2016 EMTALA UPDATE: 
A Practical Look at the Impact of EMTALA

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Overview of the Day

Morning
- EMTALA Overview.
- EMTALA High Risk Issues.
- CMS/Ongoing EMTALA Issues.
- Q & A

Afternoon
- Common EMTALA Violations.
- Real Life Scenarios.
- Responding to EMTALA Violations.
- Q & A
Violating EMTALA . . .

- **Will** negatively impact an **entire** hospital.
- **Will** drain already scarce resources.
- **Will** place the hospital in the sites of CMS.
- **Can** result in a “fine” from the OIG.
- **Can** result in a public relations nightmare.
- **Will** definitely cost lots of time and money!
EMTALA: Under the Microscope!

CMS espouses a standard of:

100% Compliant
100% Of The Time

This leaves no margin for error!
MY EMTALA HOT TOPICS!

Performing appropriate medical screening exams.

Providing care for psychiatric patients.

Providing care for intoxicated patients.

On-call physician coverage responsibilities.

Use of ED for non-emergency services.

Public Health Concerns.

Reporting EMTALA violations!
EMTALA Overview

**What is EMTALA?**

- Federal law formally known as the Emergency Medical Treatment and Labor Act (“EMTALA”) (1986).
- Simply, a safety net of emergency care for **ALL**.
- Early stage of national health care.

**Why did Congress create EMTALA?**

- Increasing incidences of “patient dumping.”
- Increased competition among hospitals.
- New methodology for Medicare to pay hospitals.
EMTALA Overview

Specifically, EMTALA is the federal law requiring:

- A Medicare hospital with a dedicated emergency department (DED),
- To provide a medical screening examination (MSE),
- For a person presenting to the DED requesting an MSE,
- To determine if an emergency medical condition (EMC) exists and provide necessary stabilizing treatment,
- Before discharging or appropriately transferring the patient.
EMTALA Overview

EMTALA also requires hospitals to comply with the following administrative requirements:

- Maintain appropriate signage.
- Maintain a central log.
- Maintain a physician on-call list.
- Maintain records for required period.
- Report violations when necessary.
EMTALA Overview: DED

Question: Does the hospital have a DED?

• State licensed DED; OR
• Held out to the public as providing treatment for EMCs on an urgent basis without an appointment; OR
• During the previous calendar year, and based upon a representative sample of patient visits, a hospital department or facility provided treatment for EMCs on an urgent basis, without an appointment, for at least 1/3 of its visits.
EMTALA Overview: Signage

At a minimum, a hospital’s EMTALA signage must:

- Specify rights of individuals with EMCs and women in labor who present to the DED for emergency services.
- Indicate whether the facility participates in Medicaid.
- Wording of signage must be clear and in language understandable by population served by that hospital.
- **Must be posted in place(s) likely to be seen by those seeking emergency services.**
- Be very careful of any “go away” signage!
EMTALA Overview: Present to DED

EMTALA requires a hospital with a DED to provide an MSE to a person who “comes to the emergency department”:

- Individual presents at the hospital’s DED requesting examination or treatment of any medical condition.

- Individual presents on hospital property requesting examination or treatment of what may be an EMC – look to prudent lay person standard.

- Hospital property = within 250 yards of main hospital and part of hospital premises.
EMTALA Overview: Present to DED

Hospital owned and operated ambulances are included under the definition of “hospital property.”

- Patients in a hospital owned and operated ambulance are considered on hospital property wherever they are located.

- Look to exceptions for best patient care.

Non-hospital owned and operated ambulances are not considered hospital property.

- Patients not on hospital property until their ambulance arrives on the physical premises of a hospital.
EMTALA Overview: MSE

A hospital must provide an appropriate MSE within its capabilities:

- A MSE is a process designed to reach reasonable clinical confidence as to whether an EMC exists for a specific patient.
- If no EMC exists, EMTALA no longer applies.
- Qualified medical personnel (QMP) must perform an MSE – look to professional positions approved by Board of Directors.
EMTALA Overview: MSE

A hospital must provide an appropriate MSE for each patient, *using appropriate resources*.

Hospitals do not need to use unnecessary resources to determine if an EMC exists.

One size does not fit all – however, consistency is important for similar patients and symptoms.
EMTALA Overview: MSE

When is a MSE not necessary to perform?

- Nonemergency uses of a hospital’s ED.
- For example, if a patient requests services that are not for a medical condition, such as preventative services or gathering evidence, a hospital is not obligated to provide a MSE.

**BE VERY CAREFUL HERE** – document well the requests of competent patients and hospital policy.
EMTALA Overview: EMC

An EMC is defined to include a medical condition with acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual (or of an unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction or any bodily organ or part; or
- Women with contractions: inadequate time to safely transfer or transfer may pose a threat to the health or safety of the woman or unborn child.
EMTALA Overview: Stabilize

If an EMC exists, a hospital must provide necessary stabilizing treatment within its capabilities and capacity.

EMTALA defines “stabilized” to mean:

“that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).”

A hospital must comply with the EMTALA definition of “stabilized”, not just the “clinical” definition of “stabilized.”
EMTALA Overview: Stabilize

The treating physician or QMP determines if a patient is stable under EMTALA. Stabilization is a critical point in EMTALA compliance and requires continuous monitoring.

EMTALA stops if a patient is stabilized!
EMTALA Overview: Transfer

If a hospital is unable to stabilize a patient, it should transfer the patient to a more appropriate hospital when a:

- Patient requests the transfer (in writing) after being informed of the hospital obligations and of the risks of transfer and acknowledging the same;
- Physician certifies the benefits of transfer outweigh the increased risks and a summary of the same; or
- If a physician is not physically present, the certificate is signed by QMP after consultation with a physician who agrees and subsequently countersigns;
- AND appropriate EMTALA transfer.
EMTALA Overview: Transfer

An appropriate transfer requires:

- Transferring hospital provides treatment of EMC within its capabilities and capacity that minimizes risks to the individual’s health; AND

- Receiving hospital accepts transfer and has capabilities and capacity to treat; AND

- Transferring hospital sends copies of records related to patient available at the time of transfer and the name and address of any on-call physician who refused or failed to appear within a reasonable time to provide stabilizing treatment; AND

- Transfer is effectuated via qualified personnel and transportation equipment.

A discharge from an ED is considered a type of transfer!
EMTALA Overview: Reporting

EMTALA regulations require a recipient hospital to report an alleged EMTALA violation when:

- It has reason to believe it may have received an individual who was transferred with an unstable EMC from another hospital in violation of the EMTALA requirements for a transfer of a patient.

CMS wants such a report within 72 hours of occurrence.

Whistleblower protection for employees (and possibly members of Medical Staff).

No duty to report oneself to State/CMS!
EMTALA Overview: When Does EMTALA Stop?

EMTALA is no longer applicable when:

- A MSE is performed and no EMC exists; or
- A patient’s EMC has been stabilized; or
- A patient has been admitted in good faith as an inpatient for stabilizing treatment.

Holding a person for observation does not stop EMTALA – observation status is not equivalent to inpatient status.
EMTALA Overview: CMS Guidance

VERY IMPORTANT!

Review CMS EMTALA Interpretive Guidelines
EMTALA Overview: CMS Guidance


Online version is periodically updated.

CMS also provides guidance through Memoranda issued by the Survey and Certification Group of CMS.
EMTALA: Areas of High Risk

Areas of high risk require more education, thought and attention.
Areas of High Risk: Signage

• Signage identifying acceptable payer sources.
• Signage informing patients of wait times.
• Signage informing patients of narcotics dispensing policy.
• Signage directing patients to urgent care service.
Areas of High Risk: MSE

A MSE is an area of great concern:

- in consistency of MSEs;
- problems with psychiatric and intoxicated patients;
- policies are known, but not followed.

If a health care provider fails to perform an appropriate MSE, then it will most likely fail in providing any needed stabilizing treatment.
Look closely at the difference between “clinically” stable and stable under EMTALA.

The EMTALA standard is different, and higher than the “clinical” standard.

CMS questions whether hospitals across the nation understand the difference and significance of the definitions of “stable.”
Areas of High Risk: Stabilizing Treatment

CMS Example of Stable:

A patient diagnosed with an appendicitis might have relatively normal vital signs, but is still in need of surgery and therefore continues to have an EMC that has not been stabilized.
Areas of High Risk: Psychiatric Patients

Community hospitals are seeing more and more patients with mental illnesses.

When warranted, a hospital must provide a MSE which takes into account both the medical and psychiatric conditions of a patient.

If you have an open ED, you can provide a basic level of service for the mentally ill.

Placement is most often the big issue!
Areas of High Risk: Psychiatric Patients

Psychiatric patients expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, are considered to have an EMC.

Psychiatric patients are considered stable when they are protected and prevented from injuring or harming themselves.

Both of these determinations are patient specific.
Areas of High Risk: Psychiatric Patients

Use of chemical or physical restraints may be utilized for purposes of transfer, but such use does not necessarily create long-term stability of patient. The underlying medical condition may persist.

A hospital must use great care when determining if a patient is stable for transfer to:

- another acute care facility.
- a psychiatric facility.
- a jail.
Areas of High Risk: Psychiatric Patients

A hospital must have a legal right to detain a competent patient who requests to leave.

Look to use of “involuntary hold” procedure:

- Patient suffers from a mental illness; and
- Harm to themselves or others.

Is the patient voluntarily staying?

Law Enforcement has greater rights.
Areas of High Risk: Psychiatric Patients

*How should hospitals handle patients in police custody who claim a psychiatric condition?*

*How should a hospital handle violent psychiatric patients?*
Areas of High Risk: On-Call Physicians

As a general requirement of the Medicare program a hospital must maintain an appropriate on-call schedule.

CMS does not prescribe how a hospital designs its on-call schedule, however, it must maintain a call schedule which takes into consideration the needs of the community and the resources of the hospital.

CMS does not have a specific test for specialty call coverage at a hospital (no 3 specialty-24/7 requirement).
Areas of High Risk: On-Call Physicians

Hospitals are permitted, not required, to allow physicians to be on call simultaneously at two or more facilities – **must adopt policy**.

Hospitals are permitted, not required, to allow physicians to perform elective surgery or other procedures while on call – **must adopt policy**.

- Exception for CAH when they pay physicians for on-call services.
Areas of High Risk: On-Call Physicians

A hospital must adopt a policy for reasonable response time for on-call physicians.

*In general, a Hospital should not send an ED patient to a physician’s office for an EMC or stabilizing treatment.*

Hospitals should provide ongoing education for their on-call physicians about their EMTALA obligations - - **VERY IMPORTANT.**
Areas of High Risk: On-Call Physicians

If permitted by hospital policy, an on-call physician has the option of sending an appropriate non-physician practitioner to fulfill his/her on-call duties.

The ED physician is responsible for determining if an on-call physician must come to the hospital to see an ED patient.

**NEVER** allow an on-call physician to make the decision as to whether he/she must come to the hospital – **use chain of command procedure when needed.**
AREAS OF HIGH RISK: ON-CALL PHYSICIANS

If an ED physician requests an on-call physician to come into the ED to examine a patient, the on-call physician must comply with the request in a reasonable amount of time.

If the physician refuses to come into the ED, the hospital must follow its on-call policy for an alternate plan of action.

An on-call physician can incur a civil monetary penalty for failing to come to the hospital ED to examine a patient at the request of the attending ED physician.
Areas of High Risk: Intoxicated Patients

Just because a person is intoxicated does not mean he/she suffers from an EMC.

However, a hospital cannot determine if an intoxicated person suffers from an EMC unless its staff performs an appropriate MSE.

Patient consent is often difficult to obtain from intoxicated patients.
Areas of High Risk: Intoxicated Patients

If an intoxicated person consents to a MSE, the hospital can perform such an examination.

- Look to chief complaints and other symptomology.
- Given the current condition of the patient, can the hospital perform a thorough MSE?
- Does the person suffer from an EMC?

Competent patients who are intoxicated can generally consent to their care.
Areas of High Risk: Intoxicated Patients

If an intoxicated person refuses care, the hospital, in general, cannot force the person to receive the care.

- Is the person competent?
- Is there an opportunity to use the “involuntary hold” process?
- Use all reasonable powers of persuasion to convince patient to receive appropriate care and remain safe.
- If a competent patient refuses all treatment and demands to leave the facility – use the AMA process and get the patient’s signature if at all possible.

The key to avoiding EMTALA liability here is to document, document and document more.
Areas of High Risk: Intoxicated Patients

In order to reduce exposure to EMTALA liability for the care of intoxicated patients a hospital should draft and implement a policy for managing intoxicated patients.

Do not leave this to chance!
Areas of High Risk: Requesting Payment From Patients

First, a hospital has a legal duty to comply with EMTALA, regardless of whether a patient can pay for services.

Second, accept the fact that CMS does not care if you get paid for any services provided in your ED!

Third, CMS is very concerned that third party payers, including Medicaid, are inappropriately influencing decisions of hospital EDs throughout the country.

Areas of High Risk: Requesting Payment From Patients

CMS is now clear that hospitals may only request payment from an ED patient when:

- the patient has been screened and determined not to have an EMC; or
- the patient’s EMC has been stabilized; or
- the patient has been admitted in good faith as an inpatient for stabilizing treatment.

Hospitals may ask for basic insurance information as part of a reasonable registration process as long as the inquiry does not delay a MSE or stabilizing treatment – this does not include pre-authorization.
Areas of High Risk: Requesting Payment From Patients

Never allow managed care organizations to insert personnel who can keep you from complying with EMTALA.

Managed care organizations cannot stop a hospital from providing health care services to its enrollees – but it can refuse to pay the hospital for the services.

Most managed care plans will cover emergency services in line with a hospital’s compliance with EMTALA – BUT AT WHAT RATE?
Areas of High Risk: Requesting Payment From Patients

Hospitals need a clear and compliant policy on requesting payment from ED patients.

Without a written policy, consistent compliance is almost impossible.

There will always be a need to educate “finance” personnel on the “collections” requirements of EMTALA.
Areas of High Risk: Transfer Patients

When does EMTALA apply to a patient transfer?

In general, when an ED patient suffers from an “emergency medical condition” and requires services to stabilize his/her condition that the transferring hospital cannot provide.
Areas of High Risk: Transfer Patients

EMTALA defines a “transfer” as follows:

- A movement, including a discharge;
- Of a patient outside a hospital’s facilities; and
- At the direction of a person employed by (or affiliated or associated, directly, or indirectly) with the hospital.

The definition does not include deceased patients or patients who leave “against medical advice.”
Areas of High Risk: Transfer Patients

If a patient is stable, EMTALA does not govern the transfer.

If a patient is an inpatient at a hospital, EMTALA does not govern the transfer.

However, a single, EMTALA-compliant “transfer” policy helps ensure EMTALA and overall Medicare compliance for all transfers.
Areas of High Risk: Transfer Patients

When does a hospital have to accept a patient from another hospital?

- Unstable patient in other ED;
- Patient needs services that transferring hospital does not provide and accepting hospital does provide;
- Accepting hospital has the capability and capacity to treat the patient.

Once a patient is stabilized or admitted in good faith as an inpatient EMTALA stops.
Areas of High Risk: Transfer Patients

Transferring patients out of your ED carries increased risk because “others” will be able to critique your actions.

Always remember, no matter how busy the ED may be on any given day, there is a policy in place for transferring patients – FOLLOW IT.

One deviation from your policy can be costly!
Areas of High Risk: Refusal of Care

EMTALA does not require that a hospital provide care contrary to the wishes of a competent patient or authorized representative.

If a patient refuses care, document it in the record.

Documentation should include treatment offered, applicable benefits and risks of treatment offered and treatment alternatives, that the hospital’s EMTALA obligations were explained to the patient and the patient’s informed refusal or request for alternative care.

A hospital should obtain a patient’s signed refusal for care.
Any Questions?
EMTALA: Ongoing Issues

A Look at Ongoing Issues Impacting the Operations of Those Governed by EMTALA
EMTALA: OB Issues

EMTALA applies to women in labor.

CMS states that a woman experiencing contractions is in true labor unless a physician or other approved medical personnel certifies that the woman is in false labor.

EMTALA also applies to infants “born alive.”
EMTALA: Non-Emergency Use of ED

If the nature of an individual’s request makes clear that his/her medical condition is not of an emergency nature, the MSE can be reflective of the complaints or symptoms.

- Hospital must be able to document patient requests, i.e., blood pressure check, scheduled appointment, flu shots or gathering of evidence, for example.

**BE VERY CAREFUL** – CMS will review these non-emergency ED uses very closely.
EMTALA: Extraordinary ED Surge

CMS issued guidance relating to EMTALA flexibility during extraordinary surge for ED services, such as a H1N1 outbreak.

- MSEs are scalable according to symptoms.
- Hospitals may set up alternative screening sites on campus.
- Hospitals may set up screening at off-campus hospital controlled sites - look to state licensing laws.

See CMS S&C-09-52 (August 14, 2009).
EMTALA: Observation/Inpatients

Does *observation* or *inpatient status* end EMTALA obligations?

*Observation status* does not end EMTALA obligations.

*Inpatient status*, generally, does end EMTALA obligations.

Â A CMS rule provides that a hospital’s EMTALA obligations end upon a good faith inpatient admission.

Â In 2012 CMS reconsidered this Rule, but in the end, reconfirmed the Rule.
EMTALA: Special Capability Hospitals

CMS has clarified its existing position that:

... Any [Medicare] participating hospital with specialized capabilities or facilities, even if it does not have a DED, may not refuse to accept an appropriate transfer if the hospital has the capacity to treat the individual.

CMS revised Section 42 CFR 489.24(f) effective 10/1/06 to clarify its existing position.
EMTALA: Special Capability Hospitals

CMS also clarified that regional referral centers referred to in the regulation are only those centers that meet the requirements of 42 CFR 412.96 and not simply rural hospitals that accept referrals.

**IMPORTANT:** these two clarifications do not require a receiving hospital with specialized capabilities to accept an inpatient from a transferring hospital.

CMS questions if hospitals understand the law on special capability hospitals.
EMTALA: Emergency Transport

A receiving hospital may not condition its acceptance of an EMTALA-related transfer on its selection of a transport service.

In general, if a receiving hospital has specialized capabilities, it may not refuse a transfer for an individual who requires such specialized capabilities.

EMTALA: Ambulance Parking

CMS clarifies that a need may arise to request EMS to remain with incoming patients for a period of time.

**HOWEVER**, once patient is on hospital property, EMTALA applies.

See CMS SRC-07-20 (APRIL 27, 2007) and CMS SRC-06-21 (July 13, 2006).
EMTALA: Transfer of Inpatients

When an individual with an unstable EMC is admitted in good faith to a hospital as an inpatient, the EMTALA obligation for that admitting hospital ends.

In 2009 CMS refused to extend EMTALA to inpatients.

In 2009 CMS amended 42 CFR 489.24(f) to provide that hospitals with specialized capabilities do not have to accept transfer of inpatients from other hospitals.
EMTALA: Community Call Plan

In the 2009 IPPS CMS approved the use of formal Community Call Plans (CCP).

CMS views CCPs as one more opportunity for sharing scarce physician resources.

Hospitals may meet EMTALA requirements for maintaining an on-call physician schedule by participating in a formalized CCP.
EMTALA: Community Call Plan

A formal CCP must contain the following:

- Clear delineation of on-call coverage responsibilities.
- Specific geographic area to which CCP applies.
- Signatures from the appropriate representatives of each participating hospital.
- Assurances that any local and regional EMS system protocol formally includes information on community call arrangements.
EMTALA: Community Call Plan

A formal CCP must contain the following (continued):

- Statement specifying that, even if an individual arrives at a hospital that is not designated as the on-call hospital, that hospital still has an EMTALA obligation to provide a MSE and stabilizing treatment within its capabilities.

- Annual assessment of the CCP by participating hospitals.

- Continued compliance by participating hospitals with EMTALA regulations governing appropriate transfers.

A CCP does not require prior approval from CMS.
EMTALA: Scheduled Outpatients

In general, EMTALA does not cover patients who are at a hospital for a scheduled outpatient visit.

However, EMTALA would likely cover a patient before and after his/her outpatient visit.

EMTALA or the Medicare COPs would provide protection for patients.
EMTALA: Urgent Care

Hospitals may organize their urgent care centers as part of their outpatient department or emergency services department.

An urgent care clinic will qualify under the Medicare Outpatient Services CoP if:

- the hospital holds out to the public that it only provides urgent care services;
- the hospital clearly advises the public that the urgent care clinic is not an emergency services department; and
- the urgent care clinic does not meet the EMTALA definition of a “dedicated emergency department.”
EMTALA: Urgent Care

Is it a DED or urgent care service?
- Look to how it is advertised.
- Look to services performed at site.

Consider issues relating to proximity to DED.
- Do patients know where they are going?
- Is there a way to direct patients to urgent care services?

Patient arrives at DED rather than intended urgent care.
- Is there a duty to perform a MSE?
- Helping patients reach correct service – be very careful!
EMTALA: Public Health Concerns

Follow regular EMTALA policies for patients, in addition to consideration of:

- Guidance from CDC, Health Department, others
- Isolation of patients.

Ensure all appropriate hospital personnel know and follow hospital protocols for specialized care.

See CMS S&C-15-10 (11/21/14) and S&C 5-24 (2/13/15) (Ebola).
EMTALA: Public Health Concerns

Consider state and local transfer protocols.

Consider the duty of a hospital with specialized capabilities to accept an unstable ED patient in need of the specialized capabilities.

- public health designation.
- hospital holds itself out as having specialized capabilities.

Patient choice/cooperation concerns.
EMTALA: Select Issues

Use of 911 on hospital property.


Discharge of patients who are homeless.

- What are your choices?

Use of force/health care.

Waiver of EMTALA sanctions during public health emergencies.
EMTALA Litigation: *Moses*

Sixth Circuit U.S. Court of Appeals expanded EMTALA’s scope by holding:

- Third parties harmed by an EMTALA violation have standing to sue the hospital.

- A hospital has not satisfied their EMTALA obligation when a patient is admitted.

Only applies to hospitals in Sixth Circuit.
EMTALA Litigation: Moses

What is the impact of the Moses decision?

- CMS has clearly stated that EMTALA obligations end when a patient has been admitted.

- A CMS official has commented that the Moses decision changes nothing for the purposes of the government’s regulatory enforcement.

- Hospitals’ exposure to private lawsuits can increase.
EMTALA Litigation: 8th Circuit

Historically, the 8th Circuit has been more conservative on expanding the reach of EMTALA.

Summers v. Baptist Medical Center Arkadelphia (8th Circuit, 1996):

Â Held that instances of negligence in the screening process were not actionable under EMTALA.

Â Could have an action under EMTALA if purposeful discrimination or not MSE at all.
COMMON EMTALA VIOLATIONS

Missouri and Beyond
Common EMTALA Violations

AND THE WINNERS ARE:

#1 Policies and Procedures
#2 Inadequate Screening
#3 Inadequate Stabilizing Treatment
#4 Inappropriate Transfer
EMTALA Violations: Policies

The most common EMTALA citations relate to EMTALA policies and procedures.

If CMS finds a substantive EMTALA violation, a provider will also invariably receive citations for lack of adequate EMTALA policies and procedures.
EMTALA Violations: Policies

Citations often relate to failure to follow established policies or procedures.

A hospital should annually review its EMTALA policies and procedures and revise as necessary.

Ongoing EMTALA education will help ensure EMTALA compliance – *remember to educate all personnel who need to know*. 
EMTALA Violations: Screening

Failure to provide an appropriate MSE is generally the most cited violation, with the exception of policies and procedures.

Failure to provide an appropriate MSE is often cited because there are many ways to violate this EMTALA requirement.
EMTALA Violations: Screening

Common reasons CMS cites for inadequate MSE:

1. Absence of any MSE.
   a. On hospital property issue.
   b. Triage vs. MSE.

2. Sufficiency of MSE.
   a. Utilize full resources of hospital.
   b. Continuous monitoring.
   c. Medical/psychiatric issues.
   d. Regulation vs. malpractice.
EMTALA Violations: Screening

Common reasons CMS cites for inadequate MSE (continued):

3. Delay of MSE.
   a. Minors presenting to ED.
   b. Police matters.

Most of the “common” reasons do not signify “discrimination” against a patient but relate to clinical issues or conflict with other laws or hospital policies.
EMTALA Violations: Screening

A hospital can help avoid EMTALA citations for inadequate MSEs by:

- Educating *necessary* personnel on EMTALA screening and related policies.
- Reviewing and reconciling policies or laws which conflict with EMTALA.
- Auditing implementation of EMTALA screening policies and procedures.
- *Imposing discipline where necessary to modify behavior.*
EMTALA Violations: Stabilize

- Failure to provide stabilization treatment trails right behind “screening” as a most common EMTALA citation.
- If a hospital failed to provide an adequate MSE, and an EMC existed, CMS will surely cite the hospital for failing to provide stabilizing treatment.
- Even if no EMC existed, a citation is likely because it’s hard for a hospital to prove an EMC didn’t exist if it failed to provide a MSE.
EMTALA Violations: Stabilize

Common reasons CMS cites for inadequate stabilizing treatment:

1. Failure to utilize full resources of the hospital.
   a. Continuous monitoring.
   b. Limited services provided.
   c. Capability and capacity issues.

2. Failure to adequately address medical/psychiatric issues.
   a. When a patient presents with psychiatric issues every hospital has a duty to use its best efforts.
EMTALA Violations: Stabilize

Common reasons CMS cites for inadequate stabilizing treatment (continued):

b. A hospital must address both medical and psychiatric issues for patients in need of the services.

3. Released for follow-up care.
   a. Patient not truly stable.
   b. Special circumstance of patient not considered.
   c. Lack of adequate follow-up instructions.
EMTALA Violations: Stabilize

A hospital can help avoid EMTALA citations for inadequate stabilizing treatment by:

- Continually monitoring patients from admission to discharge.
- Providing all necessary stabilization treatment “within its capabilities.”
- Paying special attention to the needs of psychiatric patients and ensuring appropriate psychiatric and medical care.
EMTALA Violations: Stabilize

A hospital can help avoid EMTALA citations for inadequate stabilizing treatment by (continued):

- Providing superior instructions for patients in need of follow-up care, including the option of returning to the hospital if the need arises.
- Auditing these processes on an annual basis.
- *Imposing discipline when necessary to modify behavior.*
EMTALA Violations: Transfer

- A citation for an inappropriate transfer will often follow citations for inappropriate MSE and failure to provide appropriate stabilizing treatment.

- If a hospital fails to arrange an appropriate patient transfer, it risks:
  1. Patient dissatisfaction
  2. Its relationship with the receiving facility; and
  3. Review by CMS.
EMTALA Violations: Transfer

Common reasons CMS cites for inadequate transfers:

1. Inappropriate transport.
   a. The type of vehicle used.
   b. Personnel sent as part of transport.
2. Clinical appropriateness.
   a. Fail to monitor patient prior to transfer.
   b. Benefits outweigh risks.
3. Failure to consider special circumstances of psychiatric patients.
EMTALA Violations: Transfer

A hospital can help avoid EMTALA citations for inadequate transfers by:

- Evaluating each transport on its own merits.
- Ensuring appropriate person at receiving facility accepts patient.
- Ensuring patient/family consents to transfer.
- Auditing implementation of transport policies and procedures.
- *Imposing discipline where necessary to modify behavior.*
Any Questions?
EMTALA SCENARIOS AND REAL LIFE EXPERIENCES
Scenario #1

- Minor patient presents to the ED with a fractured arm.
- ED physician examines the patient’s arm and believes he can stabilize the fracture without the help of the on-call orthopod.
- ED physician splints the patient’s arm and recommends that the child’s mother take her son to the on-call orthopod for follow-up care within the next 3 days.
- The patient’s mother follows the directions of the ED physician but the orthopod’s office refuses to provide care to the minor without an up-front payment of $500.
Scenario #2

• A patient who had a kidney transplant and actively received dialysis presented to an outpatient dialysis center, very short of breath.
• The outpatient dialysis center called an ambulance which took the patient to a hospital that diagnosed the patient with acute pulmonary edema in the ED.
• The hospital wasn’t equipped to perform dialysis, which was necessary to stabilize the patient, and the patient declined to be transferred to a hospital that could provide dialysis.
• The patient opted to return to the outpatient center, and the hospital discharged him and allowed him to return by private car and without oxygen.
Scenario #3

- Patient was brought into the hospital ED by ambulance with a fractured hand.
- ED physician called the on-call orthopedic surgeon and requested him to come into the hospital ED to examine the patient.
- The on-call physician refused to come into the hospital because he had no experience in hand fractures, but was a back specialist.
- The ED physician called another hospital with an on-call hand surgeon, but the hand surgeon refused to treat the patient because of the refusal of the first physician.
Scenario #4

• Patient arrives at hospital in police custody after he was arrested for drunk driving.

• Although patient was drunk, he was coherent enough to refuse all treatment.

• Police officer informs the staff he intends to leave but will call to inquire about the status of the patient.

• After the police officer leaves, patient signs out AMA.
ADDRESSING EMTALA VIOLATIONS:

Creating and Implementing Effective Action Plans
EMTALA Enforcement: The Stages

Å Violation
Å Complaint
Å Survey
Å Statement of Deficiencies
Å Plan of Correction
Å Resurvey
Å Penalties
Potential Violation: ACT NOW

As soon as you are aware of a possible EMTALA violation, you should act.

Do not wait for a complaint to be filed or for surveyors to arrive at your facility.

Acting immediately to resolve a violation can benefit a hospital greatly — can help prevent an IJ determination and prevent termination action.
EMTALA Team

Assemble your best EMTALA Team.

Members of your EMTALA Team should have:

• Knowledge of EMTALA and hospital operations;

• Ability to interact well with surveyors; and

• Ability to effectuate quick change in the organization.
Effective EMTALA Action Plans

Investigate all potential EMTALA violations and implement appropriate corrective action.

- Review existing policy and procedure.
- Revise policy and procedure, if necessary.
- Re-educate personnel.
- **Impose discipline, if warranted.**
- Create appropriate audit tool.
- Audit for continued compliance.
Document Strategically

Document all actions, including EMTALA Team meetings and decisions.

Ensure that information remains fact based and not unsubstantiated opinion.

Require employees to sign in for training sessions.

Retain such records for at least 2 years.
EMTALA Investigations: Complaint Driven

EMTALA is a *complaint driven* process.

EMTALA complaints come from:

- Patients/families;
- Other health care providers; or
- Disgruntled employees.

*Today, people know where to complain, and they do!*
Regional Office Discretion

EMTALA complaints are made to CMS and/or the applicable SAs.

The CMS Regional Offices ("RO") decide whether to authorize SA to investigate complaints on their behalf.

CMS retain authority over all EMTALA investigations.
Regional Office Discretion

RO will initially give a verbal authorization for an investigation.

RO will follow up verbal authorization with the completion of the form for Report for Survey.

RO will send a letter to a complainant letting them know if an investigation was warranted.
Survey: Process

All EMTALA surveys are unannounced.

EMTALA investigations are designed to:

- Ascertain if an EMTALA violation occurred;
- Determine if a violation constitutes an immediate and severe threat to patient health and safety;
- Identify any patterns of violations at the facility; and
- Assess whether the facility has adequate policies and procedures to address EMTALA.
Survey: Process

Even if the complaint is unsubstantiated, CMS can cite other EMTALA violations or violations of the Medicare CoPs.

An IJ citation can result from an EMTALA violation or a CoP Condition Level citation.

Surveyors will generally perform a look-back of 6 months for EMTALA violations, however, CMS is not limited in time or scope in its review.
Survey: Process

Task 1 - Entrance Conference
Task 2 – Case Selection (average 30-50 sample size)
Task 3 – Record Review
Task 4 – Interviews
Task 5 – Exit Conference
Task 6 – Professional Medical Review
Task 7 – Compliance Assessment/Report
Survey: Case Selection

Although a single occurrence can be considered a violation of EMTALA, a sample audit is performed to identify patterns and additional violations.

Sample size generally 30-50 records.

Complaint case is included in sample.

Sample will include records which exhibit similar issues.
Survey: Entrance Conference

CMS requires an Entrance Conference with CEO of the hospital or his/her designees.

Members of the EMTALA Team should attend the Entrance Conference.

Assign an EMTALA Team member to accompany the lead surveyor -- *Set the stage for a relationship of cooperation.*

*Request the basis of the complaint and scope and length of survey.*

Use Entrance Conference to elicit pertinent information thereby allowing the hospital to address issues quickly.
Survey: Record Review

Continue to elicit information from surveyors throughout the survey.

Use all opportunities throughout the survey to provide surveyors with information showing EMTALA compliance and/or corrective action.

Show that corrective action began immediately.

Request daily review conferences at the end of each day to prepare for the next day.
Survey: Record Review

Records selected can highlight focus of investigation.

Surveyors review records, but only make preliminary findings.

The records selected should tell the story of patient care!
Survey: Interviews

Interviews of hospital staff and others involved in the event are part of the investigation process.

Personal interviews often elicit information that fills in gaps left after record reviews.

Hospital personnel do not have the right to “sit in” on interviews.

Interviews can be conducted by representatives of the SA and/or CMS.
Survey: Exit Conference

*Purpose*: to inform the hospital of the scope of the investigation, including nature of the complaint and any hospital CoPs surveyed.

The SA and/or CMS can still investigate further.

The SA will not present a SOD at the Exit Conference.

Can request recording of meeting.
Survey: Exit Conference

Use the Exit Conference to learn of potential EMTALA and/or Medicare CoP citations.

- The SA collects information on behalf of CMS.
- CMS retains the sole authority for determining compliance with EMTALA and its CoPs.

Use information from the SA to start corrective action immediately and further refine the corrective action plan.
Survey: Immediate Jeopardy

Immediate jeopardy ("IJ") is interpreted as a crisis situation in which the health and safety of individual(s) are at risk.

IJ defined as: [a] situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death . . . (42 CFR 289.3)

IJ citation has an immediate and profound impact on a hospital.
Survey: Immediate Jeopardy

An IJ can be supported by harm having occurred in the past and/or harm occurring in the present. However, actual harm, injury or death does not have to occur. Before issuing an IJ – high potential for these outcomes to occur is enough.

Only one individual needs to be at risk. Psychological harm is treated equally as physical harm.
Survey: Immediate Jeopardy

CMS has listed the following “triggers” to consider for an EMTALA IJ:

- Individuals turned away at ED without MSE.
- Pregnant women not appropriately screened for status of labor.
- Absence of ER and OB MSE records.
- Failure to stabilize EMC.
- Failure to appropriately transfer individual with EMC.

These “triggers” will cause surveyors to consider if further investigation needed to determine presence of an IJ. These “triggers” are general examples and are not all inclusive.
Survey: Immediate Jeopardy

If a survey team reaches a consensus of the presence of an IJ, the team leader then contacts the SA.

If the SA concurs with the team’s consensus of an IJ, the SA will inform the RO.

If the RO agrees with the decision of the SA, it will inform the facility of the IJ.

At any time, the RO has the authority to determine if an IJ exists even if the SA does not concur.

**An IJ is not appealable!**
Survey: Immediate Jeopardy

An IJ is always cited at a Condition Level.
A hospital should abate an IJ immediately.
Å identify issues prompting IJ.
Å work to correct issues immediately.
Å abatement only signifies that the "immediate threat" is "removed," not a systematic fix.
Survey: Immediate Jeopardy

If at all possible, abate an IJ before surveyors exit.

- Need on-site confirmation of correction to remove IJ.
- CMS controls on this issue.

If an IJ is not abated by surveyor exit, 23 day termination track.

- Full CoP survey within 23 day period.
- CMS directs this process.
Survey: Professional Medical Review

**Purpose**: to provide peer (physician) review using information available to the hospital at the time the alleged violation took place.

Need physician review prior to imposition of CMPs or termination of a hospital’s Medicare provider agreement for the above.

“All investigations are referred to the QIO for an advisory opinion.” CMS EMTALA Update/Dallas Regional Office (February 2013).
Survey: Compliance Report

When a SA performs an EMTALA survey on behalf of CMS the following outcomes are possible:

- No violation(s).
- No EMTALA violation(s), but CoP violation(s).
- Past EMTALA violation, no termination.
- EMTALA violation, “immediate and serious threat.”
- EMTALA violation, no “immediate and serious threat.”

A determination of an “immediate and serious threat” is not appealable at the time rendered.
Statement Of Deficiencies

A hospital should receive the SOD within 30 days of the survey, *but could be longer.*

The cover letter accompanying a SOD will state whether the hospital is on a 23 or 90 day Medicare termination track.

- IJ violations require a 23 day termination track.
- Non-IJ violations require a 90 day termination track.
Statement Of Deficiencies

A SOD will detail the EMTALA survey findings.

A SOD signifies the combined effort of a SA and CMS.

In general, to remain in the Medicare program, a hospital must respond to a SOD.
Public Disclosure

SODs and Plans of Correction ("POC") are "public" documents, **be prepared for their release, including to the media.**

CMS will release a SOD before a POC is submitted by a hospital!

The media is generally not your friend during this time of stress.
Plan Of Correction

In general, a hospital must submit a POC within 10 days of receipt of a SOD.

A POC must adequately address the following:

- Correction of the violation, if possible.
- How to ensure continued compliance.
- Discipline of employees or members of the Medical Staff.
- Implementation of appropriate audit tool to track compliance.
Plan Of Correction

In general, a hospital’s POC should include, as warranted:

- Review of existing EMTALA policies;
- Revise existing EMTALA policies;
- Re-educate employees and physicians;
- **Discipline employees and/or physicians**; and
- Create and implement EMTALA audit tool.
Plan of Correction

Very important, CMS expects to see change! Modifying future behavior is key to change.

Modifying behavior is the greatest challenge – IT’S NOT WHAT THEY KNOW BUT WHAT THEY DO!

Employee discipline is often necessary today.
CMS Authorization

CMS must approve a POC before it will authorize a SA to resurvey.

CMS will not authorize a resurvey until a hospital provides it with a credible allegation of EMTALA compliance.

- Need for quick and effective action plan.
- Compliance dates will dictate resurvey.

23 day termination track requires immediate action.
Resurvey

In general, a SA will focus an EMTALA resurvey on issues identified in the initial survey, however, it is NOT limited to these issues.

Any Medicare condition level deficiency cited on a resurvey will continue a hospital towards termination.

CMS will often convert a hospital from a 23 day to a 90 day termination at the time of a resurvey.
Cooperation

To ensure the greatest success on an EMTALA resurvey a hospital should work cooperatively with the SA and CMS.

Differences of opinion are inevitable, however, a hospital needs the cooperation of both the SA and CMS for continued participation in the Medicare program.

CMS determines EMTALA compliance, always.
EMTALA Penalties

A Civil Monetary Penalty (‘‘CMP’’) can follow an EMTALA violation.

- OIG determines if a CMP is warranted and the amount.
- Generally focuses on screening, stabilization and transfer issues.
- A CMP can be assessed for each EMTALA violation.
- OIG can consider all relevant factors, including ‘‘other instances,’’ when determining if a CMP is appropriate and at what amount.
EMTALA Penalties

The maximum CMP for an EMTALA violation will increase in 2016-2017 from:

- $50,000 to $103,139 for hospitals with 100 beds or more;
- $25,000 to $51,570 for hospitals with less than 100 beds;
- $25,000 to $51,570 for physicians.

**Important Note:** OIG can assess a CMP for each EMTALA violation.
EMTALA Penalties

The ultimate EMTALA penalty is exclusion from the Medicare program.

Even though a rising number of providers come close to exclusion, exclusion sill remains a rarely used EMTALA penalty.
EMTALA: Penalties

Individuals suffering personal harm as a result of an EMTALA violation can bring a civil action against the offending hospital and physician.

Medical facilities suffering financial loss as a result of an EMTALA violation can bring a civil action against the offending hospital and physicians.

These types of actions must be filed within 2 years after the date of the alleged EMTALA violation.
General Advice For Ensuring EMTALA Compliance

Educate those integral to EMTALA compliance!

Provide care that is best for patients.

Document well care provided to patients.

Quickly respond to EMTALA concerns.
Any Questions?
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