EMTALA: Taking the high road

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Objectives

- Provide a better understanding of the background and definitions of EMTALA
- Provide a better understanding of how these regulations effect the practice of Emergency Medicine
- Provide a better understanding of the financial consequences of any EMTALA violations
- Keep you awake for the next 25 minutes!
Disclosures

- No financial disclosures
- I am not a lawyer
- My facility just underwent a state inspection for reported EMTALA violations
- In the world of law and compliance, there is often areas that are gray.
  - Require “interpretation”
Civil Courts vs. CMS

- Center for Medicare/Medicaid Services (CMS)
  - establishes regulation and interprets the statute for inspectors.
    - Provides guidance available to healthcare providers

- Civil Courts
  - Also hears cases and may make judgments in contradiction to CMS regulation/guidance.
## My Major Sources

### Emergency Department Compliance Manual, 2016 Edition

- **Contributor(s):** By Rusty McNew, Consulting Editor
- **Update Frequency:** Published annually
- **Last Update:** 03/21/2016
- **Product Line:** Wolters Kluwer Law & Business

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My Major Sources

- CMS Hospital COP and Interpretive Guidelines
  - 2016 update

- Includes:
  - Survey Protocols
  - Hospital Regulations and Interpretive Guidelines
  - EMTALA Regulations and Interpretive Guidelines
The CMS Conditions of Participation and Interpretive Guidelines

by na (Author)

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Find the CMS CoPs you need without the hassle!

Compliance with the Conditions of Participation (CoP) is required to meet Medicare and Medicaid hospital regulations. CMS makes updates to the CoPs on its website, but few have the time to sort through the plethora of information and identify where the updated information is located. CMS also doesn’t highlight the changes, making it even more difficult to find the CoPs you need.

This is where HCPro comes in! We have taken the most recent version of CMS’ CoPs and the

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Two essential resources combined into one publication
Navigating the CMS Web site to find accurate Medicare and Medicaid hospital regulations is a difficult and confusing task, and printing out hundreds of pages is costly and time-consuming. HCPro has taken the most recent version of CMS’ Conditions of Participation and the corresponding Interpretive Guidelines—including the new prescriptive guidelines for anesthesia services—and reprinted them in an easy-to-use format.

New in this edition:
- Now includes May 2010 update of Anesthesia Services Condition of Participation, which defines in detail who can administer and monitor various anesthesia services
- The most recent CMS Hospital Conditions of Participation (CoP) and Interpretive Guidelines (IG), released in June 2009
- The 2009 EMTALA regulations and corresponding Interpretive Guidelines
Growing concerns regarding “patient dumping” spurred Congress to pass new law

Issue was already addressed by Hill-Burton, ACEP Policy, and HCFA Policy

Emergency Medical Treatment and Active Labor Act

Part of the Consolidated Omnibus Reconciliation Act of 1985

Enacted initially in 1986

Modified in 1989

Was originally 4 pages long
Basic Requirements of EMTALA

- Provide appropriate medical screening examination (MSE) to the point of identifying or excluding an Emergency Medical Condition (EMC).

- Stabilize any EMC “according to the hospital’s capabilities”
  - Provide timely consultation, treatment, and hospitalization for the EMC within the “capacity” of the treating hospital and medical staff.
EMTALA Requires

- Appropriate transfer of unstable patients to a higher level of care (HLOC) if benefits outweigh the risks of transfer.
- Report known violations by hospitals and physicians receiving such transfers.
What is an EMC?

A “medical condition manifesting itself by acute symptoms (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- “place the health of patient in serious jeopardy”
- “serious impairment to bodily functions”
- “serious dysfunction of any bodily organ or part”
What does it mean to “stabilize”? 

- 42 CFR 489.24(b) “provide treatment necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility or that ...... (in case of a woman in labor) the woman has delivered the child and the placenta”
What does it mean to “stabilize”?  

CMS Guidance:  

- Transferred Patients:  
  “when the treating physician has determined with reasonable clinical confidence that the patient is expected to leave the hospital and be received at the second facility, with no material deterioration in his or her medical condition; and believes that the receiving facility has the capability to manage the patient’s medical condition and any reasonably foreseeable complications of that condition”
What does it mean to “stabilize”?  

CMS Guidance: 

- Discharged Patients: 
  - “when, within reasonable clinical confidence, it is determined that the patient has reached the point when his/her continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an inpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions”
Medical Screening Exam

- What is it?
- Evaluation conducted by a physician or QMP, using full capabilities of E.D. (including ancillary testing) to determine whether an EMC exists.
  - Should not be delayed or differ from other pts
  - Should be appropriate for presenting signs and sx
    - Same as other patients with same complaint or sx
  - Should be appropriate for capability of hospital
  - Is an “ongoing” process
Medical Screening Exam

Who can do it?

- Qualified Medical Personnel
  - Physicians
  - NPP/APC/APP*
  - RN??*

  Must be:
  - On site
  - Have training and experience in EM
  - Within scope of practice

*requires approval in hospital by-laws
Medical Screening Exam

- Where can this take place?
  - Emergency Department
  - Other contiguous department under same provider number.
    - MSE should be the same for all patients with similar sx
    - No discrimination based on payer or PCM
    - Must document reason for screening outside the E.D.
Is there any time a MSE can be deferred and the patient sent away?

- If an E.D. is located in an area of declared national emergency
  - Must be consistent with state emergency preparedness plan.
  - Limited to 72 hours after activation of plan or cessation of the public health emergency.
EMTALA Obligation of Consultants

- Must comply with request that Emergency Physician feels is appropriate
  - Phone call vs. bedside vs. APC coverage
  - Time to respond must be “reasonable”
    - Usually defined by Hospital P&P
- Must accept in-coming transfer request if patient has capacity
  - Bed available and have done it before
EMTALA Obligation of Consultants

If you have it and they need it, you give it or else you get “IT”

–former EMTALA CMS official
When does the EMTALA obligation end?

- “Qualified Individual” determines no EMC exists
- Stable for D/C
- Stable for transfer
- Patient is admitted (NOT placed in “obs” status)
- “Unstable” patient refuses transfer
- Patient dies
When is it OK to transfer a patient with an un-stabilized EMC?

1. Transfer conducted is “appropriate”
2. Patient or responsible party requests transfer in writing after being informed of risks and hospital’s obligations
3. A physician or QMP (in consultation with physician) certifies that the benefits gained by treatment at other facility outweigh risks of the transfer.

Physician must countersign if not physically present
Kansas hospital to lose Medicare funding over EMTALA violation

Newman Regional Health, a critical access hospital in Emporia, Kan., will lose its Medicare funding April 5, according to The Emporia Gazette.

Julie Brookhart, public affairs specialist for CMS’ Kansas City Regional Office, told The Emporia Gazette that CMS discovered Jan. 5 Newman Regional had violated the Emergency Medical Treatment and Active Labor Act.

Regarding the violation, Ms. Brookhart said, “The critical access hospital failed to arrange an appropriate transfer for a patient with an emergency medical condition that was not stable.”

Newman Regional was placed on the 90-day Medicare termination track as a result of the EMTALA violation, and the hospital subsequently submitted an action plan to address the issue.

If CMS determines the hospital is fully compliant with Medicare regulations before its April 5 termination date, the hospital may be permitted to continue billing for Medicare services, according to the report.

More articles on healthcare finance:
What is an “appropriate” transfer?

- Transferring hospital provides treatment within its capacity to minimize the risk to the patient (or unborn child).
- Receiving facility has space and personnel available and accepts the transfer.
- Transferring hospital sends copies of:
  - Medical records
  - Copy of certification of EMC and consent to transfer
  - Name of any specialist who refused to appear
- Transfer effected using QMP and equipment necessary to support life of patient.
What is an “appropriate” transfer?

- Certification of EMC or Memorandum of Transfer
  - Must specifically list risks and benefits of transfer of the patient
    - NOT acceptable:
      - “higher level of care”
      - “trauma center”
    - Ideal is long hand form (not check boxes)
      - “patient requires pediatric intensive care setting which is not available at this facility”
      - “patient requires a neurology consultation which is not available here”
  - Specific risks must be included as well
    - Deterioration of condition (including death)
    - Motor vehicle crash

- Must be signed by receiving physician once patient arrives
Wake up, Henry.
What are the potential penalties for EMTALA violations?

- $50,000 fine per violation
- Exclusion from Medicare/Medicaid Programs
- Recovery of costs by receiving hospital
- Private Cause of Action
  - Potential for court imposed injunction
- Trigger criminal investigation under Civil Rights Division of DHHS
Regulating Entities

- State Department of Health
  - Usually conducts ground investigation for CMS
  - Can issue finding related to state rules also
- Centers for Medicare & Medicaid Services
  - Investigate, cite, and terminate Medicare
  - Usually accept “corrective action plan”
- Office of Inspector General (OIG) of DHHS
  - Enforcement authority over physicians and hospitals who appeal CMS findings
Regulating Entities

- The Courts
  - Federal Administrative Courts
  - State or Federal Civil Courts
    - Fewer protections
      - No peer review protection
      - FOIA applies
    - Findings can be used in Med Mal cases
South Dakota hospital set to lose Medicare funding over EMTALA violations

Written by Ayla Ellison (Twitter | Google+) / May 23, 2016 / Print / Email

CMS has identified deficiencies at Indian Health Service Sioux San Hospital in Rapid City, S.D., which constitute an "immediate and serious threat" to the health and safety of patients.

During a survey of Sioux San Hospital May 9-12, CMS discovered the hospital was not in compliance with the Emergency Medical Treatment and Active Labor Act. Based on medical record review and interviews with patients, patient representatives and hospital staff, CMS determined the hospital failed to provide timely medical screening examinations that were sufficient to determine whether emergency medical conditions existed for nine of 32 patients who came to the ED for care.

In a May 23 letter, CMS warned Sioux San Hospital that its Medicare contract will be terminated June 15. To have the "immediate jeopardy" status removed, the hospital must submit a plan for correction by May 28, and CMS must revisit the facility prior to the proposed termination date. "Termination can only be averted by corrections of these violations by June 15, 2016," said CMS in its letter to the hospital.

The Indian Health Service said it will establish a corrective action plan by May 28 to allow CMS to determine compliance.
How frequently do EMTALA violations occur and penalties get assessed?

- WestJEM May 2016
- Reviewed all OIG settlements 2002-2015
  - Violations found in 2,436 of 6,035 investigations (40%)
  - Settlements occurred in 192 of the 2,436
  - Total of $6,357,000
    - $6,152,000 against hospitals (184 cases)
    - $205,000 against physicians (8 cases)
CMS EMTALA Website

- CMS has a website that lists resources on this issue
- It includes CMS guidance to state survey agency directors & CMS regional offices
- Includes information about Technical Advisory Group (TAG), complaint procedures, EMTALA survey & certification letters, transmittals, etc.
- Available at http://www.cms.gov/EMTALA/
EMTALA Jeopardy

- Hospital posts its “narcotic policy” prominently in the waiting room of its Emergency Department

- EMTALA Violation??
EMTALA Jeopardy

Hospital posts its “narcotic policy” prominently in the waiting room of its Emergency Department

► “Severe Pain” is an EMC 42 CFR 489.24 (b)

► “…it is a violation of EMTALA for hospitals and CAH with EDs to use signage that presents barriers to individuals who…..(have) come to the ED for examination or treatment of a medical condition”

► CMS Memorandum, November 21, 2014
► Atlanta Regional CMS office memo
While patient is being evaluated by triage nurse (taking vitals and doing an exam), the registrar requests the patient’s name, demographic information, and if they have any insurance coverage.

EMTALA Violation??
EMTALA Jeopardy

While patient is being evaluated by triage nurse (taking vitals and doing an exam), the registrar requests the patient’s name, demographic information, and if they have any insurance coverage.

- There is no violation for asking about payer source as long as it does not change or delay the care of the patient.
- A hospital cannot delay care for pre-authorization with a health plan
- Cannot provide different MSE based on payer

**may raise questions or allegations of disparate care**
EMTALA Jeopardy

Specialty (psych) Receiving Hospital:

“I do not have an E.D. so I refuse to accept your patient in transfer”

EMTALA Violation??
EMTALA Jeopardy

“I do not have an E.D. so I do not have to accept the patient” (ex. Specialty hospital)

Lack of an E.D. does not exempt a specialty hospital (ex. Psychiatric hospital) participating in Medicare from its EMTALA obligation to accept patients if it has the services requested and the capacity.
EMTALA Jeopardy

County EMS calls hospital to give report and nurse tells them, “we are packed to the gills here. Your will have to wait in the hall when you get here”. Ambulance diverts to another facility.

EMTALA Violation??
County EMS calls hospital to give report and nurse tells them, “we are packed to the gills here. Your will have to wait in the hall when you get here”. Ambulance diverts to another facility

Per CMS Regulations, patient has not “presented” to the hospital and is not a fineable violation.

However, 2 U.S. appellate courts have found hospitals in violation for this exact situation.

Morales v. Sociedad Espanola de Auxilio Mutuo y Beneficencia C.A.1 (Puerto Rico), 2008.]

*county owned ambulance also key*
(Interim Guidance Letter 2003)
Patient presents to E.D. for syncope. Found to have intermittent VT. Treated with anti-arrhythmic medication and rhythm stabilizes. Vitals are normal. Patient is transferred to your similar hospital for cardiology evaluation because his insurance is “out of network” for the sending hospital.

EMTALA Violation??
Patient presents to E.D. for syncope. Found to have non-sustained VT. Treated with anti-arrhythmic medication and rhythm stabilizes. Vitals are normal. Patient is transferred to a similar hospital because his insurance is “out of network” for your hospital.

If patient has been “stabilized” (per 42 CFR 489) then EMTALA would no longer apply and this transfer would not be a violation.

If patient decompensates during transport, physicians determination of “stable” will be questioned and a violation may be possible.