Statement on EMTALA[1]

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Introduction

The Emergency Medical Treatment and Active Labor Act (EMTALA) was passed in 1986 to provide regulations for the evaluation of patients with emergency medical problems. It requires all hospital emergency departments that accept payments from Medicare to provide an appropriate screening examination to those seeking treatment, independent of insurance status or ability to pay. This applies specifically to all "participating" hospitals: those that accept payments from the Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS). Patients must be stabilized or transferred to another hospital only if the initial hospital does not have the capability to treat the condition.

An important component of EMTALA is the medical screening examination (MSE), which is used to determine whether an emergency medical condition exists. This may involve the determination of the on-call plastic surgeon. Various call schedules may exist at a given health care systems and/or facility, and surgeons may be asked or required to participate in if they have privileges. These include maxillofacial, hand and plastic surgeons, to name but a few.

EMTALA was passed to eliminate the practice of "dumping" patients; that is, refusing to treat patients because of insufficient insurance coverage or because of expectation of high treatment costs. In 2003, the Centers for Medicare and Medicaid Services revised these regulations under the "Final Rule," stating that hospital emergency rooms are not required to have specialist coverage at all times but must have procedures in place in case a specialist or on-call physician is not available.

EMTALA statute violations resulting in "dumping settlements" from the Office of the Inspector General (OIG) from 2002 to 2015 most often resulted in hospital citations and fines. Individual physician penalties were far less common. A physician can be held individually liable for fines of up to $50,000 not covered by malpractice insurance.

EMTALA is particularly germane to plastic surgeons as it relates to the provision of on-call services within the emergency room setting.

[1] The ASPS is committed to patient safety, access to care and the highest quality standards of patient care. These anecdotes are for reference purposes only, as general guidelines and not statements as to a standard of care. By way of this statement, the ASPS does not opine on the merits of the Emergency Medical Treatment and Active Labor Act (EMTALA) or its legal effect. Rather, this statement is designed to inform ASPS members of certain requirements of EMTALA and their practical effects. This statement should be considered in the context of EMTALA, the policy requirements of your practice site(s), CMS and Joint Commission requirements, if applicable, and the legal requirements of your individual states.

Intent/Purpose

A number of issues related to EMTALA have arisen with American Society of Plastic Surgeons (ASPS) members, and this position statement is designed to briefly address some of the common problems that have been encountered.

Methods

This statement was developed with the guidance of multiple members of the ASPS Health Policy Committee after a literature and public policy review.

Guidance Statements

Issue 1: Be Aware of Issues Related to Emergency Room "Call Panels"

Each health care system or hospital has unique rules and bylaws, which may dictate the protocol and expectations for specialty service consultation its emergency room (ER). It is important for ASPS members to be aware of "call panels," which are made up of specialists available to the ER for patient services. If an emergency room physician requests the on-call specialist (i.e., plastic surgeon) to evaluate the patient, it is often required regardless of the specialist's impression of the necessity of urgent consultation. As it relates to EMTALA, the definition of an emergency medical condition is often somewhat opaque and most defined by the perception of the referring (i.e., ER) provider. If the ER physician requests the on-call plastic surgeon to come in to evaluate a patient, this is required even if it is just to document in the chart that the patient can follow up in clinic.

Evaluation by a specialist is considered part of the medical screening examination (MSE), which has been clarified by the legal system. If there is a disagreement about the necessity of emergency consultation, the specialist (i.e., plastic surgeon) is required to evaluate the patient. The referring (i.e., ER) provider is required to document in the record the reasoning behind the consultation. Some hospital systems may contain bylaws which allow the emergency room physician to call on a specialist even when his or her name is not on a call roster and he or she may not be available. If a plastic surgeon is called and reaches a verbal agreement about the care of a patient within the emergency room – specifically related to whether or not emergency care is required – this should be put in writing in case another ER provider assumes care of the patient.

We recommend that ASPS members review the bylaws of their hospital, to help make an informed decision about whether or not to become a staff member at the hospital. Additionally, we recommend reviewing these issues periodically, as they may change. If one is considering a salaried position within a hospital system, it is advisable to request a sample contract in order to view expectations and regulations related to care while on call.

Issue 2: Emergency Rooms Using EMTALA to Mandate Specialist Physicians Come into the ER to Evaluate Patients

It is important that ASPS members understand all rules related to EMTALA. Most hospital systems have a 30 to 45 minute rule for emergency evaluation of patients for whom specialty consultation is required. This can be particularly challenging for a plastic surgeon if he or she is seeing patients in the office or in the middle of an operation – potentially at another hospital. It is important to have a written agreement (from the hospital) about the possibility of offering

patient transfer to another facility if specialist consult availability is limited by operative cases or clinic, a "gentleman's agreement" is not sufficient.

As mentioned above, evaluation by a specialist (i.e., plastic surgeon) is considered part of the medical screening examination, and the necessity of emergency consultation is dictated by the referring ER provider. Before taking emergency calls at a hospital, plastic surgeons should understand EMTALA issues related to provision of emergency services.

Issue 3: Malpractice Coverage

In general, EMTALA violations are NOT covered by malpractice insurance on the civil part of the violation (i.e., the carrier will not defend or cover any of the civil fines imposed; separate insurance coverage is needed at an additional cost). Members are advised to review their policy annually with their carrier.

Issue 4: Definition of Medical Emergency as It Relates to Plastic Surgery

The definition of what constitutes an "emergency" requiring the services of a plastic surgeon is somewhat vague. As mentioned, it is more likely related to the perception of the emergency room physician, or the general public (a layperson), than the perception of the ASPS plastic surgeon on call. This is one of the more challenging issues for ASPS members related to EMTALA.

Unfortunately, the scientific and clinical merit necessitating consultation may be independent of the request for specialty consultation. For instance, even complex facial lacerations can often be closed up to 48 hours after injury with similar clinical outcomes, but this may not be acceptable to the patient or the referring emergency room physician. Being proactive in terms of communication and determining what events constitute or define a plastic surgery emergency with the Director of the emergency department or health care center can be of significant benefit.

Issue 5: Significance of Emergency Consultation May Depend on Employment Status of Plastic Surgeon

If an ASPS member is on-call he or she should be called for all patients requiring emergency or secondary plastic surgery consultation, not merely the uninsured patients. It has been noted that certain hospitals and emergency rooms have referred patients to salaried plastic surgeons as outpatients following consultation in the emergency room instead of referring to the on-call plastic surgeon (if this individual is not a salaried hospital employee).

ASPS members should request a copy of a hospital's bylaws regarding specialist ER coverage with language reflecting that the on-call specialist will provide clinical services to all patients presenting to the emergency department while an ASPS member is on call. It is not fair for patients with insurance to be referred to salaried plastic surgeons while those without insurance are not. This is difficult to enforce, but it is principally important.

Additionally, ASPS members are obligated to report EMTALA violations. This should be done formally through one's own hospital administrative system and also with the referring hospital. This is important to maintain both the spirit of the law as well as to maintain the optimal referral system for patients.

Issue 6: Some On Call Refuse to See ER Patients in Follow Up Because They Do Not Take Their Insurance

If a surgeon takes "call" in an emergency room, he or she is obligated to provide emergency services to patients who present to the ER. This obligation occurs when the ASPS member agrees to comply with the bylaws of the health care facility. For secondary issues that are not emergent, ASPS members should be required to care for the patient or, alternatively, help facilitate care with a provider who takes the insurance of the patient.

This is an increasingly common problem, particularly for those with high deductibles, as these patients tend to use the ER for most of their care. Additionally, surgeons who care for patients in the ER who are out of network are obligated to disclose this fact and explain the process of out-of-network billing to the patient. In fact, it is very important for ASPS plastic surgeons to ensure that patients generally understand the nature of billing procedures for emergency consultation in the room.

Conclusions and Future Directions

This document is designed to provide general guidance for ASPS members related to EMTALA. Future revisions will be required as the laws (and their interpretation) change.

Take Home Points

- Specialist evaluation, including plastic surgery, is part of the medical screening evaluation (MSE).
- The necessity of specialist evaluation is determined by the emergency room physician, regardless of the specialist's impression about the urgency of consultation.
- ASPS members should check the bylaws of their hospital to determine all guidelines related to EMTALA.
- ASPS members should know the hospital rules for patient transfer to another facility if needed (particularly if the plastic surgeon operates and/or has clinic in another facility, but is taking call at a different hospital).
- ASPS members should review their malpractice insurance coverage, as EMTALA violations (civil) are not routinely covered.

- ASPS members should learn the specific rules of their hospital regarding referral of patients from the emergency room to an office setting. This may prevent certain ("desirable") patients from being referred to salaried plastic surgeons instead of the plastic surgeon on-call at time of presentation.
- If an ASPS member takes call in an emergency room, he or she is obligated to provide emergency services to presenting patients, and/or facilitate follow-up care for outpatient issues that arise after emergency presentation.

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