ED LEGAL LETTER™

THE ESSENTIAL RESOURCE FOR EMERGENCY MEDICINE MALPRACTICE PREVENTION AND RISK MANAGEMENT

NOVEMBER 2017 Vol. 28, No. 11; p. 121-132

INSIDE

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Non-prudent Limits on Patient Visits: Overcoming Barriers to Provide Necessary Care

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For all its headaches, the Emergency Medical Treatment and Labor Act (EMTALA) codified the moral compass of emergency medicine 30 years ago. Anyone, anytime, for any reason, regardless of ability to pay, became our standard. We work nights and holidays when others close because disease knows no breaks. When clinics, grocery stores, and other businesses leave inner cities, we stay to care for the poor and underserved, recognizing that we will not be paid by many of them, but it's our sacred calling.

Big insurance wants in on the game of free care for their "covered" insured patients. Since EMTALA requires us to provide care to their patients, big insurance companies see no reason to provide payment for care they do not feel like covering. While some argue that on the surface this is their right to pay only for necessary services, the decision to retrospectively deny coverage is a fundamental assault on the rights of patients to seek emergency care and providers to bill for legitimate services rendered. Using the "retrospectoscope" to lecture patients and providers about care for serious health threats is a disservice to us all. It is unconscionable, immoral, illegal, and potentially unconstitutional.

Background

Retrospective denials for care are not novel concepts for big insurance companies, but they now apply uniquely to emergency medicine. Starting in 2010 with the state of Washington's three visit rule and extending to the 2017 efforts in Missouri and Kansas to limit covered conditions, a renewed effort by dozens of states to blame patients for medical

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ED LEGAL LETTER

ED Legal Letter™,
ISSN 1087-7347, is published monthly by
AHC Media, a Relias Learning company
111 Corning Road, Suite 250
Cary, NC 27518
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to:
AHC Media
PO Box 74008694
Chicago, IL 60674-8694

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SUBSCRIPTION PRICES:
Print: 1 year with free *AMA PRA Category 1 Credits™*: $519.
Add $19.99 for shipping & handling.
Online only: 1 year (Single user) with free *AMA PRA Category 1 Credits™*: $469

Back issues: $83. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.
GST Registration Number: R128870672.

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Relias Learning LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.5] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

This activity is intended for emergency physicians and nurses. It is in effect for 36 months from the date of the publication.

Opinions expressed are not necessarily those of this publication, the executive editor, or the editorial board. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought in specific situations.

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emergencies has emerged. In both Washington and Kansas, the efforts were focused on the Medicaid managed care organizations (MCOs) limiting covered conditions for their insured on diagnoses such as chest pain, abdominal pain, influenza, and hundreds of other life-threatening conditions.[1] Often, these lists were designed to save money and cover up inadequate primary care networks with substandard reimbursement for providers. Such efforts do little to address the systemic failures of the Medicaid system and, instead, pass the expenses on to hospitals and providers for unmanaged chronic illnesses with serious adverse health effects.

Meanwhile, Blue Cross Blue Shield is leading efforts in Missouri and Georgia to punish private pay patients for seeking care for what the insurer deems to be unnecessary.[2] When combined with escalating deductibles that now exceed the liquid assets of many Americans,[3] these cost-shifting efforts can produce devastating outcomes for patients. Increasing bad debt also occurs with these efforts, putting the viability of practices into question. Legal protection of patients and practices must be considered for all our survival.

Prudent Layperson Statutes

Efforts to deny payment based on discharge diagnosis are not new. Such attempts in the 1980s led to the creation of the prudent layperson statutes in more than 30 states. Prior to the Affordable Care Act's inclusion of prudent layperson standards, it had been extended to Medicaid managed care plans as part of the Balanced Budget Act of 1997 and federal employees in 1999.[4] Although each state's language may differ slightly, here is an example of specific language from Washington state's statute RCW 48.43.005(12) that defines a medical emergency to be one that: "a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition a) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part."

When patients present with a condition that meets this definition, then coverage is required. Thus, the patient who is determined after the visit to have indigestion from a spicy meal, but is a diabetic, hypertensive, hyperlipidemic male with chest pain cannot be denied coverage for his visit solely based on the fact that he did not experience a heart attack.

Some theorize that providers could litigate financial injury for failure to make payments for covered conditions under the prudent layperson statute. The issue of standing and whether providers represent an intended beneficiary of the statute remains undetermined. Standing is the legal theory that an individual must assert hir or her own rights and claims before the court that is specific to his or her interest that the statute was intended to cover. Given the financial effect on the medical practices and the fact that the statutes were created to require payment to providers in these cases, it is reasonable to assume that standing would be granted to providers in the case of litigation.

The right legal standard also must be used when targeting Medicaid vs. private insurance. The Medicaid lim-

its have been barred by federal statute for 20 years and are not a source of current political controversy. In contrast, the prudent layperson protections for privately insured patients is only provided by the Affordable Care Act in states such as Missouri that do not have state level prudent layperson protections, a current area of significant political danger. If this provision were to be eliminated from federal law, it would leave the patients and providers in these states subject to even greater risk of denial.

Medicaid Requirements

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements for Medicaid plans may be violated by many of these programs and be a further legal remedy. EPSDT requires that Medicaid cover "any medical or remedial service recommended by a physician ... for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level."[5] Medicaid rules that have conflicted with EPSDT requirements previously have been declared invalid.[6] These requirements apply to any child younger than 21 years of age.

Many of the Medicaid visit limit programs involve children younger than 21 years of age and could affect their ability to maintain the best possible functional level. In fact, in a recent analysis in Washington state's Medicaid program, the non-dual eligible Medicaid population seasonal variation of potentially avoidable visits was because of children younger than 21 years of age. Most of these visits were for minor traumatic injuries, upper respiratory illness, abdominal pain, and other conditions commonly included on visit limit lists. Programs that try to prevent these visits for non-payment would risk violating the EPSDT requirement of federal law and invalidate the state level Medicaid rules, such as in Kansas.

CMS Waiver Requirements

Under current law, Medicaid programs are joint federal- and state-administered endeavors that require federal approval for most significant policy changes, often referred to under the banner of Medicaid waiver requirements. Previously, courts have ruled that where Medicaid rules conflict with federal requirements, they are unconstitutional under the Supremacy Clause of the U.S. Constitution, Article VI.[7] These changes to policy not only must be submitted for federal approval, but "may not be implemented until federal approval is actually obtained."[8] Thus, violation of the federal prudent layperson standard, EPSDT, or statutory requirements that were not properly vetted through CMS for approval could be blocked until proper approval is received. Although temporary in effect, this could lead to the opportunity for better redress and negotiation of alternative policies while any waiver works its way through the federal process.

Theft of Service

Physicians have preferred to focus on the patient and argue on the moral authority instead of consideration of their own right to payment for services rendered, but with increasing pressure, the concept of theft of service arises as a potential legal remedy. Theft of service is a legal doctrine that states a crime has occurred when: "1) the person obtains services, known by that person to be available only for compensation, by deception, force, threat, or other means to avoid payment for the services; 2) having control over the disposition of services of others to which the person is not entitled, the person knowingly diverts those services to the person's own benefit or to the benefit of another not entitled to them."[9]

While each jurisdiction will operate under its own legal statute, the concept of theft of services and potential criminal and civil remedies could be considered. Arguably, insurers have directed their beneficiaries to the ED to seek care for conditions that they know they will not pay for and, thus, have benefited from services that they are not entitled to receive. Alternatively, the insurers have obtained services and used the threat of retaliation with contract to make non-payment for a list of conditions they know requires compensation.

These legal theories have limited testing in addressing patients who have sought uncompensated care with fraudulent means, but not against large insurance companies for systematic denials of compensation. As such, this would be a potentially novel application that warrants further exploration and discussion if it can provide relief to patients and colleagues.

Prior Authorization

Prior authorization reform has become a hot button issue over the past year. Large coalitions of providers, hospitals, and healthcare organizations have banded together to demand reform of the system.[10] With a list of 21 principles available from the taskforce,[11] one key element is clear: "Prior authorization should never be

required for emergency care." Additional requirements for transparency and medical validity further argue against visit limitation policies. Many states are in the process of reforming their prior authorization and utilization management programs. Including barriers to retrospective denials that are one step removed from prior authorization could help prevent the spread of these inappropriate visit limitation lists.

While subject to the political process, the indignation that providers feel at insurers telling patients with life-threatening conditions that they cannot seek care resonates with the broader public and politicians. By working these bills through the legislative process, much as what happened with prudent layperson laws 20 years ago, it is possible that this issue could return to the shadows once more.

Emergency physicians stand at the intersection of many failed healthcare policy efforts. The ED visit limits are an attempt to punish those who care for all patients regardless of their ability to pay. These types of denials and limits may reduce potentially avoidable care, but also important and necessary care that helps our patients. These efforts threaten our ability to provide care. These attempts cannot be left to stand and must be met with the full force of the law to ensure that the safety net remains able to care for this vulnerable population. It is one more way we advocate for patients, by making sure they can receive the care they need. ■

REFERENCES

1. Craig CS. New concerns arise over application of prudent layperson standard in the ED. *CIPROMS Medical Billing*, May 18, 2017. http://bit.ly/2vTRWFG. Accessed Sept. 13, 2017.
2. Hiltzik M. A big health insurer is planning to punish patients for 'unnecessary' ER visits. *Los Angeles Times*, June 2, 2017. Available at: http://lat.ms/2w8yREb. Accessed Sept. 13, 2017.
3. Claxton G, Rae M, Panchal N. Consumer Assets and Patient Cost Sharing. The Henry J. Kaiser Family Foundation, March 11, 2015. Available at: http://kaiserf.am/2xz0pCW. Accessed Sept. 13, 2017.
4. Blachly L. ACEP initiative supporting 'prudent layperson' standard becomes law in health care reform act. *ACEP News*, May 2010. Available at: http://bit.ly/2jqnu4f. Accessed Sept. 13, 2017.
5. 42 USC 1396d(a).
6. *Samantha A v. DSHS*, 171 Wn.2d 623 (2011).
7. *Orthopaedic Hosp. v. Belshe*, 103 F.3d1491, 1496 (9th Cir. 1997).
8. *California Hosp. Ass'n v Maxwell-Jolly*, 777 F. Supp. 2d 1129,1148 (E.D. Cal 2011).
9. AS 11.46.200. Theft of Service (Alaska).
10. American Medical Association. Health Care Coalition Calls for Prior Authorization Reform. *AMA News*, Jan. 25, 2017. Available at: http://bit.ly/2k6l6P5. Accessed Sept. 13, 2017.
11. Prior Authorization Reform Taskforce. Prior Authorization and Utilization Management Reform Principles. Available at: http://bit.ly/2jsamvd. Accessed Sept. 13, 2017.

Inspector General Sets Sights on ED Psychiatric Boarding Practices

Recent large EMTALA fine likely not the last of its kind

Psychiatric patients are held routinely in EDs for hours, days, or even weeks due to lack of available facilities. Few would argue it's a high-risk situation for the patient, EPs, and the hospital; yet, the dangerous practice continues.

Now, a record $1.29 million Emergency Medical Treatment and Labor Act (EMTALA) fine has sent a strong message. "Relative to prior fines, this is huge and surprising. It definitely can be expected to change how EDs function," says **Stephen A. Frew**, JD, vice president of risk consulting at Johnson Insurance Services and a Rockford, IL-based attorney.

The EMTALA case involved 26 patients with unstable psychiatric conditions who presented to a South Carolina ED. The U.S. Department of Health and Human Services' Office of Inspector General (OIG) alleges EPs issued involuntary commitments on the patients and boarded them in the ED for six to 36 days, despite open beds in the hospital's psychiatric units. *(Read the interview in this issue with an OIG attorney for more information about the case and EMTALA obligations for psychiatric patients.)*

"The hospital cannot have a psychiatric unit and then impose

limitations on admission," Frew warns. In this particular case, the hospital only accepted voluntary admissions to its psychiatric unit. All involuntary admission cases were boarded in the ED.

"The second issue from OIG's perspective appears to be that the on-call psychiatrists were not called in to evaluate or render care to the boarded patients," Frew says. Therefore, the hospital potentially provided a different level of care to boarded patients than that provided to patients admitted to the unit. This is contrary to EMTALA. "CMS has repeatedly stated that psychiatric patients can be placed in general medical beds with direct staff supervision," Frew adds.

Sudden Jump in Intensity

The large number of ED patients involved in the South Carolina case contributed to the record-setting fine. "Many other cases have had high case numbers, but never crossed the $400,000 mark," Frew explains. "This sudden jump in intensity came as a surprise to many of us who follow EMTALA."

This case parallels the recent trend of larger fines handed down in suits related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Frew says. "Average cases have jumped to $1 million after an initial history of lower fines."

OIG recently made inflation adjustments to its fine structure. The aggravation and mitigation factors determining the amounts of fines for all cases were changed. "Some sources in the industry have theorized that the changes are for revenue generation, or for a more punitive approach to fines," Frew offers. For hospitals that lack psychiatric units or staff psychiatrists, Frew says "this case could be viewed as a hurricane on the horizon." Often, these EDs are unable to find accepting hospitals for the transfer of psychiatric patients. Thus, EDs end up boarding the patients for extended periods.

ED visits related to mental disorders increased substantially (56% for depression, anxiety, or stress reactions, and 52% for psychoses or bipolar disorders) between 2006 and 2013, according to the Agency for Healthcare Research and Quality.[1]

It is not yet clear whether OIG will fault all boarding of psychiatric patients in the ED, or only those cases where the hospital has psychiatric beds. "But I would not rule out the more sweeping approach," Frew cautions.

'Huge Potential' for Violations

In light of the recent EMTALA settlement, EDs must re-evaluate all policies for psychiatric patients, urges **Mark Kadzielski**, JD, a partner in the Los Angeles office of BakerHostetler who specializes in EMTALA compliance.

"The concept of boarding, or as I call it, warehousing patients, is problematic," Kadzielski says. "It creates a huge potential for violations of EMTALA." This is particularly concerning for patients with unstable psychiatric conditions, but holds true for all ED patients. "Holding any patients, whatever their condition or diagnoses, waiting for transfer, or waiting for a bed, in the ED, creates the potential for an EMTALA violation," Kadzielski explains.

Once a patient is admitted, EMTALA no longer applies. "But if the patient is in the ED and has not been admitted to the hospital and is boarded for whatever reason, it's a real EMTALA risk," Kadzielski says.

Patients with psychiatric emergencies can slip under an ED's radar easily. "If a person is bleeding and bandaged from a gunshot wound in the hallways waiting for a bed, that's obviously a big red flag," Kadzielski says. A person who arrives with a psychiatric emergency might be sitting on a gurney looking off into the distance and appear perfectly fine physically. "But the person who's mumbling and twitching over in the corner poses the same kind of risk under EMTALA as the person who's physically injured," Kadzielski stresses.

In the South Carolina case, the OIG looked at the boarding of psychiatric patients over several months.

EXECUTIVE SUMMARY

A record $1.29 million EMTALA fine involved psychiatric patients boarded in the hospital's ED for extended periods, and the Office of Inspector General is expected to continue focusing on this area. EDs should be aware:

- The hospital cannot offer a psychiatric unit and then impose limitations on admission.
- Hospitals cannot provide different levels of care to boarded patients than what is provided to inpatients.
- Psychiatric patients can be placed in general medical beds with direct staff supervision.

This led investigators to discover that many others were held in the ED for significant periods. "It was a very thorough, extensive, and broad investigation that resulted in this record fine," Kadzielski notes.

For plaintiff attorneys, the OIG settlement is a possible negotiating tool to use during malpractice litigation. "Certainly, there will be new opportunities for plaintiff attorneys to say, 'This kind of care has been punished by the government, so give us money now,'" Kadzielski says.

Plaintiff attorneys might be more likely to file lawsuits against EPs and hospitals on behalf of psychiatric plaintiffs who were boarded in EDs. "But those cases are going to have to be evaluated on their merits. Just because they're similar to this type of case doesn't mean they have merit," Kadzielski notes. From a risk management perspective, EDs can use the record-breaking EMTALA fine as a teaching tool. "EDs across the country should say, 'Hey, look at what happened here in this case. What are we doing here in our ED? Let's rethink our approaches and practices,'" Kadzielski offers. He says EDs should evaluate these two things:

- what resources, capabilities, and capacities the hospital has;
- what resources, capabilities, and capacities the community has.

"Recognize that, when these patients present, they are going to challenge the creativity of the ED leadership to deal with them in the best possible way," Kadzielski notes.

Boarding patients in the ED, when psychiatric beds are available in house where patients could be getting standard of care medical treatment, says Kadzielski, "just doesn't make a lot of sense. Clearly, the resource issue is what's important."

Some EDs are in an acute care hospital without psychiatric beds. The surrounding community also may lack adequate resources. In that case, says Kadzielski, "You've got to look at creating relationships with other hospitals in the surrounding community and beyond."

If the EP is told that the wait is X number of hours or X number of days for an available bed in the community, this is important to document.

"The other critical thing that EDs don't realize they have to do is to document vital signs on a regular basis. Patients can go south pretty fast while awaiting transfer," Kadzielski warns. A psychiatric patient might be stable at a certain point in time, but this can change. If no one in the ED notices that his or her condition deteriorates, a bad outcome can occur.

"The last thing you want to do is have the patient being boarded far away on a distant gurney because they are 'stable for transfer,' and have them code," Kadzielski says. ■

REFERENCE

1. Weiss AJ, Barrett ML, Heslin KC, et al. Trends in emergency department visits involving mental and substance use disorders, 2006-2013: Statistical Brief #216, December 2016. Agency for Healthcare Research and Quality, Rockville, MD.

SOURCES

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When Psychiatric Patient Comes to ED, Consider Entire Hospital's Capabilities

A South Carolina-based company called AnMed Health recently settled an EMTALA case for a record $1.29 million. *ED Legal Letter* recently spoke with **Sandra Sands**, senior counsel at OIG who served as the lead attorney on the case, about psychiatric patients and EMTALA.

• On the record-breaking EMTALA settlement:

We got to such a big penalty because there was evidence of so many incidents where AnMed hadn't met its responsibility under EMTALA. And that's not surprising, given the longstanding policy they had that patients who were involuntarily committed would not be given access to the full capabilities of the hospital, which included on-call psychiatrists and a psychiatric unit. For each one of these presentments, there were beds available in that unit. So there was a policy that, on its face, I would suggest would lead to the hospital not meeting its obligations.

The hospital corrected the underlying problem, which was a policy that led to not meeting their obligations to numbers of patients. They

also ended up looking at the issue of the incredible need in the community for psychiatric patients and plan to double the number of beds they had in the psychiatric unit. It was a particularly positive reaction in some respects, in trying to bring more services to this needy population.

• On what EDs should be looking at regarding care of psychiatric patients:

There are a lot of nuances involved to the application of the statute when it comes to psychiatric presentments. The critical question I think a hospital needs to ask itself, in terms of whether they are meeting their obligations under EMTALA, is whether the hospital is bringing the necessary services to stabilize these individuals with emergency medical conditions within the full capabilities of the hospital. It's not just what's available on a daily basis in the ED, per se, but the entire hospital system.

That typically would mean access to on-call physicians, if they were appropriate to be called in for stabilization of psychiatric emergencies, and whether there are other services available, which in this case had to do with inpatient services. Sometimes, those services are available because there is a specified unit that is set up to deal with that particular kind of emergency medical condition. Other times, it's because there are swing beds in a hospital that can be used for various kinds of emergencies. But under the law, it's incumbent upon a hospital to use its full capabilities to meet the needs of that patient. So, the primary takeaway from this case is that hospitals have to use their full capabilities to stabilize patients.

Another issue that came up in this case was patients who had involuntary commitments and didn't have financial resources. There was a policy that an attending physician could write an order for the local mental health center to evaluate the patient for commitment to a state mental health system. I'm not sure how the hospital was interpreting that, but EMTALA requires the hospital to stabilize not only any medical condition that may be present but also psychiatric emergency medical conditions.

If the hospital can't, if it doesn't have the capabilities to do that, the statute provides for an appropriate transfer to a facility that is capable. But when that hospital is capable of doing it, under EMTALA, that hospital has to do it. In order to meet its full obligations under EMTALA, the hospital must use its full capabilities to stabilize both the medical and psychiatric aspects of a patient's medical condition. Transfers that happen without that hospital's capabilities being utilized first would be potentially an abrogation of the hospital's responsibilities under EMTALA.

We all know there is a real dearth of resources for this population in many areas of the country. Localities and states have gotten together to try to come up with plans to best meet the needs of these patients, which often involves community health workers and transfer plans. Those kinds of efforts are important. However, we've had more than one case in which a hospital might try to substitute a community plan for its own capabilities. And that's where the hospital could get into trouble in not meeting its obligations under EMTALA.

The hospital needs to do whatever is within its capabilities. If its capabilities are to stabilize, it needs to stabilize, and then it can take advantage of local and state facilities to help meet the medical needs of that patient.

• On boarding of psychiatric patients in the ED:

There are situations in which the hospital doesn't have the ability to stabilize, so the responsibility is to effect an appropriate transfer. That leads to patients potentially being in the ED.

It's also possible that the hospital could keep those patients someplace other than the ED, but the main thing is that they are bringing the services that are available. For that to happen in the ED when they don't have the capabilities, and then effect an appropriate transfer — in general, that would be a permissible practice.

Even if a hospital has made the appropriate decision that somebody is suffering from an emergency medical condition, and it's appropriate to transfer that individual, it's really important that the person is re-evaluated before the transfer happens. That's a practice that should occur because of the potential, no matter what the problem is, of further deterioration. It could be that there is further stabilizing treatment that is needed to minimize the risks of transfer that needs to occur before the person is actually transferred.

It's also really important that when information is brought by anyone, by observation or otherwise, that the patient's condition may have deteriorated, for the patient to be re-evaluated, not only in terms of the transfer but also what the hospital can do to stabilize the condition.

• On medical screening examination for psychiatric patients:

When somebody presents with an apparent psychiatric emergency medical condition, the hospital needs to, within its capabilities, evaluate that psychiatric presentment. The hospital also has to do an appropriate medical screening examination as to what could be the medical presentment.

There are a number of really important reasons for this. Psychiatrists have said to me a number of times over the years that they think the

majority of people who present to a hospital ED with apparent psychiatric behavioral issues — the etiology is actually medical. Somebody having an adverse reaction to a medication is a common example. So, it's very important to look at both sides of this.

In the enforcement of EMTALA, a number of cases that we've had over the years involve somebody being treated as a psychiatric patient because of behavioral symptomology, and not getting the appropriate medical screening examination that is also required under the statute.

That is obviously not appropriate. The patient may be found stable from the medical side of it, but still show signs of a medical condition that is psychiatric. The hospital's obligations have not been met until the hospital does what it needs to do within its capabilities to stabilize that psychiatric condition. If they can't stabilize it, then the hospital needs to make arrangements for transfer to a facility where that can be dealt with.

• On receiving hospitals' obligations under EMTALA:

Psychiatric hospitals that don't have EDs are still required, if they are a Medicare provider, to meet their obligations under EMTALA. What that means is if a hospital has a patient that needs the capabilities of a psychiatric hospital to stabilize that condition, the psychiatric hospital is obligated under EMTALA to accept an appropriate request for transfer — unless it doesn't have the capacity to do so. And I've never had a case where lack of capacity has been proven to be true.

The other issue in terms of "failure to accept" is related to communication. A hospital can minimize the risk of not meeting its obligations under EMTALA by having policies and procedures that address time-sensitive issues. For example, if an on-call physician refuses to accept a transfer, there should be policies and procedures for that decision to be evaluated by either the head of the ED or other administrators right away. The hospital might then be able to protect itself in real time from a decision that an individual practitioner made, that the hospital needs to get reversed, or to do something else to meet the obligations to the patient.

The other thing hospitals should be careful about is that many on-call specialists describe their capabilities along the lines of what they would like their practice to be, or what their practice is as a general matter. But under EMTALA, their capabilities are going to be evaluated in terms of their training and what it is that they can do, not just what they choose to do.

It may be something that in general is not done by the doctor or the hospital, but the capabilities are such that it really can do it. When it's being reviewed by medical experts and the quality improvement organization, they're going to be looking at the actual capabilities of the physician and the hospital. ■

Visit Volume Linked to Being Named in Claim

Many unknowns remain on ED malpractice litigation

One in 11 EPs was named in malpractice claims during a 4.5 year period, according to a recent study.[1] Researchers analyzed more than 9 million ED visits involving 1,029 EPs. There were 98 malpractice claims against 90 physicians. "Our intent was to give EPs some idea of what factors are related to being involved in a malpractice suit, that may or may not be within their control," says **Jestin Carlson**, MD, the study's lead author. Carlson is national director of clinical education at US Acute Care Solutions.

Jesse M. Pines, MD, MBA, MSCE, another of the study's authors, says, "Understanding physician and facility factors associated with malpractice claims is an important question, and one we thought would interest a wide audience."

Claims carry significant economic and personal consequences for EPs,

EXECUTIVE SUMMARY

One in 11 EPs was named in malpractice claims during a 4.5 year period, according to a recent study. Total number of years in practice and visit volume were the only factors associated with being named as a defendant. The researchers conclude that:

- the study needs to be conducted in other databases to validate the findings;
- continuing education should go on well beyond residency;
- more data are needed about how EPs are affected by being named in a lawsuit.

facilities, and patients, notes Pines, an associate professor in the departments of emergency medicine and health policy at George Washington University.

The researchers included many different variables in their analysis. Some were suggested by previous data to be related to malpractice litigation, while others were connected only anecdotally. The study authors examined years in practice, emergency medicine board certification, visit admission rate, relative value units generated per hour, total patients treated as attending physician of record, working at multiple facilities, working primarily overnight shifts, patient experience data percentile, and state malpractice environment.

"We did not know, going in, which factors would be related. Given the undifferentiated patient population and unique nature of emergency medicine, we wanted to better understand what those factors are," Carlson explains.

The researchers hypothesized that many factors would contribute to malpractice risk, particularly patient satisfaction scores and board certification. They also expected that some facilities would be more litigation-prone than others.

"None of these ended up being important," Pines says. Only these two factors were linked:

• Physician age, with older age increasing malpractice risk. "This was a surprise, because conceptually physicians should be able to reduce their risk as they age, with greater experience and expertise," Pines offers.

• The number of cases seen. "This makes sense, because one would expect the likelihood of a rare event would be related to the exposure time," Pines notes.

Although jurisdiction was not related, the data didn't completely evaluate all the relevant factors. "There's a lot more that goes into the practice patterns in those areas that we were not able to fully evaluate," Carlson says. "It will require more work to tease out the factors that could be related to jurisdiction."

The same is true for patient satisfaction scores. "It doesn't mean the patient experience is not important. Certainly, it is a tremendous part of what we do," Carlson says. "But in our data set, it was not linked."

Since Press Ganey scores involve patients who are discharged, these aren't necessarily representative of the patient population who gets admitted to the hospital. "There is also significant month-to-month variability in scores," Carlson adds.

Although the median patient satisfaction scores did not differ in the two groups of EPs — those named in malpractice lawsuits, and those who were not named — the range of scores varied widely. The interquartile range was 25 to 90 for EPs who were not named, and 30 to 90 for those who were named. This makes interpreting its value challenging. "There may be other relationships with Press Ganey that we were not able to find in our data," Carlson says. "But we did not find it was related to being named in a malpractice suit."

The researchers studied relative value units generated per hour as a marker of the EPs' tempo and the complexity of patients they were seeing. They found it wasn't related to malpractice risk, either. "We were intrigued that more factors under the provider's control were not related," Carlson says.

Pines believes the study must be conducted in other databases to ensure that the findings are not unique to the researchers' data.

"If it is truly validated, I think we need to think carefully about how we administer continuing medical education in emergency medicine," Pines says.

For individual EPs, Pines stresses that it is important to focus efforts on continuing education well beyond residency, with a particular focus on high-risk topics that could lead to malpractice claims.

Carlson would like to see more data on how being named as a defendant in a malpractice claim affects an individual EP's practice. "As we see in our data, many will be involved in a malpractice lawsuit during their career. These rates go up as years of practice and number of patients seen increase."

There are still a lot of unknowns surrounding ED malpractice claims. It's unclear, for instance, why certain cases result in litigation and others do not. "We did not have the granularity to provide that type of analysis," Carlson laments. "Future work is needed looking at the why of malpractice suits being brought forward." ■

REFERENCE

1. Carlson JN, Foster KM, Pines JM, et al. Provider and practice factors associated with emergency physicians being named in a malpractice claim. *Ann Emerg Med* 2017 Jul 26. pii: S0196-0644(17)30786-2. doi: 10.1016/j.annemergmed.2017.06.023. [Epub ahead of print].

SOURCES

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Liability Protections for EMTALA Care Elusive for EPs

Changes unlikely at the federal level in near future

Although several states have enacted liability reform legislation for ED care, efforts at the federal level have been less successful. Some recent developments:

• **The House narrowly approved the "Protecting Access to Care Act of 2017" (H.R. 1215).** The vote was 218 to 210, with 19 Republicans voting against the bill. "The Republican opposition was based mainly on their belief that this type of medical liability bill is within the jurisdiction of the states," says **Brad Gruehn**, congressional affairs director at the American College of Emergency Physicians (ACEP).

H.R. 1215 would limit non-economic damages to $250,000, restrict attorney contingency fees, and establish a three-year statute of limitations after the injury (or one year after the claimant discovers the injury).

• **ACEP is building a co-sponsor list for the Healthcare Safety Net Enhancement Act (H.R. 836).** "It's always helpful to have a good showing from members of Congress in order to show leadership it has support," Gruehn says. This legislation would provide liability protection to physicians who perform medical services required by the Emergency Medical Treatment and Labor Act (EMTALA). "Unfortunately, an amendment to H.R. 1215 that would provide specific protections for EMTALA-related services was ruled non-germane by the House parliamentarian, and therefore couldn't be offered on the floor," Gruehn notes.

EMTALA requires EPs to provide a medical screening exam to every patient who presents to an ED, regardless of the severity of the patient's condition or his or her ability to pay. "By engaging in the practice of emergency medicine, the EP accepts this responsibility and with it, an inordinate amount of risk — far greater, many believe, than the risk facing an office-based physician or surgeon," says **Mollie K. O'Brien**, Esq., director of claims at Coverys, a Boston-based provider of medical professional liability insurance.

O'Brien notes that ED patients "bring many unknowns, from prior medical history to current medication usage." Yet, an EP does not have the right to refuse to see them. "It is reasonable to argue that in exchange for the EMTALA mandate and the heightened risk visited upon the EP, EPs should have the quid pro quo of a higher bar for liability. Gross negligence would be that answer," O'Brien says.

• **ACEP is closely watching the Good Samaritan Health Professionals Act (H.R. 1876).** This legislation would shield healthcare professionals who volunteer during a federally declared disaster from liability. Although the "Volunteer Protection Act" was enacted in 1997, it only covers providers who join nonprofits or government entities during emergencies.

"H.R. 1876 protects those who volunteer on their own," Gruehn explains.

However, there are no plans right now for the Senate to take up any of these proposals. "I don't know where it would fall on the agenda, in terms of trying to move legislation," Gruehn says. Other pressing issues include the debt ceiling, appropriations, Federal Aviation Administration reauthorization, and Children's Health Insurance Program reauthorization.

"Historically speaking, the Senate has always had more difficulty dealing with healthcare liability than the House," Gruehn notes.

Even if the Senate did consider one of the proposals, any individual senator could oppose and filibuster it.

"Therefore, it would require a 60-vote threshold to even consider the legislation going forward," Gruehn says. "Given the split of Republicans and Democrats in the Senate, that would be a very high bar to reach."

The considerable clout of trial lawyers in Washington is another longstanding obstacle. "They have a very close relationship with a number of members," Gruehn adds.

COMING IN FUTURE MONTHS

- Legal risks if high-dose intravenous analgesics given in ED
- Common allegations if ED patient deteriorates awaiting transfer
- Surprising new data on missed acute coronary syndrome
- Defense strategies if plaintiff's expert never worked in ED

Previous efforts to pass legislation on liability reform at the federal level have been unsuccessful.

"The states have been somewhat more successful," Gruehn offers. The Florida Supreme Court recently ruled that a law limiting pain and suffering damages in medical malpractice cases is unconstitutional.[1]

"That was a sharply contested 4-3 decision," Gruehn says. "Like most issues these days, Floridians and the rest of America seem to be deeply divided on political matters."

Historically, Democrats have taken the position that liability reform is a state issue and shouldn't be handled at the federal level. Now, several Republications are making the same argument.

"That has made our argument a little bit easier on the EMTALA front, because there is a federal mandate to provide that care. We've had some success even with individuals who otherwise oppose federal liability protection," Gruehn says.

Significant numbers of Democrats supporting liability reform legislation remain unlikely, he acknowledges, "but in this world, if you can get any Democratic support at all, that's somewhat impressive." ■

REFERENCE

1. *North Broward Hospital District et al. v. Kalitan*, 174 So.3d 403.

SOURCES

- **Brad Gruehn**, Congressional Affairs Director, American College of Emergency Physicians, Washington, DC. Phone: (202) 370-9297. Email: bgruehn@acep.org.
- **Mollie K. O'Brien**, Esq., Director, Claims, Coverys, Boston. Phone: (800) 225-6168. Email: coverys@pancomm.com.

CME/CE QUESTIONS

1. Which is true regarding EMTALA requirements for care of psychiatric patients in the ED?

a. The hospital can impose limits on admission only if the facility has a separate psychiatric unit available.
b. Hospitals can provide different levels of care for boarded patients and admitted patients for waits longer than 24 hours.
c. Psychiatric patients can be placed in general medical beds with direct staff supervision.
d. Psychiatric patients can be held in the ED if the patient is being transferred to an inpatient unit, but must be admitted if the patient is being transferred to an outside facility.

2. Which is true regarding an ED's obligations under EMTALA when a psychiatric patient comes to the ED?

a. Whether the hospital has met its obligations is determined by the capabilities available on a daily basis in the ED.
b. It is incumbent upon a hospital to use its full capabilities to meet the needs of that patient.
c. Psychiatric emergency medical conditions generally are not covered under EMTALA.
d. Hospitals are encouraged to substitute local and community resources for the hospital's own capabilities to meet the patients' needs.

3. Which is linked to being named in an ED malpractice claim, according to a recent study?

a. Total number of years in practice
b. Patient satisfaction scores
c. Lack of emergency medicine board certification
d. Working primarily overnight shifts

4. What did a recent study find regarding malpractice claims against EPs?

a. Younger age of EPs increased malpractice risk.
b. Press Ganey scores were linked strongly to a patient's decision to sue.
c. Few factors under the EP's control were linked to litigation risk.
d. Complex patients seen during overnight shifts posed the highest likelihood of litigation.

CME/CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify legal issues related to emergency medicine practice;
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management, and patients; and
3. Integrate practical solutions to reduce risk into daily practice.

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Statement of Ownership, Management, and Circulation (All Periodicals Publications Except Requester Publications)
UNITED STATES POSTAL SERVICE®

1. Publication Title	2. Publication Number	3. Filing Date
ED Legal Letter	1087-7347	10/1/17
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$519.00

7. Complete Mailing Address of Known Office of Publication *(Not printer) (Street, city, county, state, and ZIP+4®)*
950 East Paces Ferry Road NE, Ste. 2850, Atlanta
Fulton County, GA 30326-1180

Contact Person: Journey Roberts
Telephone *(Include area code)*: (919) 377-9913

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not printer)*
111 Corning Rd, Ste 250, Cary, NC 27518-9238

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do not leave blank)*
Publisher *(Name and complete mailing address)*
Relias Learning LLC, 111 Corning Rd, Ste 250, Cary, NC 27518-9238

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The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☑ Has Not Changed During Preceding 12 Months
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DocuSign Envelope ID: A70A0701-3D64-482A-A198-61A6875C9A30

13. Publication Title: ED Legal Letter
14. Issue Date for Circulation Data Below: September 2017

15. Extent and Nature of Circulation			Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies *(Net press run)*			115	120
b. Paid Circulation *(By Mail and Outside the Mail)*	(1)	Mailed Outside-County Paid Subscriptions Stated on PS Form 3541 (Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)	84	88
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d. Free or Nominal Rate Distribution *(By Mail and Outside the Mail)*	(1)	Free or Nominal Rate Outside-County Copies included on PS Form 3541	6	7
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DocuSign Envelope ID: A70A0701-3D64-482A-A198-61A6875C9A30

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UNITED STATES POSTAL SERVICE®

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b. Total Paid Print Copies (Line 15c) + Paid Electronic Copies (Line 16a) ▶		
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17. Publication of Statement of Ownership
☑ If the publication is a general publication, publication of this statement is required. Will be printed in the November 2017 issue of this publication. ☐ Publication not required.

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