DEPARTMENT OF HEALTH & HUMAN SERVICES
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Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 13-38-CAH/EMTALA

DATE: **June 7, 2013**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Critical Access Hospital (CAH) Emergency Services and Telemedicine: Implications for Emergency Services Condition of Participation (CoPs) and Emergency Medical Treatment and Labor Act (EMTALA) On-Call Compliance

Memorandum Summary

- ***The Center for Medicare & Medicaid Services (CMS) Welcomes use of Telemedicine by CAHs:*** Telemedicine has great potential to expand availability of specialty care services, including emergency medicine services, to rural populations. However, misconceptions about CAH CoP and EMTALA requirements may cause unnecessary concerns about, or create barriers to, using telemedicine.

- ***The CAH Emergency Services CoP does not Require a Physician to Appear On-site Whenever an Individual Comes to the Emergency Department (ED):***
  - Under 42 CFR 485.618(d), a doctor of medicine (MD), a doctor of osteopathy (DO), a physician assistant (PA), a nurse practitioner (NP), or a clinical nurse specialist (CNS), with training or experience in emergency care, must be immediately available by telephone or radio, and available on-site within 30 minutes (60 minutes for CAHs in frontier areas that meet certain conditions). Under the CAH CoPs an MD or DO is *not* required to be available *in addition* to a non-physician practitioner.
  - Under the CoP at §485.618(e), an MD or DO must be immediately available by telephone or radio contact on a 24-hours a day basis to receive emergency calls, provide information on treatment of emergency patients, and refer patients. This requirement can be met by the use of a telemedicine MD/DO as well as by an MD/DO who practices on-site at the CAH.

- ***EMTALA is Not a Barrier to Using Telemedicine to Extend CAH Emergency Services:***
  - If using telemedicine for emergency and other services, a CAH is not required to include the telemedicine physicians on its physician on-call list mandated under the EMTALA regulations at 42 CFR 489.20(r)(2) and §489.24(j), nor would it be advisable for a CAH to do so.
  - The CAH is required under EMTALA to have an on-call list reasonably related to the services it offers, composed of physician(s) who practice on-site at the CAH. This does not mean that physicians who practice on site must be on-call and available to appear in person at all times. Nor does it mean that an on-call physician must be called to appear on-site in every case involving an emergency medical condition.

Background

CMS welcomes use of telemedicine by CAHs to extend access to specialty care services, including emergency services, for the rural populations CAHs serve. However, we have learned that some CAHs have been under the impression that MDs/DOs who provide only telemedicine services to CAH patients and who participate in the screening and stabilizing of individuals in the emergency department (ED) must be on the CAH's EMTALA on-call list. This is incorrect, and it actually would not be prudent place an MD/DO who cannot make an in-person appearance at the CAH on the on-call list. Likewise, some CAHs have had the mistaken impression that even when there is involvement of a telemedicine MD/DO in the provision of care, an MD or DO who is on-call at the CAH must always be asked to come in to the CAH for emergency services.

Depending on the specific circumstances, there could be cases when it is sufficient for a telemedicine-only MD/DO to work with the qualified medical person (QMP) on site to screen and stabilize and/or appropriately transfer individuals who come to the CAH's ED. There could also be times when an on-call MD/DO would be requested to come to the CAH by the QMP, even though a telemedicine-only MD/DO is also providing services. We are taking this opportunity to clarify below the requirements under EMTALA and the CAH CoPs for MDs, DOs and other practitioners in CAHs that use telemedicine as a component of their ED services.

CAH CoP Emergency Services Requirements:

Section 1820(c)(2)(B)(ii) of the Social Security Act (the Act) requires a CAH to make 24-hour emergency care services available. Pertinent implementing regulations are:

- **§485.618(e), which requires an MD or DO to be immediately available by telephone or radio contact** on a 24-hours a day basis to receive emergency calls, provide information on treatment of emergency patients, and refer patients to the CAH or other appropriate locations for treatment. ***This requirement can be met in whole or in part through the use of an MD/DO via telemedicine.*** It is the CAH's decision whether to use a telemedicine MD/DO for this purpose, and to what extent in order to meet this requirement. For example, a CAH could use a telemedicine MD/DO 100 percent of the time, or could develop a schedule for the use of MDs/DOs who practice on-site for part of the time, with the telemedicine MDs/DOs providing these services for the rest of the time.

- **§485.618(d)(1), which requires an MD, DO, PA, NP, or CNS, with training or experience in emergency care, to be on-call and immediately available by telephone or radio contact, and be available on-site within 30 minutes on a 24-hours a day basis.** (The standard is 60 minutes for CAHs in frontier areas that meet the following conditions: the CAH is located in a frontier area or a remote location; the State has determined, that allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the area served by the CAH; and the State maintains documentation showing that the response time of up to 60 minutes is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency).

If the on-call practitioner is notified that he/she is needed at the CAH, that practitioner is required to physically appear at the CAH.

Note:

- In accordance with §485.618(d)(3), under specific conditions and only for a temporary period, instead of a practitioner a registered nurse (RN) may also satisfy this requirement, if the CAH has no more than 10 beds, is located in a frontier area or remote location, and the Governor has submitted a letter that meets specified requirements.

- ***Practitioner availability by telephone or radio (as required under §485.618(e)) may be satisfied by a telemedicine practitioner, but the requirement for on-site availability cannot be met via the use of telemedicine.***

- Any one of the listed types of practitioners satisfies the regulatory requirement. ***A CAH MD or DO is <u>not</u> required to be available <u>in addition to</u> a non-physician practitioner*** (or RN substituting for a practitioner).

EMTALA Requirements for CAHs

Section 1867 of the Act contains the EMTALA provisions, including a requirement for hospitals and CAHs to provide a medical screening examination to all individuals who come to the ED, and stabilizing treatment or an appropriate transfer for those who have been determined through the screening to have an emergency medical condition. Section 1866(a)(1)(I)(iii) of the Act contains an EMTALA-related requirement for hospitals and CAHs to maintain a list of physicians who are on-call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition.

- **§489.24(a)(i) requires that a medical screening examination be performed by a qualified medical person (QMP),** i.e., an individual determined to be qualified by the CAH by-laws or rules and regulations and who meet the requirements of §482.55 (the hospital CoP for emergency services), which requires the use of "…adequate medical and nursing personnel qualified in emergency care." ***The QMP on-site conducting the required screening examination may be assisted or directed by a qualified telemedicine practitioner.***

- **§489.20(r)(2) and §489.24(j) implement the on-call provisions related to EMTALA obligations.**

    - Unlike the CAH CoP requirements for practitioner availability in the ED, the EMTALA on-call requirement is specific to physicians. ***The EMTALA requirement <u>cannot</u> be satisfied by including non-physician practitioners*** on the on-call list.

    - ***A physician who is on-call and requested by the CAH's QMP to make an in-person appearance at the CAH*** after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition ***must come to the CAH within a reasonable amount of time.*** Failure by a physician to do so could subject both the CAH <u>*and*</u> the on-call physician to EMTALA enforcement action and penalties.

Although CMS takes enforcement action only with respect to the CAH, the Office of Inspector General may levy penalties against either or both the CAH and the physician.

- There is no EMTALA requirement for all physicians holding CAH privileges to take call.

  - ***A CAH which has only a few MDs or DOs routinely practicing on-site is not expected to have one of them on-call at all times.*** In such a situation it would not be unreasonable for the CAH to have very limited on-call coverage.

  - ***There is no requirement under EMTALA for a CAH to include on its on-call list a physician who provides emergency or other services only via telemedicine*** to the CAH's patients. Since a physician providing services only by telemedicine may be located too far away to make an in-person appearance feasible, it might not be prudent for the CAH to include telemedicine-only practitioners on its on-call list.

  - However, we also reiterate that ***CAHs have a responsibility under EMTALA to ensure that they are providing sufficient on-call services to meet the needs of their community <u>in accordance with the resources the CAH has available</u>.*** CMS expects a hospital or CAH to strive to provide adequate specialty on-call coverage consistent with the services routinely provided at the hospital or CAH. (73 FR 48662).

- ***When a telemedicine physician is providing/directing diagnosis or treatment of individuals in a CAH ED, there is no requirement or expectation under EMTALA that the CAH must always require one of the local on-call physicians to come to the ED as well.*** However, if the QMP on-site and/or the telemedicine physician determine that hands-on treatment that is beyond the capability of the on-site QMP is required to stabilize an individual's emergency medical condition, then ***a request for a local CAH physician to come to the ED could be required, depending on the circumstances:***

  - If one or more of the local physicians is on-call and able to provide the required hands-on stabilizing treatment, then the CAH is expected to request that an on-call physician come to the ED to stabilize the individual.

  - If the QMP and/or the telemedicine physician determine that the individual needs hands-on treatment that the CAH's on-call physician(s) cannot provide (e.g., the on-call physician is a family medicine practitioner and a surgical procedure is needed), then the CAH may transfer the individual to another hospital or CAH for stabilization, following the EMTALA rules for appropriate transfer. It is not necessary to have the local, on-call physician come to the ED just to certify the appropriateness of the transfer. Either the telemedicine physician or the on-site non-physician QMP, after consultation with the telemedicine physician, may sign the required certification that the anticipated benefits of the transfer outweigh its risks. If the on-site non-physician QMP signs it, the telemedicine physician must subsequently countersign. See §489.24(e)(1)(i)(B) and (C).

  - If no physician is on-call and the QMP and/or the telemedicine physician determine that hands-on treatment that is beyond the capability of the on-site QMP is required to stabilize an individual's emergency medical condition, the CAH may transfer the

individual to another hospital or CAH for stabilization, following the EMTALA rules for appropriate transfer. Either the telemedicine physician or the on-site non-physician QMP, after consultation with the telemedicine physician, may sign the required certification that the anticipated benefits of the transfer outweigh its risks. If the on-site non-physician QMP signs it, the telemedicine physician must subsequently countersign. See §489.24(e)(1)(i)(B) and (C).

Questions concerning this memorandum should be addressed to hospitalscg@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management