Act (1986)**
  - Eugene Barnes (California 1985)
  - National Media Coverage
- **A Medicare participating hospital that provides emergency services must:**
  - Provide an appropriate medical screening examination ("MSE") to any individual who "comes to the emergency department" and "requests examination or treatment"
  - If MSE reveals that an emergency medical condition ("EMC") exists, hospital must provide appropriate stabilizing treatment and/or an appropriate transfer

Why Do We Care?

- Most Importantly – Legitimate purpose/intent of EMTALA
- Required by Law and Accreditation Standards
- Significant Civil Monetary Penalties
- Risk for Medicare Participation
- Significant risk for Professional Liability Claims
- EMTALA investigations can be (and typically are) retroactive

Potential Penalties for EMTALA Violations

- **Civil Monetary Penalties from OIG**
  - **Both the hospital and on call physicians** could be liable for **$129,232**, per violation*
    - 42 CFR 1003.510; 45 CFR 102.3; 88 FR 69538
- **Personal Injury and Professional Liability Claims**
  - Patients or other hospitals may sue the hospital for the EMTALA violation.
  - Both the hospital and on call physicians may be subject to suit.
  - Judgments here can be very large – depending on malpractice laws state to state
- **Exclusion by CMS**
  - Both the hospital and on call physicians may be excluded from Medicare.
    - 42 CFR 1003.500
    - SOM Appendix V, Tag A-2400/C-2400.

* Based on the CY 2022-2023 adjusted rates. Hospital CMP depends on bed size. 100 beds or more: $129,232; less than 100 beds: $64,618

Regional Headlines

- Kentucky Hospital Loses $2.4 Million EMTALA Suit
  - Patient presented with a heart attack, the hospital directed EMTs to take the patient to a different hospital without conducting a screen, stabilizing, or treating the patient.
- S.C. hospital to pay $1.3 million for not properly treating emergency psych patients
  - Hospital settled with OIG after allegedly not providing stabilizing treatment to unstable psychiatric patients in the ED in thirty-six instances.
- Two Hospitals Pay $1.45M to Settle EMTALA Allegations with OIG Over 54 Psychiatric Patients
  - Both Tennessee hospitals allegedly did not stabilize psychiatric patients who presented to the ED in a total of fifty-four instances

EMTALA Triggers

- EMTALA obligations are triggered when a patient:
  - **"comes to the emergency department"** and
  - **"requests examination for a medical condition"**
- These concepts are interpreted and applied expansively

EMTALA Triggers

- **EMTALA applies when a patient "comes to the emergency department," which can mean:**
  - Presenting to the dedicated emergency department or
  - Presenting elsewhere on "hospital property“
  - “Hospital property” includes:
    - parking lots, sidewalks, driveways, etc., immediately adjacent to the Hospital’s main buildings and
    - other such Hospital owned structures and areas that are not immediately adjacent, but are within 250 yards of the Hospital’s main buildings and
    - Hospital owned ambulances (within limited exceptions)
  - "Hospital property" generally does not include other areas that are not part of the hospital, such as private physician offices, restaurants, etc.

EMTALA Triggers

- **"Requesting examination or treatment for a medical condition"**
  - Request may be made by another on individual's behalf
  - Request is implied if prudent lay person would believe, based on the individual's appearance or behavior, that the individual needs emergency examination or treatment
  - EMTALA may therefore apply to visitors or others who did not come to the hospital seeking such services

Medical Screening Examination

- Under EMTALA, Medical Screening Exam ("MSE") is essentially defined as the process required to determine, with reasonable clinical confidence, whether an Emergency Medical Condition exists
- Hospital must provide a MSA within the capability of the emergency department, including ancillary services routinely available to the emergency department
- MSE must include evaluation for medical conditions, pregnancy/labor, and psychiatric/behavioral symptoms if present
- Triage is <u>not</u> the equivalent of MSE
  - Triage is the clinical assessment of the individual's presenting signs and symptoms to prioritize when (<u>not if</u>) the individual will be provided the MSE

Medical Screening Examination

- **MSE obligation is met if hospital:**
  - Provides for a screening evaluation reasonably calculated to identify critical medical conditions that may be affecting symptomatic patient

    AND
  - Provides the same level of screening to all who present with substantially similar complaints, regardless of the individual's ability to pay for medical care

- **MSE must be performed by:**
  - Physician, or
  - Qualified medical personnel ("QMP") in consultation with a physician
  - Non-physician QMPs must be designated as such in the hospital and/or medical staff bylaws or rules and regulations

Emergency Medical Condition ("EMC")

- Under EMTALA, an EMC is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (such as severe pain, psychiatric disturbances, or symptoms of substance abuse), such that the absence of immediate medical attention could reasonably be expected to result in:
  - placing the health of the individual (or with respect to a pregnant woman, the health of a woman and/or her unborn child) in serious jeopardy
  - serious impairment to any bodily functions
  - serious dysfunction of any bodily organ or part
- Under EMTALA, a pregnant woman in active labor is considered to have an EMC

Emergency Medical Condition

If an EMC exists, the hospital must:

- Treat within its capabilities and stabilize the individual utilizing appropriate ancillary services

OR

- Admit the patient as an inpatient

OR

- Provide for "appropriate transfer" to another facility

Emergency Medical Condition

Documentation is critical:

- "There is no medical emergency condition" or
- "Emergency medical condition has been stabilized", etc.
- Of course, documentation must be supported by the larger course of examination, treatment, etc.

Stabilization

- A patient will be deemed stabilized if the treating physician has determined with reasonable clinical confidence that the EMC has been resolved
- For pregnant patient experiencing EMC, stabilization means that the contracts have stopped or the patient has delivered the child and placenta
- A patient whose EMC has not been stabilized may not be transferred unless:
  - Benefits of transfer outweigh the risks (and an “appropriate transfer” is completed)

    OR
  - Patient requests transfer (after being advised of the risks)

Requirements for Appropriate Transfers

- **Transfer will be deemed an "appropriate" transfer only if:**
  - patient is informed of the risks and benefits of the transfer and consents to transfer in writing (if possible)
  - the physician certifies that the medical benefits of transfer outweigh the risks
  - the receiving hospital has the space and capability to care for the patient
  - the receiving hospital and receiving physician accept the transfer

EMTALA Transfer Certificate

- **Express written certification is required for transfer of unstable patient:**
  - Patient condition
  - Reason for the transfer
  - Benefits of transfer (what can be provided at the receiving hospital that cannot be provided here)
  - Risks of transfer
  - Receiving hospital
  - Mode of transportation
  - Patient consent
  - Physician Certification and Signature
- Risks/Benefits cannot simply be a “check the box”

Unique Situations

- If an individual with an EMC leaves after the MSE, it is not an EMTALA violation unless:
  - The individual left the ED based on a "suggestion" by the hospital; or
  - The individual's condition was an emergency, but the hospital was operating beyond its capacity and did not attempt to transfer the individual to another facility
- If an individual leaves a hospital against medical advice ("AMA") or leaves without being seen ("LWBS") on his or her own free will (no coercion or suggestion), the hospital is not in violation of EMTALA
- Again – documentation is critical.

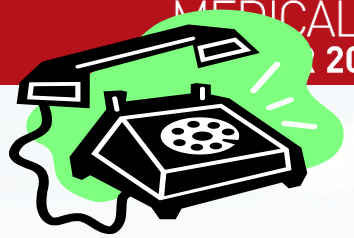
On-Call Physicians

- Hospital must maintain an on-call list of physicians who best meet the needs of hospital's patients and who are available to provide treatment or necessary stabilization of a patient.
- For clarity – per EMTALA – call coverage is a “physician” obligation
- On-call physician duties and responsibilities must be clearly defined in hospital rules and regulations and/or medical staff bylaws and in hospital policies and procedures
- The on-call list of physicians must be identified by individual physician names

On-Call Violations

- If the transfer of an unstable patient occurs as a result of an on-call physician's failure or refusal to treat the patient, the transferring hospital is required to include the name and address of the on-call physician on the transfer form provided to the receiving facility
- The receiving facility is required to report the on-call physician and the inappropriate transfer to either CMS or the State for investigation generally within 72 hours

On-Call Physicians



- Level of on-call physician coverage should be based upon the clinical resources of the Hospital
  - Who has clinical privileges at the Hospital?
  - What does the Hospital hold itself out to be?
- CMS position on the "rule of three"
- The on-call physician must come to the hospital within a reasonable period of time if requested by the emergency room physician
  - CMS does not provide a strict timeframe
  - Standard of care/accreditation requirements/secondary guidance typically guide
  - If an on-call physician cannot respond due to circumstances beyond his/her control, the hospital must have policies and procedures in place to ensure appropriate coverage
- Call coverage is a balancing act – increasingly

On-Call Physicians

- Although physicians are allowed to be simultaneously on-call at more than one hospital, all hospitals involved must be aware of the on-call schedule and have made appropriate alternative coverage arrangements
- On-call physicians may schedule elective surgery during their on-call coverage time, but must provide appropriate back-up coverage arrangements
- If consistent with hospital bylaws and permission has been given by the on-call and ED physicians, physician assistants and/or nurse practitioners may respond for on-call physicians (<u>but physician must be available to present if requested</u>)
  - NOTE: CMS will review adequacy of the PA or NP coverage on a case-by-case basis

On-Call Physicians

- Telemedicine
  - CMS guidance does contemplate the supplemental use of telemedicine coverage. However, the use of telemedicine does not (currently) negate “on call” obligations to present to the Hospital if requested
- Community Call Coverage
  - CMS does permit different hospitals within the same geographic service area to establish community call plans
  - This allows the hospitals to leverage expertise
  - These plans must be carefully crafted and coordinated with CMS

Discussion

- What types of concerns are you seeing/experiencing at your own system/hospital in relation to staffing emergency call coverage?

Discussion

- Do you find there is greater reluctance (among “newer physicians”) to want to provide call – or is this the same old struggle?

Discussion

- Do you set a minimum call obligation for all physicians each month? Do you set a minimum response time?

Discussion

- Do you allow NPs and/or PAs to participate in call?

Discussion

- Have you explored or considered any changes or other solutions to address call coverage? If so, what have you considered or pursued (e.g., reducing minimums, using telemedicine, community call plans, etc.)? Are any of these initiatives (if they have been instituted) helping (or do you anticipate they will)?

Questions?

Contact Us

For more information on these topics visit hallrender.com.

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