



MACEP News

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President's Message

Stephen Epstein, MD, FACEP



Your Board of Directors has been busy in the past few weeks with a number of important issues facing MACEP. First, as usual, MACEP continues to be active on health care in the governmental arena:

BCBSMA Contract Initiative

By now, most of you should be aware of a new contract initiative proposed from Blue Cross/Blue Shield. As a trade organization, MACEP cannot engage in swaying any assessment you must make in deciding whether or not to participate in any contract. We can, however, serve as an educational resource to our members and we have done that.

All of you should have received a mailing from MACEP regarding the Blue Cross/Blue Shield initiative with an outline of the proposal and a focus on potential questions and answers regarding the initiative. In addition, MACEP is exercising its right to petition governmental bodies and has asked a number of them to examine the content of the initiative because we believe the initiative has an effect on the prudent layperson standard of emergency that now protects citizens of the Commonwealth. We will keep you informed of MACEP's progress as we receive responses.

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PB Waiver

Many MACEP members recently testified in front of the legislature regarding a statutory proposal to change the minimum staffing standard from two to one paramedic in an ALS ambulance. While Massachusetts is the only state in the nation to have such a standard, we believe that it is the best standard for the highest quality prehospital care. Massachusetts already has a waiver system in place to allow service zones unable to meet the dual paramedic standard to provide ALS with a paramedic/intermediate or paramedic/basic team.

While that waiver system may be cumbersome, it is necessary to assure medical and quality control standards. MACEP used this opportunity to emphasize the need for continuing medical oversight in any new standards.

All of the testimony heard that day was against the proposed change. MACEP will continue to monitor the bill throughout this legislative session. Thanks to Dan Corboy, MD, MACEP's legislative chair, and to Gert Walter, MD, EMS chair, for leading the testimony.

Crowding/Ambulance Diversion

Unsurprisingly, and as you may already know, the hours of ambulance diversion in this state spiked again in January. Poorly staffed, inpatient bed capacity coupled with the usual flu season led to the increases but there is hope on two fronts.

First, the statewide Ambulance Diversion Taskforce met in December to continue their work on

Save the Day

MACEP'S Annual Meeting on May 12, 2004 at the Sheraton Hotel in Framingham is expanding to a full day and undergoing some exciting changes this year.

Drs. Brien Barnewolt and Matthew Mostofi have been busy lining up some exceptional speakers including Dr. John Strauss, the New York Chapter's "Physician of the Year- 2000", and nationally know Los Angeles malpractice attorney William Ginsburg among others.

The CME program as always is free and members are urged to encourage their colleagues, who may be interested in joining MACEP to attend as well. Watch for your mailed brochure in March but save the date in your calendars today!

possible remedies, and Christine Ferguson, Commissioner for Public Health, sent a letter to the hospitals indicating the expectation that best practice guidelines are in place and being observed at all of them.

Second, we know that a large number of psychiatric patients wind up for days (literally) in our EDs due to the difficulties of admitting them to a proper facility. We have now joined with the Massachusetts Psychiatry Society (MPS) in a coalition both to help these patients and relieve some of our crowding. MACEP's effort is being led by Mark Pearlmutter, MD, who worked successfully with the MPS in the past on medical clearance guidelines.

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MACEP News

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The deadline for receipt of all materials is the first of the month of publication.

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PRESIDENT continued

Seat belts

Who was that emergency physician promoting seat belt use on television around holiday time? It was Jim Feldman, MD, chair of MACEP's public health committee. While the seat belt bill was narrowly defeated this year, there is some hope of opening the issue again in the legislature. More information about this and other public health initiative are on the MACEP web site. Internally, MACEP continues to be active as well.

Website redesign

Speaking of the web site, Todd Thomsen, MD has redesigned the MACEP website. Not only is it easier to navigate, but will in the future allow for easier updates, keeping all of MACEP news timely. If you haven't been to MACEP's website recently, check it out! Please send suggestions to Carlos Camargo, MD, DrPH, chair of our communications committee.

Annual meeting

Save May 12th on your schedule requests to join us at MACEP's annual meeting. Brien Barnewolt, MD and Matthew Mostofi, MD of the education committee have greatly expanded the scope of the meeting this year to a full day. A new morning session of the meeting will be geared toward residents of the five training programs in Massachusetts, with the support of the residency directors. We hope many of the residents will stay on for our afternoon sessions as well. Save the date, May 12th, on your schedule to join us for an extensive CME program with some nationally known speakers presenting that day.

MENA/MACEP Joint Conference

Planning is well under way and registrations have been mailed out for the 11th Annual Joint Conference once again under the leadership of Amy Collins, MD. This year's event will be at the Westin Hotel in Waltham and we hope you have marked April 7th in your calendars as well.

Remarks

With the Annual Meeting in sight, my term as President of MACEP is beginning to draw to a close. I continue to be amazed by the good fortune I have had to be surrounded by the very talented people who make up our organization. As you can see from our activities over the past couple of months, there is much that we can accomplish for our patients through MACEP – indeed, I regard working with MACEP as patient care on the macro level. I hope you'll join at our monthly board meeting or by volunteering for a committee and help us in furthering our mission.



Medicine's Frontline

Residents Needed

James Eadie, MD, PGY 4; Brigham & Women's/Mass. General Hospital; MACEP Resident Board Member

Believe it or not, the resident voice is needed more today than ever to help shape the health policies of tomorrow. You may ask, "Can a resident really make a difference?" The answer is a resounding yes. Resident involvement in shaping policy is vital. The best way to learn is by getting involved.

Initially it can seem overwhelming. "You want me to join a committee to sit around a table and talk about problems that I can not change when I could be sleeping?" "No one really cares what residents think." If this sounds familiar, you are not alone. Most residents feel that becoming involved is difficult and don't know how to do it.

In Massachusetts there is an easy solution. Come to one of the monthly MACEP Board meetings. When I started attending two years ago, not only was I surprised by how much I learned by listening to the discussions on EMTALA, malpractice, EMS, Medicare and Medicaid but I was also impressed by the genuine interest the board had in residents and their ideas. As the old adage says, "90% of life is just showing up." Here are a few ideas for residents interested in becoming active.

MACEP Resident Section

Each residency program has a MACEP Resident Representative. We meet quarterly over dinner at a restaurant sponsored by MACEP. The dinners are a great way to learn what is going on around the state and to bring forward resident issues to the MACEP board of directors. Currently we are working to develop a health policy lecture series that will be offered at each residency program in 2004. Ask your representative for



Calendar of Events	<u>February 24, 2004</u>	<u>March 16, 2004</u>	<u>April 7, 2004</u>	<u>April 27, 2004</u>	<u>May 12, 2004</u>
	MACEP Board Meeting Radisson Hotel, Marlboro 4:30 - 6:30 pm	MACEP Board Meeting and Educational Roundtable Radisson Hotel, Marlboro 4:30 - 6:30 pm	MENA/MACEP Conference Westin Hotel, Waltham 7:00 am - 4:30 pm	MACEP Board Meeting Radisson Hotel, Marlboro 4:30 - 6:30 pm	MACEP Annual Meeting Sheraton, Framingham Resident's/CME Programs, Business Meeting, Awards

more information: Drs. Rick Gouling – Bay State; Marisa Stumpf - Beth Israel Deaconess; Tara Coles and Reena Duseja – Boston Medical Center; Josh Resnick – Brigham and Women’s / Mass. General Hospital; Kristen Malsnee – UMASS.

In addition to the program representatives, one resident is appointed to the MACEP Board of Directors. The resident’s term is for one year and he/she is a voting member of the board.

MACEP Committees

If you have specific interests, committees offer a unique way of becoming involved. Through the committees you can work with the leaders in the state and help form guiding policies. For example, you could work with the Public Health Committee advocating for seat belt and helmet laws. By working on the Legislative Committee, you might even find yourself at the State House speaking at a hearing. The opportunities are tremendous.

Our stories as residents are powerful. On the front line of medicine we see the inequalities inherent within our current system. We need to speak up on behalf of our patients. There is no grand czar with a crystal ball directing the emergency medicine and the health care system. Rather it is ordinary Emergency Physicians advocating for what is right for their patients at the bedside and at the State

House. Be an active player in shaping health care. Educate yourself, speak out on patient issues and be an advocate for resident and patient rights.

If you have any questions please email me jeadie@partners.org. I look forward to seeing you at a MACEP event. Becoming involved is easy and fun, all you’ve got to do is show up.

CEUs & Free Screening Materials Available to MACEP Members Who Participate in NASD

MACEP urges members to participate in the 6th annual National Alcohol Screening Day (NASD), a free program that offers clinicians the chance to educate the public about alcohol’s impact on health. Held nationally on April 8, 2004, the theme of this year’s NASD program is “Alcohol and Your Health: Where Do You Draw the Line?” Participating sites will be given screening forms as well as materials to educate patients about the effects of alcohol on overall health, a message relevant to anyone who drinks.

NASD is offering continuing education credits for participating physicians, nurses, psychologists and social workers. CEUs can be

obtained by holding a screening event and completing a brief self-test based on the NASD educational materials.

The NASD 2004 primary care kit includes the one-page NASD screening form, a tool that addresses the full range of alcohol use disorders, from at-risk drinking to dependence; the video “Alcohol and Your Health: Where Do You Draw the Line?”; and educational materials for clinicians, including the newly released guide, *Helping Patients with Alcohol Problems: A Health Practitioner’s Guide*.

Sites that hold the screenings also are encouraged to incorporate the screening into their everyday practice in the ED so as to increase early intervention and recognition of at-risk drinking in patients.

“Many of our patients don’t have primary care providers. If they’re receiving intervention, it’s in the ED,” says Patricia Mitchell, a research nurse who works in the Department of Emergency Medicine at Boston Medical Center, a top NASD 2003 site. Her facility has incorporated alcohol screening into the ED because, she says, “the ratio of how easy it is to implement versus the degree to which it can help someone at risk is really beneficial.”

NASD is a free program of the nonprofit Screening for Mental Health. To register for the program, visit www.NationalAlcoholScreeningDay.org or call (800) 253-7658.

National ACEP Reimbursement Committee needs your help to learn about new emergency medicine reimbursement challenges. What may start as an isolated issue can turn into a bigger problem if not addressed early. To facilitate reporting such problems the Committee has created an easy-to-use Billing Hassles Log. Go to ACEP’s home page www.acep.org and under “Practice Resources” click on “Reimbursement” and then “Billing Hassles Log”. If you are not directly involved in billing, you can still help by passing this information on to someone who is.

EMTALA: Final Rule Issued November 9, 2003, Effective November 10, 2003

The Centers for Medicare and Medicaid Services (CMS) has issued its Final Rule regarding policy clarifications of the Emergency Medical Treatment and Labor Act (EMTALA)¹. The Final Rule largely addresses the concerns of the AMA, which worked in partnership with several national medical specialty societies to ensure that key EMTALA burdens would be lifted. Highlights of the Final Rule include:

On-Call Requirements

Many of the on-call requirements have been positively revised. A **hospital² must maintain an on-call list of physicians** on its medical staff. The list is to be comprised: (1) in a manner that best meets the needs of the patients who receive care under EMTALA; and (2) in accordance with the hospital's resources, which includes the availability of on-call physicians. Thus, conditions of Medicare participation are: a hospital must maintain the above-mentioned list and physicians on the list must respond when called. However, there are now excusable reasons why a physician may not respond to the ED when called. **Hospitals can now permit physicians: (1) to schedule elective surgery during the time they are on-call; and (2) to have simultaneous on-call duties among different hospitals in the community.** If a physician is unable to respond to call due to performing surgery or responding to call at another facility, then he/she is not required to respond because the situation would be considered beyond the physician's control. Under EMTALA, physicians are not required to take call or to be on-call at all times.

Hospitals must have written policies and procedures in place: (1) to respond to situations when a particular specialty is not available; (2) to respond to situations when an on-call physician cannot respond due to circumstances out of his control; and (3) to provide that emergency services are available to meet patients' needs if it permits physicians to schedule elective surgery during on-call duties or allows physicians to have simultaneous on-call duties.

Comments accompanying the Final Rule state that although *not* required, one approach to satisfy the above "policies and procedures" requirement, would be for a hospital to have referral agreements with other hospitals to facilitate appropriate transfers of patients who require specialty physician care that is not available within a reasonable period of time at the facility where the patient first presents.

Triggering EMTALA: "Dedicated Emergency Department," "Hospital Property," & "Ground/Air Ambulances"

EMTALA is triggered when an individual who is not a patient presents to the "**dedicated emergency department**" requesting an examination or treatment for a *medical condition*. EMTALA is also triggered when an individual who is not a patient presents on "**hospital property**" requesting an examination or treatment for an *emergency medical condition*. In both scenarios, if the individual is unable to make the request, then the request is considered to have been made if a "prudent layperson" would believe that an examination or treatment would be necessary.

The Final Rule *created* the definition of a "**dedicated emergency department**" (DED). DED is any department or facility (whether or not it is located on the hospital's main campus) that: (1) is licensed by the State as a DED; (2) holds itself out to the public as providing emergency care on an urgent basis without requiring prior appointments (such as a labor and delivery department or a psychiatric unit); or (3) during the past calendar year, provided at least one-third of its outpatient services for emergency care on an urgent basis without requiring prior appointments. Where an individual arrives at a hospital's DED and requests an examination or treatment for what is clearly a non-emergency condition, EMTALA regulations require only that qualified personnel screen the individual to verify that in fact no emergency medical condition exists.

The Final Rule also *clarified* the definition of "**hospital property**" to mean the entire main hospital campus. This includes parking lots, sidewalks and driveways. This does not include other areas or structures of the hospital's main building that are not part of the hospital (such as non-medical facilities, the offices of physicians, and others who separately participate under Medicare.) The Final Rule *changed* when a patient is considered to have presented to the hospital when he is in a ground or air ambulance that is owned and operated by the hospital. Previously, whenever an individual was in an ambulance owned and operated by a hospital, then the patient was considered to have presented to the hospital and EMTALA was triggered. There are now two exceptions to that rule. Thus, an individual is not considered to have presented to the hospital: (1) if an ambulance is operated under communitywide EMS protocols that direct it to transport the patient to another hospital; or (2) if an ambulance is operated at a physician's direction who is not affiliated with the hospital that owns the ambulance. Lastly, a patient is considered to have presented to the hospital when he is in a **ground or air ambulance** that is not hospital-owned, but on hospital property at the dedicated ED for the purpose of an examination and treatment.

Prior Authorization

The Final Rule *clarified* that a hospital cannot delay treatment to inquire into a patient's ability to pay or to seek "**prior authorization**" for the provision of services from an insurer. Reasonable registration processes are permitted as long as: (1) there is no resulting delay in screening or treatment and (2) the registration does not act to discourage the patient from further treatment. An EP may contact a patient's physician at any time to seek information regarding the patient's medical history; however, this cannot inappropriately delay screening and stabilization.

EMTALA Does Not Apply

It is now clear that EMTALA never applies to an individual who: (1) has begun to receive outpatient services from the hospital; or (2) has been admitted in good-faith as an inpatient.

EMTALA Obligation Ends

EMTALA obligations end once an individual is stabilized, appropriately transferred to another hospital/facility or admitted to the hospital as an inpatient. No material changes were made to the "transfer" rule under EMTALA. - *American Medical Association Division of Legislative Counsel*

EMTALA: The New Regulations

By Lawrence S. Linder, MD, FACEP
Reprinted with permission from Fall 2003
Maryland EPIC

MACEP would like to thank Lawrence Linder, MD, FACEP and the Maryland Chapter of ACEP for graciously allowing us to reprint Dr. Linder's article on the recent EMTALA regulations that took effect in November 2003. We hope that you will find this article useful as a guide in understanding the new rules. However, the views expressed are solely that of Dr. Linder and are not intended as legal advice by him or by MACEP. The reader should consult with an attorney should they need any further clarification. *Also included for your information on page four is a brief summary of the rules written by the AMA.*

CMS (The Centers for Medicare and Medicaid Services) issued new EMTALA regulations on September 3, 2003. The new rules took effect on November 10, 2003. Although the Legal Corner usually involves state laws I felt this new federal change was important enough to discuss in our EPIC. These rules could exacerbate the current on call crisis. As usual, I will use clinical questions to illustrate the new changes and there is an entire section of questions concerning "on call" issues. However, prior to the questions, I wanted to include a brief synopsis of the rules written by the AMA. This is the most succinct and well-written summary that I found.

The questions and answers below draw from the terms and definitions provided in the shaded area. To whom does EMTALA now apply (answer yes or no for the following):

Patients in a "Dedicated Emergency Department (DED):"

- 1. A patient presents to the hospital ED asking for a blood pressure check.** Yes, they arrived at a DED and a prudent layperson might assume that a medical condition exists.
- 2. A patient presents to the hospital ED asking for a school physical exam.** No, they arrived at a DED, but there is no medical condition.

3. A patient presents to the hospital ED asking for a pregnancy test because she doesn't feel well. Yes, they arrived at a DED, and there is a medical condition because she doesn't feel well. This was not just a request for a pregnancy test.

4. A patient returns to the ED for suture removal. Yes, as above, DED and medical condition but a quick medical screening exam (MSE) should suffice. They could then be directed to a different outpatient setting if desired. EMTALA obligations end once the MSE has been finished and there is no emergency medical condition or the emergency medical condition has been stabilized.

5. An admitted patient is cut while upstairs and is brought down to the ED for suturing. No, EMTALA does not apply to admitted patients.

6. An ED patient is admitted but there will not be any in-patient beds available for several hours so they are being boarded in the ED. Most experts do not think that EMTALA would apply here because the patient is now admitted.

However there is some controversy concerning how CMS will define "admitted." Will it be when orders are written, when an admitting physician accepts the patient or when the patient is actually in their bed? Note, the admission cannot be to avoid EMTALA obligations.

7. The ED was not able to stabilize a patient's emergency condition and that patient was admitted to and is now in the hospital's intensive care unit. No, once the patient is admitted, EMTALA obligation ends.

8. Police bring a driver to the ED for a blood draw to determine his blood alcohol level. Controversial and will be looked at on a case-by-case basis. Was the intoxicated person involved in trauma or did he/she pass out? Prudent layperson standard will be used to determine if a medical condition exists.

9. A private physician says he will meet his patient in the ED and he arrives to see the patient. The distinction between private and ED patient is not relevant, EMTALA applies.

10. A patient has been sent to the ED for direct admission to a hospital bed. Most likely if they have orders, EMTALA does not apply. If they are to be seen by someone who still needs to write the orders, then they are not admitted yet, and EMTALA applies. However, as noted

in the answer to number 6, there remains some controversy concerning the CMS definition of "admitted."

11. A patient arrives in Labor and Delivery with abdominal pain. Yes, Labor and Delivery is considered a DED, and there is a medical condition.

12. A man arrives in Labor and Delivery complaining of a cold. Yes, EMTALA applies. He presented to a DED. He has a medical condition. However, EMTALA does not state that he needs to be treated in Labor and Delivery. He could be transported to the ER for his screening exam.

13. A patient arrives in the hospital's urgent care center with a minor laceration. This depends on whether the urgent care center is considered a DED. It is considered a DED if it is licensed as an ED, is held out to the public as a site that cares for emergencies, or if more than 1/3 of their visits during the previous calendar year were unscheduled and for emergency medical conditions. If the urgent care center meets one of these criteria, then it is a DED and EMTALA applies.

14. A patient arrives at a hospital's off-campus urgent care center with chest pain. The center does not have the appropriate resources to treat that patient. The main hospital campus is 30 minutes away, but another local ED is 10 minutes away. Does EMTALA require that the patient be transferred to the "mother hospital," or is it ok to send him/her to the closer facility? The patient presented to a DED and has a medical condition; therefore screening and stabilization must be done. However, the urgent care center does not have the appropriate resources available, and transfer is permitted. The appropriate transfer location is determined by the patient's status and the risks/benefits associated with each of the possible transfer destinations. It may be more appropriate to use the closer site rather than the main hospital campus.

Patients on Hospital Property

1. A visitor passes out in the hospital parking lot. The trigger for EMTALA on hospital property is different than in the DED. There needs to be an emergency medical condition for other hospital property, not just any medical condition, as in a DED. In this case EMTALA would apply because the visitor is on hospital

EMTALA continued

property and an emergency medical condition exists.

2. A patient complains of chest pain when he arrives for his regularly scheduled clinic appointment. Yes, he/she is on hospital property and there is an emergency medical condition. If the chest pain began after the regularly scheduled non-emergent care, then it would not trigger EMTALA. However, the patient would still be protected by other non-EMTALA rules because the hospital must also follow the Medicare Conditions of Participation (CoP).

3. A patient is in the clinic for a regularly scheduled blood pressure check and medication review. No, he/she is on hospital property but no emergency medical condition exists.

4. A patient is in the middle of a physician office visit (in the hospital) when she suddenly develops severe shortness of breath. No, a physician's office is not considered "hospital property," and the patient did not initially have an emergency medical condition.

5. An admitted patient needs to be transferred to another hospital for angioplasty. No, EMTALA does not apply to admitted patients (at least for the transferring hospital). However, EMTALA would apply to the receiving hospital.

6. A visitor is walking in the hospital hallway and appears confused. He has not asked for help, and no one has asked for help on his behalf. Yes, he is on hospital property and a prudent layperson would think an emergency medical condition exists. If a relative says this is his baseline mental status, then EMTALA does not apply.

7. You need to transfer an admitted uninsured patient to a tertiary care center. They say that the patient was already admitted, and therefore EMTALA does not apply and they do not need to accept the patient. Is that true? No, they are incorrect. EMTALA does not apply to the transferring hospital but it applies to the receiving facility like it always did.

Ambulances

1. A patient is in a hospital-owned ambulance (or helicopter) on the way to your hospital but is not there yet. Yes, EMTALA applies, but there are some exceptions.

2. A patient is in a private ambulance and is on hospital property. Yes, EMTALA applies, but there are some exceptions noted below.

3. A patient is in a private ambulance, which just met a helicopter that landed at your hospital, but the patient is being taken somewhere else. No, EMTALA does not apply unless the ambulance personnel ask for your medical assistance.

4. A patient is in a hospital ambulance but is going to a different hospital per local EMS protocol. No, EMTALA does not apply.

5. A patient is in a hospital ambulance but is going to a different hospital per the direction of a physician not affiliated with the hospital. No, EMTALA does not apply.

6. A patient is in a county EMS ambulance and is brought to your ED even though they know that you are on diversion. Yes, EMTALA applies; the diversion status is not relevant.

True or false questions concerning the Medical Screening Exam (MSE):

1. The EMTALA regulations now clearly define what a MSE is. No, this is still ambiguous and determined case by case.

2. A physician must perform the MSE. No, other qualified personnel can perform the MSE, but it must be spelled out in hospital policies or bylaws.

3. The triage nurse often satisfies the MSE. No, triage is not the same as a MSE.

4. Nurses and PAs can perform the MSE. Yes, if qualified and spelled out in hospital policy. So if a patient presents with a seemingly minor complaint, a nurse could conceivably do the MSE and send the patient out of the ED without ever being seen by a physician.

5. Do vital signs need to be done as part of the MSE? No. Although they would likely be required in most cases, they are not needed in every case. This is urban legend; it is not an EMTALA requirement. However, since the MSE is not clearly defined if you decide to skip vital signs, do so cautiously and don't violate any of your written policies or discriminate.

Registration Questions:

1. Can the insurance company be called to get authorization prior to the MSE? No.

2. All the ED beds are full. Can the patient be registered prior to the MSE? Yes, if it does not delay the MSE.

3. The ED is not full and a physician is available to see the patient. Can the registration process occur first? No, it cannot delay the MSE.

4. The ED physician is in the middle of the MSE and calls the HMO primary care physician to obtain more information. While they are talking, can the ED physician obtain authorization to treat?

Various experts continue to interpret this differently. The physician can get more information, but concurrent approval for authorization is still risky.

5. The MSE exam is done and the patient needs to be stabilized. Can insurance preauthorization for procedures be obtained? As above, if stabilization is needed and has not been done, then concurrent approval for authorization would be risky.

6. In the past we have been told that we are not permitted to discuss a patient's financial responsibility with them prior to screening and stabilization. However, many feel that it is a patient's right to be informed of potential financial liability for services. Do the new regulations address this? Yes. If a patient asks, their questions can be answered. However, the answers to these questions cannot delay screening and stabilization. Also, the hospital is not permitted to unduly discourage individuals from remaining for further evaluation. A staff member who is well-trained and knowledgeable in this area should answer the questions. The patient should be reminded that the hospital is ready to screen and treat them regardless of their ability to pay. They should be encouraged to defer further discussion of financial responsibility until after any necessary screening has been performed.

On-Call Issues:

1. On-call requirements have reportedly been made much more flexible. Does the hospital need to maintain an on-call list anymore? Yes.

2. Has CMS provided clear guidance to hospitals so that they know who must be on-call? No. "Each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients who are receiving services required under this section in accordance with the resources available

to the hospital, including the availability of on-call physicians.”

3. Does the hospital need to make sure that every specialty is covered on-call if there are physicians in that specialty on the medical staff for in-patients? No.

However, this is somewhat ambiguous. CMS will evaluate complaints on a case-by-case basis, taking into consideration the number of physicians on staff in that specialty, the other demands on these physicians, the frequency that the hospital receives patients with that problem, and back-up provisions arranged by the hospital in advance. The hospital will be required to meet the community’s needs as currently required by Medicare’s Conditions of Participation (CoP).

4. Can the on-call physician be on-call at more than one hospital simultaneously?

Yes. However, the physician must respond unless involved in an emergency at the other facility. The hospital needs to make arrangements in advance to address this issue, such as back-up call or transfer provisions.

5. Can the on-call physician schedule elective surgery while he/she is on-call?

Yes, the physician could finish a procedure but not start a new one before dealing with the on-call request. Also, as above, the hospital needs to make arrangements in advance to address this issue.

6. If the on-call physician has scheduled elective surgery while on-call, is it his/her responsibility to make sure that there is appropriate back-up coverage? No, the hospital needs to address this.

7. Are hospitals permitted to give preferential or no-call to senior physicians? Yes, if it doesn’t impair the hospital’s ability to cover the call schedule.

8. Does EMTALA now directly address the issue of hospitals needing to pay physicians by stating that physicians must take call? No, EMTALA does not address this, but the new rules may force hospitals to pay more specialists if they want those services covered for the ED.

9. In the past, when hospitals did not have many physicians in a given specialty, they often relied on the “rule of 3” (it was reasonable not to be on call more often than every 3 rd day). Is that still true? No. Coverage is evaluated on a case-by-case basis as noted above. The rule of 3 was convenient, but was really another urban legend.

10. Can a specialist limit his/her scope of practice when on-call? For instance, can an orthopedist state, “I specialize in hand surgery, and when I am on-call I will not see other types of orthopedic problems.” No.

11. If the hospital cannot provide on-call coverage for a certain type of problem, does that end their EMTALA obligation?

No. They need to address this scenario in their policies or bylaws in advance.

12. The new rules do not impose an obligation on physicians to take call. The duty is on the hospital to work it out in their bylaws or policies. Some of this is covered under the hospital’s Medicare Conditions of Participation (COP). If the on-call doc refuses to come in, is he/she still subject to EMTALA fines or is it all the hospital’s responsibility now.

Physicians on-call are still subject to the same fines as in the past if they violate EMTALA.

13. You have read that the on-call list must contain the physician’s name and not the “group’s” name. Is that true?

Various experts continue to answer this differently.

14. An emergency physician has requested that the on-call specialist come to the emergency department to see a patient, but the on-call specialist does not think the patient’s condition warrants his visit. Has CMS addressed this frequent occurrence? Yes. The on-call physician must defer to the emergency physician’s judgment that he/she is needed.

15. Can a nurse practitioner (NP) or physician assistant (PA) take call for the specialist? No. The physician must be the one on the call list.

16. If the on-call physician wants to send a physician assistant or nurse practitioner to see the ED patient is that acceptable? Even though the on-call physician must be the one on the call list, it may be ok to send an NP or PA to see the patient. This is determined on a case-by-case basis, and it is up to the treating emergency department physician to decide if that is acceptable.

Transfers:

1. Are there any new requirements concerning transfer forms? No, the requirements are the same. However, they may no longer be needed for admitted

patients according to EMTALA. (Transfer forms may still be advisable for admitted patients for other reasons though.)

2. You saw an elderly patient in the ED and you are sending them back to the nursing home. Do you need an EMTALA transfer form? This may depend upon whether an emergency medical condition exists, and if so, if it has been stabilized.

3. A patient in the ED has a tendon laceration and the plastic surgeon is willing to see the patient and repair it in their office now. Do you need to fill out an EMTALA transfer form? Yes, an emergency medical condition exists and they are not stable yet.

4. Many have predicted that the new, more flexible on-call rules will make it harder for hospitals to recruit on-call specialists. As this happens, more community hospitals will need to transfer patients to tertiary care centers. Some of these patients are “gray zone.” Suppose a patient is “stable” if adequate follow up can be arranged (for instance a stable jaw fracture). However, you now have no specialists taking call in that area. You contact the university hospital to arrange transfer of the patient and they state that this is a stable patient and that they will not accept him/her. You state that the patient is only stable if they get appropriate follow-up and you cannot arrange it from your hospital. Does the University Hospital have to accept the patient if they have a bed and the ability to care for that problem? The answer to this question remains unclear to me.

Other Areas/Questions:

1. Terrorists just released ricin in several American cities. A national state of emergency has been declared and your ED is being overrun by the worried well who are just coming to the hospital to make sure they are ok. Does EMTALA apply?

No. EMTALA requirements are waived during a national emergency. However, it may not be declared a national emergency until much later, in retrospect. It is a decision of the President of the United States.

2. Same scenario as above, but this is a local problem and no national state of emergency has been declared. Debated. May or may not apply to local emergencies in the future, but at this time EMTALA probably still applies.

EMTALA continued

3. In the past there was often variation in EMTALA interpretation and enforcement between various regional offices and state agencies. Has this been addressed? There is better coordination between enforcers than in the past, but it may still remain a problem. Wait and see.

4. The reach of EMTALA seems to have diminished. For instance, now citations may change from EMTALA to Conditions of Participation (CoP's). Is this better or worse? A little of both. There may be more time to respond and remedy the problem. However, CoP surveys can

be more encompassing and demanding than EMTALA.

5. CMS has been discussing a rule requiring the hospital to contact Medicare + Choice plans promptly once the patient is stabilized. Has this happened yet. No, this is still being discussed.

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