

EXPERT REPORTS ON THE NEW EMTALA GUIDELINES

from **Emergency Physician LEGAL BULLETIN**

Volume 9, Number 5, 1999

"EMTALA, known as COBRA to physicians, governs everything we do in the ED," said Robert Bitterman, MD, JD, FACEP during his lecture at the 1998 ACEP Scientific Assembly. "It's hard for emergency physicians to realize that we must also follow a legal, as well as medical, standard of care." Dr. Bitterman is Director of Risk Management and Managed Care in the Department of Emergency Medicine at the Carolinas Medical Center in Charlotte, North Carolina. He's also Clinical Assistant Professor of Emergency Medicine at the University of North Carolina Medical School. He practices academic emergency medicine full time.

Under EMTALA, anyone who comes to the ED is entitled to a medical screening exam (MSE) and stabilizing treatment, and that includes managed care patients, illegal aliens and patients managed through phone orders by their physicians. EMTALA even vitiates state consent laws for minors. "If a baby-sitter brings in a two-year-old, you must provide the MSE to determine if the child has a true emergency without waiting to reach the parents," Dr. Bitterman commented.

Private patients represent a problematic area. HCFA considers a private patient sent for tests, such as an x-ray or CBC, as simply using the services of an ED. Dr. Bitterman recommended using a different consent form for such patients, one that specifies testing only, particularly for persons brought in by the police for blood alcohol testing. However, it's illegal for a physician to examine a patient, then send him or her to the ED for treatment only. The emergency physician must first perform an MSE on behalf of the hospital, even if the patient is to receive a blood transfusion, rabies vaccine or other treatment. "The 'migraine headache' patient sent to the ED for an IM narcotic is one notorious example; not rarely the MSE reveals a subarachnoid hemorrhage or meningitis," said Dr. Bitterman. Private physicians should not be allowed to call in phone orders to the ED unless they intend to come in to examine and manage the patient's care.

Dr. Bitterman noted that through ACEP's discussions with HCFA's Advisory Committee on EMTALA, in which he participated, some interpretations have been modified to benefit emergency physicians. Take the apparently simple matter of "when does a patient come to the emergency department?" HCFA originally interpreted this language very broadly. A person in an ambulance or helicopter owned and operated by a hospital would be regarded as having "come to the ED," even if the vehicle was miles from the ED. HCFA expected the ambulance or helicopter to bring the patient to the hospital's ED for an MSE instead of to the closest appropriate hospital. Following discussions with ACEP, HCFA discarded this requirement as long as the EMS unit operates under reasonable EMS zone protocols. HCFA may, however, review the EMS policies to ensure they are not discriminatory.

HCFA's regulations, not yet tested in court, define "comes to the ED" to include all hospital property, such as the cafeteria, waiting room, parking lot and surrounding land. Also included are hospital urgent care centers, clinics, freestanding surgicenters and doctors' offices if owned by the hospital and operated under the same Medicare provider number as the hospital. "HCFA may even extend the definition to hospital-owned facilities that don't share the same Medicare coding number," Dr. Bitterman commented.

MEDICAL SCREENING EXAM

HCFA states that the MSE must be given by qualified personnel approved and designated, in writing by the hospital's governing board, but does not specify doctors or nurses. According to Dr. Bitterman, most hospitals have failed to make a designation. Also, HCFA can challenge a designation. "In a number of instances, hospitals designated nurses to perform its MSEs, but HCFA held the nurses didn't have adequate medical expertise to conduct screening exams in complicated medical cases and felt the hospitals should have had physicians conduct the MSE in these cases."

EMTALA's new guidelines state that triage is not an MSE, contrary to the belief or demands of managed care plans. Furthermore, an MSE must include ancillary services routinely available to the ED, as well as the services of on-call physicians if needed to determine if an emergency medical condition is present.

"If you need to rule out appendicitis, you must call in the surgeon on call to examine the patient or even take the patient to the OR as part of the screening process," Dr. Bitterman said.

The MSE must be the same for everyone, including managed care patients, Medicaid and private patients, and illegal aliens. EMTALA is not concerned about the adequacy of the MSE to identify an emergency medical condition. Rather, the issue is whether the ED deviated from its standard procedures to evaluate a patient with a similar condition "as perceived to exist" by the examining physician. In fact, the physician could be grossly negligent and subject to malpractice litigation, but not violate EMTALA.

All this may change, however, because of a case now before the U.S. Supreme Court based on the issue of motive. "The question is did the examining physician fail to provide screening, or screening contrary to policy and procedures, because of the patient's race, sex, economic status or some other illicit motive," said Dr. Bitterman. "Depending on the Court's ruling, in the future, HCFA or plaintiff attorneys may need to prove the hospital or physician acted with an illicit motive as the reason for disparate treatment."

MANAGED CARE

Dr. Bitterman believes that EMTALA and managed care are at odds with each other because EMTALA exists to remove financial considerations in the emergency care of all persons, while managed care seeks to reinstate economic motivation. He emphasized that HMO authorization is for payment, not for treatment. Yet, hospitals and physicians allow themselves to be manipulated by the managed care companies. "For example, published studies purporting to show 'how bad managed care is' actually showed it was the hospital and emergency physicians who delayed treating patients with emergency conditions while waiting for authorization from HMOs. Preauthorization is undeniably detrimental to patient care."

In some emergency departments the patient is told in advance that the HMO has denied payment authorization. This procedure is risky, Dr. Bitterman warned, because the courts have ruled that the burden of proof is on the hospital to show that the patient affirmatively revoked his request for the MSE. According to HCFA, the hospital must "take all reasonable steps to secure the individual's written informed consent to refuse." A Federal appellate court has ruled that in obtaining informed consent a physician must tell the patient that the managed care physician denied payment for an MSE possibly because of an economic incentive, otherwise the patient has not received adequate information to make an informed decision. Furthermore, according to HCFA, telling a patient that medical care may be paid for at another-facility is economic coercion in violation of law.

"Neither a registration clerk nor a nurse can obtain informed consent to refuse the screening exam, which is really a leaving 'Against Medical Advice,' because they are not legally allowed to determine a patient's competence," said Dr. Bitterman, "nor can the managed care physician on the phone."

HCFA's new interpretive guidelines introduce a major change regarding where an MSE is performed. It can be given anywhere on a hospital's "campus," including urgent care centers, pediatric clinics, dental clinics and the offices of on-call physicians. A patient can be triaged in the ED and sent to a physician's office on campus if it shares the same Medicare provider number. Triage and patient movement to areas other than the ED must be nondiscriminatory, determined solely on medical criteria, and implemented very carefully. If the ED triages private pregnant patients over 20 weeks gestation with pregnancy related complaints to labor and delivery, then all such pregnant patients must go to labor and delivery, regardless of medical insurance status.

Furthermore, a hospital cannot delay a patient's access to an MSE, to stabilizing treatment or to on-call physician specialists because of the method of payment. "Nor can a tertiary hospital delay accepting your patient until authorization is received from an HMO," said Dr. Bitterman.

STABILIZATION

The new HCFA guidelines make a distinction between patients who are stable for transfer and those who are stable for discharge, a change that may not be significant because the statutory definition supersedes HCFA's interpretation. A patient is considered "stable for discharge" when, "within reasonable clinical confidence it is determined that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an inpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions." Furthermore, HCFA also accepts that the determination a patient is "stable for discharge" (or stable for transfer)

does not require the final resolution of the patient's emergency medical condition prior to discharge or transfer. HCFA does state that in the event of a disagreement over whether a patient is stable for transfer, the medical judgment of the treating physician takes precedence over that of an off-site physician. This is intended to deal with managed care companies. If the managed care physician or on-call physician disagrees with your judgment, then that physician must come to the ED, personally examine the patient, and take responsibility for the patient's transfer. "Just make sure you tell the patient you don't recommend the transfer and document it," Dr. Bitterman commented, then it's up to the patient to choose whom to believe.

PHYSICIAN ON-CALL REQUIREMENT

EMTALA is by law the on call policy of every hospital in the nation. Most EMTALA violations involve managed care, but in second place and rising rapidly are violations by on-call physicians. The duty to provide on-call physicians rests with the hospitals, not the medical staff. Physicians have no legal duty to take ED call. However, physicians accept such duty voluntarily or because the medical staff bylaws require it. According to Dr. Bitterman, on-call physicians often fail to understand that they are liable under EMTALA because when they are on call they represent the hospital and not their private practice. Therefore, when on call they cannot refuse to come to the hospital or refuse to accept a transfer to the hospital as they can when acting in the capacity of their private practice.

Which physicians must take the call? HCFA states that if specialty physicians regularly provide patient services at the hospital, then someone in that specialty should take ED call, even if that specialty previously did not provide on-call services.

Under EMTALA, on-call physicians must respond "within a reasonable period of time." Although not in writing, HCFA interprets this as 30 to 45 minutes for an emergency condition in an urban area. However, New Jersey and West Virginia require the on-call physician's presence in the ED within 30 minutes. "A couple of hospitals in New Jersey had problems with recalcitrant on-call physicians," Dr. Bitterman said. "HCFA swooped down and closed the emergency departments, claiming they were a threat to the community. The hospitals should have disciplined the recalcitrant physicians, even to the point of revoking their hospital privileges if necessary."

Hospitals must draft EMTALA policies very carefully because "failure to follow your own rules" about the MSE and on-call provisions is a common reason for a violation finding.

While on-call, physicians must be available to come to the ED for emergencies promptly, and a busy office schedule or performing scheduled elective surgery are not acceptable excuses for delay. Otherwise, they and the hospital are liable. "Some physicians are responding that because they must be on call and cannot schedule elective surgery, they want the hospital to pay them for their availability," said Dr. Bitterman. "Neurosurgeons in California are getting two thousand dollars a day for standby time."

TRANSFERRING PATIENTS

Although EMTALA does not apply to the transfer of a stable patient, Dr. Bitterman strongly recommended that the same paperwork and procedures be used as for the unstable patient. Forms should have a place where a check mark indicates the emergency physician did not diagnose an emergency medical condition or considered the patient stable in case the transfer is questioned later. Stable patients can be transferred for economic reasons such as managed care needs. Understand, however, that economic transfers will always be closely scrutinized by government agencies and plaintiff attorneys, so be really sure you're comfortable transferring the patient.

Unstable transfers are of two types. They are either medically indicated or patient requested. Medically indicated transfers are intended to obtain a necessary, higher level of care that is unavailable at the transferring institution. The physician must certify in writing that the benefits of transfer outweigh the risks. Patient requested transfers include all other transfers. Although managed care transfers are not recognized by law, a patient may request transfer to a facility where it will be paid for. "Transferring unstable patients when it is not medically indicated and the needed service can be provided at your facility is clearly against medical advise and the standard AMA form should be completed just as with refusal to screen," said Dr. Bitterman. By law, the reason for the transfer of the unstable patient must be inserted in writing by the patient.

ACCEPTING TRANSFERS

Who can accept a transfer on behalf of the hospital? The law does not require that a physician be the one to accept transfers on behalf of the hospital. A hospital may designate an administrative transfer team, but Dr. Bitterman believes emergency physicians are the best persons to accept transfers from other EDs. For political reasons many hospitals assign the responsibility to their on-call physicians to accept or reject transfers. This practice is potentially hazardous; the large number of physicians who take call and their general lack of expertise or commitment to EMTALA standards place the hospital at substantial risk of violating EMTALA. Hospitals need to understand they are directly liable for the actions of their on-call physicians.

A hospital is not required to accept a transfer if it is at capacity. "But, if you're not closed to all EMS, you may not be considered at capacity," Dr. Bitterman stated. "If you normally open your recovery room for an ED patient when the ICU is full, you may need to open it to accept a transfer. Can you refuse to accept an unstable managed care patient until authorization for transfer to your hospital is obtained? Or refuse to accept a managed care plan's patients because you don't have a contract with that company? Absolutely not."

MANDATORY REPORTING REQUIREMENTS

HCFA has "tattletale" provisions that cover inappropriate transfers. If a hospital transfers an unstable patient because its on-call physician did not come in that physician's name and address must be forwarded to the receiving hospital which must then report it to the federal government within 72 hours. Failure to provide this information to HCFA is itself a violation of EMTALA.

ENFORCEMENT

Dr. Bitterman noted that HCFA has investigated more than a third of hospitals in the United States with an estimated 650 in 1998 alone. HCFA reports violations in about a third of the hospitals investigated and, on review, the Office of Inspector General only fines about a third of the hospitals cited by HCFA for violating EMTALA.

HCFA has the power to cancel a hospital's Medicare-provider agreement, which Dr. Bitterman calls the "financial death sentence." As a result, hospitals stop at nothing to come into compliance even if it means firing an emergency physician or curtailing privileges, all without due process. An emergency physician is fired in about a third of the HCFA investigations which find EMTALA violations. The new guidelines do not include any required due process or peer review for physicians. HCFA has the option to seek peer review and the guidelines recommend, but do not require, the regional HCFA office to obtain PRO review in cases where medical issues are in question.

Enforcement is not consistent across the nation. A violation in California may not be regarded as such in Wisconsin. The 50 state agencies and ten HCFA regions have their own interpretations of the law, according to Dr. Bitterman, although the new interpretive guidelines should help improve consistent application of the law. HCFA still tends to judge outcomes instead of process.

In reviewing HCFA's violation reports, the Office of Inspector General can penalize the physician and hospital or terminate the physician from Medicare. Dr. Bitterman said, "This represents the 'criminalization' of the practice of medicine, like speeding tickets. You violated the law; therefore, you must pay the \$50,000 fine no harm need come to the patient, and the fine is not covered by insurance. The OIG is supposed to obtain peer review before assessing a physician a fine, but as a negotiating tactic they may hold off because they don't want to spend the money. They simply send a letter demanding \$50,000, or 'we may terminate your Medicare provider agreement.'"

The OIG is demanding a North Carolina emergency physician pay a fine of \$50,000, even though he did not see the patient in question, under the "captain of the ship doctrine." After triage, a nurse and EMS crew independently of the physician's knowledge, transferred a public health patient to another hospital in violation of the hospital's own written protocols. HCFA settled with the hospital for \$15,000, but now wants \$50,000 from the physician and to terminate him from Medicare for one year.

Meanwhile, in malpractice litigation, plaintiffs' attorneys often wait for HCFA and the OIG to complete their investigations, then obtain the data under the Freedom of Information Act, and use it to help sue the hospital and physician for malpractice in state court. In other cases, they threaten to report the hospital to

HCFA if it doesn't settle the underlying malpractice suit. If a plaintiff attorney chooses to sue under EMTALA in Federal court, all the state's tort reform procedural provisions are preempted. These include notice requirements, peer review, expert witness rules, restraints of the discovery process, statutes of limitation, sovereign immunity and charitable immunity. Damage caps may or may not be preempted by EMTALA claims depending upon the actual language in the state's tort reform act.

Dr. Bitterman closed by noting that emergency physicians who are members of ACEP probably know more about EMTALA issues than some hospital administrators, on-call physicians, and perhaps even hospital attorneys. Thus, the leadership roles and educational burdens fall to emergency physicians to protect a hospital's compliance with EMTALA.

COBRA = Consolidated Omnibus Reconciliation Act, essentially anti-dumping laws
EMTALA = Emergency Medical Treatment and Active Labor Act