



EMTALA VS PAIN POLICIES IN THE EMERGENCY DEPARTMENT

Risk management considerations in reconciling EMTALA compliance and the management of pain patients in the emergency department.

Introduction

In light of current trends of escalating deaths from opioids and drug abuse of all kinds and combinations, emergency department, staff, physicians, and parent hospitals are coming under increased pressure from conflicting forces including.

1. Public demand for prompt relief for the 40 to 80% of the emergency department for presentations involving pain
2. Legitimate concern over rising death rates from illegal and prescription drug overdoses;
3. Gaming of the system by the 1 to 2% of patients who are “drug seekers”;
4. Inadequate pain control due to failure to diagnose the source of pain;
5. Judgmental attitudes that create an adversarial relationship between patients and providers;
6. Fear of DEA enforcement actions against providers that tends to discourage the prescribing of previously acceptable levels of pain medication;
7. Malpractice actions by pain patients for under-treatment or over-prescribing of pain medications;
8. Financial implications of patient dissatisfaction for perceived inadequate care of pain;
9. “Doctor shopping” by patients seeking a physician sympathetic to pain patients with uncontrolled pain;

10. Evolving pain treatment advice from CDC, medical groups, hospital organizations, patient pain organizations, Joint Commission and Medicare/Medicaid/private insurance companies that is potentially conflicting or confusing for providers;
11. The contrary legal and regulatory standards under EMTALA that penalize hospitals and physicians for circumventing mandatory medical screening and treatment;
12. A failure of the Supreme Court to resolve conflicts among federal appellate courts over CMS regulatory authority and its limits;

This white paper does not take a position on these legal arguments but adopts a risk management approach that seeks to prevent citations, fines, and lawsuits by anticipating the enforcement approaches of the Centers for Medicare and Medicaid Services (CMS). While other agencies and organizations – including other government bodies, such as the CDC – have varying degrees of authority, CMS has direct statutory authority to regulate and enforce EMTALA requirements, including preemptive authority over conflicting state requirements. On this basis, this white paper adopts the position that any policy or procedure which purports to address pain patients in the Emergency Department should first be EMTALA compliant.



The latest CMS pronouncements on EMTALA and pain patients:

One of the commonly recommended techniques to reduce patient expectations for pain management and discourage drug seeking conduct has been the use of "Pain Policy" signs that in different verbiage declares that patients experiencing pain will not get narcotic pain medications. After these signs came under discussion in South Carolina, the state hospital association wrote the regional CMS office in Atlanta for their EMTALA enforcement stance on such signs (other CMS Regions have subsequently indicated their concurrence with the Atlanta position stated below).

The text of the CMS position statement is:

"Thank you for your inquiry of January 18, 2013 regarding proposed notices that hospitals have considered posting in ED waiting rooms or ED patient examination rooms regarding "Prescribing Pain Medication in the Emergency Department".

The federal EMTALA statute (Sec 1867 of the Social Security Act, 42 U.S.C.1395dd) states that in the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title) comes to the emergency department and a request is made ...for examination or treatment of a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department... to determine whether or not an emergency medical condition (within the meaning of subsection (e) (1) exists.

*(e)(1) The term "emergency medical condition" means- (A) a medical condition manifesting itself by acute symptoms of sufficient severity (**including severe pain**)..... etc, (emphasis added).*

*42 CFR 489.24 (b) defines "Emergency medical condition" as (1) A medical condition manifesting itself by acute symptoms of sufficient severity (**including severe pain, psychiatric disturbances and/or symptoms of substance abuse**) (emphasis added). [per original]*

42 CFR 489.24 (d) (4) (iv) states that Hospitals may follow reasonable registration process.... However "Reasonable registration processes may not unduly discourage individuals from remaining for further evaluation", (emphasis added). Furthermore, hospitals should not deny emergency services based on diagnosis, financial status, race, color, national origin, or disability (State Operations Manual Appendix V), Such cases will additionally be referred to the HHS Office of Civil rights (OCR) for investigation of discrimination. CMS Interpretive guidelines (SOM Appendix V) state that although patients may leave the emergency department of their own free will, they should not leave based on a "suggestion" by the hospital or through coercion.

Accordingly, the language regarding "Prescribing Pain Medication in the Emergency Department" which you have provided, and any similar language which the hospital might choose to post in patient waiting rooms or treatment rooms might be considered to be coercive or intimidating to patients who present to the ED with painful medical conditions/ thereby violating both the language and the intent of the EMTALA statute and regulations.

We share your concerns and those of the provider community about the increasing prevalence of prescription drug abuse and its harmful effects. We understand the tendency of persons seeking pain medication and controlled substances for non-legitimate purposes to approach physicians, emergency departments and other health care providers for access to these drugs. Nevertheless, the intent of the EMTALA statute is clearly to assure

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that all individuals who come to the emergency department for a medical condition receive an appropriate medical screening examination to determine whether or not an emergency medical condition exists. Our concern is that some patients with legitimate medical needs and legitimate need for pain control would be unduly coerced to leave the ED before receiving an appropriate medical screening exam.

While many of the points mentioned in the information you submit are appropriate points for discussion between the patient and the physician or other health care practitioner, they should be discussed in the context of an appropriate medical screening exam rather than be posted in the ED before patients are provided an appropriate medical screening exam. Blanket statements or protocols should not supersede professional medical judgment in individual cases. After performing an appropriate medical screening exam, it is within the bounds of reasonable professional medical judgment and discretion for an appropriately licensed physician or other health care practitioner to provide or to withhold narcotic or other methods of pain control in a particular patient depending on the specific clinical circumstances.

We hope this information is helpful to you and your member hospitals."

So what does that mean in English?

The CMS letter adopts a position consistent with past enforcement actions for those with knowledge of those actions, but may not be clear to those who are not in frequent contact with regulatory language. The high points of the letter in more simple language would be:

1. Pain and symptoms of substance abuse are specially identified as potential emergency medical conditions by CMS to prevent the emergency department from summarily down-grading the patient's status or short-cutting the medical screening process.
2. Posting of any sign that might discourage a patient from remaining for medical screening and treatment will likely be viewed as an attempt to avoid EMTALA and CMS will likely cite the hospital for such signs. CMS directly warned that wording variations are unlikely to change their view of such signs. (That would also apply to any written or verbal communication of a similar nature prior to completion of the Medical Screening Exam –MSE.)
3. Every patient – including "frequent flyers", chronic pain patients, and "drug seekers" – must receive an appropriate medical screening exam, including

testing and specialty services as indicated, sufficient to rule out the presence of an emergency medical condition. Until that exam is completed and documented, CMS considers the patient to have an emergency medical condition and the burden rests upon the physician or hospital to prove otherwise.

4. Discussion of the risks and benefits of modes of treatment and pain medication should not occur prior to completion of the diagnostic phase of the Medical Screening Exam. In the event that the MSE reveals addiction or dependency issues, CMS is likely to consider this to be determination to place the patient as having an emergency medical condition (which may preclude discharge or may require specialty referral).
5. CMS specifically cautioned in the letter that **Blanket statements or protocols** (i.e. hospital policies and procedures) should not establish bans on the use of narcotic drugs, and that the appropriate pain killer should be left to professional medical discretion on a case by case basis.
6. This letter does NOT say that hospitals must prescribe or not prescribe specific drugs to specific patients. It DOES appear to require a documented medical judgment to support the decision to give or to withhold narcotic or other drugs. From a risk management perspective, this is best addressed with narrative and free text notes rather than check marks.

How to Write A Policy That Meets CMS Standards

Rather than starting out to write a separate ED Pain Policy that meets EMTALA, it is generally preferable to add the pain policy as an additional segment to the EMTALA Medical Screening Policy. This helps make it clear that the pain policy is subject to EMTALA procedures and is not a separate way of approaching pain patients. Merely referring to the Medical Screening Policy does not tend to produce EMTALA compliance.

The policy should emphasize professional medical judgment, an individual approach to patients, and detailed documentation.

At this point, it should be remembered that policies and procedures are considered to be part of EMTALA by CMS and to be part of the Standard of Care in civil litigation. It is not enough to have the right words in the policies and procedures if the staff is not complying with them. CMS expects that the policies and procedures are compliant, that staff has been appropriately and regularly trained on



those policies and procedures, and that there is a system in place to monitor compliance. In other words, the policies and procedures cannot be “just for show.”

Be cautious about incorporating outside recommendations, standards, or guidelines into the policies and procedures, as they may be interpreted by CMS or a civil court Judge as mandatory standards. These sources typically are not mandatory and often vary among outside organizations and change frequently. These may be listed as a reference or clearly indicated as additional information for consideration. On the other hand, state legal requirements -- such as for mandatory prescribing practices and reporting -- generally should be incorporated into procedures and reviewed frequently for updating.

An example of one of these external guidelines and a comments are set forth below. These follow the general guidelines of the CDC recommendations found at:

<http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>

EXAMPLE:

- A) *A single outside physician should be responsible for controlling all pain medications for a given chronic pain patient.*

COMMENT: EMTALA places responsibility for the MSE and care of the Emergency Physician with eyes on the patient. Reliance on instructions from an outside physician who has not come in to evaluate the patient has resulted in EMTALA citations. It would likely be viewed as acceptable to require referrals for follow-up care be made to a single physician for pain management.

- B) *A single outside pharmacy should be designated for filling prescriptions for the patient.*

COMMENT: Because the filling of prescriptions and designation of a single pharmacy to maintain tracking and control of the patient's use of the prescription typically occurs after the medical screening exam and any necessary stabilization, this policy would typically not be a potential EMTALA violation.

- C) *IV and IM opioids for acute episodes of chronic pain are discouraged.*

COMMENT: This provision would likely be acceptable under the CMS letter's comments if it indicated that when a physician deemed it appropriate, the rationale for the use of opioids must be documented in narrative format.

- D) *Prescriptions for opioids should be written for 72 hours or less.*

COMMENT: This is consistent with many guidelines and state laws. Because this prescription limitation would not occur prior to completion of the medical screening exam, it is unlikely to be considered an EMTALA violation.

- E) *Hospitals should develop a policies and procedures to screen emergency department patients for substance abuse. Protocols should provide for brief ED intervention and referrals to treatment programs or facilities for individuals with symptoms of substance abuse or at risk to develop substance abuse issues.*

COMMENT: This is entirely consistent with the EMTALA requirements for medical screening and CMS's consideration of symptoms of substance abuse to be an emergency medical condition. Risk management concepts, however, would suggest that the duty to rule out and/or stabilize all other emergency conditions should be emphasized prior to any effort to screen for substance abuse.

- F) *When chronic pain patients present to the emergency department for acute episodes of pain, information on the ED visit should be provided to their private physician.*

COMMENT: Unless the patient has specifically instructed the ED or hospital not to provide information to a treating physician, it is appropriate under HIPAA to share information with physicians involved in the past, current, and intended future care of the patient.



- G) *The ED physician should generally not dispense controlled substances to replace lost, destroyed, stolen, or prematurely completed medications.*

COMMENT: Consistent with the CMS concern about arbitrary limitations on physician discretion, it would be preferable to add language that when the physician deems it appropriate in a given situation, they must document details to justify deviation from the general policy.

- H) *Emergency departments should not dispense prescriptions for controlled substances to patient who cannot provide appropriate photo identification.*

COMMENT: Caution – CMS has indicated that EMTALA care cannot be conditioned on providing photo ID. Depending on the patient's medical condition and potential risks of not being properly medicated, CMS could interpret denial of a medication to be denial of care.

- I) *Emergency Department providers should consult their state prescription monitoring agency before dispensing prescription pain medications.*

COMMENT: This is a mandatory provision in many state laws and is a generally appropriate provision because it may prevent accidental or intentional overdose. Discovering an issue from a review of the monitoring system does not, however, change the physician's EMTALA duties to the patient.

- J) *Unless clinically indicated, the ED should not dispense long-acting or controlled release opioid drugs.*

COMMENT: By conditioning the policy on clinical indications, it appears to meet the CMS concern about limiting clinical judgment. From a risk management perspective, it would be appropriate to require documented justification for dispensing these in individual cases.

- K) *Hospitals are encouraged to support ED physicians who refuse to dispense opioid pain medications in the event that a patient complains.*

COMMENT: The emergency department is a difficult environment in which to practice medicine and it is more difficult due to the increased emphasis on patient satisfaction. In the event that a physician follows hospital policy and exercises sound professional judgment to give – or refuse to give—and opioid medication, the physician should be supported by the hospital. The hospital, however, should have an effective system of investigating complaints so that a reasoned judgment is made in each case to assure compliance and professional conduct.

- L) *Emergency departments should monitor frequent visitors and coordinate care among the hospital, emergency department, and medical provider to have treatment plans in place for chronic pain patients.*

COMMENT: Monitoring patients is not illegal, but setting restrictive standards that influence how the patient is processed when they present in the Emergency Department may violate EMTALA, if it results in a failure to follow EMTALA requirements up and through the MSE.

- M) *Requests for routine refills of prescriptions should not be provided by the Emergency Department.*

COMMENT: Patients presenting for refills of prescriptions should be questioned by the Triage Nurse as to how long they have been without medication and whether they have any symptoms or effects that may be related to discontinuing the medication. Where symptoms are reported or identified by the Triage Nurse, the patient is deemed an EMTALA presentation and shall be treated accordingly. Hospitals have been cited for turning away refill requests without inquiring about symptoms when those symptoms resulted in the patient being admitted at the subsequent hospital.

WARNING: DO NOT post signs that would run afoul of the CMS position stated above. Signs and educational material to discourage opioid use or reference hospital policy on prescriptions may be shared with patients AFTER the medical screening examination. Be cautious of any signs that may be accidentally viewed by patients.



EXAMPLE

Drafting example – Policies and procedures should not be simply copied from outside sources. They should be specifically developed for your own application, although examples may be used as a starting framework or concept. It is recommended that hospital legal counsel review all policies and procedures due to regulatory compliance and legal implications. The following example is not complete and is not intended for direct implementation.

- Existing medical screening policy statement ...
- Existing medical screening procedures ...
- **Insert --Pain as an element of medical screening**

Policy:

This organization acknowledges both the right of patients to appropriate assessment and management of pain and the unique role of the hospital in providing education to patients and their families about pain management and the associated risks. This right creates a performance expectation for all physicians and hospital staff to treat all patients with professionalism and respect and to refrain from conduct, statements, or documentation that may give the appearance of prejudice or judgmental opinions.

This policy does not require physicians to dispense controlled substances that are not indicated or justified by their clinical findings or which may pose an unjustified risk of harm to the patient.

Procedures:

- A. Severe pain is a potential symptom of an emergency medical condition requiring an appropriate medical screening examination (MSE) to rule out any such emergency medical condition. Until such time as appropriate MSE with necessary testing and consultations rule out any differential diagnoses that might be an emergency medical condition, the presenting patient will be considered to have an emergency medical condition for purposes of EMTALA compliance.
- B. If an emergency medical condition is determined to exist, appropriate stabilizing care will be provided to resolve the current condition.
- C. This organization's response to a patient's pain shall be based on the services it provides. If the MSE indicates that pain exists, the organization will assess and treat the pain within the capabilities and capacity of this hospital and its medical staff unless and until an emergency medical condition has been ruled out or the patient's emergency medical condition has been resolved. Where pain or its associated emergency medical condition exceeds the ability of this hospital and its medical staff to manage or resolve the patient's pain, this facility will assess the pain, stabilize the patient's condition within our capabilities, and appropriately transfer for treatment. Where the patient is documented as stable for discharge, physicians will consider appropriate referrals as part of discharge orders.
- D. The ED physician may review prior history from previous visits to the ED and hospital as necessary. Those items reviewed will be documented in the medical record of the current visit. Medical screening shall include any current testing, including testing of therapeutic levels of prescribed medications, deemed necessary for an appropriate assessment of the presenting complaints.



- E. The ED physician may contact the individual's current and former personal physicians for additional information, for informational purposes only or to call the physician in to assist in care of the patient. The private physician does not control or direct the ED physician in the discharge of medical screening requirements under EMTALA or otherwise limit or direct care. The existence of a pain management contract does not alter the patient's rights or the ED physician's obligations under EMTALA.
 - F. Patients are to be provided written discharge instructions and discharge education detailing the proper use of any medication they are provided and the potential hazards and side-effects of the medication. Discharge instructions will contain the instructions for the plan of care. The patient will demonstrate improvement in their condition prior to discharge and that improvement will be documented. Where improvement is not achieved, it may be an indication that additional assessment or specialty care is required.
 - G. Where deemed medically appropriate, the physician may dispense a minimum quantity of necessary medications following an MSE. If those medications are controlled substances under State or Federal law, the quantity shall be limited to the minimum dose and quantity to reasonably allow the patient to consult a treating physician within no more than 72 hours.
 - H. Patients presenting for refills of prescriptions should be questioned by the Triage Nurse as to how long they have been without medication and whether they have any symptoms or effects that may be related to discontinuing the medication. Where symptoms are reported or identified by the Triage Nurse, the patient is deemed an EMTALA presentation and shall be treated accordingly.
 - I. State requirements for contact with the state medication reporting program prior to prescribing controlled substances will be complied with. Reporting requirements for dispensing of controlled substances will be adhered to. (INSERT state requirements)
 - J. Use of potentially offensive, judgmental, or disparaging terms such as "drug seeker" or "drug seeking conduct" or words to similar import are discouraged, whether verbal or written. It is appropriate to document objective observations, actions, and statements without personal judgments on the motives of the patient.
- Resume Medical Screening Policy/Procedures

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