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INSIDE

Do Hospitals Have an Obligation to Check the Patient's Insurance Status Before Transfer From the ED?

In a fascinating case that raises more questions than provides answers, a Louisiana appellate court grappled with the issue of whether the Louisiana Medicaid program was required to pay for the out-of-state inpatient care provided to its Medicaid enrollee in Georgia after transfer from a Louisiana hospital emergency department.

By Robert A. Bitterman, MD, JD, FACEP
Contributing Editor, ED Legal Letter

The case of *Doctors Hospital of Augusta, Georgia vs. Louisiana Department of Health and Hospitals*[1]

A 46-year-old woman fell into a bathtub of scalding water, sustaining second- and third-degree burns over 40% of her body. EMS transported her to the emergency room at East Jefferson General Hospital (EJGH) in Metairie, Louisiana, which is in the New Orleans metropolitan area. The emergency physician determined the injury met burn center criteria, so he contacted Doctors Hospital in Augusta, Georgia, which accepted the patient in transfer.[1]

East Jefferson's emergency department charge nurse testified that they called Doctors Hospital because its representatives had been at EJGH the week before making EJGH aware of their nationally

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recognized Joseph M. Still burn unit. Doctors Hospital is more than 600 miles away from East Jefferson Hospital. The emergency physician and charge nurse didn't consider or contact any of the three certified burn units in the state of Louisiana — Baton Rouge General Medical Center, Our Lady of Lourdes Grossman Burn Center in Lafayette, or LSU-HSCS Burn Center in Shreveport, which are about 70 miles, 130 miles, and 330 miles, respectively, from EJGH.[1]

The emergency physician later testified that he "transfers patients to burn centers that have the capability and capacity to take care of the patient, who will accept the patient, and get the patient care quickly." He offered no rationale for failing to transfer the patient to one of the much closer hospitals in Louisiana. The ED charge nurse testified that EJGH had sent burn patients to Baton Rouge General Medical Center in the past and had no issues with that facility. She also provided no rationale for eschewing a closer burn unit.[1]

The three-and-a-half-hour airplane medical transport necessary to transfer the patient transpired uneventfully. The patient underwent multiple surgeries, including two within 48 hours of arriving at Doctors Hospital. More than two months later, she was discharged back to EJGH for rehabilitation.

Doctors Hospital then sent the Louisiana Medicaid program an invoice for $2.8 million.

The Louisiana Department of Health and Hospitals (LA-DHH), which is responsible for the state's Medicaid program, refused to pay Doctors Hospital for the care of its Medicaid beneficiary stating, "The reason for the denial is that the needed treatment is available within the state of Louisiana at Baton Rouge General Hospital (BRGH). Our policy is to authorize nonemergency out-of-state treatment only when the needed services are not available within the state."[1] Thus, there were two components to LA-DHH's rejection of the claim: first, that the care provided was "non-emergent" treatment, and second, out-of-state services were only covered if the care was not available in Louisiana.

Doctors Hospital's own fiscal intermediary also reviewed the claim for LA-DHH and it, too, recommended denial based on the fact that the burn care was available at BRGH and LSU. However, the reviewing physicians for both LA-DHH and the fiscal intermediary admitted in their testimony that they did not actually know if there were any beds available in the Louisiana burn units on the date in question.[1]

Subsequently, an administrative law hearing was held and the judge recommended that LA-DHH reverse its denial of payment to Doctors Hospital finding that in policy and practice, LA-DHH did not decline to pay for emergency admissions because services were available in Louisiana.[1] He concluded that the agency's policy was to honor out-of-state emergency treatment without prior authorization, and he felt the case was an emergency admission. Nonetheless, the Secretary of LA-DHH rejected the administrative law judge's findings and issued its final decision, declaring Doctors Hospital's claim to be a non-emergency and denying payment on the basis that Doctors Hospital

failed to prove that the burn centers at Baton Rouge and Shreveport (LSU) could not have provided care to the patient.[1]

Doctors Hospital next asked the Louisiana courts to overturn the agency's decision, asserting it was arbitrary and capricious, not supported by the evidence under Louisiana law, and resulted in a "windfall" to the Louisiana Medicaid program.[1]

Opinion of the Louisiana Court of Appeals

Doctors Hospital lost at the district court level, but appealed to the higher court, which determined two sections of the Louisiana Administrative Code to be the pertinent regulations to decide the case. The law entitled "Out-of-State Medical Care" states:[2]

A. Medicaid coverage is provided to eligible individuals who are absent from the state.

B. Medical claims for out-of-state services are honored when:

(1) an emergency arises from an accident or illness … *or*[3]

(4) the medical care and service or needed supplementary resources are not available within the state. Prior authorization is required for out-of-state [non-emergency] care.

LA-DHH contended option (1) did not apply because the patient did not have an "emergency medical condition" at the time of transfer, or alternatively, because the patient was in Louisiana, not out of state, when the "emergency" occurred. LA-DHH claimed that the patient had to be out of state when the emergency occurred in order for (1) to apply. Therefore, LA-DHH argued that Doctors Hospital had to satisfy option (4) by proving that the necessary medical services were not available in Louisiana.[1]

LA-DHH based its decision that the patient did not have an emergency medical condition (EMC) or need "immediate medical attention" based on the fact that the emergency physician failed to contact the closest available burn unit to obtain the most expeditious treatment possible. Instead, the physician transported the patient for 3+ hours by air to Doctors Hospital. However, the emergency physician testified that when the patient left EJGH, an EMC existed that was "emergent, guarded, and serious," and that he stabilized the EMC so that the patient could be transferred to an appropriate burn facility for treatment. Additionally, the accepting surgeon at Doctors Hospital also testified that the patient had an EMC because she met burn center criteria and the extent of her burns would lead to a significantly greater mortality rate or "serious impairment to bodily functions" without "immediate medical attention."[1]

The court, thus, overruled the LA-DHH and determined that the patient did, indeed, have an EMC, utilizing the statutory definition of an EMC in the federal Emergency Medical Treatment and Labor Act (EMTALA) and the Louisiana state counterpart to EMTALA. Federal law defines an "emergency medical condition" as:

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

A) placing the health of the individual ... in serious jeopardy;

B) serious impairment to bodily functions; or

C) serious dysfunction of any bodily organ or part."[4]

Louisiana law defines an emergency as "a physical condition which places the person in imminent danger of death or permanent disability."[5]

The court concluded that the fact that she was stabilized and transferred by air did not change her medical condition to a non-emergency condition, particularly as she received ongoing medical treatment to keep her stable during transport and immediately upon arrival at Doctors Hospital.[1]

The court also concluded that the EMC did not need to arise when the patient was physically outside the state of Louisiana in order for Louisiana Medicaid to be responsible for payment to out-of-state hospitals.[1] The court found no such language in Louisiana's regulations or in the LA-DHH's own Medicaid Training Manual requiring the patient be out of state when the emergency occurs before Louisiana will pay an out-of-state hospital for services provided to one of its Medicaid recipients.[1]

Moreover, all states must comply with federal Medicaid regulations in order to participate in the Medicaid program; and the federal regulation on "Payments for Services Furnished Out-of-State" requires that:

"A state plan must provide that the state will pay for services furnished in another state to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a beneficiary who is

a resident of the state and if the following condition is met:

(1) Medical services are needed because of a medical emergency ...."[6]

The court found no limiting language in this federal regulation either; therefore, it concluded that LA-DHH abused its discretion by attempting to "add the additional requirement for coverage that the emergency must arise from an accident or illness occurring out of state."[1]

Lastly, the court addressed the issue of whether Doctors Hospital had to prove that the medically necessary care was not available in Louisiana before it could be reimbursed for its services. Doctors Hospital argued that LA-DHH was imposing an unfair burden of proof on Doctors Hospital, wholly unsupported by any law, that would require Doctors Hospital to "prove a negative after the fact" — that an available burn center bed was not available anywhere in Louisiana on the date in question. It claimed LA-DHH was penalizing Doctors Hospital for the failure of the transferring hospital, EJGH, to ascertain whether there was a burn bed available in Louisiana before it transferred the patient to an out-of-state facility.[1]

The court found no support in the law, the regulations, or LA-DHH's manual to impose a duty upon the receiving hospital to inquire if there are any available burn center beds in Louisiana before accepting the patient. Furthermore, LA-DHH presented absolutely no evidence that the medical care needed by the patient was actually available in Louisiana at the time of the transfer.

Therefore, the court's final decision was that the patient had an EMC at the time of admission to Doctors Hospital, and that under Louisiana and federal law, the Louisiana Medicaid program was required to pay for the medical services provided to its Medicaid beneficiary in the state of Georgia at Doctors Hospital.[1]

Should East Jefferson General, the sending hospital, have transferred the patient to a closer burn center? The short answer is yes: why send a patient with an EMC that needs "immediate medical attention" an extra two hours and 530 miles away when equivalent medical treatment is right in your own backyard? Undoubtedly the much longer transport time creates additional medical risk to the patient and additional transportation risk to the patient as well as to the transport crew.

However, it is not "illegal" to skip over other hospitals or chose a distant hospital over a closer one, at least not in Louisiana or most states. Florida, contrarily, is somewhat unique in that Florida state law requires hospitals to transfer patients to the "geographically closest" appropriate hospital with the necessary service capability and capacity to handle the patient's emergency.[7]

Federal law, EMTALA, also does not prohibit an emergency department from skipping over other hospitals or transferring patients to more distant facilities.[8] Nonetheless, doing so exposes the sending hospital and the emergency physician to liability under ordinary state malpractice law for "negligent failure to send the patient to the closest appropriate hospital" if the extra transport time leads to an adverse outcome that could have been averted by transferring the patient to the closer facility. Such lawsuits are not uncommon, particularly when a hospital skips over a competitor hospital to transfer the patient to an economically affiliated hospital.

In the Doctors Hospital case discussed above, the LA-DHH claimed that Louisiana emergency departments and emergency physicians had a legal duty to be aware of which hospitals in Louisiana were certified burn centers.[1] It is certainly true that the prevailing standard of care would be for emergency departments to keep a list of available hospitals (and their contact numbers) known to be capable of providing needed emergency care that the hospital was unable to provide, whether that was burn care, neurosurgery, neonatal intensive care, or any other specialty service. But it's not true that the list must be limited to in-state facilities, or even that it must include any in-state facilities.

Should the sending hospital check the patient's insurance status before deciding where to transfer the patient? The ED charge nurse testified that she was unaware of the patient's Medicaid status, and that the clinical staff is blinded to the patient's insurance status. The emergency physician testified that he also was unaware of the patient's Medicaid status and that he normally does not check payor status, especially in emergency cases such this one, as his concern is to take care of the patient as quickly as possible. A hospital representative claimed that no one at EJGH makes a transfer decision based on the payor status of the patient.[1]

The obvious question to ask is why didn't they check the patient's

payor source before transferring the patient? First, it is not illegal under EMTALA, as many hospitals mistakenly believe, to ask the patient's insurance status at the time of transfer, or even at any time during the course of the patient's care in the ED. The federal government specifically allows hospitals to ask patients their insurance status, provided that doing so does not delay the medical screening or stabilization of the patient, or does not, in any way, discourage the patient from staying for examination or treatment.[9]

Second, where the patient is transferred could have a major economic impact on the patient. If the choice of hospitals is medically comparable, then it's clearly right to choose the one that is most financially beneficial to the patient (with the patient's permission, of course). Managed care contracts, out-of-network issues, or co-payment issues could all lead to major cost concerns for the patient. If covered by a government program, such as Medicaid, the state may have contractual relationships with preferred providers or rules on coverage that could significantly impact the patient's financial interests.

The right time to determine the patient's insurance status is at the time of disposition from the ED, whether discharge to home or transfer to another institution. Practically, it's important to know for prescribing medications or arranging follow-up for discharged patients and for choice of hospitals when transferring the patient. Shouldn't physicians have at least a moral duty, if not a legal duty, to consider their patients' economic interests, as well as their medical interests when advising patients on the best course of care?

Does the receiving hospital have an obligation to check the patient's insurance status prior to accepting a patient in transfer? The answer is clearly no. Furthermore, it is illegal for a receiving hospital to ask the patient's insurance status prior to accepting or rejecting the transfer, if the transfer is an "EMTALA" transfer.[10] However, not all transfers are governed by EMTALA. Thus, there are times when the receiving facility may ask for insurance before accepting the patient, and probably should ask if it wants to be compensated for its services. Some examples could be if the patient does not have an EMC or had one that has been stabilized, or if the patient has been admitted.[11] EMTALA no longer applies, according to CMS, so a receiving hospital would have no legal obligation under EMTALA to accept the patient in transfer.[12] It could, therefore, in these circumstances demand to know the patient's insurance status and determine whether to accept or reject the transfer based on the insurance information obtained.

Can the hospital refuse to accept an EMTALA transfer because there is a closer available hospital, as LA-DHH wanted Doctors Hospital to do because there were closer burn units in Louisiana? No. Hospitals with specialized services such as burn units have a legal obligation under EMTALA to accept patients in transfer if they have the capability and capacity to take care of the patient's EMC.[13] But there are a number of caveats to the duty to accept patients in transfer under EMTALA. First, no hospital has to accept a patient in transfer when it doesn't have the capability or capacity to handle the patient's EMC. For example, a hospital does not have to accept a neurosurgical case when the hospital's on-call neurosurgeon is already engaged in emergency surgery for the next few hours.[13]

Second, the patient must have presented to a Medicare participating hospital "dedicated emergency department" and not have been admitted to the original hospital. Both "dedicated emergency department" and "admitted" to the hospital are legally defined terms for purposes of EMTALA. For example, hospital labor and delivery departments and psychiatric intake centers qualify as "dedicated emergency departments" under the law.[14]

Third, the sending hospital must be inside the boundaries of the United States, and refusing transfers because they come from "out of county," "out-of-state," or "outside our referral area" is illegal under EMTALA.[14] The only exception to this "no territorial limit inside the boundaries of the United States" duty to accept patients in transfer is the situation in which the times and distances related to skipping over other comparable hospitals would clearly not be medically appropriate, such as transferring the patient with a ruptured aortic aneurysm an extra two hours.[13] In the Doctors Hospital case, flying the burn patient three hours to Doctors Hospital vs. flying the patient one hour to a Louisiana burn center would *not* be considered medically inappropriate under EMTALA such that Doctors Hospital could refuse the transfer from EJGH.

Conclusion

Accepting or rejecting patient transfers, particularly if the insurance issues are brought into play in the decision-making process, are fraught with a host of risks — medical and economic risks to patients, and substantial legal risks to physicians and hospitals. Every transferring emergency department and receiving hospital needs to have considered the issues in advance, done their legal homework, and implemented appropriate policies and procedures to specifically address these issues. ■

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10. 42 U.S.C.1395dd(h).
11. The patient must be formally admitted as defined by CMS: Admission to "observation status" does not count as admitted for purposes of ending EMTALA obligations.
12. Whether hospitals must accept patients with emergency conditions that have been stabilized is a debatable issue. For example, the burn patient or suicidal psychiatric patient that the ED can readily stabilize with IV fluids or securing from harm but not definitively treat the underlying emergency condition — the burns themselves or the suicidality. See 42 U.S.C. 1395(dd)(e)(A).
13. 42 U.S.C. 1395dd(g).
14. 42 C.F.R. 489.24 et seq.

Can Patients Successfully Sue if Exposed to Ebola in ED Waiting Room?

Identify patients "as soon as humanly possible"

An Ebola patient presents to an emergency department (ED) and is either misdiagnosed and discharged or is not appropriately isolated and infects others. What is the liability risk for the emergency physician (EP)?

Ebola screening should occur as early in the patient encounter as possible to limit exposures in the waiting room, advises **Andrew H. Koslow**, MD, JD, FACEP, an assistant clinical professor of emergency medicine at Tufts University School of Medicine in Boston. Koslow is also an EP at Steward Good Samaritan Medical Center.

"I know of at least one ED with a greeter at the entrance asking about relevant travel history so they are really picking up those patients in need of isolation as soon as humanly possible," he says. If no screening is done until the suspected Ebola patient reaches a treatment room through everyday processes, adds Koslow, hospitals and EPs are "putting themselves at some additional legal risk."

If ED staff fail to follow policies for Ebola screening and isolation of suspected cases, the hospital is also potentially liable. "There is at least as much liability for an institution as there is for an individual provider in that scenario, and probably more," says Koslow.

Evaluate ED Systems

It is unclear what legal standard of care an ED would be held to if a patient was inadvertently exposed to Ebola. "We just don't have enough facts right now to speak about liability specific to Ebola," says **Julian Rivera**, JD, a partner at Husch Blackwell in Austin, TX.

"What we do know, that is well-drawn in the law, is what to do about public health emergencies," says Rivera. "That is something

that has been part of risk management for decades."

EPs need to be engaged with the hospital medical staff and the hospital's infection control team, he advises. "Ebola has created such a level of fear in the United States, that emergency physicians have to be careful not to allow that fear to drive rational, good medical decision making," says Rivera.

Instead, EDs need to make sure they have good systems in place. "It's not fear-based medicine or defensive medicine — it's team-based, thoughtful medicine," says Rivera. "The team is going to be held to a standard of reasonableness."

If a patient gets any type of infection in the ED, it doesn't necessarily mean that someone committed malpractice. "Hospital-based infections exist across the country. That doesn't, by itself, create liability," says Rivera." He recommends these practices:

• Have "close-the-loop" conversations with the provider team members.

Be sure all of the important information that has been gathered by the team has been shared. "Regardless of potential liability, work to have the best communication possible within the team — including the triage nurse — under the circumstances, which may be very chaotic and overwhelming," says Rivera.

• Re-evaluate ED policies and procedures for infectious diseases.

"The best thing emergency physicians can do right now is confirm that their department systems have integrity, and that they are being utilized appropriately," Rivera says.

• Document that public health officials were notified of suspected Ebola cases.

"Also document that the ED's system has been engaged to deal with that patient," says Rivera.

Claims Often Dismissed

There are surprisingly few successful suits involving hospital-acquired infections, either in the ED or other settings, according to Koslow. "Many of the cases are dismissed. These are very difficult suits, due to causation issues," he says.[1,2]

The plaintiff attorney must prove that the EP did something wrong that resulted in harm to the patient. "The more concrete proof you have, and the better expert you have, the more likely you are to be able to show causation," explains Koslow.

In one case, a woman was able to prove she contracted herpes from a hospital roommate due to poor infection control procedures.[3] In another case, the plaintiff was able to show that technicians failed to follow infection control procedures, resulting in a patient being infected with meningitis.[4]

These cases "certainly could apply to the ED, but there is very little coming from the emergency department [setting]," says Koslow. "The cases just don't seem to be out there."

Often, this is because the experts can't prove causation. In a 2001 case, a series of experts discussed probabilities that the patient's infection was due to negligence.[5] "But it was overly vague, and the case was dismissed," says Koslow.

Causation Easier to Prove with Ebola

It's not hard to imagine a patient getting the flu or another contagious illness from another patient in an ED waiting room, but it's unlikely a plaintiff attorney would be able to prove it. This is not the case with Ebola.

"There is a defined set of risks for exposure, so the ED wouldn't be able to argue that the patient got it somewhere else," explains Koslow. For EPs to protect themselves legally, "it's no mystery what they have to do," he says — they have to screen patients adequately. Once a suspected patient is identified, they have to use the proper isolation techniques.

"Failure to do those things would certainly be grounds for a suit," says Koslow. The plaintiff attorney could argue that there was negligence if an Ebola patient was not properly isolated, "but you'd have a battle of experts going on."

Another scenario fraught with legal risks is a patient who meets the screening criteria, is placed in an isolation room with personal protective equipment, and then wants to leave the ED. "There can be a protective order in place to have someone who's been exposed quarantined," says Koslow. "But that's not an easy thing to obtain on the spot quickly when you are working in an ED."

There should be a plan to call the local or state health department or other similar authority in this circumstance, says Koslow, "and they should be involved anyway, if there is a patient suspicious for Ebola in the ED."

Higher Standard of Care Likely

A patient who was exposed to Ebola in the ED could successfully sue if he or she could prove

the EP knew, or should have known, of the risk and failed to take reasonable care under the circumstances to protect patients. "But this would be very case-specific," says **Gary Mims**, JD, a partner at Sickels, Frei and Mims in Fairfax, VA.

If an ED patient, for example, just arrived from Liberia with a high fever, the ED must take steps to protect other patients. "There is nothing special about Ebola in the legal context," says Mims. "The fact that the virus is lethal simply raises the standard of care the ED must take to avoid transmittal to other patients."

If an Ebola patient is misdiagnosed with flu in the ED and returns home and infects others, says Mims, "to analyze liability, we have to ask whether a reasonably prudent ED physician would have had Ebola on his differential."

The next question would be whether a reasonably prudent EP would discharge the patient without ruling out Ebola. "I would say that given the lethality of the virus, the answer would be no," says Mims.

The question then becomes what EDs should do with a patient who might have Ebola, and it cannot be ruled out. "If Ebola is on the differential, the ED doctor needs to call in a consultant with expertise in Ebola and quarantine that patient to the best of his ability until the experts can take over," says Mims.

The duty to diagnose strep throat and the duty to diagnose Ebola are not the same, according to Mims. "The medical approach may be the same. But the standard of care involved in the diagnosis of Ebola is much greater because the potential harm associated with misdiagnosis is much greater," he says.

The patient with suspected strep can be sent home with medication and instructions without a definitive diagnosis, says Mims. "The same is not true for the patient with Ebola on the differential, because the consequences of a misdiagnosis are much greater," he says. ■

(Editor's Note: For the latest updates on Ebola and other infectious disease threats go to http://hicprevent.blogs.ahcmedia.com.)

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Possible Malpractice Suit? Contacting the Right Person Can Make Claim More Defensible

EPs should report potential claims

Is malpractice litigation a real possibility due to an error made in the emergency department (ED) that harmed a patient?

David P. Sousa, JD, senior vice president and general counsel at Medical Mutual Insurance Co. of North Carolina in Raleigh, encourages his emergency physician (EP) clients to "err on the side of contacting the carrier, to get ahead of a possible lawsuit. We like to hear from our doctors."

When the EP reports a potential claim, witnesses can be identified and evidence can be preserved. "It could be years before somebody files a lawsuit. We want all the evidence to be there, should it come to that," says Sousa.

A timely report to the right people "will go a very long way toward managing the risk of a lawsuit," says **Francis A. Connor III**, a partner in the Providence, RI, office of Barton Gilman. "Equally important is to protect these efforts from discovery by

the patient's attorney in a subsequent lawsuit."

Who are the appropriate individuals to report an incident to? This depends, in part, on whether the EP is employed by the institution where the patient was treated. If so, and if the EP is covered under its medical professional liability policy, "a prompt report to the hospital risk manager would be the top priority," says Connor.

If, on the other hand, the EP has his or her own medical professional liability policy apart from any insurance coverage that the institution provides, the very first call should probably be to the claims department of that insurance carrier. "Report the incident and request that defense counsel be assigned immediately to advise you," Connor advises.

Navigate Pre-litigation Process

Immediate notification of any legal claim or notice of intent to sue is usually required by the terms of the EP's malpractice insurance coverage contract. Failure to notify the insurer in a timely manner may potentially void the malpractice insurance contract.

"This leaves the physician without coverage for any judgment or settlement, and for the costs of the defense," says **William M. McDonnell**, MD, JD, clinical service chief of pediatric emergency medicine and ED medical director at Children's Hospital & Medical Center in Omaha, NE.

Keeping the insurer in the dark "is not likely to make an intent to sue just go away," says McDonnell. "It is better to have the benefit of an experienced insurer, and the insurer's legal counsel, to help navigate the pre-litigation process."

Most malpractice policies are "claims-made" policies. This means that coverage is triggered by a report of a potentially covered loss to the company, which must take place while the policy is in force. "Thus, by reporting an incident immediately, you reduce the chance of not being covered, should your insurance policy no longer be in effect later," says **Marc E. Levsky**, MD, an EP at Seton Medical Center in Daly City, CA. Levsky is a board member of the Walnut Creek, CA-based The Mutual Risk Retention Group and a fellow at PIAA, a Rockville, MD-based insurance trade association.

In addition, says Levsky, the insurance company claims department can give the EP defendant important advice — such as how to preserve the medical record, how not to alter the medical record, and the persons with whom the EP may and may not discuss the case.

If the hospital asks for a statement from an EP regarding an incident, says Sousa, the EP should report this to the insurance carrier.

"We understand and appreciate that hospitals must do their job. But we also want our physicians to let us know if they are going to participate in somebody else's investigation," says Sousa. This ensures that nothing will hurt the defensibility of the claim.

In this scenario, the carrier might send an attorney to the meeting and have the EP retain counsel. "A lot of ED physicians think they are obligated to do anything the hospital asks them to do, so we don't know about it unless they call us," says Sousa.

The primary concern is that the EP will give an opinion without adequate investigation and circumspection. "We wouldn't want the emergency physician talking off the top of his head and jumping to a conclusion," Sousa explains. "It may have just turned him into the first witness to be called by the plaintiff in the case."

Protect Information From Discovery

Amendments to the ED medical record should only be made with clear acknowledgement of when and why the amendment is made, advises McDonnell.

"However, when litigation becomes likely, members of the treatment team can document clarifying information," he says. This can preserve recollections and provide a reasonable basis for those recollections later.

An EP might chart, for instance, "After a follow-up call from the parent, I realized that I did not document my complete decision-making in my original note. I had considered meningitis, but ruled it out because ..."

Any addition that looks self-serving or artificial may do more harm than good, however. If a bad outcome occurs, **John Tafuri**, MD, FAAEM, regional director of TeamHealth Cleveland (OH) Clinic and chief of staff at Fairview Hospital in Cleveland, says EPs should be "very reluctant to add anything to the record."

"It looks like you have done something you shouldn't do, even if it's done perfectly legally with no nefarious intent," he explains.

Other than something that the EP is specifically asked by the defense attorney or hospital risk management to document in writing, says Connor, "it is generally unwise to memorialize the events in question in any hand-written, digital, or audio format."

Instead, says Tafuri, the EP can

write a detailed summary of what occurred and include it as part of a letter to an attorney. "The attorney does not have to be a malpractice attorney; it could be a personal attorney," he notes. This ensures the information is protected by attorney/client privilege.

"Sometimes it's very helpful, as time goes on, to have a lot of those details in writing that you won't remember," he says.

This is a better approach than asking emergency nurses to make a late entry in the chart, advises Tafuri. Such documentation makes the EP appear defensive. "If the nurse testifies, 'The doctor told me to put that in the chart,' it looks like you were trying to cover something up," he says. "That is how the plaintiff attorney is going to spin it."

It is appropriate, however, to remind the ED nurse to document something in real time. For instance, the EP might ask the nurse, "Can you talk to the patient, too? If you get the same story — that they are not going to stay — please document it."

"It's a lot harder for a plaintiff attorney to maintain that something is not true when all of the notes reflect the same thing," says Tafuri. ■

SOURCES

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Poor Systems for ED "Bounceback" Patients Can Result in Suits

Patients who present to the emergency department (ED) more than once in a short amount of time for the same complaint or symptoms present some unique liability risks for emergency physicians (EPs), warns **Kathleen Shostek**, RN, ARM, CPHRM, senior consultant in the healthcare risk management and patient safety division of Sedgwick, a Memphis-based third party administrator for professional liability claims.

Shostek recommends these practices:

• Have a consistent means of handling patients who present to the ED two to three times in a short amount of time for the same complaint or symptoms.

"Identify high-risk conditions that may have been missed on previous visits, such as chest pain, headache, and abdominal pain," she says. "If a patient is returning, that should be a red flag to re-evaluate and start over."

• Invest in clinical decision support software or electronic medical record (EMR) upgrades.

"Look for systems that prompt the EP to consider clinical possibilities based on information gathered during the patient evaluation and diagnostic work up," advises Shostek.

• Have a formal process that includes the review of medical records and documentation by new providers during orientation, whether nurses, physicians, or mid-level providers.

"An audit of a sample of clinical records by peers should be part of the orientation for all new EPs and nurses," says Shostek.

Because the process involves physicians and clinical staff, it heightens awareness of common conditions that cause patients to return to the ED. "It also reinforces documentation expectations," she says.

Longer Timeframe Needed

Of 60 patients who returned to the ED within nine days of discharge, the primary reason given for returning was fear or uncertainty about the medical condition that brought them to the ED in the first place, according to a 2014 study.[1]

"While their medical conditions had not necessarily worsened since their prior discharge, they had ongoing symptoms for which they needed more answers and reassurance," says **Kristin L. Rising**,

MD, MS, the study's lead author. Rising is director of acute care transitions in the Department of Emergency Medicine at Thomas Jefferson University's Sidney Kimmel Medical College in Philadelphia.

The findings suggest that EPs may be able to reduce their liability risk by engaging patients, at the time of discharge, in a frank discussion about any lingering unanswered questions, says Rising. This is especially true for patients discharged without a clear diagnosis.

For instance, the EP might state, "The good news is that we do not see evidence of XYZ problems causing your symptoms. I also realize that the bad news is that we don't have an answer for why you are experiencing these symptoms today."

"At this point, providers can then engage patients to determine what they anticipate needing most in the upcoming days, and determine how to potentially help patients meet those needs before patients leave," says Rising.

William C. Gerard, MD, MMM, CPE, FACEP, chairman and professional director of emergency services at Palmetto Health Richland in Columbia, SC, recommends these practices to reduce risks of "bouncebacks":

• Embed a system in the ED's registration platform that puts the date of the patient's last visit in a pop-up screen or color-coded field.

"It amazes me how often patients fail to mention a recent visit because they think it's in our EMR, so we must know!" says Gerard.

• Have a different provider see the patient.

If a patient has an unscheduled early return, the same EP who saw them previously often sees them again. This is a mistake, according to Gerard. "They are often tagged again with that patient as their 'bounceback,' but this should be discouraged and even outlawed if you are practicing in an ED with multiple providers," he says.

This gives the patient a "second set of eyes" to prevent a possible misdiagnosis. "The initial provider may be tunneled in to a diagnosis that is wrong, and may change therapy based on lack of response without considering a different etiology of the disease process," explains Gerard.

• Identify patients as "bounce-backs" using a longer window of time.

The 2014 study of close to 5 million ED discharges and subsequent return ED visits suggests that 72 hours may be too short a timeframe to capture the majority of potentially relevant returns after a prior ED discharge, says Rising.

"For decades, we have picked 48 or 72 hours as the trigger for the 'bounceback' to alarm," says Gerard. Based on the 2014 study, he says, "it looks like nine days might be the sweet spot." ■

REFERENCE

1. Rising KL, Padrez KA, O'Brien M, et al. Return visits to the emergency department: The patient perspective. Presented at the Society for Academic Emergency Annual Meeting, Dallas, TX, May 2014; and the Academy Health annual meeting, San Diego, CA, June 2014.

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CNE/CME 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.

COMING IN FUTURE MONTHS

- Lawsuits involving psychiatric patients held in ED
- Convince plaintiff attorney not to pursue claim
- What to consider when choosing med/mal attorney
- Get dismissed from claim with multiple defendants

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CNE/CME INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.

2. Scan the QR code to the right, or log on to www.cmecity.com to take a post-test; tests are taken after each issue. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.

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5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly.

CNE/CME QUESTIONS

1. **Which is true regarding liability risks involving exposure to infectious diseases in the ED, according to Andrew H. Koslow, MD, JD?**

   A. Cases are often dismissed because experts are unable to prove causation.
   B. Plaintiff attorneys cannot argue that there was negligence if an Ebola patient wasn't properly isolated.
   C. Hospitals cannot be held liable if ED staff fail to follow policies for screening.
   D. Causation is more difficult to prove with Ebola compared to other infections.

2. **Which is recommended if an emergency physician believes a malpractice lawsuit is possible, according to Francis A. Connor III, JD?**

   A. EPs should report only actual claims, not potential claims, to carriers.
   B. The hospital risk manager should only be notified if the EP has his or her own medical professional liability policy.
   C. EPs should bear in mind there is no advantage to reporting an incident immediately under a claims-made policy.
   D. If the EP has his or her own medical professional liability policy, the EP should report the incident to the insurance carrier and request that defense counsel be assigned immediately to advise the EP.

3. **Which is recommended regarding documentation if a bad outcome occurs, according to John Tafuri, MD, FAAEM?**

   A. Amendments to the ED medical record do not need to be made with an acknowledgement of when and why the amendment is made.
   B. Adding information to the record makes a subsequent claim much more defensible.
   C. EPs should not hesitate to ask emergency nurses to make a late entry in a chart about the care provided.
   D. If the EP writes a detailed summary of what occurred as part of a letter to an attorney, such documentation is protected by attorney/client privilege.

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