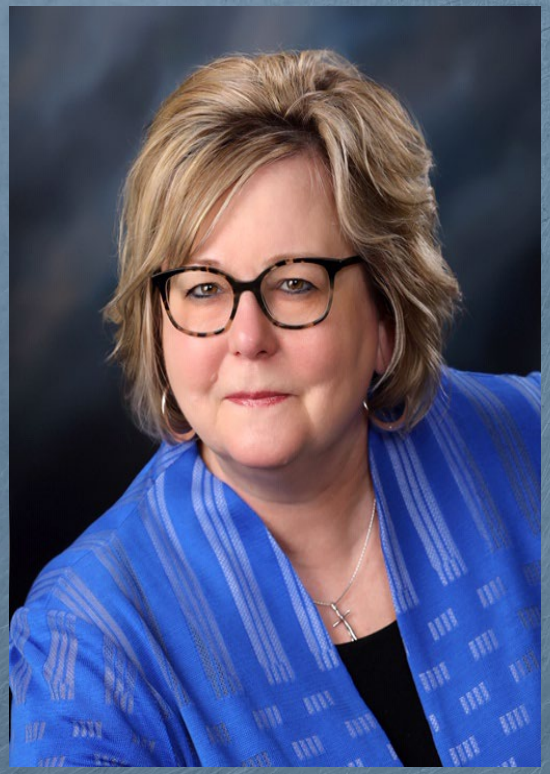
EMTALA Webinar Series Part Three

Nancy M. Ruzicka B.S., RPh., MBA, MJ, CHC
Texas Hospital Association
September 2023

Speaker



Nancy M Ruzicka B.S. RPh., MBA, MJ, CHC
Ruzicka Healthcare Consulting LLC

Over 40 years experience teaching and assisting hospitals, rural health clinics, physician practices, 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

Part Three
Learning Objectives

- Describe the on-call physician rules including when the on-call physician must appear in the Emergency Department
- Describe the Quality Improvement Organization program role with EMTALA
- Describe the Office of Inspector General role and recent deficiencies and fines related to on-call physicians

EMTALA Week One and Two 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 every patient who comes to the emergency room receives appropriate medical screening, stabilizing treatment and (if necessary) appropriate transfer to another facility

EMTALA Requirements vs. Conditions of Participation

- EMTALA requirements part of hospital/CAH provider agreement
- Violation of EMTALA requirements may result in hospital and physician fines
- Violation of EMTALA requirements require demonstration of correction prior to revisit, not just a plan of correction
- EMTALA investigation is always complaint driven and not conducted as part of any routine survey

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

---

(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

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

EMTALA Applies To?

- Any individual who comes to the Dedicated Emergency Department (as defined in hospital EMTALA policy and by practice) 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
- 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)
- Individuals being transported to hospital simply to meet up with helicopter transport to designated recipient hospital
- Inpatients-
  - Hospitals can not circumvent EMTALA stabilization and treatment by simply admitting individuals with EMC and then discharging short time later from hospital

A2406/C2406
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 as defined and approved by the Governing Body 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

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

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 (all four components) 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

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

EMTALA and Physicians

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 another hospital participating in formal written joint 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 particular specialty is not available or on-call physician cannot respond because of circumstances beyond physician control

Required 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

Formal Community Plan Participation Option Requirements

- 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, tat 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

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
  - No physician group names

A2404/C2404
Interpretative Guidelines

- Individual physician names with accurate contact information
  - If on-call availability changes, must update list
- On call list must include names of physicians who are on-call pursuant to community call plan (if exists)
- Hospitals have flexibility in how to configure on-call coverage
  - Must provide sufficient on-call services to meet community needs
- List must be maintained for minimum of 5 years

Community Call Plan Guidelines

- Strictly voluntary
- Must be in writing
- Specify geographic parameters of on-call coverage
- Hospitals not relieved of individual responsibilities to accept transfers from hospitals not participating, must still provide medical screening exam, stabilizing treatment prior to transfer (formal language)
- Show evidence each hospital representative has signed by plan and any revisions
- Annual reassessment including analysis of specialty on-call needs. Must support a Quality Assurance/Performance Improvement approach to analysis

Community Call Plans and EMS

- If EMS have protocols in place, must have attestation by participating hospitals that the CCP has been communicated to EMS
- Updates must be provided to EMS
- May want to obtain EMS input to facilitate implementation
- Even if no EMS protocols, need to inform providers'

Community Call Plan

- Does not mean on-call physicians must travel from Hospital A to Hospital B
  - If on duty at Hospital B, Hospital A can transfer individual to Hospital B for the further examination and treatment and stabilizing treatment
  - Facilitates appropriate transfers—both hospitals must fulfil their EMTALA transfer requirements
  - However hospital where individual originally presents must conduct an appropriate MSE
  - Nothing prohibits physician to go to Hospital A to provide stabilizing treatment
  - Need to consider patient condition and best interest
- Must ensure local EMS is aware of the plan

Community Call Plan

- If participate in CCP, hospitals not relieved of any recipient hospital obligations from non-participating hospitals
- Non-participating hospital must also accept appropriate transfers
- Non-participating hospitals still must provide stabilizing treatment within capability/capacity prior to transfer

Permitted On-Call Option Guidelines

- 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 policies to follow if on-call physician is unable to respond as he/she has been called to other hospital
  - All hospitals involved must be aware of simultaneous call coverage details

Permitted On-Call Option Guidelines

- 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

On-Call Policy/Procedure Requirements

- Must have written on-call policy
- Must clearly define responsibilities of on-call physician to respond, examine and treat patients with EMC
- Must address steps to follow if on-call physician can not respond due to circumstances beyond their control
  - Blizzard, flood, personal illness, transportation issues
- Must address steps to take if particular specialty not available
  - If not on staff--Steps to take if needed specialty is not available or on staff at hospital
  - If have on staff however on vacation
- Always must have a back up plan if using options such as allowing elective surgery, simultaneous call
- Acceptable plan is to transfer.. Documentation must be clear transfer needed due to specific reason

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
  - MAY allow physicians to only take call for their own patients who present to ED BUT still must ensure that there are adequate on-call services for all who need
  - Selective on-call policy can NOT be substitute for on-call services required by EMTALA
  - MUST ensure adequacy of on-call services

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 –Limited Availability

- What hospital to do?
- If ONLY 1 or 2 specialists have reasonable call schedule include some weekends, nights and day hours
- May be on call x number of days per month
- If services needed, permissible to transfer to hospital with needed services in “no coverage” periods
- Hospital policy and procedure must address what to do when specialist is not available such as transfer to another hospital

On-Call Physician Appearance Requirement Guidance

- Hospitals should ensure physicians aware of their on-call responsibilities
  - What education does hospital provide? Upon credentialing? Periodic?
- Enforcement actions can also be against physician who fails or refuses to appear within reasonable period of time
  - Distinguish between phone call response time and in person response time
- If on-call physician or QMP requested to make in-person requirement, then they must respond in reasonable period of time
  - Time period should be defined in hospital medical staff rules/regulations
  - Time period could be defined in different time periods
  - Hospital attorneys may desire to use terms such as “within reasonable period of time”
  - Surveyors will interview involved staff re response time

On-Call Appearance Requirements

- Failure to appear, if on-call, violates EMTALA
  - Must inform recipient hospital if transferring patient due to physician refusal to come in or not showing up
  - Must provide name and address to recipient hospital
- If physician on-call typically directs individual to be transferred to another hospital rather than making appearance, the physician and hospital may in violation of EMTALA
- CMS advises to have a maximum number of minutes that may elapse from when physician contacted to when physician appears

Referral of Patient to Physician Office

- Can not refer usually patients to private physician 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
- May be reasonable if specialty equipment not available at hospital
  - Have seen for specialty ophthalmology equipment that hospitals don't routinely have
- All patients in need must be moved to specialist's office
  - Regardless of payment source
  - Must be accompanied by appropriate medical personnel

On-Call Physician Appearance Requirement and Physician Representative

- Can send a representative (ARNP or PA) but must be based upon individual patient's medical need AND credentials of practitioner
- Practice must be allowed by hospital's bylaws, rules and regulations
- Must be credentialed to perform required assessments and procedures
- Designated on-call physician still ultimately responsible
- ER physician can disagree and request physician to come to ED

ED Consultation

- May consult via phone, video conferencing
- May be with physician not on-call list
- Common for exchange of imaging, lab results EKG with consulting physician
- ED physician needs to be aware that consulting physician is not available for in-person assessment
- Reimbursement for remote consultation is outside EMTALA scope

On-Call Appearance

- If on-call physician fails to appear timely but hospital timely arranges for another specialist to appear and assess/stabilize, then hospital not in violation of EMTALA
- If on-call physician fails to appear timely and hospital must transfer individual to another hospital, both sending hospital and on-call physician may be found in violation

On-Call Requirements

- Remember to include in Policy and Procedure expectation for what education is required for on-call physicians
- Remind physicians who are on call , they are NOT representing their office practice when on-call for hospital ED—they are representing the hospital
  - Of particular importance if physician is accepting transfers
  - Acting as hospital agent

EMTALA Fines and Physicians

- No recent physician fines
- Study of OIG fines from 2000—2015
- Of 196 OIG CMP settlements ONLY 8 (4%) were levied against individual physicians
- Seven fines were against on-call specialists
  - Six were against on-call physicians who failed to respond to evaluate and treat in the ED
  - One was against on-call physician who failed to accept transfer
- Only one fine was against an ED physician who failed to provide a medical screening exam

https://www.ncbi.nlm.nih.gov/pubmed/28109011

Acad Emerg Med. 2017 Apr;24(4):442-446. doi: 10.1111/acem.13159. Epub 2017 Mar 17.

Individual Physician Penalties Resulting From Violation of Emergency Medical Treatment and Labor Act: A Review of Office of the Inspector General Patient Dumping Settlements, 2002-2015.

EMTALA and Physician Fines

- Average OIG Settlement was $25,625
- Total fines amounted to $205,000
- 50% physician fines were associated with separate hospital fine
- 25% physician fines were associated with cases where patient died
- 50% of fines occurred within the first 3 years of the study

EMTALA and ED Physician Fine

- Involved a pregnant 17 year old who presented to Louisiana hospital ED
- Teenager was complaining of vaginal bleeding, abdominal pain and perineal numbness
- Came to the ED twice
- On-duty physician failed to provide a medical screening exam upon the erroneous belief that the minor could not be evaluated or treated absent parental consent

EMTALA and Accepting Physician

- Neurosurgeon was fined
- Failed to accept an appropriate transfer of an individual with unstable EMC which required specialized services available at the hospital he was providing on-call services for

EMTALA Fines and On-Call Physician

- Failure to respond to request to evaluate and treat ED patient with EMC who needed specialty care
  - Two obstetricians
  - Two general surgeons
  - One ophthalmologist
  - One orthopedist

Frequency of A2404/AC2404 Citations

- Texas Acute Hospitals (no Texas CAH citations)
  - FFY21—6.0%
  - FFY22—8.0%
  - FFY23 (to date)-10.5%

- National Acute Hospital Citations
  - FFY21—3.0%
  - FFY22—4.5%
  - FFY23(to date)-6.1%

Risk Management Considerations for On-Call Physicians

Respond Timely When Contacted by ED

- Physician on-call responsibility triggered by call from ED provider or by OB staff
- Telephone consultation may be sufficient to resolve or answer concerns
- Must appear when ED provider (MD/DO, ARNP, PA) or OB practitioner including OB RN request on-call physician to appear in person

Make Sure Cell Phone or Pager Works

- May be some areas of city/county or even hospital where cell phone cannot receive calls
- Be aware of these areas and make alternate arrangements so you can be contacted when working in these areas

Final Word on EMC Status

- ED provider (MD/DO, ARNP or PA or OB staff) have final word as to whether or not on-call physician must see patient
- CMS defers to the judgment of the individual who has actually seen and examined the patient
- Also holds true when transferring

Document

- Document discussions between ED provider and on-call physician
- Without documentation difficult to determine what was said
- Discrepancies can occur in what was said and what was heard

Excuses Don’t Work

- My practice is full. I am not taking new patients
- I don’t accept Medicaid
- I don’t participate in that insurance, HMO, PPO
- I don’t take patients from out of state, out of geographic service area or don’t accept illegal immigrants
- I need to know what their insurance is before I come in
- Too busy in office today
- Big day of elective surgery tomorrow
- Not my patient
- Too tire
- These comments can subject physician to possible fines and civil liabilities

QIO Role in EMTALA Cases

EMTALA Investigations

- Most State survey agencies only have RN or non-physicians that investigate these complaints
- Majority EMTALA complaints involve whether or not the medical screening exam was adequate
- Need physician of similar background to evaluate case
- Surveyors gather records—send to CMS who then send to QIO who has physicians who review
  - Note: Facilities need to maintain documentation of which records surveyors are given (for further internal review)

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/qio110c09.pdf

Quality Improvement Organization Manual

Chapter 9 – Sanction, *Emergency Medical Treatment and Labor Act (EMTALA), Fraud* and Abuse

TABLE OF CONTENTS
(Rev. 24, Issued: 02-12-16)

QIO Authority in EMTALA

- CMS describes QIO role relative to EMTALA and sanctions in QIO Manual Chapter 9
- OBRA 1989 added the role of Peer Review Organizations into the EMTALA requirements
- OBRA requires a 5-day QIO review prior to compliance determination as part of termination decision
- OBRA 1990 further requires a 60-day QIO review prior to assessment of civil monetary penalties

EMTALA Physician Review Worksheet

- When QIO requests a physician to review a case, there is mandated form that sets forth a number of questions
  - 11 pages
- Includes basic demographics such as patient, DOB, name of both involved hospitals
- Form asks the reviewing physician to document their rationale for their findings and to make summary comments
- Full form available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_exhibit_138.pdf

EMTALA Physician Review Worksheet

- Physician asked many questions
- Did hospital provide a Medical Screening Exam (MSE) to determine if an Emergency Medical Condition(EMC) exist?
- Was MSE appropriate considering the patient's signs and symptoms?
- If there was an EMC was the patient stabilized?
- If transferred to another hospital, was the transfer appropriate with qualified staff and equipment used?

EXHIBIT 138

(Rev. 134, Issued: 02-20-15, Effective: 02-13-15, Implementation; 02-13-15)

EMTALA Physician Review Worksheet

☐ **5 - Day Review** ☐ **60 - Day Review**

***NOTE**: A separate Worksheet must be completed by the QIO Physician Reviewer for each medical record reviewed. To facilitate accurate completion, the CMS Regional Office (RO) will complete Section I for each medical record sent to the QIO along with the request for review. The RO must label each medical record with the unique patient identifier as found on the draft Form CMS 2567.*

SECTION I

Complaint Control Number:_____ Patient *Identifier Number on Draft 2567*:_____

Name of Patient: _____ DOB: _____

Name of Alleged Violating Hospital and/or Physician: _____

_____

City: _____ State: _____ CMS Certification Number: _____

Date and Time of Admission to Emergency Services: _____

Date and Time of Discharge from Emergency Services: _____

Name of Receiving Hospital (if applicable): _____

1. Did the hospital provide a medical screening examination that was, ***within reasonable clinical confidence, sufficient to determine whether or not an EMERGENCY MEDICAL CONDITION (as defined above) existed? More specifically:***

1a. ***Was the medical screening examination appropriate given all of*** **the individual's medical complaints and signs and symptoms** ***at the time the individual presented*****?**

☐ **YES** ☐ **NO**

Please explain your clinical rationale: _____

_____

_____

1b. ***Was the medical screening examination appropriate given the hospital's capabilities*** **- including ancillary services routinely available and consultations by on–call specialist physicians?**

☐ **YES** ☐ **NO**

Please explain your clinical rationale: _____

_____

_____

_____

5 day QIO Physician Review

- CMS requires a 5 day QIO review prior to CMS determination as part of their evaluation of hospital termination
  - CMS must request
  - Physician reviewer conducts a clinical assessment and does not make determination whether EMTALA violated
  - Physician reviewer considers clinical facts that the treating physician was aware of or should have been aware of at the time of the individual's presentation to the DED

60 Day Review Process

- As a part of the 60-day review, the QIO is required to provide the physician/hospital an opportunity to discuss the case and an opportunity to submit additional information. (See 42 CFR §489.24(h)(2) and *§9135.2.1.*)
- *The* QIO 60-day review required to *support OIG enforcement* is considered a separate review and has no substantive bearing on the original Regional Office *determination* on EMTALA enforcement against the hospital

60 day Review Process

- Once CMS decides EMTALA violation exists AND the case meets criteria for referral to OIG, all documentation forwarded to QIO
- 60 day review is required before OIG imposes civil monetary penalties. The QIO review is to consider whether an individual had an emergency medical condition; the appropriateness of a medical screen examination, stabilizing treatment, or an appropriate transfer; and whether the individual's condition had been stabilized.
- For the 60-day review, the QIO must also offer the involved physician(s) and hospital(s) an opportunity to discuss the case and submit additional information before the QIO completes its review.
- QIO should utilize same physician reviewer for 5 day and 60 day review

QIO Review Results

- CMS may, but is not obligated to, release the five (5) day QIO review results to the affected physician and/or hospital, and to the individual or his/her representative.
- The sixty (60) day review remains confidential until such time as the OIG investigation is complete.

Confidentiality of Physician Reviewer

- The QIO physician reviewer's identity is confidential unless he/she consents to release his/her identity in accordance with the disclosure regulations. (See 42 CFR §§480.132 and 480.133.)
- The QIO physician peer reviewer identity is kept confidential from all requestors, including CMS unless the reviewer agrees to the release of his/her identity. See 42 CFR §§480.139(a) and 489.24(i).
- Physician peer reviewer name is redacted from all documentation provided to CMS and other parties, unless the physician agrees to release his/her name

QIO Physician Reviewer Selection

- QIO should select reviewer of the same specialty as the physician who attended the individual OR of the specialty indicated by the clinical condition of the patient
- Selected physician should practice in a similar setting as that of physician who attended to the patient
- Specialist must agree in writing to conduct the review in accordance with QIO manual and agree to testify as expert witness if necessary

60 Calendar Day Timeframe

- Day 1--QIO receives record from CMS Regional Office
- Day 15—Notify involved hospital AND if appropriate the physician via certified letter
  - Letter informs hospital/physician that there is opportunity to discuss case via person or phone
  - May submit additional information within 30 days
- Day 20-Presume letter has reached hospital
- Day 50-Discussion with hospital/submission complete
- Day 60-QIO has finalized physician review

QIO-Hospital/Physician Meeting

- Can discuss case in person or via phone
- Opportunity to present additional information pertinent to specific EMTALA violation
- Have right to decline this opportunity
- Have right to legal counsel present
  - QIO may control scope, extent and manner or attorney questioning or presentation
  - QIO may also have legal counsel present
- QIO may limit number of witnesses and length of testimony
- QIO keeps audio recording

OIG Fines and Additional Examples

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

Hospital and Physician Fine

- April 2014
- Trinity Medical Center d/b/a Trinity Bettendorf, Iowa, agreed to pay $40,000 to resolve its liability for Civil Monetary Penalties under the patient dumping statute. OIG alleged that Trinity failed to provide appropriate screening or stabilizing treatment for an individual who came to Trinity's emergency department with emergency medical and psychiatric conditions.
- Gregory Bohn, M.D., Iowa, agreed to pay $35,000 to resolve his liability for Civil Monetary Penalties under the patient dumping statute. OIG alleged that Dr. Bohn, the on-call surgeon at Trinity Bettendorf, refused to examine or treat a patient who had an emergency medical condition that required surgery.

Failure to Provide Adequate MSE

- On September 27, 2019, Doctors Hospital of Augusta (DHA), Augusta, Georgia, entered into a $180,000 settlement agreement with OIG. The settlement agreement resolves allegations that DHA violated the Emergency Medical Treatment and Labor Act (EMTALA) when it failed to provide an adequate medical screening examination and stabilizing treatment for a patient The first patient was a 25-year old female who presented to DHA's Emergency Department (ED) complaining of ingestion of an unknown substance and a loss of consciousness. The patient was reportedly tearful and anxious, and complained of a headache, neck pain, face pain, and left shoulder pain A nurse triaged the patient and gave her an Emergency Severity Index score of three, which was "urgent" according to DHA's triage policy. A physician medically screened the patient; however, the screen did not include necessary laboratory tests related to the patient's presenting symptoms. The patient was entered into DHA's medical screening exam process for non-emergent patients and was asked for funds in order to continue evaluation. The patient was unable to pay, so she was discharged. The patient immediately sought treatment at another hospital, where she was treated.

Failure to Provide MSE and Stabilizing Treatment CMP

- On November 22, 2019, Rockdale Medical Center (RMC), Conyers, Georgia, entered into a $70,000 settlement agreement with OIG. The settlement agreement resolves allegations that the hospital violated the Emergency Medical Treatment and Labor Act (EMTALA) when it failed to provide a medical screening examination, stabilizing treatment or proper transfer to a 79-year-old female.
- Specifically, the patient presented to RMC's Emergency Department (ED) by ambulance after being involved in a motor vehicle crash with multiple injured individuals. EMS contacted RMC's ED for guidance about disposition of the injured individuals and the ED physician at RMC directed that the patient be taken to a trauma center. When one of the ambulances arrived in RMC's ambulance bay with the patient, a hospital nurse approached the ambulance and told the driver that the patient was supposed to go to the trauma center.
- The ambulance then transported the patient to the trauma center without the patient receiving a medical screening examination. During the transport, the patient's condition deteriorated, and she ultimately died at the receiving hospital.

Failure to Accept Transfer Civil Monetary Penalty

- On June 17, 2021, Three Rivers Behavioral Health (Three Rivers), West Columbia, South Carolina, entered into a $25,000 settlement agreement with OIG. The settlement agreement resolves allegations that the hospital violated the Emergency Medical Treatment and Labor Act (EMTALA) when it failed to accept the appropriate transfer of a patient with an unstable emergency medical condition.
- Specifically, the patient presented to the Emergency Department of a small community hospital complaining of headaches, hearing voices, and thoughts of killing herself by shooting herself or jumping off of a bridge. Because it did not have the capabilities to stabilize the patient's emergency medical condition, the hospital faxed the patient's medical record to Three Rivers with a request for a "bed for this [patient]." Soon thereafter, Three Rivers called the transferring hospital and claimed that Three Rivers "had no appropriate beds available for this patient at this time." In fact, Three Rivers had 26 available beds in its adult and crisis stabilization units. OIG determined that the fax and telephone conversation clearly constituted a request for transfer and that Three Rivers refused to accept the appropriate transfer of the patient when it had both the capabilities and the capacity to stabilize the patient's emergency medical condition.

Failure to Accept Appropriate Transfer

- Same hospital as previous slide
- The second patient was an 84-year-old female with pneumonia, and severe hypernatremia and hyperglycemia. The patient needed Intensive Care United (ICU) level care and the transferring hospital did not have an ICU. A physician at DHA refused to accept the transfer of the patient, stating that the referring facility could manage the patient. DHA had the capability and the capacity to care for the patient.

Resources for Pattern of Deficiencies and Civil Monetary Penalties

https://qcor.cms.gov/main.jsp

This site details substantial deficiencies and deficiency patterns and trends

https://oig.hhs.gov/fraud/enforcement/cmp/cmp-ae.asp

This site details all CMP and Affirmative Exclusions

Common Physician Questions About EMTALA Obligations

I (on-call specialist) disagree with emergency room physician and I do not think that I need to see the patient. Do I still need to go to the ED?

- Disagreements may occur about the patient's condition or the need for the on-call physician to come to the hospital.
- CMS states " We also believe any disagreement between the two (ER physician and on-call physician) regarding the need for the on-call physician to come to the hospital and examine the individual must be resolved by deferring to the medical judgment of the emergency physician or other QMP who has personally examined the individual and is currently treating the individual."
- https://www.govinfo.gov/content/pkg/FR-2003-09-09/html/03-22594.htm

Can I ask the ER physician to send patient to my office rather than going to ED?

- Interpretative guidelines state it is not acceptable to refer physician's offices for exam and treatment.
- Exceptions:
  - Can be transferred to physician's office if office has specialized equipment and capability that the transferring hospital does not.
  - Example-Ophthalmologists usually have better equipment in office that is necessary for examining patient to determine if EMC is present. Movement to office becomes medically indicated transfer to higher level of care than the hospital can provide. Therefore all EMTALA rules of appropriate transfer apply.
- Remember treatment in ED only applies to patients who have an EMC and are unstable per CMS definitions.
  - ER physician splints displaced fracture and sends to on-call orthopedic surgeon for reduction and further treatment. If ER physician "stabilizes" fracture, EMTALA no longer applies.
  - Must be legally stable at time of discharge from ER
  - Whether or not stable, is solely on judgement of ER physician

I am on-call for the ED and the ER physician called me to come and treat a patient who has been dismissed from my practice. Do I have to respond and go into the hospital to treat the patient?

- EMTALA applies and the on-call physician must respond timely and go into the ER to treat the patient.
- Some risk management specialists recommend that the physician send a follow-up letter to the patient reminding them that although they were treated in an emergency situation at the hospital, the physician-patient relationship remains terminated
  - May want to consult with attorney prior to sending letter

After I treat the patient in the ED, what are my obligations?

- Once patient's condition is stabilized or patient is transferred, the on-call physician's EMTALA obligation ends
  - On-call orthopedic surgeon who sees patient for broken leg must care for patient through that acute episode and generally not have to treat patient for any unrelated condition
- Physician may still have other obligations to provide follow-up care risk allegations of patient abandonment
  - Need to be aware of Texas Medical Board responsibilities
  - Need to be knowledgeable of hospital medical staff bylaws, rules and regulations to determine specific responsibilities for follow-up

I am only neurologist in town. Am I required to be on-call all the time?

- Individual physicians are not required to provide 24-hour ED coverage
- Each hospital has discretion to maintain on-call list in manner to meet patient and community needs
- Must have policies and procedures to be followed when particular specialty is not available
- If hospital does not have on-call coverage for particular specialty, the hospital lacks capacity to treat patients who need that service.
  - Appropriate to transfer the patient (or refuse to accept the transfer)

Case Studies

Case 1

A 45-year-old man presents to a rural hospital's ED with acute respiratory failure secondary to a flare-up of interstitial lung disease. The ED physician requests a transfer to a tertiary hospital for a higher level of care. The on-call physician at the tertiary hospital refuses, saying that there are other, closer hospitals that should be called instead.

Analysis

- If the potential recipient hospital has empty beds and is capable (resources, staff) of taking care of the patient, the transfer should be accepted. The on-call hospitalist who said the patient should be transferred to another hospital may be found to be in violation of EMTALA.
- Refusal to accept a valid transfer from another hospital is an EMTALA violation. There is no EMTALA rule stating that the closest facility must be contacted for transfer.

Case 2

A 62-year-old man presents to the ED of Hospital A with acute chest pain, and acute coronary syndrome is suspected. Hospital A has the capacity to treat the patient. The ED physician, however, calls the on-call hospitalist at Hospital B and wants the patient to be admitted to Hospital B (located in a different state). His reason for transfer is that his hospital does not accept the patient's state medical insurance card and Hospital B does

Analysis

- The ED physician may be found in violation of EMTALA as he has identified an EMC and it is not clear if the EMC is stabilized. If the transfer were to occur, the on-call hospitalist might also have violated EMTALA.
- Insurance (or any financial considerations) should never be a part of risk/benefit consideration for a transfer.
- Not reporting an inappropriate transfer is itself an EMTALA violation. If a patient is inappropriately transferred, it needs to be reported to CMS within 72 hours.

Case 3

A 60-year-old woman presents to a community hospital ED with hematemesis shortly after midnight. The ED physician suspects acute variceal gastrointestinal bleeding and requests to admit the patient under the hospitalist service. The hospitalist calls the on-call gastroenterologist to come and evaluate the patient. The gastroenterologist says he is tired and has a full day of procedures tomorrow. He says, “If the patient is that ill, you need to send her to the university hospital,” then hangs up.

Analysis

- In this case, the gastroenterologist is on call and if he can treat variceal bleeding and has the hospital privileges for the procedure, then he is clearly violating the EMTALA by not doing so. Not only the hospital but the on-call gastroenterologist is subject to civil monetary penalty and sanctions.
- If a physician is listed as on call and is requested to make an in-person appearance to evaluate and treat an individual with an EMC, the physician must respond in person in a reasonable amount of time. EMTALA applies to consulting and admitting physicians as well as ED physicians
- Sending hospital does not have mandatory responsibility to report; however could
- May be in best interest of community to have conversation between the two hospitals.

Case 4

A 75-year-old woman with stage 4 chronic kidney disease is dismissed by Nephrologist A from his practice because of lack of payment and no-shows. This patient is now being followed by Nephrologist B from a competing medical group.

Tonight, she presents to the ED not feeling well along with nausea and vomiting. Evaluation reveals end-stage renal failure and hyperkalemia not responding to standard treatment. The ED physician calls Nephrologist A (listed as on call for the hospital). He replies back saying, “I am on call for my group only, and besides, I am not going to come at 11 p.m. to see a patient I dismissed from my practice.”

Analysis

- In this case, Nephrologist A may be in violation of EMTALA and subject to penalty and sanctions.
- If a physician is on call for a hospital, that means she or he is an on-call doctor for the hospital, not for her or his group alone. Exceptions include hospitals with physicians from competing groups on call for the same specialty at the same time, so all physicians should familiarize themselves with the call structure at their hospitals.

Case 5

Physician calls the hospital compliance officer stating “I am the only neurologist in town, I cant take call for both hospitals, 24/7, 365…. What do I do?

Analysis

- In this case, both hospitals need to have a reasonable call schedule for the neurologist
- Both hospitals need to agree as to whether or not the neurologist can be on simultaneous call
- Both hospitals need to have policies on what to do when neurologist is needed and is either on call/busy at the other hospital or when he is not on call at either hospital (appropriate transfer)

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

↓

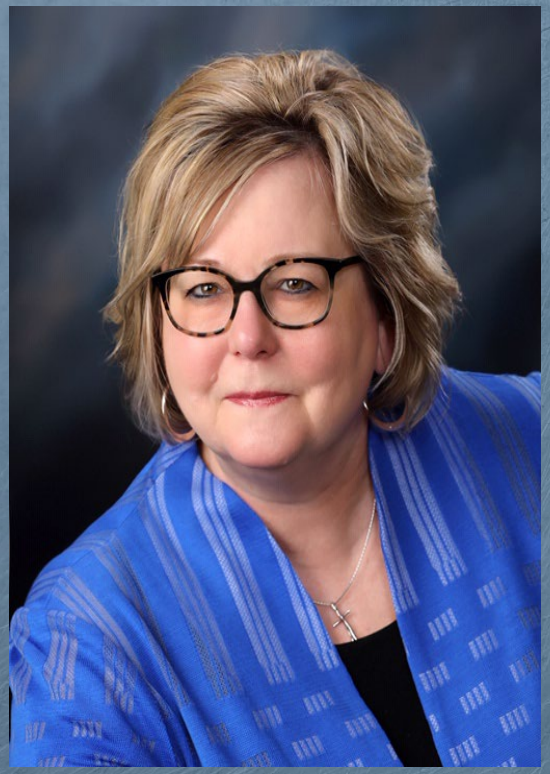
Hospital provides triage

↓

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."

Questions?



Speaker

Nancy M Ruzicka B.S. RPh., MBA, MJ, CHC
Ruzicka Healthcare Consulting LLC

Contact Information
Address: 2210 Ridgewood Dr.
Altoona, IA 50009
Email: nancy@ruzickaconsulting.com
Phone: 515/360-2086