EMTALA Webinar Series
Part Two

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Texas Hospital Association

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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 Two
Learning Objectives

- Review what language is required on EMTALA signage and where must be located
- Describes what constitutes an adequate medical screening exam for behavioral health, obstetric and other patients
- Describe what constitutes an appropriate certification of false labor
- Illustrate what an appropriate transfer entails and what must be included on the transfer form

EMTALA Week One Quick Review

What are the EMTALA regulations?

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

In response to the practice of some hospitals of refusing to see or transferring the poor and uninsured

Purpose was to ensure each individual who comes to the emergency room receives appropriate medical screening by qualified staff, stabilizing treatment for any EMC and (if necessary) appropriate transfer to another facility

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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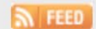
(Rev. 191, 07-19-19)

Transmittals for Appendix V

Part I- Investigative Procedures

I. General Information
II. Principal Focus of Investigation
III. Task 1 - Entrance Conference
IV. Task 2 - Case Selection Methodology
V. Task 3- Record Review
VI. Task 4- Interviews
VII. Task 5-Exit Conference
VIII. Task 6- Professional Medical Review
IX. Task 7- Assessment of Compliance and Completion of the Deficiency Report
X. Additional Survey Report Documentation

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	2019-03-0[illegible]	2019

Where and Who Does EMTALA Apply To Within Hospital/CAH?

EMTALA Applies To?

- Any individual who comes to the Dedicated Emergency Department and requests examination or treatment for ANY medical condition
- Any individual who comes to the hospital (other than DED) and requests examination or treatment for what may be an emergency medical condition (labor, chest pain)
- Prudent layperson standard
- Individual in any ambulance on hospital property
  - This means the parking lot, driveway, sidewalks, outpatient labs and clinics, cafeteria, public restrooms , the ED waiting room, and hospital owned & operated ambulances.
  - Any site within 250 yards of a principal building on the hospital campus, excluding non-medical facilities, such as banks, shops or restaurants.
- Individual in hospital owned ambulance for purposes of screening and treatment

- Individual does not have to be Medicare beneficiary
- Individual does not have to have insurance
- Individual does not have to be citizen

Who Does EMTALA NOT Apply To?

- Scheduled Outpatients-even when EMC develop AFTER outpatient services begin
- Persons clearly requesting non-emergency services (ie., physician office sent patient over for non-emergency lab services)
- Inpatients-
  - Hospitals can not circumvent EMTALA stabilization and treatment by simply admitting individuals with EMC and then discharging short time later from hospital

What about Individual in Observation Status?

- Individuals who are placed in observation status are not inpatients, even if they occupy a bed overnight.
- Placement in an observation status of an individual who came to the hospital’s DED does not terminate the EMTALA obligations of that hospital or a recipient hospital toward the individual.
- Therefore all requirements of EMTALA apply including ongoing monitoring AND ALL transfer requirements if transfer is necessary

If EMTALA Applies, What Next?

- Conduct a Medical Screening Examination based upon clinical signs and symptoms by a physician (MD/DO) or Qualified Medical Person to determine whether or not an Emergency Medical Condition (EMC) exists
- If EMC exists, the hospital/CAH must either provide treatment to resolve the EMC OR transfer the individual in accordance with the transfer requirements

Medical Screening Examination Regulations and Requirements

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
- One of top two frequently cited EMTALA regulation in 2021 -2023
  - 69%-81% Acute (national)
  - 60%-72% Texas
- In CAH, second most frequently cited EMTALA regulation 67%-75% (national) Numbers too low in Texas for trend
- Lack of compliance results in the majority of fines

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 in a ground or air ambulance owned and operated by the hospital for purposes of examination and treatment for a medical condition at a hospital's dedicated emergency department, even if the ambulance is not on hospital grounds.
  - IF person is on hospital property in non-hospital owned ground or air ambulance for purposes of examination or treatment at the hospital

If Triggered, What Constitutes an Adequate Medical Screening Examination

- It depends—
- At a minimum it includes a physical (and mental when necessary) evaluation to determine if there is an emergency medical condition by physician or Qualified Medical Person
- Must be based upon individual's presenting signs and symptoms and capability/capacity of hospital
- Provides all necessary testing and on-call services available within hospital's capability
- 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, disability, age, sex

Medical Screening Exam

- More than triage which is the clinical assessment that determine priority to be seen
- Must be ongoing process
- Will be different depending upon clinical signs and symptoms
- Screening will vary depending upon capability and capacity
- Individual with chest pain and difficulty breathing will be triaged different than an individual bit by their pet guinea pig
- Same screening exam for all who present with same symptoms (same standard of care)
- Can occur via telehealth if clinically appropriate
- Process required to reach, within reasonable clinical confidence, the point at which it can be determined whether an EMC exists

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 licensure
  - Certified Nurse Mid-Wives (only for labor/delivery)
  - Obstetrical Nurses with Physician Consultation

Qualified Medical Person

- QMP must be capable of ordering necessary diagnostic procedures and testing without exceeding scope of professional license or hospital privileges
- RNs without advanced training generally do not meet this criteria
- Exceptions have included experienced OB nurses in consultation with MD/DO
  - Hospital needs to adopt specific P/P addressing the education and training of the OB nurse
  - Must also address physician consultation requirements

MSE and Moving Patient to Another Department

- If patient screened in ED, when can the patient be moved to another department to further screen or stabilize without it being considered a transfer?
- Bona fide reason to move the patient
- All patients with same medical condition are moved regardless of their ability to pay
- Appropriate personnel accompany the patient

Minor Child and Medical Screening Exam

- A minor child can request an examination or treatment for an EMC
- Hospital is required by law to conduct the examination if requested by an individual or on the individual's behalf to determine if an EMC exists.
- Hospital personnel should not delay the MSE by waiting for parental consent.
- If after screening the minor, it is determined no EMC is present, the staff can wait for parental consent before proceeding with further examination and treatment.

OIG and MSE Fines

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

Lack of Adequate Screening Exam

On June 23, 2023, CHI Health Lakeside (Lakeside), Omaha, Nebraska, entered into an $80,000 settlement agreement with OIG. The settlement agreement resolves allegations that Lakeside violated the Emergency Medical Treatment and Labor Act (EMTALA) when it failed to provide an appropriate and timely medical screening examination to a patient.

On October 10, 2020, patient N.N., a 37-year-old male, presented to Lakeside's Emergency Department (ED) by private vehicle at approximately 10:38 am complaining of chest pain and seizure activity. Upon arrival, N.N.'s friend, the driver of the vehicle, parked in the lot across from the ED entrance. After attempting unsuccessfully to assist N.N. out of the vehicle, the friend ran into the ED to request assistance for N.N. The ED registrar instructed the friend to pull around to the ambulance entrance. After returning to the vehicle, the friend managed to assist N.N. out of the vehicle, but struggled to escort N.N. through the parking lot to the ED entrance. Right outside the ED doors, N.N. collapsed, appearing to lose consciousness. Seconds later, a physician assistant walked by N.N. on her way into the ED without acknowledging or offering assistance to N.N., who began seizing and vomiting. At approximately 10:40 a.m., a bystander brought a wheelchair out and assisted the friend in lifting N.N. into a wheelchair. The friend attempted to push the wheelchair into the ED but was unable because N.N.'s legs were caught in the foot pedals. The friend continued to waive his arms toward the ED entrance, seeking medical assistance.

Lack of Adequate Screening Exam (Continued)

At approximately 10:44 a.m., the friend managed to wheel N.N. into the ED. N.N. was immediately brought back to a room to be triaged by ED staff, approximately six minutes after the friend first requested emergency medical assistance. An electrocardiogram revealed that N.N. had suffered a heart attack. At approximately 11:28 a.m., N.N. was taken to the heart catheterization lab for an emergency catheterization and stopped breathing. At 12:27 p.m., N.N. was pronounced dead.

Lakeside failed to provide an appropriate medical screening examination to N.N., who presented on hospital property suffering from an emergency medical conduction, despite repeated requested for assistance by the friend on behalf of N.N., and despite the fact that N.N. clearly required emergency examination and treatment based on his appearance and behavior

Lack of Adequate Screening Exam

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.

Lack of Adequate Screening Exam

Acute hospital ED staff failed to provide an adequate screening exam to patient #9 who presented with right foot and ankle pain. Physician A failed to attempt appropriate de-escalation techniques for patient's agitation and yelling. Instead physician engaged in heated verbal altercation that ended with patient's arrest and transport to jail prior to medical screening exam being conduct. Physician A said it was obvious the patient was not in life threatening situation and was just a "belligerent drunk." Physician A indicated he normally would do exam and get x-ray; however the patient's cursing set him off.

Patient returned to ED approximately 7 hours later for an appropriate MSE of right foot and ankle pain. During second visit, physician B performed a history, focused exam and ordered x-rays. Patient was diagnosed with right foot and ankle sprain

MSE and Pregnant Woman

Labor Defined

- Process of childbirth beginning with latent or early phase of labor and continuing through the delivery of the placenta
- Woman experiencing contractions is ALWAYS 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 (in writing) after a reasonable time of observation, the woman is in false labor

Appropriate Medical Screening Exam for Pregnant Woman

- Many general emergency department will direct women who are over 16-20 weeks gestation with pregnancy related complaints to Labor/Delivery for examination (this makes labor/delivery area a dedicated emergency department)
- Any doubt about nature of complaint then have ED nurse triage (per facility policies)
- If pregnant woman has experienced trauma (car accident), the OB nurse can go to the ED to evaluate the woman if needed
- Make sure hospital has P & P and all staff in ED and OB know the policy

Appropriate Medical Screening Examination of Pregnant Women

- For pregnant women having contractions, a MSE must include at a minimum
  - Ongoing evaluation of Fetal Heart Tones (FHT)
  - Observation and recording of the regularity and duration of uterine contractions
  - Includes fetal position and station
  - Includes cervical dilation status of membranes (leaking, intact, ruptured)

Medical Screening Exam of Woman Experiencing Contractions

- ACOG recommends that a woman experiencing contractions be observed for a period of 1-2 hours before it can be determined the woman is or is not in labor
- Other suggested criteria include:
  - Gestation of 20 weeks or greater but less than 37 weeks
  - Persistent uterine contractions (4 q 20 minutes or 8 q 60 minutes) AND
  - Documented cervical change OR
  - Cervical effacement of 80% or greater OR
  - Cervical dilation of greater than 1 cm

Certification of False Labor

- Physician or QMP must examine patient to determine if Emergency Medical Condition
- All women in true labor are considered to have an Emergency Medical Condition and are considered unstable
- If physician, nurse mid-wife or QMP diagnoses the woman is in false labor, then they are required to certify the diagnosis PRIOR to discharge
- Written/electronic documentation must include that the woman has been examined for a reasonable time of observation and the individual is certifying that the woman is in false labor
  - Include the name and title of the person conducting the exam
  - Include the date and time of certification
- False labor can not be presumed simply based upon discharge home (which is a transfer)

Born Alive Infants Protection Act of 2002

- CMS reissued 2005 guidance in 2019 as reminder
- An infant that is born alive is a person and an individual and is entitled to a medical screening examination
- If the infant is born alive in the hospital's dedicated ED (either traditional ED or labor/delivery area that is defined as a dedicated ED) and a request is made for screening OR prudent layperson believes an exam is needed based upon appearance or behavior, the hospital has an EMTALA obligation
- BORN ALIVE IS DEFINED AS :
  - At any stage of development who after such expulsion or extraction breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, cesarean section or induced abortion.

How Does BIPPA interact with EMTALA?

- If an infant was born alive in the DED (traditional ED or labor/delivery) AND a request made on infant’s behalf for screening of a medical condition OR based upon the infant’s appearance or behavior that the infant needed exam or treatment based upon a prudent layperson standard AND the hospital failed to provide such an exam or failed to resuscitate, the hospital and physician could be liable under EMTALA

What Should Hospital Do When No Obstetrical Department?

- Must still provide a medical screening exam to determine whether EMC exists or person is in active labor
- If unable to stabilize (deliver mom and baby with placenta) must transfer
  - Make sure to do TWO physician certifications with risks and benefits for both mom and unborn child
- Woman experiencing contractions is always in EMC unless false labor determined

OIG Fines and MSE of Pregnant Woman

OIG Fines and MSE of Pregnant Woman

On December 26, 2019, San Mateo Medical Center (San Mateo), a small hospital in San Mateo, California, entered into a $20,000 settlement agreement with OIG. Based on OIG's investigation, San Mateo failed to provide an appropriate medical screening examination, stabilizing treatment, and transfer for a 23-year old pregnant woman.

On August 24, 2016, the patient presented to San Mateo's Emergency Department (ED) complaining of abdominal pain for about four hours, with some vaginal discharge and bleeding. She was approximately 25 weeks pregnant. San Mateo did not perform a vaginal exam and did not determine if the patient was in labor. San Mateo's ED physician arranged for the patient to be transferred to another hospital for a higher level of care. The ED physician was informed that it would take 45 minutes for ambulance transport to arrive at San Mateo's ED, so he recommended that the patient be transferred by private vehicle.

The patient delivered her baby in her car on the way to the receiving hospital and the patient self-diverted to a different hospital, where she arrived 26 minutes later. The baby was not breathing upon arrival to the hospital and the Neonatal Intensive Care Unit was unable to resuscitate the baby.

OIG Fines and Inadequate Medical Screening

Paulding County Hospital (PCH), Paulding, Ohio, entered into a $50,000 settlement agreement with OIG. Based upon the OIG investigation, the hospital failed to provide an adequate medical screening and effectuate an appropriate transfer for a patient.

The patient, a 33-week pregnant woman, presented to PCH's Emergency Department (ED) complaining of leaking fluids, pelvic pain, and vomiting. A nurse at PCH's ED brought the patient to an examination room. The nurse told the patient that the hospital did not have an obstetrician on-site, and that the patient could either start treatment at PCH and be transferred later, or that her male companion could drive her immediately to another hospital, where her obstetrician practiced. After being told this, the patient left PCH by private vehicle to another hospital, a thirty-minute drive. PCH never provided the patient or her unborn child a medical screening examination.

At the receiving hospital, the patient underwent an emergency C-Section and delivered a male infant without a heartbeat. The receiving hospital's efforts to revive the infant were unsuccessful.

MSE of Patients Exhibiting Psychiatric or Behavioral Health Issues

Medical Screening Examination of Individual Experiencing Psychiatric Disturbances

- Difficult and most risk prone of ED patients to manage
- CMS appears to place the care provided to patients in ED with psychiatric conditions as one of their highest priorities
- When patients present to ED with medical issues, many hospitals are not providing a mental health screening when patient also exhibits symptoms of psychiatric or behavioral health issue.

Demand for Psychiatric Services Greatly Exceeds Supply

- Community hospitals are seeing more and more patients with mental illnesses.
- A study published in Health Affairs in 2016 found:
  - A 55% jump nationally in ED visits related to mental health from 2002 to 2011, from 4.4 million to 6.8 million, whereas,
  - The number of inpatient psychiatric beds available nationally to serve these patients plummeted nearly 80% from 1970 to 2010, from about 500,000 to 114,000.
- CMS believes if you have an ED you can provide a basic level of service for the mentally ill. (QSO 19-15 FAQ7)

Appropriate MSE for Psychiatric Patients

- Who will perform MSE?
  - ED physician or ED ARNP or PA alone
  - ED physician (or ED ARNP or PA) with assistance of telemedicine
  - ED physician along with internal or external behavioral health specialists (LISW or others)
  - Other QMP as designated by hospital
- Supervising ED physician ultimately responsible for MSE in the ED
- What resources available to hospital?

Appropriate MSE for Psychiatric Patients

- MSE should include:
  - For patient with known psychiatric disease presenting with symptom exacerbation
    - Full medical and psychiatric history
    - Targeted physician exam and mental status exam
    - Urine toxicology screening and non urine drug screen lab testing should not be routinely performed.
  - Additional screening tests may be valuable for patients with:
    - New onset psychiatric symptoms who are over 65 years
    - Immunosuppressed patients
    - Patients with concomitant medical disease

Medical Screening of Mental Health Patients in the Emergency Department: A Systematic Review.
J Emerg Med. 2018 Dec;55(6):799-812. doi: 10.1016/j.jemermed.2018.09.014. Epub 2018 Oct 10.

https://www.ncbi.nlm.nih.gov/pubmed/30316619

Appropriate MSE for Psychiatric Patient

- Should include assessment of whether the individual is suicidal, homicidal or “gravely disabled”
  - The phrase “gravely disabled” has been used by CMS to imply a danger to oneself due to an inability to appropriately care for oneself, including refusal to take necessary medicine.
- Hospitals may used “contracted services” to assist with psychiatric MSE as long as clinicians are appropriately credentialed by hospital

Take threats of suicide or homicide very seriously because hospital’s evaluation will be scrutinized very closely

Appropriate MSE for Psychiatric Patient

- CMS appears to hold every hospital and CAH responsible for providing an appropriate MSE for psychiatric patients
- CMS requires a hospital to consider and use all of its available resources to provide an appropriate MSE for a patient that may suffer from a psychiatric or behavioral health condition
- Appropriate MSE must be provided even if the hospital does not provide inpatient psychiatric service

Medical Patients with Possible Psychiatric Issues

- Not every patient requires a psychiatric evaluation as part of an MSE, however, a physician should listen and observe patients for cues of instability.
- If a patient appears depressed or speaks of depression, evaluate for mental health issues.
- If a patient with no psychiatric history threatens a homicidal or suicidal act, evaluate for mental health issues.
- If a patient seems psychiatrically unstable in any way, evaluate for mental health issues.

Psychiatric Patient Leaves ED Before Receiving MSE

- Be careful as to how a psychiatric patient is "triaged" given that they may be at higher risk of leaving prior to receiving MSE
  - Where do you place these individuals awaiting MSE?
  - Citations have been issued in situations where psychiatric patients elope from the ED prior to MSE
- CMS will look closely at the condition and needs of the patient upon presentation to ED and what did the hospital do to ensure that the patient received timely MSE

Psychiatric Patient Refusal of Exam

Patient brought by someone in private vehicle to ED front entrance for medical evaluation, specifically psychiatric, but the person refuses to exit the vehicle? What is most appropriate way to handle as this can lead to forceful removal of patient from private vehicle?

- It depends
- Don’t refuse to do exam
- Don’t tell them to drive to ED entrance
- Does hospital have trained security or other staff (in de-escalation) to assist?
- May be appropriate to obtain court committal and request law enforcement assistance

OIG Fines Relating to Inadequate MSE of Individuals Exhibiting Psychiatric Symptoms

OIG Fines and Psychiatric Condition MSE

Southeastern Regional Medical Center (SRMC), Lumberton, North Carolina, entered into a $200,000 settlement agreement with OIG. OIG alleged the hospital failed to provide an appropriate medical screening exam, stabilizing treatment, and/or an appropriate transfer for four individuals.

Specifically, in the following two instances, SRMC failed to provide an appropriate medical screening examination and/or stabilizing treatment.

The patient was a 49-year-old male, presented to SRMC's ED on August 27, 2015, with lethargy and overdose of multiple medications. The patient said he was depressed and expressed suicidal ideations. The ED physician ordered blood and urine tests, an EKG, and a head CT, and noted the patient had a history of depression and chronic back pain. The patient was placed on suicide precaution watch, but no psychiatric evaluation was ordered. The patient was discharged about 4.5 hours later with diagnoses of polypharmacy and asthenia with discharge instructions for near-syncope and weakness.

Four days later, the patient died due to a self-inflicted gunshot wound to the head.

OIG Fines and Psychiatric Condition MSE

Southeast Missouri Hospital (SEM), Cape Girardeau, Missouri, entered into a $100,000 settlement agreement with OIG. The OIG alleged that the hospital failed to provide an adequate medical screening examination and stabilizing treatment for two patients who presented to SEM's Emergency Department (ED)

OIG alleged that instead of being properly evaluated and treated, the patients were discharged with unstabilized emergency medical conditions to the custody of police pursuant to a hospital policy: if a patient had a blood alcohol level (BAL) above 100, the patient was given to local law enforcement and taken to jail. The first patient was 25 years old when she called a crisis hotline and an ambulance was dispatched to her residence. She was transported to SEM's ED for evaluation of a possible suicide attempt by overdose. The patient's BAL was 422 and the ED physician discharged her into the custody of local law enforcement where she was detained in jail and expected to see a counselor.

The second patient was 41 years old when he presented to SEM after attempting suicide by overdose. The patient was depressed, had a history of psychiatric problems, and had recently been admitted for electroconvulsive therapy. The patient's BAL was 288 and he was discharged into the custody of local law enforcement and taken to jail. The next day the patient was seen by a counselor in jail and then released from custody. The patient returned to SEM that evening after again attempting suicide by overdose. The patient had slurred speech, was lethargic and had a flat affect and was admitted to the intensive care unit in guarded condition.

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

Necessary Stabilizing Treatment

If any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either--

- **Within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition.**
- **For transfer of the individual to another medical facility in accordance**
- Cited in 5.6%-7.7% Texas Investigations
- Cited nationally 20%—26% national investigations

Hospital Stabilization Obligation Guidelines

- Required to provide regardless whether hospital will be paid
- Stabilization is dependent upon capabilities of hospital
  - Physical space
  - Equipment/supplies
  - Specialized services (surgery, psychiatry, OB, Intensive Care, pediatrics, trauma)
- Also dependent upon capabilities of staff—level of care that personnel can render

Stabilized Definition

- 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

Deemed Stabilized Guidance

- Treating physician or QMP has determined within reasonable clinical confidence EMC has been resolved
- If resolved
  - Discharge home with follow-up directions to obtain any necessary outpatient treatment to resolve underlying medical condition
  - Inpatient admission for continued care of underlying condition

State of Texas Lawsuit and EMTALA

- Summer 2022 , CMS “reiterated” hospital responsibilities in regards to providing stabilizing treatment to women who are pregnant and experiencing contractions
  - From a practical perspective, this guidance implied that hospitals need to perform abortions if needed to stabilize mother’s EMC
- Texas AG filed lawsuit against HHS and was granted injunction by court
- Only State involved with this lawsuit

Court Ruling

The Court concluded that the Guidance extends beyond EMTALA’s authorizing text in three ways:

- it discards the requirement to consider the welfare of unborn children when determining how to stabilize a pregnant woman
- it claims to preempt state laws notwithstanding explicit provisions to the contrary; and
- it impermissibly interferes with the practice of medicine in violation of the Medicare Act,”

HHS Reaction

HHS is complying with the court's injunction, which states that:

- The defendants may not enforce the Guidance and Letter's interpretation that Texas abortion laws are preempted by EMTALA; and
- The defendants may not enforce the Guidance and Letter's interpretation of EMTALA—both as to when an abortion is required and EMTALA's effect on state laws governing abortion—within the State of Texas or against members of the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) and the Christian Medical and Dental Association (CMDA).
- HHS currently is appealing that ruling

Required EMTALA Signage Regulations and Requirements

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—Minimum of 18 x 20 inches
- 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

Frequency of Signage Citations

- General Acute Hospitals-
  - FFY 2021 –9.8%   Texas-22%
  - FFY 2021—13.6%   Texas 32%
  - FFY 2022—11.8%   Texas 30.8%
- Critical Access Hospitals
  - FFY2021—10.5%
  - FFY 2021—12.5%
  - FFY 2022—13.5%

Common Reasons for Sign Citation

- Missing signage
  - OB/Labor treatment areas where women are being evaluated
  - Signage taken down during remodeling/renovation
  - Not in each treatment room
- Signage covered up
- Signage not of appropriate size or unable to be seen by patient

Transfer Requirements and Transfer Forms

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
- Remember definition of transfer includes movement (including discharge of individual outside a hospital's facility at the direction of any person employed by or affiliated with hospital
  - Would include discharge of psychiatric patient to jail
  - Would include discharge of woman in active labor home
- Cited in 16%-30.8% Texas investigations
- Nationally cited 20%-27% investigations

Psychiatric Patient Stabilization

- Expression of suicidal or homicidal thoughts or gestures, if determined dangerous to self or others,--considered to have an EMC.
- Stable when they are protected and prevented from injuring or harming him/herself or others.

Psychiatric Patient Stabilization

- Administration of chemical or physical restraints for purposes of transferring an individual from one facility to another may stabilize a psychiatric patient for a period of time and remove the immediate EMC
- Underlying medical condition may persist and if not treated for longevity the patient may experience exacerbation of the psychiatric condition.
- Practitioners should use great care when determining if the medical condition is in fact stable after administering chemical or physical restraints.

Woman Experiencing Contractions Stabilization

- Only way to stabilize a woman experiencing contractions is to deliver the baby including placenta.
- A women experiencing contractions is always considered to be in true labor and in emergency medical condition unless determined not to be in true labor and certified not to be in true labor.

Written Physician /QMP Transfer Certification

- Expected clinical medical benefits outweigh the increased risks of the transfer
- Must specify transfer reason
- Specific to the clinical 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
  - If physician is authorizing via telemedicine, the hospital must still have mechanism for timely signing

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

Consent to/or Request for Transfer Form Documentation

- Must provide patient with Notice of Hospital Responsibilities
  - Brief statement of hospital's obligations under the statute. Obligations include:
    - Right to receive medical examination or treatment within the the capabilities of the hospital to stabilize an emergency medical condition OR if necessary be transferred to another medical facility
    - Right to be informed of the risks of the transfer and benefits of the transfer
    - Right to refuse the examination, treatment or transfer.
    - Care and treatment for your EMC is offered even if you cannot pay, do not have medical insurance or are not entitled to Medicare or Medicaid

Consent to/or Request for Transfer Form Documentation

- Benefits outweigh risks certification by physician
- Must be clinical in nature
- Benefits can include:
  - Need for diagnostic equipment/services (need to specify exactly what is needed) not available
  - Need for higher level of care or service not available (be specific—need for ICU, burn unit)
  - Do not leave it ambiguous
- Risks of Transfer—clinical based upon patient—bleeding/shock, maternal/fetal complications
- Certification must include whether patient is stable or unstable (in EMC)—Remember all Women in Labor are Unstable
- Patient signature indicating have consent to the transfer

Consent to/or Request for Transfer Form Documentation

- Following must also be on the form
  - Patient Name
  - Transferring hospital and transferring physician name
  - Receiving hospital name—include town hospital is located in as many hospitals have similar/same names
  - Receiving full name and title of individual who accepted
  - Mode of transfer-including personnel sent and equipment
  - Date and time of acceptance of patient by receiving hospital
  - Vital signs close to the time of Transfer
  - What records sent
  - If utilize QMP, have place for both QMP and physician countersignature

Appropriate Means of Transfer

- CMS believes if individual is being transferred due to lack of services or to higher level of care- ambulance most appropriate
- Personal vehicle is almost never appropriate
- If individual is in need of psychiatric services, ambulance, local law enforcement (if involuntarily committed) or secure vehicle is appropriate
  - If using local law enforcement or secure vehicle, individual should be medically stable

Refusal of Transport Means

- Usage of ambulance (from hospital to higher level of care) is considered part of treatment
- If patient refuses ambulance obtain or attempt to obtain refusal of exam/treatment form
  - Refusal can be for any reason –financial
- Need to explain risks (deliver baby enroute) or issues related to psych care

Transfer Deficiency Example

ED staff failed to ensure that 1 of 20 patients who presented to ED received an appropriate transfer. Failure to arrange an appropriate transfer for patient who presented with psychiatric emergency resulted in patient being discharged to jail.

- Patient brought into ED at 11:33 pm by local police after engaging in erratic and bizarre behavior. Family reported patient had not been taking medication
- Patient was verbally aggressive and yelling abusive language at ED staff while remaining in policy custody
- Telepsych consultation obtained and ARNP determine patient was danger to self and required further inpatient psych hospitalization for further evaluation and stabilization
- Patient was administered Geodon, Benadryl and Ketamine
- Patient remained in handcuffs due to ED physician concern about safety
- Staff searched for inpatient beds; however none were currently available
- At 503 am, ED physician documented law enforcement could admit to jail (even though there was documentation of need for inpatient care)
- No involuntary court committal obtained
- ED physician agreed to the need for inpatient psych care; however current ED lacked ability to deal with violence and aggression even though hospital had available security staff
- Enroute to jail. Jail informed sheriff that jail could not handle patient's psychiatric issues and instructed them to go to another hospital which did have inpatient beds
- Discharging patient to a setting without medical professionals to treat unstabilized EMC placed patient at significant risk for further deterioration

OIG Fines and Transfers

OIG Fine and Transfer

- St. Rose Dominican Hospital - Siena Campus (St. Rose), Henderson, Nevada, entered into a $90,000 settlement agreement with OIG.
- Based upon OIG investigation the hospital failed to provide an appropriate medical screening examination, stabilizing treatment and transfer for a patient. The patient presented to St. Rose's Emergency Department (ED) complaining of dizziness, black stool, yellow skin and stiff muscles. He was transferred with low blood pressure and without having received any blood products, and went into cardiac arrest and died shortly after arriving at the receiving hospital.

OIG Fines and Transfer

South Georgia Medical Center (SGMC), Valdosta, Georgia, entered into a $40,000 settlement agreement with OIG. The settlement agreement resolves allegations that, based on OIG's investigation, SGMC violated the Emergency Medical Treatment and Labor Act (EMTALA) when it failed to provide examination and treatment by its on-call urologist for a 27-year old male. The patient had presented to SGMC's Emergency Department (ED) complaining of pain from an episode of priapism lasting five days. He was seen by an ED physician who contacted SGMC's on-call urologist. The urologist, however, did not come in to the ED to further examine or treat the patient. Instead, the urologist requested that the patient be transferred to another hospital for treatment. The transfer did not take place for more than eight hours and was to a hospital approximately 150 miles away. Priapism is a serious medical condition and delaying proper treatment can lead to penile injury, necrosis, or loss. The patient's transfer was medically inappropriate and put the patient at further risk by delaying needed medical treatment.

OIG Fines and Transfer

Southeastern Regional Medical Center (SRMC), Lumberton, North Carolina, entered into a $200,000 settlement agreement with OIG. The settlement resolves allegations that, based on OIG's investigation, SRMC violated the Emergency Medical Treatment and Labor Act (EMTALA) when it failed to provide an appropriate medical screening exam, stabilizing treatment, and/or an appropriate transfer for four individuals.

SRMC also failed to meet its EMTALA obligations when it failed to re-evaluate the patient at the time of transfer to determine whether: (1) the benefits to each patient continued to outweigh the risks, (2) the previous arrangements for appropriate personnel and transportation equipment were appropriate given the patient's deterioration, and (3) additional medical treatment was needed to minimize the risks to the individual's health, and in the case of a woman in labor, the health of the unborn child.

The patient, a 44-year-old female, presented to SRMC's ED for evaluation of an altered mental status when she was found unresponsive with an empty bottle of butalbital beside her. A CT scan revealed an extensive acute subarachnoid hemorrhage with possible artery aneurysm bleed. At 9:30 p.m., the ED physician certified that the medical benefits of neurosurgery at a hospital over 122 miles away outweighed the risks of transfer. However, the patient was not transferred until 2:16 a.m. the following day, when her condition had significantly deteriorated.

Recipient Hospital

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

Recipient Hospitals Responsibilities Guidelines

- Applies to all Medicare participating hospitals with specialized services even if hospital has no dedicated emergency department (psychiatric hospitals)
- Requirement to accept does not apply to acceptance of inpatients (may be asked if individual is already an inpatient)
- Requests to transfer should generally not be made over great distances due to patient stability during transfer; however may be necessary (psychiatric)
- May not condition acceptance of patient based upon mode of transport
- Lateral transfers are not required-benefits do not outweigh risks
- CMS does not define specialized capabilities or facilities

Citations and OIG Fines Related to Lack of Acceptance of Patient Transfer

OIG Fines and Lack of Acceptance of Transfer

Gateway Medical Center (CHS), entered into a $40,000 settlement agreement with OIG. Based upon OIG investigation, the hospital failed to accept an appropriate transfer.

A 13-year-old presented to a hospital Emergency Department (ED) complaining of testicular pain. An ultrasound indicated no evidence of blood flow in the right testicle and a large amount of fluid surrounding the testicle. In order to access the needed specialized services of a urologist, which that hospital did not have, the ED requested that CHS (another hospital) accept the patient for transfer.

CHS's on-call urologist, however, refused to accept the transfer of the patient, recommending instead that the patient be transferred to a hospital other than CHS. OIG alleged that CHS declined to accept the appropriate transfer when it had both the capability and capacity to stabilize the patient's emergency medical condition.

OIG Fines Due and Lack of Acceptance of Transfer

Phoebe Putney Memorial Hospital, Albany, Georgia, entered into a $50,000 settlement agreement with OIG. Based upon OIG investigation the hospital failed to accept an appropriate transfer.

A 54-year-old man presented to another hospital's 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 that hospital. Accordingly, the ED physician at the transferring hospital attempted to transfer the patient to Phoebe Putney for neurosurgical services. Phoebe Putney treated the patient approximately one week earlier for the previous hematoma.

Phoebe Putney 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 and immediately admitted to its neuro ICU, where he remained for several days before being discharged.

OIG Fines and Lack of Transfer Acceptance

Palms West Hospital (Palms), Loxahatchee, Florida hospital, agreed to pay a maximum penalty of $50,000 in a settlement agreement with OIG. Based upon the OIG investigation, the hospital refused to accept the transfer of a toddler who had ingested Drano.

The mother of an 18-month old toddler brought her daughter to a hospital emergency department (ED) for ingestion of an unknown quantity of Drano. Poison control recommended that the toddler be treated by a pediatric gastroenterologist (GI), which that hospital did not have. The ED physician contacted the Hospital Corporation of America's Transfer Center (TC) to arrange a transfer of the patient. As protocols required, TC had a copy of Palms' on-call list. TC called Palms to confirm that pediatric GI services were available and to arrange for the transfer of the toddler.

The ED physician at Palms accepted the transfer, but later rescinded the acceptance believing that she had made a mistake about on-call coverage. As a result, the toddler was transferred to another hospital. Palms, however, did have a pediatric GI available on call when the request was made to transfer the toddler. TC failed to check on the transfer request in a timely manner and learned of the refusal after the patient had been transferred to another facility.

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

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Hospital discharges patient with or without treatment

Reveals emergency medical condition

Hospital provides treatment to stabilize emergency

Patient's EMC is resolved and patient is stable – may be admitted to hospital for continued care or transferred.

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."

Questions?

Speaker

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