

Federal Law and the Mercy Physician

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From discussions with PMHS Counsel Rebecca O'Connor, J.D., PMHS Consultant Alan Steinberg, J.D., MHP Psychiatric Coordinator Patricia Neumeyer, MSW and information provided by Stephen Frew, J.D., Robert Bitterman, M.D., FACEP, J.D., and Daniel Sullivan, M.D., FACEP, J.D. Quotations from Stephen Frew reproduced with permission.

Introduction and Summary

Would you be surprised to find a federal inspector arriving in your office? Perhaps handing you a bill for \$50,000, due immediately? And cutting off all your Medicare payments? It could easily happen to you, or to someone you know.

You are at risk if you violate any of the terms of the Federal ***Emergency Medical Treatment and Active Labor Act***. (And no, this doesn't just apply to docs working in the ED.) Do you know how easy it is to violate this law without knowing it? As it turns out, it's **very** easy to violate this law, and "ignorance of the law is no excuse."

This law is known as the "anti-dumping act," "COBRA" (from "Consolidated Omnibus Budget Reconciliation Act," where it first appeared), and the "Patient Transfer Act," but usually as **EMTALA**.

Why does it exist?

EMTALA exists because doctors and hospitals were bad, the public was screaming, and Congress did something about it.

In 1985, Eugene "Red" Barnes came out of an abandoned "crack house" with a stab wound in the left side of his head, and collapsed in front of bystanders. When he arrived at Brookside Hospital, the emergency physician examined him and called the on-call neurosurgeon -- but the neurosurgeon refused to accept the patient. The emergency physician called a second neurosurgeon (not on call) who refused to take care of the patient. The emergency physician called two nearby hospitals with neurosurgeons on staff. The neurosurgeon at one of the hospitals refused the patient because he was too tired. The other hospital refused to accept the patient unless the emergency physician performed burr holes in the ED. Finally a third hospital with neurosurgery agreed to take the patient, but only if the emergency physician rode along with the patient in the ambulance. So Mr. Barnes' care was, shall we say, a bit delayed. So it's not surprising that, even with (finally) getting surgery, Mr. Barnes died three days later.

This case made the term "patient dumping" a hot item. Dumping was widely discussed in the press, including a piece by Dan Rather on [the national news](#). Attorney Melvin Belli took the case to court and won a five million dollar verdict against Brookside hospital and physicians there.

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As Congress was investigating, many other cases came to light, even more blatant. And they continue to this day. Here is a headline from the Public Citizen web page (<http://www.citizen.org/hrg/healthcare/articles.cfm?ID=6148>):

FLORIDA: Baptist Hospital, Miami

A woman presented to an ER with abdominal pain. She was found to have a large mass in her lower abdomen as well as an elevated white blood cell count, possibly indicating infection. She was admitted for surgery. Before the surgery took place, the surgeon visited the patient and requested a deposit prior to his performing the procedure. The patient stated she did not have the deposit, so the surgeon gave orders to discharge her. She left without receiving treatment.

There were cases when small hospital EDs had critically ill patients who needed to go to a big hospital, but the small hospital couldn't transfer the patient. The big hospitals had beds. The big hospitals had specialists who could treat the condition. But the big hospitals didn't want uninsured patients. And the big hospitals didn't want patients with the "wrong" insurance. And as a result, people died. See <http://www.medlaw.com/oklacase.htm> for the court records from another particularly blatant example. As you read the record of this hearing, it's easy to sympathize with the moonlighter in the small ED. He had a dying patient trauma patient on his hands and couldn't get anyone to take the patient.

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There were cases of hospitals refusing uninsured patients in active labor, with resulting dead babies. (Bad press, that.)

I won't elaborate more. Just let your imagination go wild -- and you *may* come close to how bad this sounded to the public and Congress. And then you'll understand why Congress enacted EMTALA. And then you'll understand why, if you, or your hospital, complain about the inconvenience of EMTALA compliance, the Federal government and the people of the United States just *don't care*.

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Summary: Some physicians and hospitals were greedy and lazy. Our medical community failed to act against the bad apples. The public became outraged. And the Feds stepped in with EMTALA. And if you say we should police ourselves: *too late*. EMTALA's already Federal law and we have to live with it. All of us.

As Linda Karr of the Philadelphia CMS Office puts it (my paraphrase of our 5/8/02 phone conversation): Basically, we're patient advocates. If someone is doing their best to take care of a patient as best they can, they're not likely to be cited. The old dictum of 'treat the patient as if it were your mother and then you'll probably be OK if you get into court' applies pretty well to EMTALA situations. But, as people say, "the devil is in the details" and there are some sneaky details that might trip you up. But the easiest way to start approaching EMTALA is to analyze the four most critical parts. First the money bit, and then the three central principles.

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\$50,000 Fines

CMS, the Centers for Medicare & Medicaid Services, previously **HCFA** (the Health Care Financing Administration), is part of the Department of Health and Human Services (DHHS) which has an Office of Inspector General (OIG). The OIG investigates complaints of EMTALA violations. And if they find a violation, they can

assess fines of \$50,000 per incident -- against hospitals and against individual physicians. Note that this is *not* covered by malpractice insurance, and does *not* have to go through a court. If the investigator finds you've been bad, you get fined, that's it.

If the investigator finds the you or the hospital has been bad, they not only fine you, they cut off all Medicare (and maybe Medicaid) payments to you or the hospital. Permanently. Well, maybe not permanently. If you grovel in public, admit how bad you've been, and show how you've changed and will never be bad again, they may let you off the hook. (Think of the Chinese court system where public self-criticism is required.) You *can* appeal to CMS/DHHS, and even if they rule against you, you can go to court to try to get things reversed.

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EMTALA Principles

There are many more details than can be covered in this article, as long as the second part of it may be. Some specific implications for your practice are discussed in the second part of the article (*Nitty-Gritty Details*, below.) But there are the three important principles of EMTALA - a violation of any one of these principles can get you or the hospital fined and your Medicare payments shut off.

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Yes, you can challenge the fines and the cutoff of Medicare payments, but good luck. Certainly, If you grovel in public, admit how bad you've been, and show how you've changed and will never be bad again, they may let you off the hook. (Think of the Chinese court system where public self-criticism is required.)

These three principles are as follows.

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I. Principle the First: Medical Screening Exam and Stability

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Everyone who Comes To The Hospital and who makes a Request for Emergency Care must receive a Medical Screening Exam that is the same for everyone, regardless of insurance, lack of insurance, race, color, smell, or anything else. (Originally this was all about insurance, but the law is about equal treatment in general.) Everyone whose Medical Screening Exam shows an Emergency Medical Condition must have Commencement of Stabilizing Treatment prior to any disparate treatment, *especially* any discussion of ability to pay or insurance coverage or HMO membership.

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What if someone is in the ED just because it's a convenient place for the plastic surgeon to take out some stitches, or for the orthopedist to replace a splint with a cast, or the police bring someone in for a blood alcohol? As long as there is no Request for Emergency Care, then EMTALA doesn't apply.

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Note the capitals. Each of these terms has a legal definition that's *not* the same as the common understanding of the term. "Emergency Medical Condition" is *not* the same as "emergency medical condition." A sprained ankle or ear infection may not be an "emergency medical condition" but it certainly is an "Emergency Medical Condition." Got it?

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"Stability" is a difficult concept under EMTALA, and there are five types of stability:

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1. Unstable

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You shouldn't transfer unstable patients, unless the hospital can't care for the patient, and benefits of transfer outweigh risks.

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2. Stable for Transfer

A patient is Stable for Transfer when you can state about the patient, *within reasonable clinical confidence*, that there will be *no material deterioration in his/her medical condition* during transport. (Quotes from the official HCFA/CMS Interpretive Guidelines). Unless the hospital doesn't have the capacity to care for the patient, the patient must be Stable for Transfer before you can transfer the patient.

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3. Commencement of Stabilizing Treatment

This is when the Emergency Medical Condition has been identified, and we've started appropriate care, but the patient isn't yet stable for discharge. If you want to consider transferring the patient based on insurance, this is the level of stability you've got to get to. However, the patient has to be **Stable for Transfer** as well. For example, someone who you think may have an MI and are admitting as a "rule-out" is pretty much not stable for transfer (see EMTALA: The Nitty-Gritty Details: EMTALA Stability, below, for details).

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4. Stable for Discharge

This is when any Emergency Medical Condition has been treated (at least partially) and the patient is stable enough that the patient can be discharged to home, or to jail or prison, or to a non-hospital psychiatric or drug detox treatment facility. (Note that the same criteria for stability apply to all of these which are "discharges" and not "transfers"; under EMTALA, you only "transfer" to another hospital.) However, it is possible to discharge someone whose Emergency Medical Condition has not yet resolved, provided you've made adequate arrangements for follow-up care.

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5. Emergency Medical Condition Has Resolved

This is the gold standard. Patient is "all better."

II. Principle the Second: On-Call Docs

This doesn't just deal with the Emergency Department. The ***entire capacity of the hospital***, whatever we offer to paying inpatients, has to be available to every drunken bum who staggers into the hospital and asks for help. That includes on-call docs for every specialty at the hospital. And whoever is on-call isn't on-call for their service, they're on-call for the ***hospital***, and are legally acting for the hospital. And if the on-call doc doesn't answer the page, or refuses to come in when requested by the ED, or refuses to admit a patient, then the on-call doc is bad, has to be disciplined by the hospital, and the hospital may share in liability for whatever the on-call doc did (or didn't).

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III. Principle the Third: Obligation to Accept Transfers

Under EMTALA there is also, unrelated to Medical Screening Exam or Emergency Medical Condition issues, a responsibility for hospitals to take transfers. If any hospital in the U.S. calls and says they have a patient they can't take care of, for whatever reason, and it's something we can take care of, ***we have to take the***

patient. No ifs, ands, or buts, **we have to take the patient.** We shouldn't even *ask* about insurance, lack of insurance, or HMO status.

(Well, there **are** actually a few ifs, related to whether we really can take care of the patient or not. If we don't have beds, or the on-call doc isn't available, the emergency physician on duty in the ED can refuse the transfer.) The new Pittsburgh Mercy Health System transfer acceptance policy now says:

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An official version, with a reporting form, is available online at <http://www.pitt.edu/~kconover/DEMweb/mercy-transfer.pdf>.

To summarize and expand, even at the risk of belaboring the non-obvious.

I. Medical Screening Exam, Emergency Medical Conditions, Commencement of Stabilizing Treatment, and Stabilizing

- ❖ Everone and anyone who comes to our hospital and who makes a Request For Emergency Care has to be treated the same regardless of insurance, HMO status, or lack of insurance, as follows:
- ❖ We've got to do a Medical Screening Exam, that has to be the same for everyone, and that is designed to uncover any potential emergency condition. (And to the Feds, an emergency condition includes a kid's untreated otitis media, so we're not talking just cardiac arrests and traumas here.)

The Medical Screening Exam has to be by a physician, unless we have a written policy that some other medical personnel can perform the Medical Screening Exam. Mercy and MPH allow a CRNP or PA supervised by a physician to do the Medical Screening Exam; under EMTALA, residents can perform a Medical Screening Exam if they have the independent right to write prescriptions without a countersignature. [Stephen Frew, 4/24/00 website comment]

- ❖ We've got to stabilize any emergency conditions we find, or at least Commencement of Stabilizing Treatment before we can even consider treating people differently based on insurance. Even *asking* about insurance prior to the Medical Screening Exam and Commencement of Stabilizing Treatment can be considered an EMTALA violation if the patient leaves as a result, because CMS may consider it "financial coercion." [Stephen Frew, 8/7/00 and 3/9/02 website comments] It *is* OK to gather standard financial information from patients prior to the Medical Screening Exam, provided we do it the same way for everyone and it in no way delays or prevents the Medical Screening Exam or Commencement of Stabilizing Treatment.

On-call docs

- ❖ If we have a specialty on staff at our hospital: we have to have an ED on-call list for that specialty.
- ❖ All docs on Active Staff have to take call (and Courtesy Staff may have to take call).

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- ❖ Whoever is on call has to come to see a patient within a “reasonable time” (30-60 minutes) whenever the ED calls with an emergency consult to see the patient. No exceptions, unless the consult is just to admit, or just to discuss a case.

Accepting Transfers

Please see the new Pittsburgh Mercy Health System Transfer <http://www.pitt.edu/~kconover/DEMweb/mercy-transfer.pdf>

- ❖ If a hospital wants to send us a patient because they can't take care of the patient, and we have the beds (even if just in the ED) and the on-call specialists to care for the patient, that the sending hospital lacks we have to accept the patient for transfer. (See the official PMHS policy about this, above).
- ❖ This applies regardless of whether we “take” the patient's insurance, regardless of whether the patient has any insurance, and regardless of whether the patient is “stable” in EMTALA terms.

The sections below contain the detailed working-out of these principles, as derived from court decisions, CMS (née HCFA) decisions and advisories and letters, interpretive guidelines for the OIG (Office of Inspector General) inspectors, and opinions of those expert in the field. These sections only contain those aspects that impact directly on physician practices; there's a lot more about EMTALA that I've left out (logs, etc.). I've focused primarily on aspects applicable to docs who have privileges at Pittsburgh Mercy Health System, but the principles apply at any hospital in the U.S. that gets Medicare money (i.e., except for VA and military hospitals).

If you have a feeling that there is worse to come below, you're absolutely right. As it turns out, there are many, many implications of EMTALA that aren't immediately obvious from the above principles. These are covered in the big section on Nitty-Gritty Details, below.

But, as you learn more about EMTALA, and you get that sinking feeling in the pit of your stomach, think again. For the most part, what EMTALA requires us to do is “do the right thing for the patient.” Yes, it may require us to do some silly things. But mostly it just requires us to be good doctors.

Disclaimer and References

The article is written, as much as possible, in plain, simple, non-legal language, and as a result won't make lawyers or even persnickety and knowledgeable doctors entirely happy. It's written for physicians and surgeons, not for lawyers, administrators, or anyone else, so it leaves out many of the non-physician-related aspects of EMTALA. It represents a detailed review of all of the available literature on EMTALA as of early spring 2002. One of the problems in dealing with EMTALA is that of figuring out what it really means. CMS (née HCFA) says that everything you need to know is in the law, the attendant regulations, and the official Interpretive Guidelines the CMS regional offices use to enforce the law. [Insert rude noise here] As it turns out, there is a lot more information available, such as letters of clarification

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from CMS regional offices, what CMS has approved in the way of plans of correction after a hospital has been cited, and most importantly, court decisions about EMTALA cases. Where do you find this information? Well, you can review the available publications (see below). Problem is that some of these references disagree, and some are out of date. Or, you can ask a lawyer who has expertise in EMTALA cases, and who has researched it. This article is a synthesis of all of these.

So for more accurate and complete details, please refer to

- ❖ The official *Interpretive Guidelines* put out by HCFA in 1998, available online at http://www.hcfa.gov/pubforms/07%5Fsom/somap_v_001_to_012.htm.
- ❖ the published EMTALA materials, especially the November 9, 1999 document put out by HCFA (available on the two websites [below](#)).
- ❖ the EMTALA forum at www.medlaw.com,
- ❖ Frew's book on EMTALA containing past forum discussions (available at the above website; note that references like [Stephen Frew, 1/1/01 website comment] can apply to past messages available in the book but no longer online),
- ❖ Dr. Dan Sullivan's EMTALA website at www.thesullivangroup.com,
- ❖ the book "Providing Emergency Care Under Federal Law: EMTALA" (Robert A. Bitterman, M.D., J.D., FACEP). available through the American College of Emergency Physicians (www.acep.org).

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There may be significant differences in what these references say. There are differences in interpretation: for example, Stephen Frew, J.D., is known for a strict and conservative approach to EMTALA. But in many cases he is the main source of public information about specific EMTALA aspects. And whatever is in print or online may soon be made obsolete by new court decisions, advisory opinions from CMS, or observed actions by CMS in plans of correction. As much as possible, I have provided references to source materials in the text below.

EMTALA: The Nitty-Gritty Details

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EMTALA Stability

As far as EMTALA, there are five types of "stability" (~~including~~ "unstable") that apply to transfer decisions, as described above, and explored in more detail here. Note that these are not truly "levels" but more like parallel tracks. Thus, it's possible to be "stable for transfer" but not "stable for discharge: Emergency Medical Condition resolved"; or Note also that "Emergency Medical Condition" applies to things that physicians don't see as a true "emergency," e.g., an undiagnosed otitis media!

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5. Emergency Medical Condition Has Resolved

This is the "gold standard": this means the otitis media is no longer painful and the patient is on appropriate antibiotics; the inflamed appendix is out; the

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patient's enzymes are negative and the congestive heart failure has resolved; or the patient is no longer suicidal or grossly psychotic.

4. Stable for Discharge

The patient's condition is adequate for the patient to be managed as an outpatient; the patient no longer requires hospital care. If the patient's Emergency Medical Condition has still not resolved, it's still OK to send the patient home, as long as

(a) the patient really is medically OK to go home, and

(b) you've arranged adequate follow-up (e.g., talked with a follow-up doctor who has agreed to see the patient in the office and continue the workup or treatment).

An example is someone with an undisplaced fracture that requires casting for definitive care, but is currently too swollen to cast. Such a patient can have a non-circumferential splint placed in the Emergency Department, and then be referred to an orthopedist's office in a few days for casting. This is referenced in the HCFA Interpretive Guidelines, Tag A407, where it says: "*Stable for transfer*" or "*Stable for discharge*" does not require the final resolution of the emergency medical condition.

3. Commencement of Stabilizing Treatment

A "middle of the road" and reasonable interpretation of the HCFA regulations would allow you to discuss insurance and transfer based on insurance after you've started actually treating the Emergency Medical Condition.

For an otitis media, this means you can diagnose the patient, start the patient on amoxicillin and Auralgan, and then transfer the patient. Which is silly, because you can send the patient home at this point.

For an appendicitis, this is after you start taking out the appendix, but it's again silly to transfer someone off of the OR table after you're already into the peritoneum. However, once the appendix is out and the patient has no evidence of complications, you could transfer to another hospital for recuperation based on insurance reasons.

For congestive heart failure and chest pain, this means that you've started Lasix and the patient is urinating. And that the patient is pain-free. However, if you haven't ruled out myocardial infarction with multiple sets of enzymes, we know that the patient, statistically, has a small but significant chance of a malignant arrhythmia such as ventricular fibrillation or v. tach (that's why we admit such patients on a monitor, after all). And we also know that such arrhythmias are better taken care of in the hospital than in the back of an ambulance. And therefore there is a good argument that the patient, although stabilizing treatment has started, isn't "stable for transfer" (see below).

For a patient in the Emergency Department who is suicidal or grossly psychotic, this means that the patient has been seen by a psychiatric nurse, you or the psychiatric nurse have consulted in detail with the psychiatrist over the phone, have established and documented a detailed treatment plan, and you have

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started at least part this treatment plan. (See below [under *Psych Issues*](#) for more details.)

Pain relief is clearly part of EMTALA stabilization -- a patient discharged with inadequately-treated pain is "unstable" and an EMTALA violation. [Stephen Frew, 8/3/00 website comment]

Precertification: if you have a patient who requires admission to the floor, or transfer to another hospital when you don't have appropriate beds, delaying this admission or transfer for "precertification" by the insurance company is likely, if investigated, to be cited as an EMTALA violation. *It is not appropriate to seek, or direct a patient to seek, authorization until after the MSE and commencement of stabilizing treatment.* [64 Federal Register 61353 (1999), quoted in Bitterman p. 54] [42 USC 1395dd(h)] See the section on **Psychiatric Issues** near the end of this document for more about "precertification."

2. Stable for Transfer

This means the patient is unlikely to suffer deterioration en route to another hospital. This is the minimum level of stability, and is required prior to transfers for purely medical reasons, unless the patient simply can't be stabilized (see above). Note that this is **not** stable enough for you to discuss insurance issues with the patient or consider transfer for insurance reasons. Specifically, the legal wording is as follows:

For transfer between facilities: a patient is stable for transfer if the patient is transferred from one facility to a second facility and the treating physician attending to the patient has determined, within reasonable clinical confidence, that the patient is expected to leave the hospital and be received at the second facility, with no material deterioration in his/her medical condition; and the treating physician reasonably believes the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of that condition.

If there is a disagreement between the treating physician and an off-site physician (e.g., a physician at the receiving facility or the patient's primary care physician if not physically present at the first facility) about whether a patient is stable for transfer, the medical judgment of the treating physician usually takes precedence over that of the off-site physician.

If a physician is not physically present at the time of transfer, then qualified personnel (as determined by hospital bylaws or other board-approved documents) in consultation with a physician can determine if a patient is stable for transfer.

[HCFA Site Review Guidelines, State Operations Manual, *COBRA Investigations*, Tag A407 Effective: June 14, 1998:

http://www.hcfa.gov/pubforms/07%5Fsom/somap_v_001_to_012.htm]

One difficult question is that of "rule-out MI" patients: are they Stable for

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Transfer? Most clinicians would say "yes" but most lawyers would probably say "no." Here's the logical train of thought from a legal aspect. "Why are you admitting the patient on a monitored bed?" Because the patient might have an MI. "But why a **monitored** bed?" Because those who have MIs have a small but significant risk of a sudden v. fib arrest, especially in the first 24-48 hours. "OK, you're admitting on a monitor because of the danger of sudden cardiac arrest, what if this happens in the back of an ambulance en route to the other hospital?" Well, paramedics are good at managing cardiac arrest. "I see. So you have paramedics run cardiac arrests in the hospital?" Well, no, we have doctors and nurses run the cardiac arrest. "Why?" Well, um . . . "Isn't it because doctors and nurses running a cardiac arrest are better trained, especially if there is a difficult resuscitation?" Yes, but . . . "Do you really think that one paramedic in the back of an ambulance is as good as a full code team in a hospital?" Well, maybe not, but . . . "Wouldn't you say that the patient is safer in the hospital?" Yes, but the chance of cardiac arrest is so small . . . "Well, if it is really so small, why don't you send the patient home?" I give up.

In case you had learned about COBRA/EMTALA prior to 1998, note that in that year HCFA issued new interpretive guidelines that bifurcated "stable" into "stable for discharge" and "stable for transfer." [Bitterman p. 95]

1. Unstable

If the patient is unstable, but the hospital doesn't have the capacity to take care of the patient's Emergency Medical Condition, then a transfer is appropriate, if the benefits outweigh the risks, and this is certified by the physician in writing.

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Transfers, Diversion ("Condition Red"), and Level of Care

When Hospitals Must Accept Transfers

If a hospital has the capacity to care for a patient with specialty needs (e.g., Mercy Hospital and burn patients, or most any big hospital with monitored beds and a stable "rule-out MI" patient), and that hospital gets a request from a hospital without such a capacity, it must accept the transfer. And this applies so long as any sending hospital in the U.S. wants to transfer, even if the hospital is on the other side of the country. Hospitals with appropriate capacity to accept a patient in transfer **cannot** ask about insurance prior to accepting transfers, regardless of "stability."

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And if you try to transfer to a hospital, but the hospital refuses or delays a transfer based on insurance ["reverse dumping"], you should document this carefully in the patient's medical record and report this to your superior, or otherwise if your hospital has specific reporting procedures, for a possible report to CMS (née HCFA). [Stephen Frew, 3/16/02 website comment] *A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units...) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities of facilities if the hospital has the capacity to treat the individual.* This was added to the EMTALA law in 1989 specifically to prevent "reverse dumping." [Bitterman pp. 110, 114] Note that the new PMHS

transfer acceptance policy includes such a form and instructions for reporting (available online at <http://www.pitt.edu/~kconover/DEMweb/mercy-transfer.pdf>)

A letter from November 2001, available on the CMS website (<http://www.hcfa.gov/medicaid/lcsp/112901.htm>) is worth mentioning. It indicates that a hospital must, before it transfers the patient to another hospital due to "lack of capacity," do everything it can reasonably do to care for the patient rather than transferring, **including calling in staff from home**:

Ref: S&C-0206

DATE: November 29, 2001

FROM: Director, Survey and Certification Group, Center for Medicaid and State Operations

SUBJECT: Hospital Capacity-EMTALA

...

1. Requirements for a Sending Hospital When it Lacks Capacity

...

In determining the capability and capacity available at the hospital the surveyor would assess the following criteria as outlined in the SOM [Interpretive Guidelines], Appendix V, Page V-23:

...

The capacity to render care is not reflected simply by the number of persons occupying a specialized unit, the number of staff on duty, or the amount of equipment on the hospital's premises. Capacity includes whatever a hospital customarily does to accommodate patients in excess of its occupancy limits (§489.24 (b)). If a hospital has customarily accommodated patients in excess of its occupancy limits by whatever means (e.g., moving patients to other units, calling in additional staff, borrowing equipment from other facilities) it has, in fact, demonstrated the ability to provide services to patients in excess of its occupancy limits.

...

2. Recipient Hospital Responsibilities

A recipient hospital is obligated to accept a transfer request if a patient is in need of specialized capabilities offered by the recipient hospital and the recipient hospital has the capacity to receive the patient. Even if both the sending and receiving hospitals have similar capabilities and facilities, a patient may require service beyond the capability of the sending hospital [at the time of the transfer], if these services are available at the recipient hospital. In that instance, the recipient hospital is obligated to accept the patient from the sending hospital.

The interpretive guidelines (SOM, Appendix V, page V-34) are clear that a (recipient) hospital has to accept the patient only if:

"the patient requires the specialized capabilities of the hospital in accordance with this section. If the transferring hospital wants to transfer a patient because it has no beds or is overcrowded, but the patient does not require any specialized capabilities, the receiving ... hospital is not obligated to accept the patient.

If the patient required the specialized capabilities of the intended receiving ... hospital, and the hospital had the capability and capacity to accept the transfer but refused, this requirement has been violated."

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Although this last bit might be seen as a way to refuse transfers, in practice it usually possible to argue that “specialized capabilities” includes hospital beds with monitors, or a bed with closer observation and treatment than possible in the ED, so this really does little to restrict the need of hospitals to accept transfers when they have beds and the sending hospital does not.

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The times a hospital can refuse a transfer are if

1. the ED is on divert status and cannot take a single additional patient in the ED, AND no appropriate inpatient beds are available OR
2. the patient requires a higher level of care than the ED (e.g., invasive arterial-line or Swan-Ganz monitoring, if not done in the ED) AND there are no appropriate inpatient beds for a direct admission, OR
3. For whatever reason, on-call speciality or subspecialty physicians or surgeons are not available to take care of the patient.

Please see the new PMHS transfer acceptance policy at <http://www.pitt.edu/~kconover/DEMweb/mercy-transfer.pdf> for PMHS’s specific policy in this regard

If the patient doesn’t really require the hospital’s special capability, it is acceptable to refuse a transfer -- but it is extremely difficult to tell this over the phone, unless it’s something obvious like the other hospital wants to send Mercy a patient for HBO treatment that we simply don’t have. The fact that there are no “burn” beds doesn’t seem to matter as long as we have some sort of ICU beds that could accept a burn patient.

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Transfers for physician convenience are not acceptable under EMTALA. When the patient can be cared for at a hospital, but the physician or patient or family wants the patient transferred to another hospital due to personal choice, are not required by EMTALA. That is, unless one could argue, after the fact, that the patient was being transferred to a “better” hospital and that the transferring hospital really didn’t have the capacity to care for the patient. If the physician requesting transfer states that his or her hospital cannot adequately care for the patient, regardless of whether the transfer request came from patient or family, then the transfer *is* required by EMTALA. [Stephen Frew, 1/28/02 website comment] Regardless of whether EMTALA *requires* a hospital to accept a transfer, all transfers must meet EMTALA requirements such as adequate notification of the receiving hospital, and sending copies of appropriate documentation and x-rays.

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If an inpatient bed is reserved for a transfer, and an equally sick patient comes into the ED, a conservative opinion holds that the transfer gets dibs on the inpatient bed, and that the ED patient must be stabilized as best as possible and transferred if necessary. [Stephen Frew, 8/28/00 website comment] This is a gray area, and in such a situation, it is probably best to let people who know the most about the bed situation and the patients in question (likely the emergency physician and the hospital nursing supervisor) jointly make a decision that provides the greatest good for the greatest number of patients.

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Trauma centers are allowed to refuse all transfers except for trauma patients, and keep a few beds reserved for trauma patients. This does *not* apply to an ICU bed held open for decompensating inpatients (the “arrest bed”) however. [Bitterman p. 113] If

beds are reserved for patients currently undergoing catheterization, surgery, etc., they are considered “full” to CMS; but if the bed is for someone planned to come out of surgery tomorrow, that is not “full” and must be available to accept patients from a transfer. [Stephen Frew, 11/10/01 website comment]

A receiving hospital cannot base its acceptance on an agreement to take the patient back once specialty treatment is complete. “Transfer-back Agreements” can be made between hospitals, but have to be general policies and cannot be applied only to selected patients. [Stephen Frew, 5/11/00 website comment]

Receiving hospitals cannot demand that their ambulances or helicopters or transport teams be used for a transfer. [Stephen Frew, 3/8/01 website comment] If a “sending hospital” is transferring a patient to a “receiving hospital,” under EMTALA the transportation arrangements and costs are the responsibility of the sending hospital. If delays in ambulance transport, due to insurance issues with ambulance payment, might cause the patient harm, the sending hospital may have to make arrangements with another ambulance service and guarantee payment to avoid EMTALA liability. Note too that ambulance services called to perform interhospital transfers may not be bound to respond under EMTALA. [Stephen Frew, 1/16/02 website comment] With virtually no exceptions, **all** transfers, including those to specialty facilities or specialty physician offices, must go by ambulance, with trained medical personnel, rather than privately-owned vehicle; Frew suggests using a patient refusal of ambulance form if a patient refuses to go by ambulance. [Stephen Frew, 11/7/01 website comment]

If a hospital (e.g., an emergency physician at Mercy Providence Hospital) accepts a patient for transfer (regardless of EMTALA “stability”) then it is an EMTALA violation for another physician or nurse to refuse such a transfer, especially if based on insurance status. [Stephen Frew, 8/31/00 and 12/18/01 website comment] If a non-emergency physician wants a patient transferred (for example, after seeing the patient in the ED), then **that** physician has the responsibility for arranging the transfer, not the emergency physician. [Stephen Frew, 2/28/01 website comment] There is no EMTALA requirement that a **physician** accept a transfer; any person acting for the hospital can do so. Frew and other strongly recommend a “on-call” center for accepting transfers. *If it were my choice, I put the ED physician in the coordinator’s role for all transfers, so they are at least aware of what the accepting physicians are doing or not doing and the status of the house to receive additional patients at all times, because the ED doc is the one that ultimately stuck with the patient in a bad situation.* [Stephen Frew, 1/25/01 website comment] Please see the PMHS transfer acceptance policy regarding this:
<http://www.pitt.edu/~kconover/DEMweb/mercy-transfer.pdf>.

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Diversion and “**Condition Red**”: for the ED Only

Under Federal law, which preempts all **conflicting provisions of** state and local laws, divert status (“Condition Red” in southwestern Pennsylvania parlance) relates to the situation in the Emergency Department, and **only** the Emergency Department. If an additional ambulance patient is likely to strain the resources in the Emergency Department to where it is unsafe for patients, then the ED should go on divert status. If a hospital is on “divert” status (“Condition Red”) a hospital can **still** accept transfers to inpatient beds. [Stephen Frew, 3/28/01 and 1/25/02 website comments]

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Transfers, Special Facilities, and “Level of Care”

If a hospital has a specialty rehab hospital within its building, any transfers from the rehab hospital floor to the main hospital ED, or to a main hospital inpatient bed, is a full EMTALA transfer and must meet all EMTALA requirements. If the hospital has a Skilled Nursing Facility (SNF), and the SNF is not physically located at the hospital, EMTALA doesn't take effect until the patient reaches the hospital. If the SNF is using “swing beds” in conjunction with an acute care hospital, CMS will view the beds as acute beds, and internal movement from a SNF bed to an acute bed would thus be exempt from EMTALA. However, movement from this in-hospital SNF to another hospital would be an EMTALA transfer. [Stephen Frew, 4/12/00 website comment] Please see the PMHS transfer acceptance policy regarding this: <http://www.pitt.edu/~kconover/DEMweb/mercy-transfer.pdf>.

Some states require that all patients who are inpatients be transferred to another inpatient bed, not an ED bed, and in those states, EMTALA enforces these state laws. [Stephen Frew, 2/1/02 website comment] Also, some states have laws requiring that a physician accept transfers, rather than a nurse, transfer center person, or other hospital representative. However, per the Pennsylvania Department of Health, there are no such requirements in Pennsylvania.

Transferring a patient from a critical care unit at one hospital to an ED at another hospital will **not** be well-viewed by CMS; the specialist should either be in the ED awaiting the patient, or the patient should go directly to an ICU bed. *Simply accepting a specialty patient and then dropping them in the lap of an emergency physician and Emergency Department is not appropriate care. All patients need prompt evaluation after transfer, because it is an inherently destabilizing event.* [Stephen Frew, 4/13/00 website comment] When Frew helps hospitals develop EMTALA-compliant transfer policies, he generally requires that the accepting physician be there at the hospital to evaluate the patient when the patient arrives. [Stephen Frew, 9/18/00 website comment]

Considering that PMHS has contracts to take care of prisoners, the following is an important point. If a prisoner has a documented need for hospitalization, such as an acute medical or psychiatric condition, it is an EMTALA violation to transfer the patient back to infirmatory or psychiatric facility at the jail or prison unless that facility is licensed as a hospital. [Stephen Frew, 11/7/01 website comment] Neither the Allegheny County Jail nor the State Correctional Institution of Pittsburgh are licensed as hospitals by the state. And what is more important to CMS (née HCFA) is that they are not billing Medicare as hospitals. Therefore, inmates transferred to the ED with Emergency Medical Conditions, including psychiatric Emergency Medical Conditions, cannot be transferred back to the jail or prison until they are Stable for Discharge (not just Stable for Transfer).

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There is a problem associated with this; rules on most locked psychiatric units prohibit firearms, and according to the Commonwealth of Pennsylvania, the guards for felons must be armed. We had considered the possibility of sending the patients to a state psychiatric institution such as Mayview, where armed guards are permitted on the forensic unit, but as per my discussion with Linda Karr of CMS on 5/8/2002, such a transfer would not be considered a legitimate transfer under EMTALA and will not be permitted. She pointed out that when Federal and state law or hospital

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regulations conflict, the Federal law prevails. And thus, we must admit such patients to our psychiatric units, and the question of whether the guards are armed or not will have to be dealt with by the hospital and the state, given that Federal law requires the patients to be admitted to the psychiatric unit.

We also sometimes send patients to places such as Gateway Rehab, Greenbriar, or other residential psychiatric or drug rehabilitation programs. These are *not* licensed by the state as hospitals, *nor* are they billing Medicare at hospitals. So if you want to send a patient to one of these places, *it's not a transfer!* Even if you *think* you're "transferring the patient," in CMS's eyes, you're discharging the patient from the hospital, just like you discharge a patient to home or to a nursing home. So you don't have to do all the EMTALA transfer paperwork, but the patient has to be Stable for Discharge.

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When a patient is sent from a hospital to another hospital or a freestanding center for a test (e.g., MRI) that is a transfer from the hospital in EMTALA terms, according to Stephen Frew, based on a Supreme Court decision and a letter from the CMS (née HCFA) Baltimore office. EMTALA transfer forms must be completed. [Stephen Frew, 11/7/01 website comment, Bitterman p. 120]. Frew says a single set of EMTALA transfer documents serves as a "round-trip ticket" and the patient can be transferred back without additional transfer paperwork -- unless the test shows a significant problem, in which case the patient must stay at the receiving institution. [Stephen Frew, 3/11/01 website comment] Usually, the medical director of the testing unit is designated as the receiving MD and has authorized his/her staff to accept on his/her behalf. [Stephen Frew, 5/16/00 and 11/7/01 website comment] However, on 5/8/2002 I spoke with Linda Karr of the Philadelphia regional office of CMS (ours). She says that such transfers, whether to an ophthalmologist's office, or to another hospital for a MRI or CT scan, don't require any transfer paperwork *as long as the patient returns to the hospital* for final evaluation and discharge. And, if for some reason the patient ends up staying at the other hospital, the EMTALA transfer paperwork can be faxed after the fact.

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A patient who arrives at a hospital from another country has the same rights to a Medical Screening Exam and stabilizing care as any other patient who Comes To The Hospital asking for emergency care. [Stephen Frew, 7/27/00 website comment]

On-Call Physicians and EMTALA

EMTALA has a lot to say about on-call physicians, and the implications of the HCFA regulations may be surprising to emergency physicians, and are very likely surprising to many on-call physicians.

Written Policy and Physician as Hospital Agent

HCFA requires a written policy for on-call procedures for every medicare-participating hospital. And those physicians, when on call or otherwise acting to accept or send patients in transfer, not only have specific responsibilities under EMTALA, but also are legally considered agents of the hospital and thus have legal responsibilities to the hospital, as well. [Bitterman p. 84]

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Mercy's Credentialing Policy (2.E.1.c/d, 4/27/00) states: (c) *The granting of clinical privileges includes responsibility for emergency service call established to fulfill the Hospital's responsibilities under the Emergency Medical Treatment and Active Labor Act and/or other applicable requirements or standards.* (d) *Clinical privileges shall be voluntarily relinquished only in a manner that provides for the orderly transfer of applicable obligations.* This precise wording also appears in the **Mercy Providence Hospital Credentialing Policy**.

Physicians who are not on-call, but who accept a patient for transfer, are in such cases *also* acting as agents of the hospital.

Complete Coverage For All Specialties

The hospital's medical staff must provide an on-call schedule for all specialties and subspecialties represented on the medical staff and that the hospital "offers to the public." (i.e., this includes dermatology, neurology, pulmonary, GI, endocrine, radiology, pathology, podiatry, dentistry, oral surgery etc.) There was even a citation and fine for the failure of a dermatologist to respond to an emergency consult.

[Stephen Frew, 1/4/02 website comment] Even if a hospital doesn't have a particular service (like a psych ward) but has specialists on call for consults, then those specialists must be on call for their specialty. Note that this is only for physicians, CMS (née HCFA) doesn't permit CRNPs or PAs to take call in lieu of physicians, and doesn't allow groups to be listed for call, ***it has to be a specific physician.*** I spoke with Linda Karr of the Philadelphia CMS office about this and they are very insistent on this point; they want to be able to, in the event of an investigation, look at old on-call logs and be able to tell which specific physician was on-call at a specific minute.

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The test for whether something is a "specialty": if specialists are available to paying inpatients, then they must have an on-call list for the ED. [Stephen Frew, 5/17/00, 5/22/00, 9/18/00, 1/6/01 and 12/27/01 website comments] CRNPs and PAs may respond for a physician or surgeon, but this doesn't substitute for a timely response by the physician or surgeon. [Stephen Frew, 3/28/01 website comment] The only exception would be if the services are offered a day or two a month by a specialist from out of town, unless the hospital holds itself out to the public as offering that service. [Stephen Frew, 10/23/00 website comment]

When on-call, the physician is legally acting on behalf of the hospital, not on behalf of the physician or the physician's practice. On-call physicians must accept transfers that the hospital can handle, regardless of the impact on the physician's practice. [Bitterman p. 91]

The **Mercy Medical Staff Rules and Regulations** (4/27/00, *Admission, Transfer And Discharge Of Patients*, items 6/7) state:

6. *Unassigned emergency cases requiring admission shall be admitted to the service most clearly indicated in accordance with the rules and regulations governing the operation of the Department of Emergency Medicine and the department to which the patient is being admitted.*

7. *Unassigned patients shall be admitted to the service of the active staff member who, at the time, is serving in the capacity of preceptor or who is responsible for the care of the patients admitted to that department or division. The care of such non-*

private patients shall be carried out in accordance with assignments and directions issued by the chairperson of the department in which the patient is admitted.

Specialists on call, when called from the ED or asked by another hospital to accept a patient for admission, cannot say "admit to medicine and I'll be the consultant" -- if there is a specific request to admit to that specialist's service from the emergency physician, and that specialist has admitting privileges for paying inpatients, then that specialist must accept the admission from the ED or in transfer. Examples include admitting a patient with a CVA to neurology, or a GI bleed to a gastroenterologist. *CMS in citation instances has stated that the ED and hence the transferring facility are to have direct access to all specialty and subspecialty services without having to go through a primary admitting or attending physician. Recent appeals have upheld citations for a situation similar . . . [Stephen Frew, 4/11/00, 3/13/01, 12/18/01 and 1/11/02 website comments] CMS is clear that the [specialists] must be on a call list DIRECTLY accessible to the ED physician, and the system may not require that the ED first obtain an admitting physician to arrange the consult. [Stephen Frew, 3/14/02 website comment]*

Although an on-call physician cannot refuse a patient, the patient can refuse an on-call physician. [Stephen Frew, 4/11/00 website comment]

Can an emergency physician send a patient to an on-call physician's office for treatment there instead of in the Emergency Department? In general, no. . . . *where a physician is on-call in an office it is not acceptable to refer emergency cases to their office for examination and treatment. The physician must come to the hospital to examine the patient.* [HCFA Interpretive Guidelines, V-15, emphasis in the original; quoted in Bitterman, p. 95.] Prior to October 10, 2000, patients could be sent to an office that was owned and operated by the hospital, but that is no longer the case. There are a few exceptions: if an ophthalmologist or other specialist has equipment in the office not available in the hospital, it is acceptable to transfer the patient to the office, but this then is seen by some as a transfer in the full EMTALA sense and thus to require appropriate paperwork and transfer forms. [Bitterman p. 121] However, on 5/8/2002 I spoke with Linda Karr of the Philadelphia regional office of CMS. She says that such transfers, whether to an ophthalmologist's office, or to another hospital for a MRI or CT scan, don't require any transfer paperwork **as long as the patient returns to the** hospital final evaluation and discharge. And, if for some reason the patient ends up staying at the other hospital, the EMTALA transfer paperwork can be faxed after the fact. But if the patient is sent to an office, not another hospital, the patient **has to come back to the ED** for final evaluation and disposition.

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Courtesy and Senior Staff Categories

There must be 24/7 coverage unless there are only two physicians on active staff in a particular specialty, in which case each must cover 10 days a month, according to CMS (née HCFA). However, a hospital can, on its own, require two specialists to cover the entire call schedule. [Stephen Frew, 5/11/00, 6/12/00, 7/24/00, 1/25/01, 11/16/01 and 12/27/01 website comments] [Bitterman p. 85] Call must generally be 24 hours, and cannot be limited to office hours, although it can exclude weekends. [Stephen Frew, 4/14/00 and 8/25/00 website comments] These "10-day" rules are not written down anywhere, but are the result of observing what CMS OIG inspectors

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have required in cases where citations were issued and plans of correction were needed. [Stephen Frew, 1/17/01 website comment] There is generally no requirement for a second backup physician, although this has been cited in one city. [Stephen Frew, 2/12/01 website comment]

In answer to a question about what happens if a hospital refuses to implement a full call schedule: *The hospital gets cited, and unless it FORCES the schedule on people to get compliant, the hospital will not be fined, it will be CLOSED (federal \$\$\$ terminated, which will usually bankrupt a hospital).* [Stephen Frew, 6/16/00 website comment]

Courtesy staff who are limited in their admissions may or may not need to take call depending on how limited their privileges are. CMS (née HCFA) has in the past said that 50 admissions/outpatient surgeries/consults per year is too high to qualify for courtesy staff exemption from EMTALA on-call responsibilities, regardless of whether the physician is officialy on "courtesy" staff. [Stephen Frew, 8/1/00, 1/31/02 and 2/1/02 website comments]

Mercy's Medical Staff Bylaws (3.4: COURTESY STAFF, 3.4.1, Definition): *The Courtesy Staff shall include physicians, dentists, and podiatrists who only occasionally admit or treat hospital patients, and physicians responsible for house coverage who are not currently in a postgraduate program. They must accept call responsibilities as assigned by the Department Chairperson and/or defined in the departmental Rules and Regulations.*

It is acceptable, if the call schedule is completely covered, to allow certain staff members within a specialty to have "senior status" and not take call. However, this "senior status" has to be documented in the Medical Staff Bylaws and only those with "senior status" can avoid on-call responsibilities. Mercy's Bylaws do not include a Senior Staff category, only a non-admitting retired-from-practice "Emeritus Staff" category. *The EMTALA site review guidelines clearly indicate that all specialties (by sub-specialty groupings) must be on-call if they routinely are available to the hospital -- i.e. those that come in ONLY for scheduled clinics would not be required to take call. Those that have a reasonably frequent (25-45 patient contacts per year) admissions and consults, and patient procedures are on the borderline, and those with 50+ admissions or consults are likely to be required to be listed. These numbers are not absolutes, but represent the range of activity I have seen in CMS enforcement and advisory input from CMS on actual plans of correction.* [Stephen Frew, 7/25/00, 8/7/00 and 2/27/02 website comments] As Frew says: *In a very literal legal sense, they don't have any choice but to participate in call or to lose their privileges...* [Stephen Frew, 6/2/00 website comment]

Anyone who is on active staff in a particular specialty, and who doesn't have senior status (see above) must generally participate in call. HCFA doesn't consider it acceptable for someone to perform elective procedures or admissions and not participate in call -- ***if someone refuses to participate in call, or refuses to come in when on call, the hospital is expected to discipline that physician, and if repeated violations, terminate that physician's privileges for elective surgery and medicine as well as emergency call.*** Although hospitals can reimburse staff for taking call, there is no requirement that they do this. *It is not generally acceptable to CMS to*

give up only emergency privileges and retain the right to do scheduled patients of the same type of conditions. [Stephen Frew, 12/6/01 website comment]

Call Responsibilities

The on-call MAY NOT ask about means or ability to pay and MAY NOT lawfully turn down the patient. [Stephen Frew, 4/19/00 website comment] Please see the PMHS transfer acceptance policy regarding this:

<http://www.pitt.edu/~kconover/DEMweb/mercy-transfer.pdf>.

By Federal law, on-call responsibilities are on behalf of the hospital, not the practice, and thus apply even if:

- ❖ the on-call physician has discharged a particular patient from his or her practice, [Stephen Frew, 7/2/00 and 10/23/00 website comments]
- ❖ the on-call physician's practice is "full,"
- ❖ the on-call physician has a personality conflict with this patient,
- ❖ the patient is "difficult": verbally abuses staff, likely to file malpractice action, etc. [Stephen Frew, 6/16/00 website comment]
- ❖ the patient has had prior surgery with another surgeon, [Stephen Frew, 7/2/00 website comment]
- ❖ the patient has repeatedly signed out AMA [Stephen Frew, 12/6/01 website comment]
- ❖ the patient has sued the physician for malpractice [Bitterman p. 91]
- ❖ even if the physician doesn't "take" the patient's insurance. [Stephen Frew, 4/20/00, 7/2/00 and 1/17/01 website comments]

Those on-call **must** respond to requests for ED or in-house patients when requested. If a physician is not busy with an emergency surgical case at our or another hospital where he or she also has call responsibilities, or physically unable to respond (e.g., roads closed due to snowstorm), the physician is required to respond in person to see the patient when requested. If he or she does not respond, or refuses to respond, within a reasonable period (see below) and it is reported (i.e., a patient complains) then the hospital and physician can be fined \$50,000 (not covered by malpractice) and the hospital and physician may have all of their Medicare payments suspended. [Stephen Frew, 9/11/00 website comment] Note that these responsibilities do **not** apply if the physician or surgeon is not on-call. [Stephen Frew, 10/23/00 website comment]

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Simply being too tired or too busy in the office is not acceptable, according to Bitterman. However, others maintain that if an on-call physician is so tired that it would be unsafe for him or her to care for a patient, this can be a good reason to refuse a transfer -- however, there will have to be **detailed** documentation of the circumstances leading to such an exceptional situation, in case there is a complaint and the OIG investigates. If a surgeon has a scheduled case, and the patient is not already under anaesthesia, the surgeon **must** bump elective cases to answer the

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consult. Bitterman's book provides a list of "unacceptable excuses" (although some of those listed below have some rare exceptions):

- ❖ *"I have an office full of patients. I'll be there in 4 hours."*
- ❖ *"I'm doing elective surgery. Call someone else or transfer the patient to another hospital."* See below: elective surgery is only an acceptable excuse if the patient is on the table and already under anaesthesia.
- ❖ *"I'd rather admit that patient at another hospital. Send the patient there and I'll take care of him over there."*
- ❖ *"I'm on call at another hospital and treating emergencies over here. Send the patient here and I'll take care of him."*
- ❖ *"Sounds like that patient should be seen by a different specialist. Call the on-call physician from that specialty to see the patient first."*
- ❖ *"I traded call with Dr. Jones while I'm at the ball game. Call him."* [Keith Conover, M.D., FACEP: as discussed with Linda Karr of CMS on 5/8/2002, it is reasonable trade call, **provided that** the physician covering call has similar privileges, the coverage is acceptable under departmental policies, and the Emergency Department (and I would add, "and the hospital operator") are aware of the change in coverage. (Such changes will have to be noted and recorded; I would suggest that the secretary in the ED keep a master copy, which is kept on file for five years. And the ED secretary should be responsible for notifying other parts of the Emergency Department to update their daily call lists.) In such a case, there should be no calls refused because "I'm at the ball game" as the calls should always go to the correct physician the first time.
- ❖ *"My practice is full. I'm not taking new patients."*
- ❖ *"I don't accept Medicaid." "I don't participate in that MCO."*
- ❖ *"I don't take patients from out of county, outside the hospital's referral area, or from out of state."*
- ❖ *"I don't accept illegal aliens"*
- ❖ *"Dr. Smith took care of him the last time he was hospitalized through the Emergency Department, so call Dr. Smith."* [Bitterman pp. 96-98]

If an on-call physician is busy seeing an emergency at another hospital for which he or she is on-call, or a surgeon is taking an emergency case to the OR, then the on-call physician or surgeon is expected to respond to the emergency consult as soon as reasonably possible. If the delay for the physician to respond would jeopardize the patient, the hospital must transfer the patient to a facility that can care for the patient's Emergency Medical Condition. Note that **only** taking care of another patient with an Emergency Medical Condition, or being in the middle of even elective surgery, is an adequate excuse for delay; seeing routine consults, office patients, or an elective surgical case that isn't on the table doesn't count. [Stephen Frew, 2/12/01 website comment] It is acceptable for surgeons to perform elective surgery while on-call, except occasionally at trauma centers, based on state but not Federal EMTALA requirements. [Stephen Frew, 7/27/00 website comment]

Posted by [Stephen A. Frew JD](#) on March 14, 2002 at 22:31:57:

In Reply to: [Who decides when oncall comes in: EP or oncall?](#) posted by Keith Conover, M.D., FACEP on March 12, 2002 at 17:24:15:

: Sorry to keep pelting you with questions.

: On page 93, Bitterman's book, to which you contributed, says "it is ultimately the responsibility of the on-call physicians, in light of their expertise, to decide if, when and how soon to physically see a patient."

: This is different than what you've said here on this forum, which stipulates that if the emergency physician requests the on-call to come in, the on-call must come in (30-60 minute principle in urban areas).

: Is this a difference of interpretation or is it a change in our understanding of EMTALA based on issued opinions or cases?

: Thanks once more!

ANSWER: As you will note, different sections are written by different authors in that publication. Dr. Bitterman tends to want to rationalize EMTALA as much as possible to common medical practice. In this case, I would suggest that Bob overlooked 2 issues -- #1 CMS always cites if the ED asked the on-call to come in and they (over the phone) determine that they do not think they should have to. This is cited as a refusal. #2 -- The EMTALA site review guidelines specifically state that on the issue of patient stability and need for care, the physician with eyes on the patient is presumed to be correct and their opinion controls vs a physician who is not present.

This principle is VERY clear in an otherwise not-so-clear EMTALA world. [Stephen Frew, 3/14/02 website comment]

Having the patient seen by a resident is not a substitute for the attending seeing the patient in person, but may be adequate if the consult is just for admission; see below. Nonetheless, if words are uttered about a request for the attending to respond to the ED, the attending must respond and a resident response does not get around the "30-60 minute rule." [Stephen Frew, 5/25/00, 2/27/02 and 3/14/02 website comments]

Response Time and Response Issues

There are three types of consultation to an on-call physician.

1. A telephone consult: those requesting the consult simply need to speak with the physician to obtain advice or discuss a case to decide on disposition.
2. A consult to admit: in such cases, the time within which the physician must see the patient is established by the bylaws of the hospital medical staff.
3. A consult to see the patient in the ED (or to see an inpatient on an emergency basis) -- to assist in the Medical Screening Exam to determine if the patient has an Emergency Medical Condition, or to stabilize an Emergency Medical Condition -- this is when the on-call **has** to come see the patient in person, or face a \$50,000 penalty (not covered by malpractice) if a complaint is filed. [Stephen Frew, 2/22/01 website comment]

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A “reasonable time” used to be defined by JCAHO as returning a phone call within 30 minutes. However, this has been preempted by Federal EMTALA law. [Stephen Frew, 3/19/01 website comment] And some CMS (née HCFA) regional offices have been observed insisting that a “reasonable time” for response to an emergency consult in urban areas is 30 minutes for STAT cases and 60 minutes for routine cases; and the ED determines whether it’s STAT or routine. The timer starts ticking as soon as the ED places the call to the answering service or pages the pager, and stops when the physician is at the patient’s bedside. *EMTALA site review guidelines require that the hospital have a medical staff bylaw requirement for response. They indicate the response must be within a reasonable length of time. Hospitals have been cited for not having a time requirement specified.* [Stephen Frew, 5/3/00 and 2/1/02 website comments] Hospitals must monitor on-call physicians’ response times. [Bitterman p. 93] West Virginia and New Jersey have a 30-minute state requirement, but Pennsylvania does not. [Stephen Frew, 1/2/02 website comment]

Admission is not considered a substitute for a response. [Stephen Frew, 2/22/01 and 2/1/02 website comments]

If the emergency physician agrees that admission or 23-hour admission is appropriate, but there may have been some question whether the request was for admission or for an in-person response, the on-call physician should request the emergency physician to specifically document on the chart that the consult is for admission and not for a response to come and see the patient immediately. [a personal suggestion from Keith Conover, M.D., FACEP] Note however that Frew says *once the ED physician utters the words that he wants the on-call to come in, EMTALA is in operation to require the response.* [Stephen Frew, 6/12/00 website comment]

The emergency physician on duty decides to admit or send a patient home. This decision cannot be made by a resident in phone contact with a physician who is not physically in the ED. At least one emergency physician was also cited for not overruling a private attending physician who came to the ED and sent a patient home. [Stephen Frew, 3/27/02 website comment]

If an on-call physician is not available in a reasonable time, the emergency physician is required to basically “go up the ladder” calling people to take care of the patient. If there is a second call (as Mercy has for internal medicine), that would be the first choice. If no second call physician is available, Bitterman suggest the standard is for the emergency physician to call the following, in order, to solve the problem:

- ❖ the on-call physician’s department chief,
- ❖ the chief of the medical staff,
- ❖ the vice-president for medical affairs, and then
- ❖ the CEO of the hospital.

The Medical Staff Rules and Regulations for Mercy Providence Hospital, *section G. EMERGENCY DEPARTMENT, sub section 2. CONTACTING PHYSICIANS & ASSIGNING PATIENTS WITHOUT PHYSICIANS*, states:

a. At all times the wishes of the patient should be observed in the selection of a physician to care for the patient. Patients should be asked if they have a physician they would like to be called to care for them.

b. When desired by the patient, the personal physician of each patient should be called wherever indicated in this policy. If he/she cannot be reached within 30 minutes, the E.D. doctor should inform the patient and call the appropriate physician from the on-call roster. If the on-call physician cannot be reached within 30 minutes, the E.D. physician may use his/her discretion to locate a proper physician to assume care of the patient.

[Keith Conover, M.D., FACEP: as per my discussion with Linda Karr of CMS 5/8/2002, the response time doesn't have to be in the Bylaws but can be in the Medical Staff Policies or Rules and Regulations, so what Mercy Providence Hospital has is adequate. However, Mercy Hospital of Pittsburgh does not have an actual number of minutes for a response anywhere I have been able to find in the medical staff Bylaws or Rules and Regulations; we will have to revise them to be in compliance with EMTALA, she says.]

If the emergency physician is forced to transfer the patient due to failure of the on-call physician to respond, the emergency physician must document in the transfer information the name and address of the on-call physician who failed to respond. [Bitterman p. 96]

Follow-Up Issues

Although many hospitals include seeing a patient in follow-up as part of on-call responsibilities, neither Mercy Hospital of Pittsburgh nor Mercy Providence Hospital have this in their medical staff bylaws or policies.

However, consider the following. A patient is discharged to home to follow-up with an orthopedist with a fracture that requires reduction and casting. This is "unstable." If there is a problem with the on-call orthopedist refusing to see the patient, and reduction is delayed as a result, and there is a complaint, HCFA is likely to go back "upstream" and decide there was a failure to stabilize in the ED, and especially if the on-call orthopedist (or his resident) discussed it with someone in the ED, that orthopedist may be found in violation of EMTALA. And fined \$50,000 (not covered by malpractice) as well as the hospital being assessed the same fine, and all Medicare payments being cut off to both the orthopedist and the hospital for a failure of on-call responsibilities. [Stephen Frew, 2/25/01 and 11/9/01 website comments] Please also note the category, discussed at the beginning of this article, of "Stable for Discharge, Emergency Medical Condition Not Resolved." So sending a patient out in a splint, when there is too much swelling to cast, to be casted in the orthopedist's office, is acceptable -- provided the orthopedist doesn't later refuse to care for the patient based on insurance or lack of insurance or lack of money.

Sometimes, there are requests that EDs have patients call the follow-up clinic or office and let that clinic or office determine the timeframe for follow-up. Stephen Frew notes that the emergency physician is in the best situation to determine the appropriate timeframe for follow-up. And he strongly recommends against letting

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clinics and offices determine the timeframe for follow-up. [Stephen Frew, 11/24/01 website comment]

See the section on specific specialty/subspecialty issues, below, for more on follow-up questions.

Specific Specialty/Subspecialty Issues

A lot of EMTALA violation citations have resulted from orthopedic situations. To quote Stephen Frew, J.D.: *Sending an angulated fracture that has been reduced in the field to an ortho's office for casting because the ortho is too busy to come into the hospital -- or the on call refusing to come in until he has finished with office hours -- is a violation of EMTALA. If HCFA finds it, the hospital will be cited in either case. The on-call is likely to be cited in either case.*

Now, on the issue of tendons, HCFA has cited a number of tendon cases as being in need of stabilization, not just close and come back when it is convenient.

Temporary splinting and referral has resulted in numerous citations, and I was specifically advised by CMS personnel that they expected all definitive care that could be and should be done to be effected at the hospital by the on-call orthoped or other physician and NOT referred to the office. The second issue is that of equal care, so if any VIP could get it reduced or casted now, everyone must. Where the fracture is too swollen to cast or other specific medical indication suggests that the patient should NOT be treated at this time, but they are stable for discharge home, orders for follow-up care are permitted. [Stephen Frew, 12/28/01 website comment]

Regarding cosmetic closures when patients come to the ED: if the emergency physician requests that the plastic surgeon come and see the patient, even if the initial patient request was only for cosmetic reasons, the consult falls under EMTALA just like any other consult, and failure to respond, if cited, will result in a fine. [Stephen Frew, 6/4/00 website comment] (If it is just a phone consult to discuss the matter, that's different -- KC).

Orthopedic/Hand Follow-up and "Failure to Stabilize" in the ED

Sending patients from the ED with a splint, to follow up in the office for reduction, is a major source of EMTALA citations.. It is also true that when Medicaid patients are discharged from a hospital, they have to be provided with a list of follow-up physicians who accept Medicaid, and so if the follow-up physician refuses to see a Medicaid patient, the hospital may be liable under EMTALA. [Stephen Frew, 4/25/00, 4/27/00, 7/11/00, 8/3/00 and 8/11/00 website comments]

On the issue of follow-ups, this is very problematic:

This situation often results in patient complaints that in turn lead to EMTALA investigations. The vast majority of these complaint cases are highly focussed in one area -- orthopedics. Technically, EMTALA does not regulate this area of the process, but it does indirectly tie into EMTALA and does result in citations via several typical CMS reactions:

1. *If the hospital bylaws say 1 follow-up visit, then CMS cites under EMTALA for failure to follow hospital policy. This is the most direct application.*
2. *Sometimes the follow-up is cited because CMS determines the patient should have been seen in the ED for on-call services and the failure to come in and the subsequent discharge for follow-up care was a failure of call and a failure to stabilize or adequately assess and/or test and/or get consult before discharge.*
3. *Sometimes the discharge is based on the definition of stable for discharge that indicates that it is reasonable to manage further on an out-patient basis and that the receiving physician AGREED to see the patient and was included in the plan of care instructions at discharge, and therefore cannot decline the patient when they get to the office.*
4. *The last variation is that the CMS inspectors cannot find a way to cite the incident, but they find other things to cite and make casual reference to the need to "also deal with" the office follow-up issue.*

Bottom line -- this increases the chances of getting a complaint, which in turn increases the probability of a visit, which in turn has a 75% probability of getting the hospital cited for something. Not good.

Where the ED is aware of a typical process of "wallet biopsy" at the referred office that results in patients not being seen, extreme care must be exercised on discharges for follow-up to those offices -- and if there is any doubt, the on-call should be brought in to treat in the hospital with reduction/ surgery and fixation. [Stephen Frew, 11/1/00, 12/3/01 and 12/28/01 website comments]

Bitterman says ...the first time a patient is sent to an orthopedist's office for fracture reduction but denied care because of lack of insurance, managed care status, or any other reason must be the **last** time a patient is sent to that physician's office from the Emergency Department. From that moment forward, any time a patient needs immediate treatment, the orthopedic surgeon must be told to come to the Emergency Department to treat the patient. [Bitterman p. 95]

If a fracture is not seen and treated because it is the weekend or after hours, it is "disparate" or discriminatory treatment and both the hospital and orthopedic surgeon will be cited. The hospital, ED physician, and on-call may get fined. [Stephen Frew, 8/31/00 website comment]

As far as tendon lacerations, Frew says: *Now, on the issue of tendons, HCFA has cited a number of tendon cases as being in need of stabilization, not just close and come back when it is convenient. That suggests that the patient must be transferred to [a] neighboring facility that has an available hand surgeon. [Stephen Frew, 1/29/01 website comment]*

OB Issues

Please note that under EMTALA, whether uterine contractions are an Emergency Medical Condition is a complex question, and it would be best if all obstetricians reviewed chapter 8 of Bitterman's book. In summary, the chapter says that an Emergency Medical Condition exists only when the following apply:

- ❖ The patient is pregnant and having contractions,

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- ❖ There is not adequate time to effect a safe transfer to another hospital before delivery, and
- ❖ Transfer or discharge poses a threat to the health and safety of the woman or the unborn child. [Bitterman, p. 127]

It is standard for all pregnant patients with presumed contractions or other OB-related complaints, gestational age more than 20 weeks, to be triaged in the Emergency Department and then to be sent to labor and delivery. However, this must be done without respect to insurance status or having an obstetrician on staff at the hospital. The Medical Screening Exam can be performed by obstetric nurses, provided this is spelled out in the regulations approved by the hospital's governing board. [Bitterman p. 130]

[Regarding whether a patient sent in to L+D with ? contractions can be sent home after a nurse exam in consultation with the OB physician by phone] *CMS position requires:*

1. Designation of non-physician classifications of qualified medical personnel for MSE be established by Board or by specific provisions of the medical staff bylaws approved by the Board .

2. The person must function pursuant to written protocols that establish clinically objective criteria for what conditions or circumstances a physician must come in and complete the MSE -- we have successfully utilized a scoring system in plans of correction. Up to the threshold score, the RN may call the MD and discharge the patient with written instructions, and MD countersigns order later. ("Not meeting admission criteria")

If the dx is "false labor", only a physician may make that diagnosis and requires a physician to promptly come in and assess.

3. The person must function within scope of practice per the state nursing board

4. There need to be written competencies, job descriptions, policies and procedures to set up the system and define the MD response obligation

5. The process must be the same for everyone -- no differentiation on whether "aligned" or not, or insurance company

If you follow these steps, CMS still reserves the right to disagree with the application or sufficiency of the plan in general or as applied to an individual case and cite a case or process for violations -- generally, however, they accept a tightly drawn process.

They want to see an objective system that is not subject to physician "preferences" or financially influenced treatment patterns and provides a clearly defined point for MD response. CMS has accepted our scoring approach in many reviews. [Stephen Frew, 2/17/02 website comment]

Note that Mercy Hospital of Pittsburgh's EMTALA policy is that "The Department of Emergency Medicine Medical Screening Examination shall include an examination by a physician, or by a Nurse Practitioner or Physician Assistant supervised by a physician. All patients who present to the Department of Emergency Medicine will receive a Medical Screening Examination prior to communication with any third-party payers." [4/96] Note also that this applies to patients who "come to the hospital" and request emergency care, including patients going directly to the cath lab or labor and delivery.

Dental Issues

EMTALA would apply to dental cases, such as I have seen in several citations, that involved pain abatement, abscess treatment, attempts to reimplant a tooth in a trauma case, etc. Referral for routine dental care following those treatments has been allowed, but if treatment of the abscess required removal of the tooth, that would be expected.

EMTALA enforcement policies have generally allowed formal transfer of patients to specialty offices if the office has specific equipment necessary to the patient's care that is not available in the hospital (not just the ED, but anywhere in the hospital). This has been permitted when the patient had no other medical conditions that might deteriorate while the specialty care is given in the office...if there are other conditions, then the care must be given in the current hospital or transfer made to a hospital capable of providing the specialty care in-house. [Stephen Frew, 12/3/01 website comment]

Office Practice Issues

[Regarding sending a migraine or similar patient from the office to the ED, for narcotic pain medications, with a Medical Screening Exam already done in the office] CMS has allowed phone orders -- the problem with that is that DEA does not allow the ED to dispense schedule 1 and 2 drugs, which typically are your pain killers, without an on-site ED exam. BTW-- the legal definition of an MSE is that it is performed IN the hospital. If a nurse dispenses to an out-patient with a faxed order he/she is risking a potential arrest (happened once) and the hospital pharmacy license is at risk. Also, you should be aware that "frequent fliers" are to receive an MSE on every visit under EMTALA. [Stephen Frew, 2/18/02 website comment]

The Medical Screening Exam cannot be performed in an office, it must be done in the hospital. [Stephen Frew, 3/5/02 website comment]

Also, see the section on "Private Physicians Seeing Patients in the ED" near the end of this article.

No Delays In Diagnostic Testing For Convenience

If we have ultrasound techs, vascular ultrasound techs, etc. on call, and you want to get a diagnostic test, and you send the patient home to come back in the AM, or board the patient in the ED until a more convenient time for the techs (e.g, in the morning when they normally arrive), this is considered an inadequate Medical Screening Exam. One hospital in Missouri lost \$1,200,000 from an EMTALA-based suit from just this situation. Sending patients home from the ED to come back for diagnostic testing, if part of the workup for an Emergency Medical Condition, is also a violation. [Stephen Frew, 11/01/00 website comment]

Insurance Admission Issues

The Bylaws and Regulations of the medical staff at Mercy Providence Hospital and Mercy Hospital of Pittsburgh state that there will be no communication with any

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third-party payer until the attending emergency physician says the Medical Screening Exam is done. And if the Medical Screening Exam requires additional testing that has to be performed at another hospital, then it is against the regulations to talk with third-party payers prior to transfer.

If a physician on-call for a particular specialty isn't signed up for a patient's particular flavor of insurance, EMTALA says that he or she still has to admit the patient regardless. And because of prudent layperson language, especially given Pennsylvania's Act 168, insurance companies are required to pay for such care for an Emergency Medical Condition even if not from a participating physician.

Yes, it's a hassle to get paid for such patients, but the Feds don't care. And, As Stephen Frew, J.D., says: "most hospitals do not aggressively review these denials with the result that they continue to incur avoidable denials that may mount in the millions of dollars at some facilities. They don't track them, they don't review them, they just take whatever the insurance company sends them. I have found in 30 years of legal practice that insurance companies will key in on the "suckers" for skimping on payment, and they are more "careful" on hospitals and patients that demand they be accountable for proper payment."

As far as assigning some patients to a clinic service, and the possibility of having a patient admitted to the clinic service if the first-call and second call medical docs don't "take" a particular type of insurance:

Posted by Stephen A. Frew JD on January 09, 2002 at 15:10:35:

In Reply to: Clinic Admissions posted by Keith Conover, M.D., FACEP on January 07, 2002 at 16:56:52:

: Many hospitals in our area have a "clinic" service -- supervised by internal medicine and surgery and ortho attendings. Those who need to be admitted to medicine or surgery or ortho and who are uninsured or who have Medicaid get sent to the clinic attendings, those with insurance get sent to the private docs on call. (It doesn't always work this way, there are a few Medicaid or uninsured who have their own private docs, and a few with insurance who go to the clinic, but the clinic is mostly uninsured or Medicaid.)

: There is no significant difference in the care people get when admitted (though some may argue that the care on the clinic service may be slightly better as the attendings are all academic teaching types and not all of the private attendings are).

: 1. Are there any EMTALA implications for this system? As far as I can see, we only admit people once we've initiate stabilizing treatment, so asking about insurance (or assigning an attending) based on insurance status should be OK.

ANSWER: As long as scope of evaluation and care is consistent in the two programs, EMTALA is probably satisfied, because you are providing the care. If there are differences, however, it might be enough to invalidate it. CMS would look at issues like length of stay, unscheduled returns, tests administered, complication rates and outcomes, and if the two approaches are materially different in any way CMS finds offensive, it will be deemed to be "disparate treatment" and a violation.

: 2. If we have such a system, and we have a first-call private medical doctor and second-call private medical doctor on call for insured admissions, and one or two

docs on call for clinic admissions -- is there any problem with the following. If the first-call and second-call private attendings don't work with an insurance company for a new, unassigned patient, we set up a procedure to admit such patients to the clinic attending. (The clinic service will, usually quite gratefully, accept people with any sort of insurance.) Yes, the private attendings could probably get paid for the admission but it often is so much work that it's simply not worth it for them.

ANSWER: If you called private #1 and private #1 is on the call list for his/her specialty, and said "I need you to come in and see patient A" and #1 refused because of finances, you have a potential issue. #1 cannot refuse a request to come in and should not be inquiring about insurance as a condition of coming in.

: If we look at this in the right way, even if EMTALA applies, we aren't having an oncall person "refuse" an admission, we are bit making any difference in care based on insurance, we are only choosing which of various on-call attendings based on insurance.

ANSWER: I am not saying that it cannot ever be successfully framed and documented in a compliant manner, but I am saying that unless a great deal of care is taken in how the policies and procedures are created, implemented and monitored, it will eventually become a violation as it degenerates into blatant financial screening of patients.

Mercy Hospital of Pittsburgh has not found it worthwhile to pursue this avenue, at least yet. Therefore, all on-call doctors must accept all admissions, regardless of insurance status, on pain of being reported for an EMTALA on-call violation.

Psych Issues

Stability and Psych Patients

EMTALA micro-regulates psychiatric emergency care, and thus there are differences from medical patients. It does provide some exceptions to the standard EMTALA provisions for transfer of psychiatric patients to state institutions (not relevant in the Pittsburgh area). And there are special definitions of stability for psych patients. Specifically, the 1998 interpretive guidelines state:

For purposes of transferring a patient from one facility to a second facility, for psychiatric conditions, the patient is considered to be stable when he/she is protected and prevented from injuring himself/herself or others. For purposes of discharging a patient (other than for the purpose of transfer from one facility to a second facility), for psychiatric conditions, the patient is considered to be stable when he/she is no longer considered to be a threat to him/herself or to others.

[INTERPRETIVE GUIDELINES : 489.24(c)(l)]

http://www.hcfa.gov/pubforms/07%5Fsom/somap_v_001_to_012.htm]. To clarify: a psych patient is "stable for transfer" if protected from self-harm. So if a hospital has no psych beds, and the patient is "stable for transfer" the patient can be transferred. However, **one cannot transfer a psych patient based on insurance (or lack thereof), until Commencement of Stabilizing Treatment, even if Stable For Transfer.** Got it?

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Patients with psychiatric problems bad enough to be admitted **must**, by the interpretation of Stephen Frew, with which Pittsburgh Mercy Health System agrees, have stabilizing care for their "Emergency Medical Condition" initiated. In the case of depressed patients, this means that the patient has been seen by a psychiatrist or psychiatric R.N. (not just an emergency physician or social worker) in the Emergency Department, a detailed and individualized treatment plan has been formulated, and this treatment plan has been started. **Sometimes**, such patients will be seen in the ED by a psychiatric nurse or psychiatrist, who establishes and documents an individualized treatment plan, including counseling and psychiatric medications, these are started in the Emergency Department, and the patient can then be transferred. However, **sometimes**, suicidal or psychotic patients will have to be admitted before we can reasonably say **there is** of their "Emergency Medical Condition." Simply making the patient Stable For Transfer (a lower level of stability; see above under "EMTALA Stability") **is not adequate**. [Stephen Frew, 12/6/01, 1/9/02 and 1/31/02 website comments] Frew points out that state, county, or city psych arrangements for care of indigent patients (think "catchment areas") are completely preempted by Federal EMTALA law. [Stephen Frew, 7/31/00 and 2/6/01 website comments] However, if your hospital has no psych beds and you need to transfer a patient, it makes sense to make your first call to the hospital in the patient's "catchment area" since that's closest to where the patient lives.

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Psych Patients, Insurance, and "Precertification"

If a hospital doesn't have any psych beds, then you have to transfer the patient to someplace that does have psych beds. In such a case, delaying the transfer of a patient to obtain "precertification" from an insurance company, is an EMTALA violation. In the same way, delaying the admission of a patient to the psychiatric unit until one obtains "precertification" is an EMTALA violation. [Bitterman p. 115] *a receiving hospital cannot ask a transferring hospital to delay a transfer until it obtains payment authorization from a MCO. This, too, is illegal.* [Bitterman p. 115] *The OIG position on duty to accept on transfers is that the receiving hospital cannot delay acceptance to obtain payment information. If it is a transfer situation, the on-call [physician] is "the hospital" for enforcement purposes. . . . My position now is:*

- 1) *Hospitals seeking to transfer patients to higher levels of care in appropriate circumstances as defined by EMTALA should not be asked about means or ability to pay or hospital guarantee of payment prior to the acceptance of transfer by the intended destination hospital or responsible physician accepting or denying acceptance on behalf of the intended destination hospital.*
- 2) *If asked, do not provide the information even if the patient is fully insured.*
- 3) *In any case where a transfer is turned down after the intended receiving facility has asked about finances of the patient or any guarantee of payment by the sending facility, it should be reported as a possible EMTALA violation within 72 hours of the event to the responsible office of the Centers for Medicare and Medicaid Services (CMS) to avoid possible EMTALA liability on the part of the sending hospital for failure to report.*
- 4) *The fact that the transfer was turned down after inquiry about means or ability to pay or demand that the sending hospital guarantee the bill should be described in*

detail in the medical record to adequately protect the sending hospital under EMTALA transfer rules and to assure that all legal defenses and remedies are preserved in the event the resulting delay and outcome causes patient litigation against health care providers. [Stephen Frew, 11/3/01 and 3/2/02 website comments]

Posted by [Stephen A. Frew JD](#) on March 14, 2002 at 22:36:49:

In Reply to: [Psych Patients](#): posted by Keith Conover, M.D., FACEP on March 12, 2002 at 19:48:20:

: The interpretive guidelines specifically state:

: "For purposes of transferring a patient from one facility to a second facility, for psychiatric conditions, the patient is considered to be stable when he/she is protected and prevented from injuring himself/herself or others. For purposes of discharging a patient (other than for the purpose of transfer from one facility to a second facility), for psychiatric conditions, the patient is considered to be stable when he/she is no longer considered to be a threat to him/herself or to others." [INTERPRETIVE GUIDELINES : 489.24(c)(1) <http://www.medlaw.com/siteguide.htm>].

: As you have pointed out in prior posts on this forum, you have indicated that a psych patient, even though "stable for transfer" (i.e., restrained and protected from suicide) cannot be lawfully transferred until the hospital has "initiated stabilizing care" which, in almost all cases, requires admission. We are considering a policy that requires and defines "initiation of stabilizing care" for psych patients, including (1) psych nurse evaluation, (2) phone consultation with a psychiatrist, (3) an individualized and documented treatment plan, and (4) treatment has been started according to plan and documented.

: Rarely, during the day, this might occur in the ED, but for the most part, patients will have to be admitted first. Any suggestions about the above outline of "initiating stabilizing care" for a psych patient?

: A companion to this commitment will be that when we have no beds, and want to transfer a psych patient to somewhere else, and the patient is "stable for transfer" but we have not "initiated stabilizing care" we will have to, in defiance of time-honored practice in this area, say "no, we didn't precert the patient with the insurance company. No, we won't give you any insurance information about this patient, as we haven't been able to initiate stabilizing care for his Emergency Medical Condition. Yes, under EMTALA, you are required to accept the transfer anyway."

: So when they refuse, what do we do? "Reverse dumping" isn't mandatory to report under EMTALA. Do we document the refusal, send them a letter from our legal counsel, noting that there seems to be a potential EMTALA violation, and if there is a repeated pattern of refusals of transfers, we will contact CMS OIG?

: (I suspect the best way to avoid this is to let the ED grapevine work for a couple of weeks, but still we may have refusals.)

: Thanks very much once more.

ANSWER: I believe your intended course is necessary to comply with EMTALA, and I also believe that refusal to accept the patient on financial precert grounds is a violation. As I wrote in the E-Bulletin some months ago, some CMS regions believe that refusal of transfers is a mandatory reporting incident and that I now recommend

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reporting. Politics being what they are, you may want to take your chances for a while and try to let the system work. Just remember -- the last hospital that got kicked out of Medicare for EMTALA violations was a private psych hospital that made admission and transfer decisions based on pre-cert (among other sins).

[Stephen Frew, 3/14/02 website comment]

There **are** situations where one might be able to legitimately transfer a patient even if one has psych beds, or delay a transfer of a psychiatric patient until precertification.

This requires that the patient has had **Commencement of Stabilizing Treatment**, has had counseling about insurance status, and refuses transfer (in writing) until such time as insurance has "approved" the admission. However, this can only occur if the patient is capable of informed consent about the plan of care, and there is

documentation of the **Commencement of Stabilizing Treatment**. Pittsburgh Mercy Health System has developed a checklist form to use in such situations to ensure that all procedures have been followed and there is no EMTALA violation; see

<http://www.pitt.edu/~kconover/DEMweb/psych-checklist.pdf>. (See "Stability and Psych Patients," above, for an outline of what is required.) Note that the procedure on this form must be followed in **all** cases, not just those in which we might want to transfer a patient based on insurance (i.e., no difference in treatment of patients until **Commencement of Stabilizing Treatment**).

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Psych Subspecialty and Bed Issues

What if the hospital has med-surg beds but no psych beds and is asked to take a psych patient in transfer? CMS (née HCFA) says that hospitals must take the transfer to a med-surg bed and assign a sitter. Stephen Frew suggests that, since there are definite risks associated with this, that hospitals that want to refuse such transfers document why the particular patient cannot be adequately served in that manner.

[Stephen Frew, 2/18/02 website comment]

Pittsburgh Mercy Health System considers that a medical bed with a sitter is a poor substitute for the therapeutic environment of a true psychiatric unit. Therefore, we will not accept transfers of psych patients to such beds unless there are no other psychiatric beds available in the region. We will not admit patients to medical beds with a sitter unless required by medical reasons. This will be documented in new psychiatric admission policies and procedures [in development 4/2/02]. [Keith Conover, M.D., FACEP: I spoke with this on 5/8/2002 with Linda Karr of the CMS Region III office in Philadelphia; she says our current policy, of transferring patients if we don't have psych beds, is in the best interests of the patient, and would not be considered an EMTALA violation by their office.]

Posted by Stephen A. Frew JD on January 09, 2002 at 15:20:59:

In Reply to: Psych Transfers: type of patient posted by Keith Conover, M.D., FACEP on January 07, 2002 at 17:05:38:

: This is a question about "types" of patient and hospital capabilities, related to psych patients.

: In Pittsburgh, we routinely transfer psych patients from one facility to another (probably more psych transfers here than any other kind.)

: Some of these transfers are because a facility doesn't have any beds, but most are because a facility doesn't have any beds of an appropriate type. For example, there are only two facilities in town that have adolescent and child psych, and only certain places that are "dual diagnosis": both significant psych and significant drugs/alcohol. There are some places that are pure psych (not set up to take care of significant drugs/alcohol) and some places that are pure detox.

: Question 1: who should make the clinical determination as to which "class" of patient we've got: the emergency physician seeing the patient, or the psychiatrist who has been consulted only by phone, and what if they disagree?

ANSWER: EMTALA states specifically that it is the physician with eyes on the patient who determines issues like stability and necessary appropriate care (which I would suggest is what "type" amounts to) appropriate destination, etc. NOT the psychiatrist over the phone.

: Question 2: some psych facilities are cutting back on staff and are worried about handling very violent patients. Up until now the area hasn't used this as a classification or type of patient on which to make transfer decisions. Is there a recognized way to acknowledge a new "type" of patient or hospital capacity? Can we look at other areas, any court decisions, or HCFA publications? EMTALA will surely be in place for these transfers, I would think, as hospitals would be transferring patients because they can't initiate stabilizing care.

ANSWER: Essentially, CMS will look at the "type" of patients mostly in order of: 1) laws 2) regulations 3) policies and procedures 4) quality of care and base their determination on those factors in somewhat of a subjective manner. If a hospital establishes a new policy or procedure that creates the recognized "type" as a specific definition, CMS would probably follow it if it were in writing and reasonably applied without discrimination. Once in writing, deviations would be potential sources for citations.

What about "dual-diagnosis" and adolescent and very violent patients? Can they be transferred from one hospital to another, even though both have psych beds available, because one hospital doesn't "take" that type of patient?

In Pennsylvania, acute care hospitals are licensed in a general sense, and there is no special "licensure" for psychiatric units at hospitals. However, the state does have a special licensure for drug and alcohol detox facilities. Some such facilities are non-hospitals, and since we can't discharge patients with an Emergency Medical Condition to a non-hospital, you can't, for example, transfer a patient to Gateway Rehab. (If the patient is **Stable for Discharge** however, you can **discharge** to such a facility.)

Some hospitals are also dual-licensed as drug and alcohol detox centers. However, neither Mercy Hospital of Pittsburgh or Mercy Providence Hospital are so licensed. There is a tradition of transferring patients who have both psychiatric and drug or alcohol problems to hospitals that have special "dual-diagnosis" tracks -- Mercy Providence Hospital in particular. However, since hospitals with psychiatric units routinely care for at least some people with drug and alcohol problems as well as psychiatric problems, it is difficult to see how a particular patient fits a profile such that "our hospital doesn't have the capacity to treat this patient." Therefore, transfers

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solely for “dual-diagnosis” reasons are not legitimate transfers under our understanding of EMTALA. [Note that this was agreed to in a meeting 4/17/02 with the PMHS Legal Counsel, the psychiatric coordinators of both MPH and MHP, the Chair of psychiatry at MPH, and the head of social services at MHP.]

What about children and adolescents with psychiatric problems that require admission? Do we have to admit them to our “adult” psychiatric unit? Or should we transfer the patient to a facility that has a “child and adolescent” psychiatric unit?

CMS (née HCFA) maintains that they have to mandate a similar level of care in rural and urban areas. And in rural areas, psychiatric facilities take care of both adult and adolescent/child patients. Ergo, urban hospitals with psych facilities cannot transfer psych patients as long as they have beds, regardless of age.

However, one can make a powerful argument to the contrary, as follows. A rural psych hospital that cares for patients of all ages has staff and physicians who have experienced at providing care for psych patients of all ages. However, in many urban areas, child and adolescent patients are routinely sent to hospitals that specialize in such patients. Therefore, the urban hospitals with “adult” psych units actually have *less* capacity to care for child/adolescent patients than the urban psych hospital that cares for all ages. To put it bluntly, the adult psych units are incompetent to take care of child/adolescent psych patients. Based on this, PMHS considers that it does *not* have the capacity to care for child or adolescent psychiatric patients, and will transfer such patients to hospitals with specialty capacity in such areas. (The facilities here are Southwood and Allegheny General Hospital, both of which bill Medicare and Medicaid as acute care hospitals and thus are “hospitals” in the eyes of CMS). The psychiatric admission policies for Mercy Hospital of Pittsburgh and Mercy Providence Hospital provide objective criteria on how to decide if a patient requires specialty adolescent/child psychiatric care, or whether the patient can be treated as an adult.

What about very violent patients? It is generally accepted that any psychiatric facility must be able to deal with very violent patients. Therefore, transferring a patient from one psych facility to another just because the patient is very violent will be difficult to justify under EMTALA, and would have to have very careful and specific documentation, and if it occurs at all, should only occur after admission and careful evaluation.

It might be the case that a psychiatric unit might not be able to accept a very violent patient due to lack of staff. In such a case, just like in the case of low nursing staff on a medical unit, the unit would be expected to exhaust all avenues for obtaining additional staff (calling in backups, “pulling” staff from other units) before refusing such a patient.

However, also see the section about prison inmates, above: *Transfers, Special Facilities, and “Level of Care.”*

Emergency Department Issues

Triage of emergency patients must be by a nurse, not a clerk, EMT, or other non-nurse medical personnel. [Stephen Frew, 11/11/01 website comment]

Direct Admits in the ED

For direct admits who have to go to the ED because not bed available: an office visit and office note does not replace the Medical Screening Exam. The Medical Screening Exam must be conducted in the hospital. [Stephen Frew, 3/5/02 website comment]

Private Physicians Seeing Patients in the ED

If a patient's private attending physician or surgeon wishes to see a patient in the ED instead of the patient being seen by the ED physician on duty, the following apply:

1. Delaying the Medical Screening Exam to allow the private attending to see the patient may be an EMTALA violation. It is appropriate to triage the patient as with other patients, and put the patient in the queue to be seen by the emergency physician on duty exactly as any other patient with the same problem. If the private physician sees the patient before the emergency physician sees the patient, that's fine, otherwise the emergency physician should see the patient.
2. Private physicians must meet the standards of the emergency physician: the private physician is seeing the patient **and providing the Medical Screening Exam for the hospital** and therefore must document, provide discharge instructions, and in all respects treat the patient to the level expected of the hospital's emergency physicians. According to (conservative) attorney Stephen Frew, private docs seeing patients in the ED must have the same certifications and privileging as emergency physicians in that department. A more liberal interpretation would still hold them to the same standard of care as the hospital's emergency physicians.
3. In summary, there must be no disparate treatment of patients because they are to be seen by a private physician rather than the emergency physician on duty. [Stephen Frew, 12/14/01 website comment]

I favor that all MSE's be provided by the ED physician. I lobby strongly against private physicians seeing patients in the ED. If they are to be allowed to see patients, then several criteria should be in place -

#1 no calls prior to triage -- the physician will only be called at the signed request of the patient in order to protect patient confidentiality (many patients dont want their private doctor to know about their ED visit).

#2 -- the patient will be seen in triage order by the ED physician without delay for the arrival of the MD (if the MD has not arrived, they will be seen by the ED physician when their name is called)

#3-- patients will receive an ED bill for the hospital portion of the visit

#4 -- The law holds the hospital responsible for all compliance and delivery of care consistent with EMTALA in the same way as if delivered by the ED physician, so a private physician wishing to see patients in the ED in lieu of the ED physician must follow all ED policies, procedures, and practices

#5 -- The physician must have all certifications and maintain them current that an ED physician must have under the privileging standards of the department

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#6 -- In states that have limited scope to malpractice coverage, the coverage must include services rendered in the emergency department of the hospital as an emergency services provider

#7 -- All records are the property of the hospital, and the physician will be provided copies of the ED visit records upon execution of a proper consent by the patient (this will become very important under HIPPA)

It is extremely important that private physicians understand that they will be personally liable for up to \$50,000 in fines per patient visit to the ED, if they violate EMTALA and that in a malpractice they may be held to the standard of a reasonable EMERGENCY PHYSICIAN which is specialty level of care. [Stephen Frew, 12/6/01 website comment]

"Pulling" Nurses from the ED

Frew regards the practice of "pulling" nurses from the ED to the floors when the ED isn't busy is an open invitation to EMTALA citations, and recommends the reverse: when patients are boarding in the ED, that nurses from the floor come down to care for them, so that ED nurses are available to take care of new patients who come in. [Stephen Frew, 3/19/01 website comment]

Pulling nurses from the ED that results in any delay in triage or prompt care of ED patients poses a gigantic risk of EMTALA violation with loss of medicare, civil law suits, and fines.

As a matter of fact, the federal law requires the ED be staffed at a level to meet the needs of all reasonably anticipated patients...i.e. you have to staff for a reasonable percentage of peak volume at all times, unless you have historical data to show average presentation level and staff to meet that plus "x%". Again, failure to meet that standard can cause the hospital to lose its Medicare and may be used in law suits to show negligent staffing.

On a final note, CMS actually requires the reverse of your hospital's plan -- they require that a plan be in place to supplement the triage function when the ED becomes busy, even if that means pulling nurses from the house. [Stephen Frew, 3/9/02 website comment]

Before anyone starts moving nurses out of the ED, there better be some very good professional documented analysis of ED staffing levels and margin of safety and extensive discussion with your insurance company risk management folks, because the ED represents the largest potential liability risk for EMTALA violation.

As a hospital attorney, unless the data was clearly and unbiasedly supportive of the fact that the ED was over-staffed after providing for a margin of safety, I would absolutely oppose diverting ED resources to the house. When the ED is very busy and admission patients back up in the ED, I advocate house nursing supplement the ED nurses to care for the admission patients to keep the ED functional.

Waiting Times

[regarding non-urgent patients waiting up to 6 hours in the waiting room of an ED]
You will be required to periodically reassess the patients in the waiting area and

document this no less than every two hours or other period defined by your policies and procedures. Many hospitals have been cited for delays if that amounts to improper triage, constructive denial of care, or failure to monitor while waiting. [Stephen Frew, 12/6/01 website comment]

Reporting Issues

All reporting of potential EMTALA violations should be through the normal chain of command at a hospital -- it is hospitals, not individual physicians or nurses, who are responsible for reporting. [Stephen Frew, 11/2/01 website comment]

It is mandatory, on pain of citation, for hospitals to report of inappropriate unstable transfers they receive. If a hospital investigates a potential case and finds there did seem to be an EMTALA violation, it is mandatory that the hospital report this to CMS (née HCFA) on pain of being cited itself -- however, there is no mandatory reporting requirement for individual physicians or nurses. Reporting of other violations is not mandatory. CMS has a 72-hour timeframe for reporting violations but as best is known this is not mandatory. [Stephen Frew, 8/3/00 and 2/20/02 website comments] [Bitterman p. 114]

Although reporting of "reverse dumping" (refusing to accept transfers) is not mandatory, Frew now strongly recommends reporting all such incidents:

1) Hospitals seeking to transfer patients to higher levels of care in appropriate circumstances as defined by EMTALA should not be asked about means or ability to pay or hospital guarantee of payment prior to the acceptance of transfer by the intended destination hospital or responsible physician accepting or denying acceptance on behalf of the intended destination hospital.

2) If asked, do not provide the information even if the patient is fully insured.

3) In any case where a transfer is turned down after the intended receiving facility has asked about finances of the patient or any guarantee of payment by the sending facility, it should be reported as a possible EMTALA violation within 72 hours of the event to the responsible office of the Centers for Medicare and Medicaid Services (CMS) to avoid possible EMTALA liability on the part of the sending hospital for failure to report.

4) The fact that the transfer was turned down after inquiry about means or ability to pay or demand that the sending hospital guarantee the bill should be described in detail in the medical record to adequately protect the sending hospital under EMTALA transfer rules and to assure that all legal defenses and remedies are preserved in the event the resulting delay and outcome causes patient litigation against health care providers. [Stephen Frew, 11/3/01 and 3/2/02 website comments]

EMTALA prohibits hospitals from taking action against "whistle-blowers." A whistle-blower is any physician, medically-qualified person or employee, who refused to authorize a transfer of a patients with Emergency Medical Conditions that have not been stabilized, or reported an EMTALA violation. [Bitterman p. 110]

