

# What EMTALA Means to the Practicing Physician

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# Today's focus

- EMTALA obligations under the new regulations
  
  - Special issues of concern to physicians
    - Duties toward emergency patients
    - Call obligations
    - Legitimate and illegitimate transfers
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# EMTALA Obligations

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# What is EMTALA?

- Emergency Medical Treatment and Labor Act
  - Enacted 1986
  - New regulations effective Nov. 10, 2003
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## What is EMTALA? *(cont.)*

- A requirement for hospital emergency departments
  - Some obligations may apply elsewhere in the hospital, but this is not generally a physician concern
  - Applies in hospital-based urgent care centers but not in freestanding (i.e., physician-owned) urgent care centers
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## What is EMTALA? *(cont.)*

- ❑ Duty to screen for emergency medical condition (EMC)
  - ❑ Duty to stabilize EMC before discharging or transferring patient
  - ❑ “Appropriate” transfers only
  - ❑ Duty of hospital with specialized capabilities to accept transfer
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## What is EMTALA? *(cont.)*

Hospital obligations of particular importance to physicians –

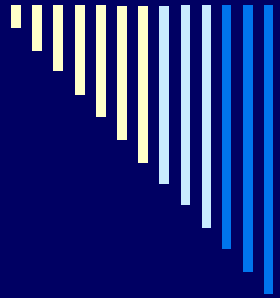
- Hospitals must make available to emergency patients *all services* the hospital otherwise offers
  - Hospitals must maintain a list of on-call physicians
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# “Emergency medical condition”

- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the woman or her unborn child) in serious jeopardy;
    - Serious impairment to bodily functions, or
    - Serious dysfunction of any bodily organ or part
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# “Emergency medical condition”

*(cont.)*

- With respect to a pregnant woman who is having contractions—
    - There is inadequate time to effect a safe transfer to another hospital before delivery, and
    - Transfer may pose a threat to the health or safety of the woman or the unborn child.
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# Screening

- An EMTALA screening is –
    - A *medical* screening examination
    - To determine with reasonable clinical confidence
    - Whether or not an emergency medical condition exists
  
  - Not the same thing as triage
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## Screening *(cont.)*

- Screening may be by a physician or a “qualified medical person” (QMP)
  - Appropriate designation of QMPs –
    - Scope of practice in accordance with state licensing laws
    - Designated in official document approved by hospital’s Board
    - *Not* designated on an ad hoc basis by Director of Emergency Services
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## Screening *(cont.)*

- If screening determines that there is no emergency medical condition, there is no further EMTALA obligation.
  - If screening finds an EMC, hospital must either –
    - Provide treatment to resolve the EMC; or
    - Effect an “appropriate” transfer
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## “Screening and Stabilization”

Stabilization has occurred when treating physician has determined, within reasonable clinical confidence, that –

- The EMC has been resolved (i.e., patient is “stable for discharge”); or
  - The patient is “stable for transfer”
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# Resolution of EMC

Resolution of emergency medical condition  
need not resolve underlying medical  
problem.

*Example: Patient with asthma whose  
acute respiratory symptoms have been  
relieved*

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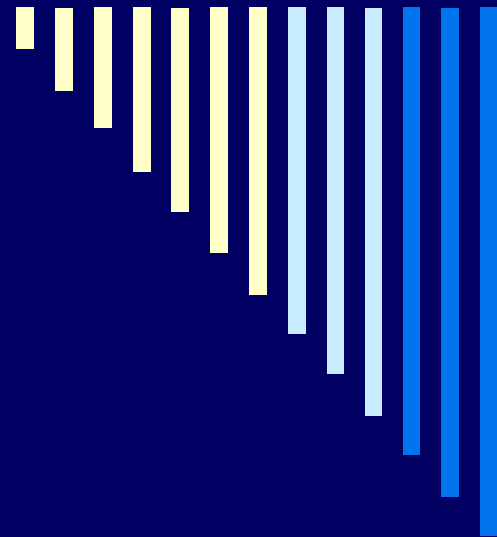


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## “Stable for transfer”

Treating physician –

- has determined, within reasonable clinical confidence, that the patient is expected to leave the hospital and be received at a second facility *with no material deterioration* in medical condition; and
  - reasonably believes that the receiving facility is able to manage the patient’s medical condition and any reasonably foreseeable complications
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May a patient who is not medically stable be transferred?

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## Permissible transfers of medically unstable person

- Medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the patient (and, in the case of labor, the unborn child) from effecting the transfer; *or*
  - Patient or legally responsible patient representative requests transfer in writing
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## Transfer when medical benefits of transfer outweigh the risks –

- Physician must sign certification that benefits outweigh risks
  - Physician must have actually deliberated and weighed the medical risk and the medical benefits of transfer before signing
  - If physician is not physically present, QMP may sign certification after physician makes determination after consultation with QMP and patient
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## “Appropriate” transfer

Transfer is “appropriate” when –

1. Transferring facility provides treatment to stabilize patient
  2. Receiving facility has capacity, and accepts patient
  3. Medical records accompany transfer
  4. Transfer is effected through qualified personnel and equipment
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## “Appropriate” transfer *(cont.)*

1. Transferring hospital must provide medical treatment –
    - Within its capacity
    - To minimize risks to health of patient (and, if pregnant woman, health of unborn child)
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## “Appropriate” transfer *(cont.)*

### 2. Receiving facility must –

- Have available space and qualified personnel for treatment of the patient
  - Have agreed to accept the transfer and provide appropriate medical treatment
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## “Appropriate” transfer *(cont.)*

3. Medical records accompanying transfer
    - Records relating to the emergency medical condition available at the time of transfer
      - Observations, symptoms
      - Preliminary diagnosis
      - Treatment provided
      - Results of diagnostic studies (telephone reports OK)
      - Informed consent
      - Certification, if patient is transferred unstabilized
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## “Appropriate” transfer *(cont.)*

### 3. Medical records accompanying transfer *(cont.)*

- May be copies
  - Need not include test results not yet available or historical records from hospital’s files (these should be sent to the receiving hospital “as soon as practicable”)
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## “Appropriate” transfer *(cont.)*

4. Qualified personnel and equipment
    - What is appropriate depends on circumstances
    - Should include necessary and medically appropriate life support services
    - Physician at sending hospital determines what is required in terms of personnel and equipment
    - Sometimes it may be necessary for a physician to accompany patient
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# Penalties

- \$50,000 civil fine for –
    - Negligent violation of duties involving examination, treatment, and transfer
    - Signing a certification for transfer when the physician knew (or should have known) that the medical benefits of transfer didn't outweigh the risks
    - Misrepresenting a patient's condition or other information
  
  - Exclusion from Medicare for “gross and flagrant” or repeated violations
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## Penalties *(cont.)*

Key protection for physicians:

QIO review required in any situation where a medical opinion is necessary to determine hospital or physician liability under EMTALA

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## Penalties *(cont.)*

Major area of physician exposure = Refusal of specialist to see patient when on call

- At hospital where patient first seeks emergency care
  - At receiving hospital if first hospital attempts to transfer patient, and the transfer is refused because the relevant on-call physician refuses to accept the patient
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# New EMTALA regulations

- Published Sept. 9, 2003
  - Effective November 10, 2003
  - Clarifications helpful mostly to hospitals
  - For physicians, key provision is new subsection 42 C.F.R. § 489.24(j), which deals with requirements for availability of on-call physicians
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# New Regulation on Availability of On-Call Physicians

1. Each hospital must maintain an on-call list of physicians on its medical staff
    - In a manner that best meets the needs of the hospital's patients who are receiving services required under EMTALA
    - In accordance with the resources available to the hospital, including the availability of on-call physicians.
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## New Regulation on Availability of On-Call Physicians *(cont.)*

2. Hospital's written policies and procedures —
    - Must describe how hospital will respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control; and
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## New Regulation on Availability of On-Call Physicians *(cont.)*

2. Hospital's written policies and procedures —
    - Must provide that emergency services are available to meet the needs of EMC patients, if hospital elects to permit on-call physicians —
      - To schedule elective surgery during the time that they are on call, or
      - To have simultaneous on-call duties.
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## The On-Call Requirement: Guidance from CMS

- ❑ No physician is required to be on call at all times.
  - ❑ The hospital must have policies and procedures to be followed when a particular specialty is not available, or when the on-call physician cannot respond because of situations beyond his/her control.
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## The On-Call Requirement: Guidance from CMS *(cont.)*

- This requirement may be met by adopting hospital policies that establish procedures for back-up on-call physicians, or for the implementation of an appropriate EMTALA transfer.
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## The On-Call Requirement: Guidance from CMS *(cont.)*

- There is no predetermined “ratio” that CMS uses to identify how many days that a hospital must provide medical staff on-call coverage based on the number of physicians on staff for that particular specialty.
  - In particular, CMS has no rule stating that whenever there are at least three physicians in a specialty, the hospital must provide coverage in that specialty 24/7.
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## The On-Call Requirement: Guidance from CMS *(cont.)*

- ❑ CMS does not set requirements on how frequently a hospital's staff of on-call physicians are expected to be available to provide on-call coverage
  - ❑ Requirement that on-call list must be maintained to best meet patients' needs was intended "to explicitly acknowledge the limits on availability of on-call staff in many specialties and geographic areas."
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# Special Issues of Concern to Physicians

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## Special issues *(cont.)*

- Does EMTALA apply in my office if my office is located in a hospital building?

No. Definition of “hospital property” specifically excludes physician offices.

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## Special issues *(cont.)*

- Is there a legal requirement that I have to take emergency call?

Not specifically, in federal law. However, you may have contractual obligations under the Medical Staff Bylaws of hospitals at which you have privileges.

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## Special issues *(cont.)*

- I'm a member of the Medical Staff at two hospitals. Can I be on emergency call for both of them at the same time?

It depends. If both hospitals adopt on-call policies that permit it and that specify what happens if an on-call physician is unavailable because he/she is responding to call at the other hospital, it's OK.

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## Special issues *(cont.)*

- Can I perform surgery while I'm on call for the Emergency Department?

OK if the hospital adopts on-call policies that permit it and that specify what happens if an on-call physician is unavailable because he/she is performing surgery.

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## Special issues *(cont.)*

- Can I get paid for taking call?

Maybe...

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## Special issues *(cont.)*

Whether a physician can get the hospital to pay him/her for taking call depends on a variety of factors:

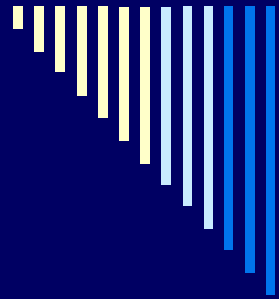
- Importance of coverage in specialty
  - Difficulty of getting doctors to take call in that specialty (CAUTION: Antitrust!)
  - Legal concerns
  - Relative bargaining power of hospital vs. physicians
  - Medical staff culture
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## Special issues *(cont.)*

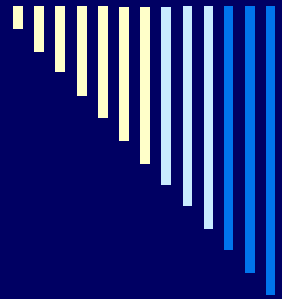
- I want to transfer a patient when medical needs/resources available demand it – but how do I do it without getting in trouble?
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## Transfer checklist for physician at hospital

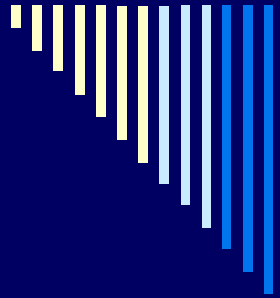
- Does the patient require specialized services not available at the present hospital?
  - Have you determined, within reasonable clinical confidence, that the patient can leave the hospital and be received at a second facility with no material deterioration in medical condition?
-



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## Transfer checklist for physician at hospital *(cont.)*

- Do you reasonably believe that the receiving facility is able to manage the patient's medical condition and any reasonably foreseeable complications?
  - Have you informed the patient of the risks versus the benefits of the transfer?
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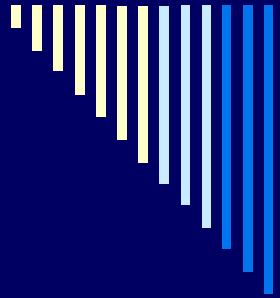


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## Transfer checklist for physician at hospital *(cont.)*

If the patient isn't medically stable –

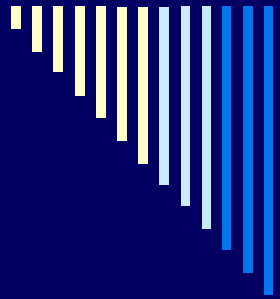
- Have you signed a certification that the benefits of transfer outweigh the risks?
  - Alternatively, has the patient him/herself or a legally responsible person acting on his/her behalf requested the transfer in writing, ), after being informed of hospital's EMTALA obligations and of the risk of transfer?
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## Transfer checklist for physician at hospital *(cont.)*

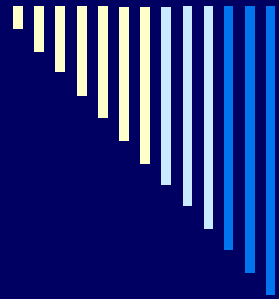
- Does the receiving hospital have available space and qualified personnel for the treatment of the patient?
  - Has the receiving hospital agreed to accept the transfer and provide appropriate treatment?
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## Transfer checklist for physician at hospital *(cont.)*

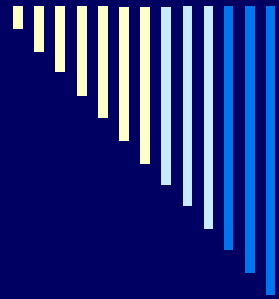
- Have you made a determination of the most appropriate mode, equipment, and attendants to effect the transfer?
  - Have you written in the medical record the basis for all of these determinations?
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## Transfer checklist for physician at hospital *(cont.)*

- Are appropriate medical records accompanying the transfer?
  - Have arrangements been made for any late-arriving test results to be faxed or forwarded to the receiving hospital?
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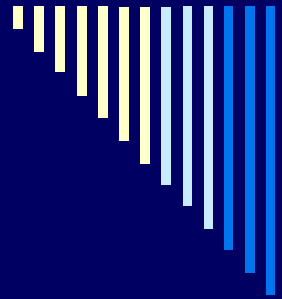


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## Transfer checklist for physician at hospital *(cont.)*

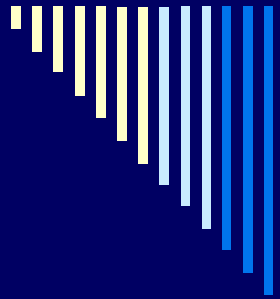
If the patient isn't medically stable –

- Is a copy of your certification or the patient's signed request for transfer accompanying the transfer?
  - Have you included in the medical record at your own hospital your certification or the patient's written request for transfer?
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# Transfer checklist for on-call physician

- Did you come in to the hospital?
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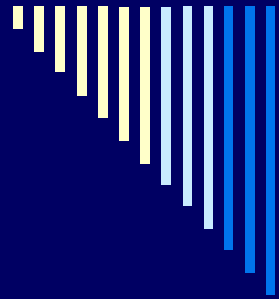


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## Transfer checklist for on-call physician *(cont.)*

If you order a transfer without coming in –

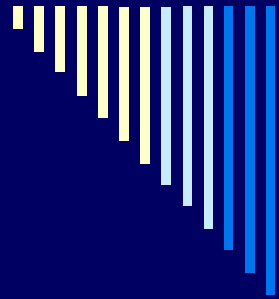
- Did the patient require specialized services not available at the current hospital?
  - Are the medical benefits of transfer greater than the risks of transfer?
  - Would delaying the determination of these questions until you get to the hospital increase the risks to the patient?
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## Transfer checklist for on-call physician *(cont.)*

- Did you consult with an emergency department physician or qualified medical person at the emergency department before making the determination that transfer was necessary?
  - If the patient was capable of it, did you consult with the patient?
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## Transfer checklist for on-call physician *(cont.)*

- If there was no physician in the emergency department, and a QMP signed the certification, have you co-signed it?

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Questions?

## What EMTALA Means to the Practicing Physician

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