

REDUCING PROFESSIONAL AND FINANCIAL RISK UNDER EMTALA

A Review of Current EMTALA and
Florida Law



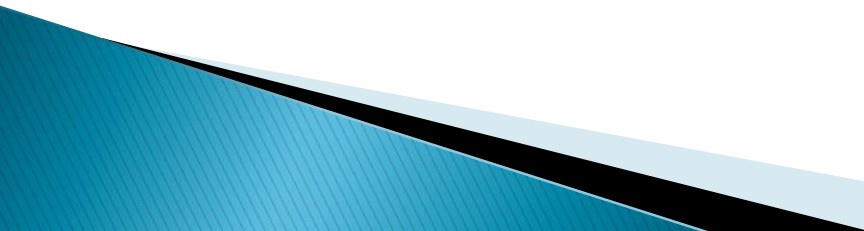
Some Recent Headlines

South Carolina Hospital Fined \$1.28 Million for EMTALA violations

Doctor fined \$40,000 for not showing up at Emergency Room

Chicago Hospital and Docs settle EMTALA lawsuit for \$12 Million

Why have this Education?

- ▶ CMS requires hospitals to regularly conduct training for staff and all On-Call Physicians on EMTALA
 - ▶ An EMTALA violation affects the entire Hospital
 - ▶ EMTALA investigations are time-consuming and disruptive to both Hospital and physicians
 - ▶ EMTALA is rarely the end of CMS scrutiny
 - ▶ EMTALA affects Patient Satisfaction and public relations and image of Hospital and Physicians
 - ▶ Fines, penalties and civil judgments are very expensive
 - ▶ EMTALA violations and associated costs and attorneys' fees are frequently excluded from professional liability insurance coverage
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What is the CMS Compliance Expectations for EMTALA:

100% Compliant on a 24/7/365 Basis

Receiving hospitals are required to report 100% of any suspected EMTALA violations within 72 hours of patient arrival

Patients, hospital staff and physicians who report EMTALA violations are 100% protected from retaliation or adverse employment action

The Federal EMTALA Statute:

42 U.S.C.A. Section 1395dd and 42 C.F.R. 489.24

- ▶ The Hospital must provide an appropriate medical screening examination within the capability of the Hospital to any individual who comes to the emergency dept. and requests examination or treatment to determine whether or not an emergency medical condition exists
- ▶ If an emergency medical condition exists the hospital must provide such treatment as may be required to stabilize the medical condition or transfer the patient as permitted by law.

Florida's "EMTALA" Statutes

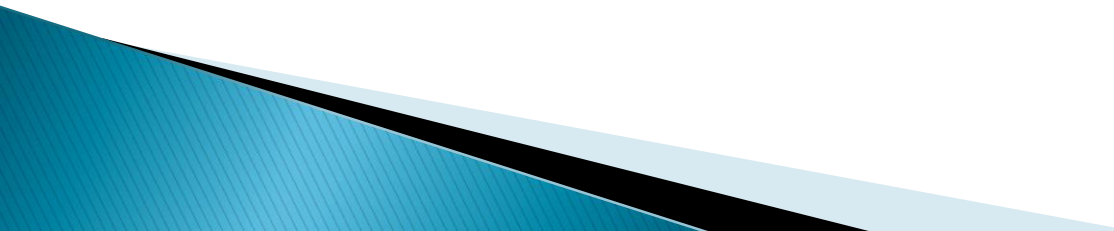
Florida Statutes Section 395.1041 and F.A.C. 59A-3.255

- ▶ Every Hospital which has an emergency department must:
 - ▶ • provide emergency services and care, within the hospital's service capability, for an emergency medical condition when any person requests such care or when requested by any emergency medical services provider providing care to or transporting the person
 - ▶ • a Hospital may not discriminate in providing emergency care, including economic, insurance status or ability to pay

The interpretation and application of both Federal EMTALA and Florida EMTALA require:

- ▶ 1. The Wording of the Statute itself
- ▶ 2. The Federal EMTALA Regulations – 42 C.F.R. 489.24
- ▶ 3. Medicare State Operations Manual – Provider Certification Appendix V
- ▶ 4. Applicable Case Law interpreting these Statutes and Regulations in published case decisions and legal opinions

Consequences of Violation: Regulatory Actions

- ▶ HHS Fines of up to \$50,000 per Occurrence (both the Hospital and the Physician(s)), including the ER and On Call physician, jointly and severally – not dischargeable in Bankruptcy
 - ▶ Suspension or Revocation of Medicare Provider Agreement and Status (Hospital)
 - ▶ Exclusion from Participation in Medicare and Medicaid (Physician and Practice)
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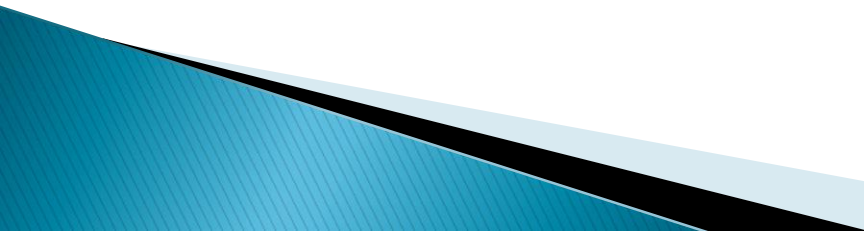
Consequences of Violation: Civil Actions (lawsuit)

- ▶ For damages and injuries caused by or associated with an EMTALA violation
 - Federal Statute – Hospital Only Liability – also brought by a “Receiving Hospital” – Brought in Federal Court only
 - However, if care by the Physician was below the applicable Professional Standard of Care, Federal Courts have permitted included Professional Liability Actions for negligence under State Law claims
 - Florida EMTALA – State Court statutory cause of action against Hospital, Physician and Staff for personal harm caused by a violation of Florida EMTALA for a 1) refusal to examine or 2) any examination or care which falls below Standard of Care and therefore constitutes a failure to provide necessary treatment, including damages and attorneys’ fees.
 - Physician who violates EMTALA may be held liable as a third-party defendant for contribution or indemnity in patient’s EMTALA and malpractice lawsuit against hospital.
McDougal v. Lafourche Hospital

Breaking It Down

- ▶ “Individual” is:
- ▶ Any person who “comes to the Emergency Department”, **without regard to his or her status, insurance coverage, eligibility for Medicare or Medicaid, or ability to pay for emergency medical services *and without differentiation as to the care or treatment provided.***
- ▶ Minors, without consent of parent or guardian obtaining the consent would delay **an examination.**
- ▶ Persons in custody of law enforcement are considered Individuals under EMTALA and have been extended EMTALA rights by Federal Courts.

“Comes to the Emergency Department”

- ▶ – Patient presents to the E.D.
 - ▶ – Patient is on hospital property within 250 yards of the hospital “main building”
 - ▶ – Patient in a vehicle owned by the hospital for patient transport
 - ▶ – Patient in a non-hospital owned ambulance at the time the ambulance arrives on hospital property
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“Requests examination or treatment”

- ▶ It is sufficient if the Individual (or someone acting on his or her behalf) *intends* to seek emergency medical treatment – no specific form of request is required.
- ▶ If the Individual’s appearance or behavior would cause a “prudent layperson observer” to believe or conclude that a medical examination or treatment is or may be needed.

“Examination”

- ▶ Under EMTALA, an “Examination” means:
- ▶ The process required to reach, *with reasonable clinical confidence*, the point at which the Individual does or does not have an Emergency Medical Condition. It is not limited or isolated to Triage, although most Examinations begin with Triage.

CMS' Requirements for Examination

- ▶ E.D. Log Entry with Disposition
- ▶ Triage record
- ▶ Ongoing recording of Vital Signs
- ▶ Oral history
- ▶ Physical Examination
- ▶ Use of all necessary available testing
- ▶ Use of On Call Physicians when appropriate
- ▶ Vital Signs at Discharge or Transfer and

Appropriate Documentation of the above

Hospital Practice Guideline or Protocol should be used to avoid variances and *Differentiation*

The Medical Screening Examination must be *within the Hospital's Capability*

- ▶ The term “within the Hospital’s Capability” applies both to the Medical Screening Examination and to any Treatment provided.
- ▶ The Code of Federal Regulations and Medicare State Operations Manual state that it means “within the capabilities of the staff and facilities available at the hospital” and includes “ancillary services routinely available” **including those provided by On Call Physicians and physicians in other departments, per rules and procedures which have been adopted by the hospital, and includes those services, resources and staff which are available to Inpatients.**

Other Medical Screening Examination Requirements

- ▶ It should be performed by a qualified physician
- ▶ It may be necessary for an On Call Physician to perform the Examination
- ▶ It may only be performed by a non-physician, IF:
 - The non-physician is qualified by licensure, education, training and experience to perform medical screenings for Emergency Medical Conditions
 - The Hospital has designated in its By-laws or published Rules and Regulations the criteria for determining whether the non-physician is so qualified and has specified practice limits
 - The hospital has fully complied with its By-laws or Rules and Regulations
 - The hospital has fully documented the qualifications process and designated the non-physician in writing

Definition of “Emergency Medical Condition”

- ▶ It is a Legal definition, *not* a Medical or Clinical definition

Federal EMTALA:

A medical condition manifested by acute symptoms of sufficient severity (including pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the Individual or fetus in serious jeopardy
 - Serious impairment to bodily functions
 - Serious dysfunction of any bodily organ or part
 - And with respect to a pregnant woman having contractions:
inadequate time for a safe transfer or when transfer poses a threat to the health of the mother/unborn child
- ❖ Florida EMTALA definition is nearly identical

Obligations of the Hospital and Physician:

If the Medical Screening Examination determines that an Emergency Medical Condition exists, the Hospital (and the Physician) are required to:

- ▶ 1. Provide such further medical examination and such treatment **as is required to stabilize the medical condition**, within the **capabilities of the staff and facilities available** at the hospital, or
- ▶ 2. Transfer the individual to another medical facility **as permitted by the (EMTALA) statute.**

How does CMS define a “stabilized the medical condition”?

If the treating physician in the Emergency Department (including an On-Call physician) determines that:

- ▶ The emergency medical condition has been resolved (even if the medical condition persists);
- ▶ The patient is considered stable for discharge: when the treating physician determines with reasonable clinical confidence that the patient has reached the point where treatment can be reasonably performed on an outpatient basis; or
- ▶ No material deterioration is likely, within reasonable medical probability, from or during a transfer
- ▶ CMS interprets “Stabilized” for EMTALA purposes as a different, HIGHER standard than “clinically stable”

Issues and Problems

- ▶ There is no definitive or conclusive Legal definition of “Stabilized Medical Condition”.
- ▶ Courts allow a physician’s determination as to “stabilized” to be reviewed and determined by a Jury under a professional negligence standard.
- ▶ A patient can be considered medically “critical” and still be legally considered as “stabilized” under EMTALA (Brooker v. Desert Hospital)
- ▶ Inability or lack of capabilities to stabilize patient mandates a transfer to another facility
- ▶ Creates two sets of rules for patient transfers: “stabilized” and “unstabilized” patient transfers

Inpatient Admission and EMTALA

- ▶ CMS takes position that EMTALA and the “obligation to stabilize” no longer apply once the patient is admitted as an In-patient.
- ▶ Caveats:
 - The Inpatient admission must be medically appropriate at the time of admission
 - The patient must receive appropriate in-patient care designed to address the cause of the emergency medical condition (Morgan v. North Miss. Medical Ctr.)
- ▶ Admission to Observation does NOT terminate the EMTALA obligations

Hot Topic: Issues relating to Behavioral Health or Psychiatric Patients

- ▶ Patients presenting with symptoms of significant behavioral health disorders or psychiatric disturbances, including of ideations of suicide, and symptoms of substance abuse are covered by EMTALA and must be given an adequate and appropriate Medical Screening Examination. This is a separate and independent requirement of any other applicable law, including the Baker Act.
- ▶ The Examination must be performed by a physician or an authorized professional (By-laws must provide for the same)
- ▶ These Disorders and behaviors can constitute an “Emergency Medical Condition” requiring Stabilization

CMS has never developed a definitive list of EMC or guidance for such patients

- ▶ Prior drafts or proposals have included the following as types of EMCs:
 - Drug or alcohol induced coma
 - Severe depression with ideations of suicide
 - Delusions
 - Assaultive, self-mutilative, or destructive behaviors
 - Inability to meet nutritional needs
 - Impaired reality testing
 - Delirium tremens, detoxification impacts or seizures

What does EMTALA require:

- ▶ 1. An appropriate and reasonable Medical Screening Examination by a physician or authorized professional. (Note: not every possible condition or diagnosis must be detected)
- ▶ 2. Stabilize the patient. Definition: When the patient is protected and prevented from injuring or harming himself or others. The period of Stabilization may be temporary in order to permit appropriate transfer of the patient and may include lawful and reasonable physical or chemical restraints when clinically indicated and appropriate.
- ▶ Caution must be exercised in Discharging a patient who has been Stabilized (*Moses v. Providence Hospital*, but see *Pettyjohn v. Mission St. Joseph's Health System*)

Issues dealing with Pregnant Patients and Labor

EMTALA clearly covers Patients in Labor (*i.e.* the “LA”)

- ▶ “Labor” under EMTALA is defined to mean the patient experiencing contractions, except in the case of “false labor”.
- ▶ Patients experiencing contractions cannot be legally determined to be in “false labor” unless:
 - 1. Patient is observed for a **reasonable time**
 - 2. Physician or **specially qualified** practitioner makes the determination
 - 3. The determination of false labor is **appropriately documented**.

Any “emergency medical condition” must be stabilized.

“Stabilized” for actual Labor means: Delivered or Contractions have stopped.

Transfers of Patients

- ▶ Transfer = Movement of the Patient to anywhere outside the Hospital facility, including discharge from the E.D.
- ▶ Transfers of Patients with an Emergency Medical Condition from the E.D. can only be performed in two circumstances:
 - 1. When the EMC has been Stabilized; or
 - 2. As to a non-Stabilized patient, when **all regulatory requirements are satisfied and met**

Requirements for Non-Stabilized Patient Transfer:

1. The Patient **has requested** transfer to another medical facility; has been fully informed; and the **physician* has certified** in writing that the benefits of transfer outweigh any medical risks; and **appropriate documentation is made**, or
2. The hospital **does not have the capacity to treat and transfer is medically indicated and appropriate and is fully documented**;
3. Receiving facility is provided **all medical records**; and
4. **Qualified and appropriate transport is available and actually utilized.**

A Patient in Labor may **only** be transferred under scenario No. 1 above

When do EMTALA Obligations End?

- ▶ 1. When the Medical Examination Screening determines there is no Emergency Medical Condition present.
- ▶ 2. When the Emergency Medical Condition has been resolved;
- ▶ 3. When the Patient's Emergency Medical Condition has been Stabilized;
- ▶ 4. When a proper and legal Patient Transfer has been effected and completed, including Discharge from the E. D. **with appropriate discharge instructions and a follow-up care plan.**
- ▶ 5. When the Patient is admitted as an In-Patient and appropriate Inpatient care is provided.

EMTALA Obligations relating to On-Call Physicians

- ▶ The hospital must maintain a list of physicians who are on call for duty after the initial examination to provide further examination, evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition. 42 C.F.R. 489.20(r)(2) and a Condition of Participation in Medicare
- ▶ The list must be composed of members of the hospital's medical staff and must reasonably reflect the needs of the community and the capabilities of the hospital to provide [inpatient] care to its served patient population.

Specific Duties of the On-Call Physician:

- ▶ 1. To take and timely respond to a call from the attending or treating physician in the E. D. – ER Physician is in control, the On-Call physician has no ability or authority to make a decision as to whether or not to come the hospital. (Conflicts must be resolved through a process set forth by a *written* procedure or protocol).
- ▶ 2. To appear, in person, at the hospital in a reasonable period of time after the call is received. (CMS recommends 30 minutes, but generally no more than 45 minutes to 1 hour – include in Medical Staff By-laws).
 - Having an Extender or Nurse respond to or take the call in lieu of the physician is an immediate EMTALA violation
 - Must Discontinue seeing patients in the office and not commence a new procedure or surgery (Medical Staff By-laws)
- ▶ 3. To provide further examination, evaluation and treatment to the patient to stabilize the emergency medical condition
- ▶ 4. To arrange for Transfer of the patient to another facility when appropriate.

Other Common On-Call Physician EMTALA Violations

- ▶ 1. Refusing to come to the E. D. based on disputing or arguing with the E. D. physician over results of the medical screening examination, the determination of existence of an Emergency Medical Condition prior to Physician examining patient.
- ▶ 2. Attempting to substitute an Extender or Nurse for the On-Call Physician.
- ▶ 3. Having the patient come to the physician's office for examination or treatment when the patient's condition has not been stabilized. (Also deemed an improper and illegal patient transfer.)
 - If the physician has special diagnostic or treatment equipment needed for stabilization of the patient which cannot be moved to the hospital, then an unstable patient can be "transferred" to the physician's office provided all transfer criteria, processes and documentation are met or fulfilled.
- ▶ 4. Discriminating in types or scope of treatment among patients based on insurance status or ability to pay.

Is the On-Call Physician Obligated to see a Patient for Follow-Up?

- ▶ Under the terms of the EMTALA statute and Regulations: **NO**, the physician is not obligated. (Phillips v. Bristol Medical Center)
- ▶ However
- ▶ The Medicaid State Operations Manual states that follow up care responsibilities of On Call Physicians are to be addressed through the hospital's Medical Staff By-laws
- ▶ **But the Physician may not be “off the hook”!**

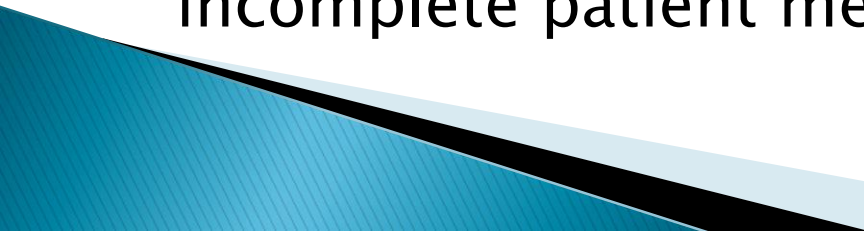
How some Courts have dealt with On-Call Physician Follow-up care responsibilities:

- ▶ 1. Courts have created a fiction and then used the argument that the EMC was never actually stabilized.
- ▶ 2. Held the hospital responsible under EMTALA for disregard of the Hospital's duty to arrange appropriate follow-up care at time of Patient's discharge from E. D.
- ▶ 3. Held the physician liable in a civil action for professional negligence based on the premise of the formation of a physician-patient relationship (when the On-Call physician has spoken with or has seen the patient)
- ▶ 4. Held the physician liable based on a theory that patient is the intended beneficiary of a oral contract between the hospital and On-Call Physician when the E. D. has made arrangements with the On-Call physician for follow-up as part of the post-discharge process

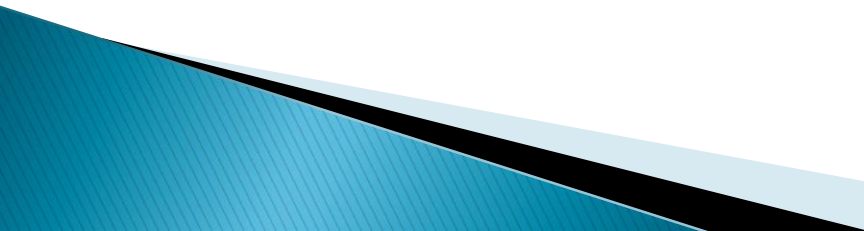
The 10 Most Common EMTALA Violations (based on Citations and Fines issued)

- ▶ 1. Lack of required or appropriate Policies and Procedures:
 - Who is authorized to perform an MSE
 - Timeliness standard for On-Call Physicians and On-Call Physician “availability”
 - Responsibilities to provide post-discharge follow-up care
 - Protocols and procedures for patient transfers
 - Protocols and procedures for MSE of behavioral health and substance abuse patient
 - Every other EMTALA Violation will include a Policies and Procedures Violation

10 Most Common (cont'd)

- ▶ 2. Untimely, inadequate or incomplete Medical Screening Examination
 - ▶ 3. Inadequate or Insufficient Stabilizing Treatment
 - Discrimination or disparity of treatment based on ability to pay
 - Treatment of insufficient type or duration
 - Treatment or Stabilization delayed
 - ▶ 4. Inappropriate Transfer of Patient, including criteria for transfer not met, physician certification, lack of transfer arrangements with receiving hospital, method of patient transport, and incomplete patient medical records
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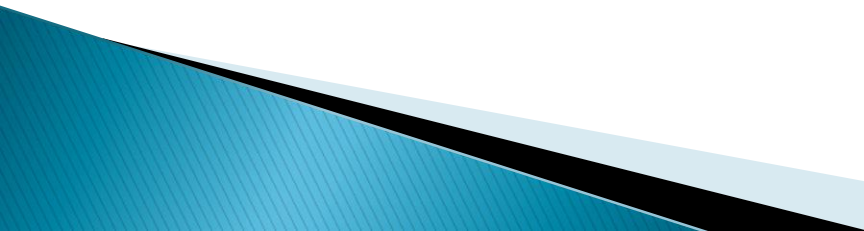
10 Most Common (cont'd)

- ▶ 5. On Call Physician violation
 - Timeliness of answering Call and Availability
 - Illegal substitution of Extender or RN
 - Disparity in Treatment based on ability to pay
 - Diversion of Patient to Physician's office
 - ▶ 6. Discrimination in Treatment
 - ▶ 7. Behavioral Health and Substance Abuse Patients
 - Improper or inadequate MSE
 - Failure to appropriately Stabilize
 - Discharge prior Stabilization or inadequate Follow Up Care plan
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10 Most Common (cont'd)

- ▶ 8. Pregnant Patients or Patients in Labor
 - Inadequate MSE
 - Failure to properly document “False Labor”
 - Improper Discharge

 - ▶ 9. Absence of EMTALA Education and Training of Staff and Physicians

 - ▶ 10. No, wrong or inadequate Patient Discharge instructions from the E. D.
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QUESTIONS?

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