EMTALA Webinar Series Part One

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Speaker

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Over 40 years experience teaching and assisting hospitals and other healthcare facilities in understanding applicable Federal and State laws, rules, regulations and interpretative guidelines.

Previous experiences include:
-Director of Integrity & Compliance, Privacy Official at Mercy Medical Center, Des Moines
-Director of Regulatory Compliance, UnityPoint Health, West Des Moines
-Twenty years with Iowa Department of Inspections and Appeals (state survey agency)

Part One
Learning Objectives

- Describe basic requirements of EMTALA.
- Describe why EMTALA is the most-frequently cited deficiency.
- Discuss who and where EMTALA applies in the facility.
- Provide examples of how the hospital can stay current on changes in regulations.

Overview of EMTALA Regulations

What are the EMTALA regulations?

- Emergency Medical Treatment and Labor Act
  Enacted in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA)

- Federal Mandate

- Also known as the anti-dumping statute

- Ensures public access to emergency services regardless of ability to pay

Why did Congress Enact?

- In response to the practice of some hospitals of refusing to see or transferring the poor and uninsured or underinsured (Medicaid) or refusing to see non-citizens
- Grew out of Congressional concerns about the impact of the 1983 Medicare prospective payment system..
  - There was a lot of fear [in Congress] that fewer services than necessary for Medicare patients.
- Third reason for passage of EMTALA was that some hospitals were no longer obligated to provide indigent care under the Hill-Burton Act.
  - That law, passed in 1946, provided capital funds for reconstruction and improvement of hospitals, with the proviso that they must make care available to low-income uninsured patients, sometimes for 25 years and sometimes in perpetuity
  - By 1986 most hospitals were no longer subject to Hill-Burton obligations and it was much less effective in terms of care for the uninsured..
- Purpose was to ensure every individual who comes to a Medicare participating hospital receives appropriate medical screening examination to determine if the individual had an emergency medical condition. MSE had to be conducted by qualified personnel and then the hospital either provided stabilizing treatment and (if necessary) appropriate transfer to another facility regardless of ability to pay

Early Examples

- Private hospital called a local public hospital and asked them to accept a pregnant female who was unstable (experiencing contractions)
- Physician at private hospital was recorded as stating “Don’t give me all that crap. She does not have any insurance, This hospital does not to take care of her, OK? This is a private, capitalistic, money making hospital. They’re on my back to have her transferred.”
- This recording played on CBS 60 Minutes in 1985 prior to the law being passed
- Early 1980’s

Another Example

- In 1985, individual came out of abandoned crack house with stab wound on left side of head and collapsed in front of bystanders. When he arrived at the hospital, the ER physician examined him and called the on-call neurosurgeon, but he refused to accept the patient. ER physician called second neurosurgeon (not on call) and he refused.
- Calls were placed to two other hospitals. One neurosurgeon refused because he was too tired. Second refused unless burr holes placed in head at first ED. Third one would only accept if ER physician rode in ambulance.
- Care was delayed and patient died 3 days later.
- Case was filed by Marvin Belli who won a $5 million case against the hospital and physicians there

Has Anything Changed in 35 Plus Years?

Largest Civil Monetary Penalty

- On June 23, 2017, AnMed Health (AnMed), in Anderson, South Carolina, entered into a $1,295,000 settlement agreement with OIG. The settlement agreement resolves allegations that, in 36 incidents investigated by OIG, AnMed violated the Emergency Medical Treatment and Labor Act (EMTALA).
- In these incidents, individuals presented to AnMed's Emergency Department (ED) with unstable psychiatric emergency medical conditions. Instead of being examined and treated by an on-call psychiatrist, and despite empty beds in its psychiatric unit to which the patients could have been admitted for stabilizing treatment, the patients were involuntarily committed and kept in AnMed's ED for between 6 and 38 days each.
- The following is an example of one such incident. A patient presented to AnMed's ED via law enforcement with psychosis and homicidal ideation and was involuntarily committed. The patient did not receive psychiatric examination or treatment by available AnMed psychiatrists and was not admitted to the psychiatric unit for stabilizing treatment. Instead, the patient was kept in the ED for 38 days and at one point was seen by a psychiatrist from another facility that was familiar with her condition. The psychiatrist prescribed a variety of medications for agitation. The patient eventually was discharged home.

Most Current Civil Monetary Penalty

- On May 1, 2023, New Orleans East Hospital (NOEH), New Orleans, Louisiana, entered into a $95,000 settlement agreement with OIG. The settlement agreement resolves allegations that, based on OIG's investigation, NOEH violated the Emergency Medical Treatment and Labor Act (EMTALA) when it failed to provide an adequate screening examination to a patient and failed to provide an adequate screening examination and stabilizing treatment to a second patient.
- The first patient, C.G., presented to NOEH's emergency department (ED) at 6:58 P.M. on June 14, 2021, complaining of throat, toe, and groin pain. Triage was initiated at 8:23 P.M. and C.G complained of having bugs crawling on his body and that someone was trying to kill him. C.G. refused to answer questions and screamed and cursed at clinical staff. At 8:30 P.M., C.G. was removed from the hospital by security. NOEH failed to provide an adequate medical screening examination for C.G.
- The second patient, A.C., presented to NOEH's ED at 12:00 A.M. on June 20, 2021, via ambulance. A.C. complained of abdominal pain and was brought to the waiting room. A.C. asked to be, and was assisted to the bathroom where she spent an extensive period of time and was found unresponsive. Between 2:00 and 3:00 A.M., after requesting to be taken outside, A.C. was wheeled out of the ED to a location near NOEH's entrance. While sitting at the entrance, A.C. fell from her wheelchair. At 3:10 A.M., a security guard wheeled A.C. across the street to a bus stop. At approximately 4:00 A.M., a security guard found A.C. on the ground unresponsive at the bus stop. ED staff went to the bus stop to attend to A.C and return her to the ED. A.C. was pronounced dead at 4:34 A.M. NOEH failed to provide an adequate medical screening examination and stabilizing treatment to A.C.

Another Current CMP

- On February 10, 2023, St. Agnes Healthcare, Inc. (St. Agnes), Baltimore, Maryland, entered into a $104,942 settlement agreement with OIG. The settlement agreement resolves allegations that, based on OIG's investigation, St. Agnes violated the Emergency Medical Treatment and Labor Act (EMTALA) when it failed to provide a medical screening examination and stabilizing treatment for a patient.
- On February 7, 2019, patient T.L. presented to St. Agnes's Emergency Department (ED) at approximately 12:50 P.M. via emergency medical services (EMS). T.L.'s symptoms included nausea and vomiting over the previous two days. T.L. was brought to a hallway in the ED where T.L. remained in the custody of EMS until shortly after 1:00 P.M. Between 12:50 and 1:35 P.M., T.L. had at least three seizures with decorticate posturing in the presence of ED staff before T.L. was screened or examined by St. Agnes' medical personnel. At approximately 1:35 P.M., ED staff moved T.L. to a hospital room and began resuscitation efforts. Prior to these efforts, T.L. was not triaged by ED staff and did not receive a medical screening examination. An hour after the start of resuscitative efforts, T.L. was pronounced deceased

Current Civil Monetary Penalties

- On December 29, 2021, Tristar Centennial Medical Center (Tristar Centennial), Nashville, Tennessee, entered into a $725,000 settlement agreement with OIG. The settlement agreement resolves allegations that, based on OIG's investigation, Tristar Centennial violated the Emergency Medical Treatment and Labor Act (EMTALA) when it failed to provide, with the staff and facilities available, further medical examination and treatment required to stabilize 29 patients' emergency medical conditions. In each of these incidents, a patient presented to Tristar Centennial with an unstable psychiatric emergency medical condition. In two of these incidents, rather than admitting the patient to Tristar Centennial's onsite psychiatric unit had the capability and capacity to treat the patient, Tristar Centennial discharged the patient home with an unstable emergency medical condition.
- For other presentations, rather than admitting the patient to Parthenon Pavilion, Tristar Centennial held the patient inappropriately in its Emergency Department (ED) for over 24 hours before transferring the patient.
- The decision to transfer the patient, and where to transfer the patient, was made by Tristar Centennial and the Tristar Behavioral Health Transfer Center and was based, in part, on the patient's insurance status. Tristar Centennial asserts that its decision to transfer the patients was based on a recommendation from a mobile crisis team.
- A second Nashville Tristar hospital also entered into a separate $725,000 agreement for 25 different patients

EMTALA Basics

EMTALA Regulations

- EMTALA requirements part of hospital/CAH/REH provider agreement
- Part of the EMTALA regulations are contained under 42 CFR 489.29 Basic Commitments which contains the basic “contract” between entities that bill Medicare and the Medicare program
- This regulation (42 CFR 489.20 (q)(r) then refers to 42 CFR 489.24 where the “Special Responsibilities of Medicare Hospitals in emergency cases” are further defined

EMTALA Requirements vs. Conditions of Participation

- Violation of EMTALA requirements may result in hospital and physician fines
- Violation of EMTALA requirements require demonstration of correction (credible allegation of compliance) prior to revisit, not just a plan of correction
- EMTALA investigation is always complaint driven and not conducted as part of any routine survey

The Cost of “Dumping”

- Fines-- up to $119,942 per each negligent violation for hospitals over 100 beds. And up to $59,973 per each negligent violation for hospitals under 100 beds (adjusted effective March 17,2022)
- Up to $119,942 per negligent violation for physicians if violation occurs in hospital over 100 beds. And up to $59,973 for negligent violation for physicians occurring in hospitals under 100 beds.
- If physician violation is gross and flagrant or repeated, the physician faces exclusion from Medicare
- Private lawsuits for money damages
- Costs of compliance depend on hospital size but range from $50,000--over $150,000 in both direct and indirect costs including lost productivity
- Termination from the Medicare program
- Increased surveillance by CMS and State Survey Agency

Why Increasing Fines?

- President Obama signed new law in November, 2015 Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015.
- This law amended a 1990 law which was enacted to improve the effectiveness of federal Civil Monetary Penalties (CMP) and to maintain their deterrent effectiveness
- Requires that each CMP be adjusted with an initial “catch up” adjustment from the time of enactment of original CMP
- Make subsequent annual adjustments for inflation.
- Adjustment published in the March 17, 2022 Federal Register

EMTALA Resources

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf
- Latest version of EMTALA Interpretative Guidelines

- https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/policy-and-memos-to-states-and-regions.html
- This website contains the latest directions to the surveyors
- New interpretative guidelines posted here prior to CMS republishing the entire document

- https://www.cms.gov/regulations-and-guidance/legislation/emtala/
- This website contains all information related to EMTALA

State Operations Manual

Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases

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(Rev. 191, 07-19-19)

Transmittals for Appendix V

Part I- Investigative Procedures

Part II - Interpretive Guidelines - Responsibilities of Medicare

Quality, Safety & Oversight - General Information

- Spotlight
- Accreditation of Advanced Diagnostic Imaging Suppliers
- Accreditation of Medicare Certified Providers & Suppliers
- CMS National Background Check Program
- Civil Monetary Penalties (Annual Adjustments)
- Civil Money Penalty Reinvestment Program
- CLIA
- CMS Federal Grant Opportunity
- Contact Information
- Diabetic Self-Management Training (DSMT) Accreditation Program
- National Partnership to Improve Dementia Care in Nursing Homes
- Nursing Home Quality Assurance & Performance Improvement

Policy & Memos to States and Regions

CMS Quality Safety & Oversight memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

Show entries: 10

Filter On:

Title	Memo #	Posting Date	Fiscal Year
DRAFT ONLY- Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities	19-13-Hospital	2019-05-03	2019
DRAFT ONLY-Clarification of Ligature Risk Interpretive Guidelines – FOR ACTION	19-12-Hospitals	2019-04-19	2019
Transplant Program Survey Activity Transition	19-11-Transplant	2019-03-29	2019
Specialized Infection Prevention and Control Training for Nursing Home Staff in the Long-Term Care Setting is Now Available	19-10-NH	2019-03-11	2019
April 2019 Improvements to Nursing Home Compare and the Five Star Rating System	19-08-NH	2019-03-05	2019
Revisions to Appendix Q, Guidance on Immediate Jeopardy	19-09-ALL	2019-03-	2019

Emergency Medical Treatment & Labor Act (EMTALA)

CMS Guidance to State Survey Agency Directors

Emergency Medical Treatment and Labor Act Technical Advisory Group (EMTALA TAG)

Emergency Medical Treatment & Labor Act (EMTALA)

In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

Downloads

CMS-1063F [PDF, 716KB]

State Operations Manual: Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases [PDF, 531KB]

Related Links

Revisions to Appendix V - Inpatient Prospective Payment System (IPPS) 2009 Final Rule Revisions to EMTALA Regulations [Survey and Certification Letter 09-26]

Policy & Memos to States and Regions

Transmittal (11/22/2004): Payment for Emergency Medical Treatment and Labor Act (EMTALA) - Mandated Screening and Stabilization Services

CMS-1350-NC: Emergency Medical Treatment and Labor Act (Published February 2, 2012) -- PDF Version

CMS-1350-NC: Emergency Medial Treatment and Labor Act (Published February 2, 2012) -- Text Version

CMS-1350-ANPRM: Emergency Medical Treatment and Labor Act: Applicability to Hospital and Critical Access

EMTALA Definitions

Definitions

- Important to incorporate into hospital policy/procedure
- Not contained in the Interpretative Guidelines
- Importance as the legal definitions vary from what staff/providers commonly think/believe

Capacity

- Ability of hospital to accommodate the individual requesting exam or treatment of the transferred individual
- Encompasses such things as numbers and qualified staff availability, beds, equipment
- Also includes hospital's past practices of accommodating additional patients in excess of its capacity limits

Comes to the Emergency Department

- Presented at hospital's dedicated emergency department
- Requests examination or treatment for a medical condition (or have request made on individual's behalf)
- Request is considered to be made if prudent layperson believes based on individual's behavior or appearance that the individual needs examination or treatment for a medical condition

Comes to the Emergency Department

- Presented on hospital property (other than dedicated emergency dept. and requests exam or treatment for what may be a emergency medical condition or had such a request made on their behalf

Comes to Emergency Department

- In a ground or air ambulance owned AND operated by the hospital for purposes of exam or treatment for a medical condition even if the ambulance is NOT on hospital grounds.
- NOT considered to have come to the Emergency Department IF
  - Operated under Community EMS protocols that direct to transport the individual to hospital other than hospital that owns the ambulance
  - The ambulance is operated at the direction of physician who is not employed or affiliated with hospital that owns ambulance

Comes to Emergency Department

- In a ground or air ambulance (NOT OWNED BY HOSPITAL) on hospital property for presentation for examination or treatment at hospital's dedicated emergency department.
- NOT on hospital property if ambulance contacts hospital staff and staff indicate the hospital is on diversionary status that is hospital does not have the staff or facilities to accept any additional emergency patients
- IF ambulance disregards hospital staff and transports to hospital, then individual is considered to have come to the emergency department

Dedicated Emergency Department

- Any department or facility of hospital (on or off hospital campus) that:
  - Licensed by State as an emergency room
  - Held out to public (by name, posted signs, advertising) as place that provides care for emergency medial conditions on an urgent basis without requiring a previously scheduled appointment)
  - During previous calendar year, provides one-third of all outpatient visits for treatment of emergency medical conditions on urgent basis without previously scheduled appointment

Emergency Medical Condition

- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) that the absence of immediate medical attention could reasonably be expected to result in—
  - Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or unborn child) in serious jeopardy
  - Serious impairment to any bodily functions or
  - Serious dysfunction of any bodily organ or part OR

Emergency Medical Condition

- With respect to a pregnant woman who is having contractions—
  - There is inadequate time to effect a safe transfer to another hospital before delivery; OR
  - That transfer may pose a threat to the health or safety of the woman or unborn child

Hospital

- Includes
  - General acute hospital
  - Psychiatric hospital
  - Rehabilitation hospital
  - Long term acute hospital
  - Critical Access Hospital
  - Any Medicare certified hospital
- Does NOT include:
  - VA hospital unless also Medicare certified OR
  - Hospital on Indian reservation unless also Medicare certified

Hospital Property

- Entire main hospital property
  - Parking lot
  - Driveway
  - Sidewalk
- Excludes
  - Physician offices
  - Separately certified Medicare entities-RHC or SNF
  - Restaurants, shops or other nonmedical facilities

Inpatient

- Individual admitted to hospital for bed occupancy for purposes of receiving inpatient hospital services with expectation that he/she will remain overnight and occupy bed even though the situation later develops that the individual can be discharged or transferred to another hospitals and does not actually use a hospital bed overnight

- Does not include patients who are classified as observation—Therefore EMTALA regulations including transfer requirements still apply

Labor

- Process of childbirth beginning with latent or early phase of labor and continuing through the delivery of the placenta
- Woman experiencing contractions is in true labor unless a physician, certified nurse-midwife or other qualified medical person acting within scope of practice as defined by medical staff bylaws; CERTIFIES after a reasonable time of observation, the woman is in false labor

Stabilized

- With respect to an emergency medical condition
  - No material deterioration of the condition is likely with reasonable medical probability to result from or occur during the transfer
  - Or with respect to a woman who is experiencing contractions and is in true labor, that woman has delivered the child and the placenta

To Stabilize

- With respect to emergency medical condition
  - Provide medical treatment necessary to assure within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during transfer
  - Or with respect to a woman in labor, that the woman has delivered the child and placenta

Transfer

- Movement (including discharge) of an individual outside a hospital's facilities at the direction of any person employed or affiliated with hospital
- Does not include movement of person declared dead or leaves the facility without permission of such person

EMTALA Investigation Process

- Unannounced
- Focus in on initial specific allegation and discovery of additional violations
- Identity of complainant and the patient will always be kept confidential

Entrance Conference

- Following information will be requested:
  - Dedicated ED logs for the past 6-12 months
  - ED policies/procedures
  - Consent and transfer forms
  - ED committee meetings for 12 months
  - ED staffing schedule (physicians 3 months and nurses for last 4 weeks) or appropriate time frame
  - Medical staff bylaws, rules and regulations
  - Medical staff meeting minutes for past 6-12 months
  - Current medical staff roster
  - Physician on-call lists for past 6 months
  - Quality Assessment and Performance Improvement Plan and minutes
  - Select physician credentialing files
  - In-service training records

Surveyor Case Selection

- Sample size 20-50 records (minimum number)
- Sample Selection-based upon nature of complaint
  - Will use ED log to select
  - Similar cases
  - Transfer cases
  - Refusals of exam, treatment or transfer
  - Leaving Against medical advice or leaving without being seen
  - Patients returning to ED within 48 hours

Investigation

- Record review
- Interviews
  - Will interview everyone involved with the particular case
  - ED Nursing Director
  - ED Physician Director
  - Director of Quality improvement
- Exit Conference

Discrimination

- Will look to see if patterns of discrimination related to:
  - Race
  - Color
  - National Origin
  - Age
  - Disability
  - Sex
  - Citizenship
- Will refer to Office of Civil Rights

A2400/C2400
42 CFR 489.20(l)
Hospital Agrees to Comply with 489.24-Special Responsibilities of Hospitals in Emergency Cases

- General requirement
- Requires hospitals to:
  - Provide appropriate MSE to any person who comes to ED
  - Provide necessary stabilizing treatment to individual with EMC or woman in labor
  - Provide for an appropriate transfer of individual if hospital does not have capability/capacity or individual requests
  - No delay in treatment to inquire about insurance or payment
  - Obtain written informed refusal of exam, treatment or transfer
  - Take no adverse action against physician or QMP who refuses to transfer individual in EMC or against employee who reports violations

A2400/C2400 Interpretative Guideline

- Surveyors review ED policies/procedures and medical staff bylaws, rules and regulations to determine if they reflect all EMTALA requirements
- If hospital violates any part of 489.24, then surveyors will cite corresponding violation under A2400/C2400

A2401/C2401
42 CFR 489.20(m)
Hospital agrees to:

- To report to CMS or State Survey Agency any time it has reason to believe it may have received an individual who has been transferred in unstable EMC from another hospital in violation of transfer requirements (489.24(e))

A2401/C2401 Interpretative Guidelines

- Limited required reporting requirement
- Only relates to receiving an improper transfer
- Surveyors look for evidence the receiving hospital knew or suspected the individual had been at another hospital prior to receiving and had not been transferred properly

A2402/C2402
42 CFR 489.20(q)
Hospital agrees to:

- Post required signage in ANY ED or places likely to be noticed by persons entering ED as well as individuals waiting for exam and treatment in areas other than ED
  - Entrances
  - Admitting areas
  - Waiting rooms
  - Treatment areas
- Sign must specify rights of individuals to exam and treatment of emergency medical conditions and women in labor
- Sign must indicate whether the hospital participates in Medicaid program

A2402/C2402
Interpretative Guidelines

- Signage must be visible at 20 feet
- Must specify individual rights under EMTALA
- Wording must be clear and simple
- Wording must also be understandable by population served by hospital
- Must be in all areas of hospitals specified in regulations

IT'S THE LAW

IF YOU HAVE A MEDICAL EMERGENCY OR ARE IN LABOR, YOU HAVE THE RIGHT TO RECEIVE, within the capabilities of this hospital's staff and facilities:

An appropriate Medical SCREENING EXAMINATION

Necessary STABILIZING TEATMENT (including treatment for an unborn child) and, if necessary,

An appropriate TRANSFER to another facility

Even if YOU CANNOT PAY or DO NOT HAVE MEDICAL INSURANCE

or

YOU ARE NOT ENTITLED TO MEDICARE OR MEDICAID This hospital (DOES/DOES NOT) participate

A2403/C2403
42 CFR 489.20
Hospital agrees to:

- Maintain medical and OTHER records related to individuals transferred to or from the hospital for a period of 5 years from date of transfer
- Applies to both transferring and receiving hospitals

A2403/C2403
Interpretative Guidelines

- Must be retained in original or legally reproduced form
- Can be in hard copy, microfilm, microfiche, optical disks, computer disks or computer memory
- Minimum 5 year retention period (Remember there are other medical record retention periods per individual state requirements)

A2404/C2404
42 CFR 489.20(r)(2)
Hospital agrees to:

- Maintain an on-call list of physicians who are on the hospital's medical staff or have privileges at the hospital
- Or have privileges at another hospital participating in formal written community call program
- Physicians are available to provide treatment necessary after initial exam to stabilize individuals with EMC who are receiving services under EMTALA requirements AND in accordance with resources of individual hospital/CAH

A2404/C2404
42 CFR 489.20(r)
Hospital must have Policies/Procedures for On-Call Physician Availability

- Respond to situations in which specialty is not available or on-call physician cannot respond because of circumstances beyond physician control

On-Call Policies/Procedures

- Provide emergency services are available to meet needs of individual with EMC if hospital elects to:
  - Permit on-call physicians to schedule elective surgery during time on-call
  - Permit on-call physicians to have simultaneous on-call duties (at more than one hospital)
  - Participate in formal community call plan

A2404/C2404 Interpretative Guidelines

- On-Call List Requirements and Options
  - General provider agreement requirement (EMTALA related)
  - Clearly identifies and ensures hospital staff is aware of which physicians, specialists, and sub-specialists are available
  - List includes physician with hospital privileges
  - Must be up-to-date AND reflect current privileges of each physician
  - Individual physician names with accurate contact information
  - Hospitals have flexibility in how to configure on-call coverage

Permitted On-Call Options

- Scheduled Elective Surgery
  - Can permit physicians to perform elective surgery
  - Can also adopt policy that does not allow
  - CAH need to be aware of Medicare payment policy regulations outside of EMTALA should they chose to reimburse physicians for call coverage
  - IF physician is on-call and has scheduled elective surgery, the hospital must have planned back-up in event of call during surgery and unable to respond in reasonable time

Permitted On-Call Options

- Simultaneous Call
  - Hospitals are permitted to allow physicians to be on-call at two or more hospitals
  - May also adopt policy that does not allow simultaneous call
  - If allow simultaneous call, must have written P/P to follow if on-call physician is unable to respond as he/she been called to other hospital
  - All hospitals involved must be aware of details of simultaneous call coverage

Formal Community Plan Option

- Clear delineation of on-call coverage-when is each hospital responsible for on-call coverage
- Description of geographic area plan applies to
- Signature by hospital representative
- Assurances that local and regional EMS includes information
- Statement that if individual arrives at hospital that is not designated as on-call, that hospital still has obligation to provide a medical screening exam and stabilizing treatment and appropriate transfer if necessary
- Annual assessment of the plan by all participating hospitals

Other On-Call Guidelines

- Medical staff exemptions
  - No EMTALA or Medicare requirement for ALL physicians on staff to take call
  - Hospital may allow certain physicians (senior physicians) not to take call
  - CAN NOT allow physicians to only take call for their own patients who present to ED
  - MUST ensure adequacy of on-call services

Other On-Call Policy/Procedure Requirements

- Must clearly define responsibilities of on-call physician to respond, examine and treat patients with EMC
- Must address steps to take if particular specialty not available
- Must address steps to take if on-call physician can not respond due to circumstances beyond control

Evaluation of On-Call List Adequacy

- On-call list must be consistent with services hospital provides
- No requirements for frequency that physicians must provide call
- No rule that states if there are 3 physicians (specialty) that the hospital must provide 24/7 coverage in that specialty
- IF hospital performs a significant number of procedures, then it is reasonable to expect adequate on-call coverage

On-Call Physician Appearance Requirement

- Hospitals should ensure physicians aware of their on-call responsibilities
- Enforcement actions can also be against physician who fails or refuses to appear within reasonable period of time
- If on-call physician requested to make in-person requirement, then they must respond in reasonable period of time
- Can not refer patients to private office if on-call for the examination/treatment
  - May be allowable if department is provider-based but must be for medical need and not specialist convenience
- Can send a representative (mid-level) but must be based upon individual assessment by on-call physician
- May consult via phone, video conferencing

A2405/C2405
42 CFR 489.20 (r)(3)
Central Log

- Hospital must maintain a central log for each individual who “comes to the emergency department” who is seeking assistance. Must document
  - Whether he/she refused treatment
  - Was refused treatment
  - Whether was transferred, admitted and treated, stabilized and transferred or discharged

A2405/C2405 Interpretative Guideline

- Purpose is to track care provided to each individual seeking emergency care
- Can maintain log in form that works
- Can have separate logs for each area defined a dedicated ED
- Can keep in paper or electronic
- Surveyors will review at least 6 months surrounding event and check for completeness, gaps, or missing information

A2406/C2406
42 CFR 489.24
Special Responsibilities of Hospitals in Emergency Cases

- Must provide an appropriate medical screening exam within hospital ED capability including ancillary services routinely available to determine whether EMC exists or not
- Exam must be conducted by individual who is determined qualified by hospital bylaws, rules and regulations

A2406/C2406 Interpretative Guidelines

- EMTALA obligation triggered when
  - Person presents to the hospital's dedicated emergency department and requests treatment or exam for any medical condition
  - Person comes elsewhere on hospital property and requests examination or treatment for what might be an emergency condition
  - IF "prudent lay person" believes the person is suffering from emergency medical condition when on hospital property
  - IF person is on hospital property in non-hospital owned ground or air ambulance for purposes of examination or treatment at the hospital

EMTALA Not Triggered by:

- Use of hospital's helipad for the transport of individuals to another hospital if only reason for meeting at helipad is for transit
  - IF individual's condition deteriorates and ambulance staff request assistance, then EMTALA triggered and another MSE must be done and stabilizing treatment provided
- Individual is registered as outpatient and suffers an EMC while receiving outpatient care, no obligation to conduct MSE under EMTALA
  - Medicare COP protect that patient's health and safety

IF EMTALA Triggered, What is Medical Screening Examination?

- More than triage –which only determines order in which patients are seen
- Examination by a physician or qualified medical person (QMP) to determine if emergency medical condition exists
- Provides all necessary testing and on-call services available within hospital's capability
- Process required to reach, within reasonable clinic confidence, the point at which it can be determined whether an EMC exists
- Not an isolated event-ongoing process

Medical Screening Examination

- Must be based upon individual's presenting signs and symptoms and capability/capacity of hospital
- MSE represents a spectrum ranging from simple process such as H/P to a complex process requiring ancillary studies and procedures including: lumbar punctures, CT scans, lab or other diagnostic testing
- Ongoing monitoring required until patient is stabilized, admitted or transferred
- Must be non-discriminatory-not based upon payment sources, race, national origin etc.

Who Can Perform a MSE?

- Left to hospital discretion
- Must be qualified by state licensure
- Qualifications must be described in written document approved by governing body
- Generally includes:
  - MD/DO
  - Mid-level practitioners (PA or ARNP) within scope of practice and as defined by individual hospital and state licensure
  - Certified Nurse Mid-Wives (only for labor/delivery)
  - Obstetrical Nurses with Physician Consultation

What if an EMC exists?

- If medical screening examination reveals an EMC, the hospital must either:
  - Within the staff and facilities available to the hospital further medical treatment as may be required to stabilize the medical condition OR
  - For the transfer of the individual in accord with the requirements of an appropriate transfer
- If admitted as inpatient for further treatment, EMTALA obligation ends
- EMTALA does not apply to inpatients
  - Medicare COP protect

Use of Dedicated ED for Non-Emergency Services 42 CFR 489.24 (c)

- If request is clear for non-emergency services, only required to perform necessary screening to determine no emergency medical condition
- Possible situations include:
  - Referrals for non-emergency test
  - Request for medication refills
  - Immunizations or allergy shots
  - Blood Alcohol Tests
    - Be careful, may have underlying EMC

A2407/C2407
42 CFR 489.24(d)
Necessary Stabilizing Treatment for EMC

- Within capabilities of staff and facilities provide further medical examination and treatment as required to stabilize the medical condition
- Transfer to another medical facility in accord with transfer requirements

A2407/C2407 Interpretative Guidelines

- Provide stabilizing care and treatment within capability/capacity
  - Varies from hospital to hospital
- May appropriately transfer before all resources used IF patient requests transfer and refuses treatment at sending hospital
- If EMC resolved in ED-options
  - Discharge home with follow-up instructions
  - Inpatient admission for continued care

A2407/C2407 Interpretative Guidelines

- IF individual seeking care is member of managed care plan-
  - Hospital MUST still provide MSE by QMP to determine if EMC is present and if so, provide stabilizing treatment
  - True even if individual is enrolled in managed care that restricts enrollee choice of hospital/provider
  - Managed health care plan only states which services it will pay or decline payment but does not alleviate hospital of EMTALA obligation

Example of Stabilized Emergency Medical Condition

- An individual presents to the hospital complaining of chest tightness, wheezing, and shortness of breath and has history of asthma
- A physician (or QMP) completes MSE and diagnoses an asthma attack which is EMC
- Stabilizing treatment provided (medication and oxygen) to alleviate acute respiratory symptoms
- EMC resolved but underlying medical condition of asthma still exists
- After stabilizing patient hospital no longer has EMTALA obligation. May be discharged home, admit to hospital or transfer for further care

Refusal to consent to treatment

- Still under A2407/C2407
- Hospital meets its requirements if offer of further medical exam and treatment is made and hospital informs patient of risks and benefits but individual does not consent
- Medical record must contain description of exam and treatment refused
- Must take reasonable steps to obtain written refusal
- Cant attempt to coerce into making decisions by informing them that they will have to pay for care if remain OR that care will be free or lower cost if transfer

A2408/C2408
42 CFR 489.24(d)(4)(5)
Delay in Examination or Treatment

- May not delay providing appropriate MSE to inquire about method of payment or insurance status
- May not seek or direct patient to seek authorization from insurance for screening or stabilization until AFTER MSE is completed and hospital initiated further medical exam/treatment as required to stabilize EMC
- ER provider may contact individual physician to inquire about history and needs as long as no delay in services

Reasonable Registration Process

- Hospitals may follow reasonable registration processes for individuals for whom examination or treatment is required by this section, including asking whether an individual is insured and, if so, what that insurance is, as long as that inquiry does not delay screening or treatment. Reasonable registration processes may not unduly discourage individuals from remaining for further evaluation.

A2408/C2408
Interpretative Guidelines

- Requirement applies to both referring and receiving hospital
- May be violation if receiving hospital delays acceptance of transfer of individual with unstabilized EMC pending verification of financial information

A2408/C2408
Refusal to Consent to Transfer

- If hospital offers to transfer individual to another hospital AND informs the individual of risks/benefits but individual does not consent to transfer
- Must take all reasonable steps to secure written informed refusal
- Written document must indicate:
  - Person informed of risks and benefits
  - Reasons for refusal
  - Description of proposed transfer that was refused

A2409/C2409
42 CFR 489.24 (e)
Restricting Transfer Until Individual is Stabilized

- May not transfer individual with EMC that has not been stabilized UNLESS
  - Appropriate transfer per regulations OR
  - Individual requests transfer in writing indicating reasons for request and awareness of risks and benefits of transfer OR
  - **Physician** Certification that Benefits outweigh Increased Risks

Written Physician /QMP Certification

- Expected clinical medical benefits outweigh the increased risks of the transfer
- Must specify reason
- Specific to the condition of patient upon transfer
- If physician not present in ED at time of transfer, QMP must sign the certification AFTER a physician has been consulted with AND agrees with certification. Physician must countersign the certification within time frame as defined by hospital

Appropriate Transfer Requirements

- Transferring hospital provides medical treatment within capacity to minimize risk of transfer
- Receiving hospital has agreed, has space and personnel
- Qualified personnel and equipment during transfer
- All medical records sent with patient and
  - Written consent or certification
  - Other records as soon as practicable
  - Name and address of on-call physician, if failed to appear and this caused the transfer to occur

A2409/C2409 Interpretative Guidelines

- Transfer with Physician Certification
  - If transferring pregnant woman in labor, physician must certify the expected benefits outweigh risk to both mom and the unborn child
- Physician countersignature on certification(if not present) must be obtained within timeframe specified by hospital
- Date and time the physician or QMP completed certification should closely match date and time of transfer
- Certification must be in writing. Can not be implied by findings in medical record

Transfer at Request of Individual

- Individual with EMC may request transfer
- Hospital must inform of EMTALA obligations
  - Provide stabilizing treatment within capability and capacity regardless of ability to pay
- Must assure the individual has been advised of the **medical** risks
- Request must be in writing
  - Must include reason for request
  - Must include acknowledgement of risks/benefits

Transfer Record Documentation

- Documentation of permission from receiving hospital to send patient
  - Date and time of transfer request
  - Name and title of person accepting transfer (best practice full name)
  - What hospital is patient going to (best practice –document name of town where hospital located)
- What medical records were sent
  - If sent after transfer (not available) then must telephone or send electronically as soon as available
- Mode of transfer-personnel and equipment involved
- Vital Signs close to time of transfer
- Certification of Risks vs Benefits

A2410/C2410
42 CFR 489.24 (e)(3)
Staff Protections

- Hospital may not penalize or take adverse action against physician or QMP who refuses to authorize a transfer of individual with EMC that has not been stabilized
- Hospital may not take action because employee reports violation
- These protections need to be in hospital policies/procedures

A2411/C2411
42 CFR 489.24(f)
Recipient Hospital Responsibilities

- All transfer patients MUST be accepted
  - If the receiving hospital has capabilities and capacity to treat AND
  - If patient has an EMC AND
  - If the receiving hospital has specialty services not available at the sending hospital
  - AND if the patient had not been previously an inpatient at the transferring hospital
- ONLY applies when patient is coming from another hospital and NOT nursing home, physician office or jail
- Applies to any patient transfer from within the United States boundaries

EMTALA Overview

Patient comes to the dedicated emergency department requesting exam or treatment for any medical condition or is on hospital property requesting treatment for an emergency medical condition

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Hospital provides triage

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Hospital provides Medical Screening Examination

- Reveals no emergency medical condition
  - ↓ Hospital discharges patient with or without treatment
    - ↓ Patient's EMC is resolved and patient is stable – may be admitted to hospital for continued care or transferred.
- Reveals emergency medical condition
  - ↓ Hospital provides treatment to stabilize emergency
    - ↓ Patient's EMC is resolved and patient is stable for discharge home if reasonable to get continued care as outpatient or later as inpatient. Patient receives plan for follow-up care with discharge instructions.
  - ↓ Hospital unable to stabilize emergency condition
    - ↓ Hospital provides unstable patient with an "appropriate transfer."

Most Frequently Cited EMTALA Deficiencies General Acute Hospitals

- 180 investigations in FFY 2021 Texas Investigations--18
- 264 investigations in FFY 2022 Texas Investigations-25
- 120 investigations in FFY 2023 Texas Investigations-13

- 4953-4996 Active General Acute Hospitals

- A2400-General Compliance- 70%-74% (Texas—12%-39%)
- A2406-Medical Screening Exam-67%-71% (Texas –60%-72%)
- A2407-Stabilizing Treatment-20%-27% (Texas 5%-8%)
- A2409-Appropriate Transfer-19%-21% (Texas 16%-30%)

Most Frequently Cited EMTALA Deficiencies Critical Access Hospitals

- 49 investigations in FFY 2021 Texas Investigations--3
- 48 investigations in FFY 2022 Texas Investigations--5
- 11 investigations in FFY 2023 (to date) TX Investigations-2

- 1370-1376 Active Critical Access Hospitals

- C2400-General Compliance—20%-33%
- C2406-Medical Screening Exam-20%-33%
- C2405-Emergency Room Log-0%-67%
- C2409-Transfer Requirements-33%-50%
- C2402-Signage—33%-100%

Deficiency Examples

Inadequate MSE

The individual presented to Emergency Department (ED) at 7:37 a.m., complaining of chest pain. The individual was immediately given an electrocardiogram (EKG) that was read by a physician two minutes later. The EKG was normal. The triage nurse documented the individual's chief complaint as "chest pain since last night, also nausea, vomiting, and diarrhea." The individual was sent to the waiting room without drawing any labs.

The individual's spouse subsequently repeatedly asked for medical assistance because the individual was lying on the floor due to worsening chest pain. When a nurse finally responded, she told the spouse that they would have to wait.

No reassessment of the individual was performed. At 11:21 a.m., the medical record noted that the individual left without treatment.

The individual presented to a second hospital at 11:25 a.m. where the individual received an emergency heart catheterization and was diagnosed with triple vessel disease. The individual needed an urgent coronary bypass and was sent back to Hospital A (original hospital where patient presented) where the individual underwent a triple coronary bypass the next day.

Lack of Appropriate Psych Screening

- Hospital (over 100 beds) failed to provide an appropriate psychiatric screening examination or stabilizing treatment for three patients who presented to the emergency department (ED) when an on-call psychiatrist was available.
- A woman presented to the ED complaining of depression and suicidal thoughts, but was later discharged with instructions to follow-up with her primary care physician.
- A child presented to the ED following violent outbursts, but was later discharged with instructions to follow-up with his primary care physician.
- A man presented to the ED stating his mind was "disturbed," While under “close supervision” later eloped from the ED into single degree weather wearing paper scrubs while his discharge was processed. His body was found about 300 feet from hospital with the cause of death attributed to hypothermia.

Lack of Acceptance of Transfer

A 54-year-old man presented to Hospital A Emergency Department (ED) suffering from a subdural hematoma. A CT scan showed that this subdural hematoma was on top of a previous hematoma. The patient needed to be evaluated by a neurosurgeon, which was not available at Hospital A. Accordingly, the ED physician at the transferring hospital attempted to transfer the patient to Hospital B for neurosurgical services. Hospital B had treated the patient approximately one week earlier for the previous hematoma.

Hospital B refused to accept the transfer when it had both the capabilities and capacity to treat the patient. Subsequently, the patient was transferred to another hospital (Hospital C)and immediately admitted to its neuro ICU, where he remained for several days before being discharged.

Questions?