EMTALA Update 2015

Emergency Medical Treatment and Labor Act

Speaker

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Proposed Changes by the OIG

- The OIG has proposed changes to the EMTALA law
- This was posted in the FR on May 12, 2014
- There is a 60 comment period
- Discusses and clarifies many existing sections
- Does make a couple of important proposed changes
- Hospitals should be familiar with this document and watch for the final changes when they become available
Proposed Changes in Summary

- Clarify that on-call physicians at any participating hospital subject to EMTALA, including the hospital a patient initially presents to and the hospital with specialized capabilities or that has received a request to accept a transfer, face potential CMP and exclusion liability under EMTALA; and
- Revise the factors to clarify that aggravating circumstances include: a request for proof of insurance or payment prior to screening or treatment, patient harm, unnecessary risk of patient harm, premature discharge, or a need for additional services or subsequent hospital admission that resulted or could have resulted from the incident, and whether the individual presented with a medical condition that was an emergency medical.

Proposed EMTALA Changes


FEDERAL REGISTER

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Part III

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

My CMS-2000 Data and E-Logs Program, Fraud and Abuse, Revisions to the Rule of General Medical Civil Monetary Penalty Rules, Proposed Rule
Proposed EMTALA Changes

- Put the EMTALA authorities all in one section
- Removed outdated references to the pre-1991 knowing requirement
- Clarify the CMP may be assessed for each violation
- Clarified that all participation hospitals are subject to EMTALA
  - Including those hospitals with specialized capabilities

Proposed EMTALA Changes

- Proposed to revise responsible physician to clarify that the on-call physician at any participating hospital is subject to EMTALA
- Clarifies that this includes taking care of a patient when the hospital has received a request to accept an appropriate transfer
- Otherwise the physician can be excluded and face a fine
- Any physician, including on-call physician, who fails to exam, treat, or transfer a patient appropriately can be penalized

Proposed EMTALA Changes

- On-call physician who fails to appears within a reasonable amount of time or refuses to show up is subject to EMTALA liability
- This includes on-call physicians at the hospital where the patient appears and the other hospital that has specialized capabilities
  - ie refusing to accept an appropriate transfer
- CMS is modifying the definition of responsible physician to make it clear between the on-call physician at the hospital the patient presents and where they would send the patient
Proposed EMTALA Changes

- Wanted to clarify the OIG’s enforcement policy
- Lists factors that will be considered in making both CMP (civil monetary penalties) and exclusion criteria
  - Removed mitigating factors
  - See list of aggravating factors
  - OIG will consider if physician failed to follow EMTALA in the past
  - Violations involve a case by case inquiry
  - This would include if the hospital failed to screen the patient in a timely manner and they left

Access to Hospital Complaint Data

- CMS issued Survey and Certification memo on March 22, 2013 regarding access to hospital complaint data
- Includes acute care and CAH hospitals
  - Does not include the plan of correction but can request
  - Questions to bettercare@cms.hhs.com
- This is the CMS 2567 deficiency data and lists the tag numbers
  - Updated quarterly
    - Available under downloads on the hospital website at www.cms.gov

Access to Hospital Complaint Data

- There is a list that includes the hospital’s name and the different tag numbers that were found to be out of compliance
  - Many on restraints and seclusion, EMTALA, infection control, patient rights including consent, advance directives and grievances
  - Shows one of the most common deficiencies against hospitals is in the area of EMTALA with 696 citations March and 1140 Nov 2013 and 1275 Mar 2014 and 1325 April 21, 2014 and 1725 Nov 4, 2014
- Will you be prepared if a surveyor shows up tomorrow with an EMTALA complaint??
### Deficiencies

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<th>Apr 2014</th>
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### Deficiencies

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### CMS Region 4 and 5

- Posting signs regarding guidelines regarding narcotic policy might be considered to be coercive or intimidating to patients who present to the ED with painful medical conditions
- Therefore violating both the language and intent of the EMTALA statute and regulation
- Some patients with legitimate need for pain control might be unduly coerced to leave the ED before receiving an appropriate medical screening exam
- Consider removing the ED guidelines that may be posted in your ED although no prohibition against following SOC
Posters Regarding Prescribing Pain Medication

ACEP Now


ED Waiting Room Posters on Prescribing Pain Medications May Violate EMTALA

Statements from CMS region 4 effort could prove fatal for not having implications for ED

The Basic Concept of EMTALA

- Hospitals that participate in the Medicare program must provide a medical screening exam to determine if the patient is in an emergency medical condition (EMC) and if so must be provided stabilizing treatment or transfer

- Passed to prevent hospitals from denying care to anyone in an emergency, not just pregnant woman; and to prevent hospitals from transferring patients before they were adequately stabilized.

Other Emergency and Acute Care Facility

Opioids and Other Controlled Substances (OUDs) Prescribing Guidelines

These guidelines are intended to be in the best interests of the patient and the physician. They are intended to enhance the overall quality of care and to ensure that patients receive the best possible care. They are not intended to replace the judgment of the physician, who should always be the final arbiter of the best care for each patient. EMTALA, which should always be adhered to provide for appropriate treatment for the care of each patient.

- 1. The Basic Concept of EMTALA

- 2. The basic concept of EMTALA...
Original Case
- Case ignited blitz of national coverage
- Eugene Barnes, 32 YO male brought on 1-28-85 to Brookside Hospital ED
- Had penetrating stab wound to scalp and the neurosurgeon refused to come
- Called 3 other hospitals and refused to take
- Finally sent to San Francisco General four hours after arrival but patient died

Cases Congress Heard
- William Jenness taken to hospital in care after auto accident. Hospital asked for $1,000 deposit in advance before they would treat,
- He couldn’t pay so transferred to a county hospital,
- It took four hours before he reached the operating room,
- Six hours after the accident, he died,

Cases Congress Heard
- Anna Grant, in labor, went to a private hospital, and was kept in a wheelchair for 2 hours and 15 minutes
- Check only once and no test were done
- If any were done would have shown fetus to be in severe distress
- She was told to get herself to the county hospital
- Baby was still born at the county hospital
Cases in the News

- Patient waits in the emergency dept lobby for nearly two hours at Vista Medical Center East
- Patient had complained of chest pain (rated as 10 on scale of 1-10), nausea, and SOB
- Nurse went to get patient and she was leaning on her side unconscious with no pulse
- Lake county coroner rules that the death of Beatrice Vance was a homicide

Who are the Players?

- CMS or the Center for Medicare and Medicaid Services
- OIG is the Office of Inspector General
- QIO (Quality Improvement Organization)
- State survey agencies (abbreviated SA and an example is the Department of Health)
  - In Ky it is the OIG

History

- In 1985, Congress enacts EMTALA which became effective in August 1, 1986
- It has changed dramatically since the original law was enacted
- Called the “genesis of EMTALA”,
- Note the word “ACTIVE” is not part of the name anymore
- EMTALA or Emergency Medical Treatment and Labor Act
History

- Congress enacted EMTALA as part of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA, Section 9121)
- Initially referred to as “COBRA”
- More commonly called EMTALA
- Also known as the Patient Transfer Act or the “Anti-dumping Law (SSA, Section 1867)

CMS EMTALA Website

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

- Exam and treatment of women in labor
- Payment for EMTALA
- Final rule on EMTALA
- Interpretive Guidelines rewritten and issued May 29, 2009 with amendment on July 16, 2010
  - Amended Tag 2406 on waivers
- Provider agreement under SSA

Major Revisions May 29, 2009

Part II - Interpretive Guidelines - Responsibilities of Medicare Participating Hospitals in Emergency Cases

The Interpretive Guidelines are issued for hospitals where the regulation is broken into regulatory situations (Tag numbers), followed by the regulatory language and provide detailed interpretation of the regulations to surveyors.

Basic Section 1566 Commitments Relevant to Section 1567
Responsibilities - Tags: A-2400 C-2400...A-2405 C-2405
(Rev.4, Issued: 05-25-09, Effective implementation: 05-25-09)
Tag A-2400 C-2400
(Rev.4, Issued: 05-25-09, Effective implementation: 05-25-09)
§489.20(d)
(The provider agrees to the following)
1. In the case of a hospital as defined in §489.3(a) to comply with §489.24.

Location of CMS Hospital CoP Manuals

Medicare State Operations Manual
Appendix

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the SOM to display Text. Click on the red button in the "Download" column to see any available file in PDF.
- To return to this page after opening a PDF file on your desktop, use the browser's "Back" button. This is because closing the file usually will also close most browsers.

New Website

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<tr>
<th>App. No.</th>
<th>Description</th>
<th>PDF File</th>
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<tbody>
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<td>Psychiatric Hospitals</td>
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Current CMS EMTALA Manual

State Operations Manual
Appendix V -- Interpretive Guidelines -- Responsibilities of Medicare Participating Hospitals in Emergency Cases (Rev. Oct. 2010)

Transmittals for Appendix V

Part I - Investigative Procedures
1. General Information
2. Principal Persons Investigated
3. Task 1: Entrance Conference
4. Task 2: Case Selection Methodology
5. Task 3: Record Review
6. Task 4: Interviews
7. Task 5: Exit Conference
8. Task 6: Professional Medical Review
10. Additional Survey Report Documentation

Part II - Interpretive Guidelines -- Responsibilities of Medicare Participating Hospitals in Emergency Cases

EMTALA is Appendix V

<table>
<thead>
<tr>
<th>Appendix Letter</th>
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<tr>
<td>PP</td>
<td>Interpretive Guidelines for Long-Term Care Facilities</td>
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<tr>
<td>Q</td>
<td>Determining Inpatient Severity</td>
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<td>Responsibilities of Medicare Participating Religious Nonmedical Healthcare Institutions</td>
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CMS 3 Page EMTALA Summary Sheet

Certification and Compliance For The Emergency Medical Treatment and Labor Act (EMTALA)

The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals with emergency departments to provide a medical screening examination to any individual who comes to the emergency department and requests such an examination, and provides hospitals with emergency departments from refusing to examine or treat anyone who presents an emergency medical condition. The term "hospital" includes critical access hospitals.

The provisions of EMTALA apply to all individuals (not just Medicare beneficiaries) who attempt to gain access to a hospital for emergency care. The regulations define an "emergency medical condition" as a condition serious enough to make the absence of medical treatment potentially life-threatening or to cause serious impairment to the individual or the individual's health.

In turn, the regulations define "dedicated emergency department" as any department or facility of a hospital that either:

1. Is licensed by the state as an emergency department;
2. Hs access to the public as providing treatment for emergency medical conditions; or
3. Is one-third of the visits to the department in the preceding calendar year are provided treatment for emergency medical conditions on an urgent basis.

Hospitals with dedicated emergency departments are required to take the following steps:

This is a very important website

- Hospitals may want to have one person periodically check this, at least once a month
- This is where new interpretive guidelines are published
- This is where new EMTALA memos are posted

The CMS Survey and Certification Website

- Click on policy and memos to states and regions
EMTALA and Ebola

- CMS issues 4 page survey memo on November 21, 2014 and questions at hospitalSCG@cms.hhs.gov
- Every hospital, including CAHs, with a DED, must conduct an appropriate MSE on all patients coming to the ED
- This includes patients suspected of having been exposed to Ebola
- All EDs are expected to be able to apply appropriate Ebola screening
- And if necessary to isolate and notify state agency

EMTALA and Ebola

- If patient has Ebola then must follow current guidelines
- If any complaints, CMS will take into consideration the public health guidance in effect at the time
- Hospitals are encouraged to monitor the CDC’s website for the current guidance and information
- CMS has received a number of inquiries from hospitals regarding their EMTALA obligations
- EMS or public health protocols may develop community wide protocols for bringing patients only to specified hospitals if suspected of having Ebola

CMS Memo Q&A Ebola

- CMS Issues 13 page FAQ memo on Feb 13, 2015
- CMS issued after receiving many questions on this topic
- Hospitals with specialized capabilities should accept appropriate transfers if they have capacity to provide care including those with Ebola
- The states are formally identifying hospitals that are qualified as a EVD treatment facility
- CDC’s 3 tiered system does not violate EMTALA: frontline healthcare facility, Ebola assessment hospital and Ebola treatment hospital
- Questions can be addressed to hospitalSCG@cms.hhs.gov
ENA and Ebola

- ENA has many resources available
- Discusses how we triage patients
  - Determine if the patient has a fever
  - Ask patients about travel to Ebola effected area in the last 21 days
  - If yes isolate until further screening is done
- Discusses how to don and doff PPE
  - Use a buddy system to make sure equipment is put on and taken off correctly
- Guidelines on how to transport patients
ENA Website on Ebola Resources

- Ebola News and Resources
  - ENA Website on Ebola Resources
  - General Information and Disease Transmission
  - ACEP Resources on Ebola

- ACEP Resources on Ebola
  - Healthcare Resources for Suspected Ebola Cases
  - ACEP Ebolavirus Panel Members
Identify, Isolate, Inform

CDC ED Evaluation

CDC Resources on Ebola
OSHA Resources on Ebola

Introduction

OSHA Resources on Ebola

www.osha.gov/SLTC/ebola/
CMS Also Issues Memo October 10, 2014

CMS S&C Memo  EMTALA & CAH

EMTALA, CAH & Telemedicine

• CMS welcomes the use of telemedicine by CAH
• CAH not required to have a doctor to appear when patient comes to the ED
• PA, NP, CNS, or physician with emergency care experience must show up within 30 minutes
• If MD/DO does not show up must be immediately available by phone or radio contact 24 hours a day
• This can be met by use of telemedicine physician or the physician on site
CMS Memo Dec 13, 2013

- CMS issues 7 page memo dated Dec 13, 2013 regarding payor requirements and collection practices
- These are covered throughout this program but every hospital should be familiar with this memo
- EMTALA is a federal law and pre-empts any inconsistent state law
- Some proposed or existing payment policies of third party payors of hospital services are in violation of the federal EMTALA law

Hospital cannot request payment or co-pays until after an appropriate medical screening exam (MSE) is done and they have initiated stabilization treatment

The ACA provided several provisions requiring certain insurers to cover emergency services, including stabilization, with preauthorization

Some have asked CMS to intervene if they believe a state Medicaid policy conflicts with EMTALA

CMS will only approve ones that do not conflict with EMTALA
There are two important Office of Inspector General Advisory Opinion related to EMTALA

Issued September 20, 2007, No. 07-10 (also issued second one, No. 09-05 on May 21, 2009)

OIG agrees not to prosecute a hospital for paying for certain on call services for on call physicians

Physicians agree to take call rotation on even basis,


Physicians are paid a rate for each day on call

18 days a year are gratis

Rate based on specialty and whether coverage is weekday or weekend, likelihood to be called, severity of illness, degree of inpatient care required

Rates provided at fair market value

Program open to all
OIG Opinion 2009 No 09-05

- Second one was concerning a 400 bed non profit general hospital and only provider in that county area for acute care services
- Had many times where no one on call and had to transfer patients out
- Proposed to allow on-call doctors to submit claims for services rendered to indigent and uninsured patients presenting to the ED
- Signed an agreement that this was payment in full and would show up in 30 minutes

OIG Opinion 2009 No 09-05

- Got $100 for ED consultation, $300 per admission, $350 for primary surgeon and for physician doing an endoscopic procedure
- OIG allowed finding it did not include any of the four problematic compensation structures and presented a low risk of fraud and abuse
- Payments were fair market value and without regard to referrals or other business generated by the parties

Paying for On-Call Physicians

- Arrangement does not take into account and the value or volume of past or future referrals
- Each and every arrangement has to be based on the totality of its facts and circumstances
- Safe harbor for personal services used (contract, over one year) but does not fit squarely since aggregate amount can not be set in advance
- Arrangement in this case presents low risk of fraud and abuse
Paying for On-call Services

- Bottom line is that hospitals should be aware of the OIG advisory opinions
- Hospitals should have a process to support the rationale for paying physicians for on-call services
- Hospitals should be able to justify the reasonableness of the amount of the payments
- Try and get the on-call payment arrangements to fit within the fraud and abuse laws to satisfy the OIG

OIG Compliance Program Guidance for Hospitals

- Department of HHS, OIG, issued "Supplemental Compliance Program Guidance (CPG) for Hospitals issued January 2005"
- Available at http://oig.hhs.gov/fraud/complianceguidance.asp
- OIG promotes voluntary compliance programs for hospitals
- This document contained a section on EMTALA

[Partial text not visible]
EMTALA OIG CPG for Hospitals

- Hospitals should review their obligations under this federal law
- Know when to do a medical screening exam
- Know when patient has an emergency medical condition
- Know screening can not be delayed to inquire about method of payment or insurance

EMTALA OIG CPG for Hospitals

- Even if on diversion and patient shows up-they are yours
- Do not transfer a patient unless there is a transfer agreement for unstable patients with benefits and risks
- Provide stabilizing treatment to minimize the risks of transfer
- Medical records must accompany the patient
- Understand specialized capability provision

EMTALA OIG

- Must provide screening and treatment within full capability of hospital including staff and facilities
  - Includes on call specialist
- **On call physicians** need to be educated on their responsibilities including responsibility to accept transferred individuals from other facilities
- Must have policies and procedures
- Persons working in the ED should be periodically trained and reminded of EMTALA obligations and hospital’s P&P
Medicare State Operations Manual

- CMS issued Appendix Q on Guidelines for Immediate Jeopardy on February 14, 2014
- These guidelines for CMS surveyors contain an EMTALA trigger
- These apply to all facilities that receive Medicare/Medicaid reimbursement including Critical Access Hospitals

Location of EMTALA Manual  App V

State Operations Manual
Appendix Q - Guidelines for Determining Immediate Jeopardy
(Rev. 10/1, round: 02/11/10)

Transmittals for Appendix Q
1. Introduction
2. Definitions
3. Principles
4. Immediate Jeopardy Triggers
5. Procedures
6. Implementation
7. Documentation
8. Enforcement
9. Penalties

Attachment A
483(l): Requirements: Abuse
483.24: Condition: Physical Environment
483.24: Standard: Safety of Patients
483.24: Standard: Maintenance of Patient Rights: Privacy

Guidelines for Determining Immediate Jeopardy

- This includes failure to perform medical screening exam as required by EMTALA or to stabilize or provide safe transfer
- Individual turned away from the emergency department (ED) without a medical screening exam
- Women with contractions not medically screened for status of labor

CMS Guidelines for Determining Immediate Jeopardy

- Absence of ED or OB medical screening documentation
- Failure to stabilize emergency medical condition
- Failure to appropriately transfer an individual with an unstable medical condition

TJC Standards

- RC.02.01.01 Medical record must contain emergency care and treatment
- The time and means of arrival to the ED
- If the patient left AMA
- All orders, progress notes, medication given, informed consent, use of interpreters, adverse drug reactions
- Records of communication with patients including telephone calls such as abnormal test results from the ED
TJC EMTALA Standards

- Summarize care provided in the ED and emergency treatment prior to arrival
- RC.02.01.01 Conclusion reached at the termination of care in the ED
  - The patient's final disposition
  - Condition
  - Instructions given for follow-up care, treatment, and services

CMS Regional Offices (RO)

- The RO evaluates all complaints and refers that warrant SA investigation (state agency)
- SA or RO send a letter to complainant acknowledging and letting person know if investigation is warranted
- Look to see if violation of the Provider agreement or related Special responsibilities in emergency cases
- CFR electronically available free of charge at

Electronic Code of Federal Regulations

- e-CFR

Regional Offices

- There are 10 regional offices (ROs)
- See list at end of addresses of all ROs
- RO gives initial verbal authorization for investigation
- Then prepares Form for Request for Survey (1541A)

### Request for Survey Form

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<td>Name and address of Hospital</td>
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<td>3.</td>
<td>Provider Number</td>
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<td>4.</td>
<td>RO Complaint Control Number</td>
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<td>Hospital Accredited By:</td>
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<td></td>
<td>○ ACHD  ○ ACA  ○ Nonaccredited</td>
</tr>
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**DO NOT INFORM THE HOSPITAL OF THE SURVEY**

5. **In Complaint Cases, Type of Emergency (check all that apply):**
   - Local
   - Other
   - Medical
   - Trauma
   - Psychiatric
   - Surgical
   - Other

6. **Source of Complaint (check all that apply):**
   - Patient or Patient's Family
   - Quality Improvement Organization
   - Receiving Hospital
   - Medicare Intermediary
   - Transferring Hospital
   - Other (specify)

Regional Office

- RO also sends hospital Form 562 Medicare/CLIA Complaint Form (determine allegation, whether finding substantiated or not, number of complainants per allegation, source of complaint, date received etc.),
- May complete FORM 2802 Request for validation of accreditation survey for hospital (accredited by TJC, DNV Healthcare, CIHQ, AAHHS, or AOA, areas surveyed, conditions (governing board, patient rights, pharmacy) or standards
- State Agency does not notify hospital in advance
Introduction to EMTALA

- EMTALA is a CoP (Condition of Participation) in the Medicare program for hospitals and critical access hospitals
- Hospitals agree to comply with the provisions by accepting Medicare payments
- Hospitals should maintain a copy of these interpretative guidelines (the most important resource) on their intranet and have a hard copy
- Recommend hospitals have a resource book on EMTALA in ED, OB, and behavioral health units

CMS EMTALA Interpretive Guideline

- First, the regulation is published in the federal register
- Next, CMS take and adds interpretive guidelines and survey procedure
- Not all sections have a survey procedure

Interpretive Guidelines

- Each section has a tag number
- To read more about any section go to the tag number such as A-2403/C-2403
- A indicates a hospital standard and C is for Critical Access Hospitals
- 68 pages long and starts with Tag 2400 and goes to Tag to 2411
- First part is the investigative procedures and includes entrance, record review, exit conference etc.
Interpretive Guidelines

- Part II is the section on responsibilities of Medicare Participating Hospitals in Emergency Cases
- Includes on-call physician requirements
- Includes use of dedicated emergency departments (DEDs)
- Includes stabilization and transfer requirements

Completely Rewritten in 2009 & Updated 2010

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

Transmittal for Appendix V

Part I - Investigative Procedures

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

Current CMS EMTALA Manual

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

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IX. Task 7 - Assessment of Compliance and Completion of the Deficiency Report
X. Additional Survey Report Documentation

Part II - Interpretive Guidelines – Responsibilities of Medicare
EMTALA Sources of Law

- Special Responsibilities of Medicare Hospitals in Emergency Cases EMTALA is located at 42 C.F.R. 489.24
- Federal Register and CFR are available free off internet at http://www.gpoaccess.gov/fr/index.html
- Available at http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=d07ae216364918701edc2b46eb3f1419c&rgn=div8&view=text&node=42:4.0.1.5.27.2.212.5&idno=42

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- http://listserv.access.gpo.gov/cgi-bin/wa.exe?SUBED1=FEDREGTOC-L&A=1
Two Other Important Laws

- There are also two other important laws that address EMTALA issues
- First is the Basic Commitment Section 1866 which is Agreement with Providers (42 U.S.C. 1395cc) which is relevant to the second one
- Also referred to the Essential of Provider Agreement
- Second is section 1867 (42 U.S.C. 1395dd) on Examination and Treatment for an Emergency Medical Condition (EMC)

Can Get eCFR Free Off Website

- Can get eCFR free off website

Basic Section 2400

- Defines hospital to include CAH so all hospitals are governed by EMTALA
- Requires that a medical screening exam (MSE) be given to any patient who comes to the ED
- Requires that any patient with an EMC or in labor be provided necessary stabilizing treatment
- Requires hospital to provide an appropriate transfer such as when patient requests or hospital does not have the capability or capacity to provide the necessary treatment
Essentials of Provider Agreement

- Basic Commitment Requires the following:
- To maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition
- Must maintain medical records for five years from date of transfer

Provider Agreement

- To post conspicuously in any emergency department, a sign specifying the rights of individuals with respect to exam and treatment for EMC and for women in labor
- Sign must be specified by the secretary
- Sign must say if you participate or not in Medicaid program
- Note that more information on EMTALA sign in section 2402
- Make sure sign is clearly visible from a distance of 20 feet so at least 18" by 20" unless in posted in small room
IT'S THE LAW

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

- An appropriate Medical SCREENING EXAMINATION
- Necessary STABILIZING TREATMENT (including treatment for an unborn child) and, if necessary, An appropriate TRANSFER to another facility
- Even if YOU CANNOT PAY or DO NOT HAVE MEDICAL INSURANCE or YOU ARE NOT ENTITLED TO MEDICARE OR MEDICAID

This hospital (DOES/DOES NOT) participate in the Medicaid Program

EN CASOS DE EMERGENCIA MÉDICA O DOLORES DE PARTO, USTED TIENE EL DERECHO DE RECIBIR LOS SIGUIENTES SERVICIOS, de acuerdo a las capacidades de los empleados del hospital y sus facilidades:

- Un EXAMEN MÉDICO apropiado,
- Un TRATAMIENTO NECESARIO de urgencia (incluyendo el tratamiento para el bebe antes de nacer), y si es necesario,
- Un TRANSFERIMENTO apropiado a otro hospital, aunque usted no pueda pagar o no tenga un seguro médico o no tenga derechos a Medicare o Medicaid.

- Este hospital □ participa / □ no participa en Medicaid.

Required by § 1866(a)(2)(B) of the Federal Social Security Act

Who Does EMTALA Apply To?

- Applies to hospitals who participate in the Medicare
- EMTALA is a condition of participation (CoP) just like the hospital and critical access CoPs
- Is not limited to Medicare patients and includes any individual who comes to the ED requesting care
Who Does EMTALA Apply To?

- If no verbal request is made it would include if a reasonable prudent layperson observer would conclude they need emergency care (not breathing)
- That present themselves to an area of the hospital that meets the definition of dedicated emergency department of DED
- There are three criteria to what constitutes a DED

Who Does EMTALA Apply To?

- Dedicated ED includes if licensed by state as ED, holds itself out to public as providing emergency care, or during preceding calendar year, provided at least 1/3 of its outpatient visits for treatment of EMC
- Example hospital has an emergency department (ED), or trauma center
- It covers all individuals regardless of payment source

Who Does EMTALA Apply To?

- Does not cover people on the phone
- It does covers patients in a car at the ED doors trying to access the ED
- It covers patients anywhere on hospital property seeking emergency care, for example they come in the wrong entrance to the hospital and are looking for the ED
- Covers non-citizens of the US and minors
No Delay in Exam or Treatment 2400

- Hospital may not delay an appropriate MSE to inquire about the individual’s method of payment or insurance status
- CMS and OIG issue a special advisory bulletin on November 10, 1999 (Fed Reg. Volume 64, No. 217, 61353) which is still relevant today
- Every hospital should read this to understand how to meet compliance with this section

Special OIG/CMS Advisory

[Image]

Payment Issues 2400 and 2408

- The hospital can obtain basic information such as name, chief complaint, and physician
- The hospital may seek authorization for payment and services after the medical screening examination and once patient is stabilized
- Hospitals can not condition screening and treatment upon completion of a financial responsibility form or provision of co-pay for the services
- Consider bed side registration when beds are open
Payment Issues

- Hospitals can not delay a medical screening exam or stabilizing treatment to prepare an ABN (advance beneficiary notice) and obtain a beneficiary signature on this form (also 2408)
- Can collect registration information if no delay such patient is triaged and there is no bed is available but need to document to create a clear record
- The obligation to pay for emergency services under Medicare managed care contracts is based on the “prudent layperson standard”

Payment Issues

- Hospital can ask for an insurance card as long as does not delay treatment (2406)
- Hospital can ask for medical information when needed from a health plan but not payment information
- Again, once the patient is stabilized the hospital can get insurance information or authorization from an insurance plan

Reasonable Registration Processes

- Hospitals can follow reasonable registration processes
- This may include asking if individual is insured as long as does not delay screening or treatment
- Can collect demographic information and who to contact in case of an emergency
- No prior authorization from managed care
Receiving Hospital  2408
- This applies equally to the receiving hospital
- Hospital with specialized capability has bed and staff and must accept patient
- Can not delay transfer of an unstable patient pending receipt or verification of financial information

Financial Questions from Patient
- This person must be knowledgeable about EMTALA
- This person should tell the patient that the hospital stands willing and ready to provide a MSE and stabilization
- Staff should encourage the patient to defer further discussion of financial responsibility under stabilized
- Do not give ABNs (advanced beneficiary notices) to ED patients upon arrival

Whistle-Blower Protection  2400 and 2410
- Hospital may not penalize or take adverse action against a MD or qualified medical personnel (QMP) for refusing to authorize transfer of an individual with an EMC that has not been stabilized
- Can not penalize a hospital employee who reports a suspected violation
Patients Who Want to Sign Out AMA

- The physician should obtain a written informed refusal of the examination or treatment (2407)
- This includes getting a written refusal for an appropriate transfer (2407, 2408)
- Remember that CMS provides the patient the right to refuse treatment
- Can refuse a part of the treatment without signing out AMA

Patients Who Want to Sign Out AMA

- There are 3 steps to patients who want to leave AMA
- Offer the patient further medical exam and treatment
- Inform of risks and benefits of withdrawal prior to receiving this care
- Take reasonable steps to secure written informed consent for refusal

AMA Documentation

- The medical record should include a description of the risks discussed
- If the patient leaves without notifying anyone, document the fact the patient was there, what time they discovered she left while retaining all triage notes
- Source: OIG/CMS Advisory Bulletin and Tag 2407
**Against Medical Advice**

- CMS says the hospital will be found in violation of EMTALA for patient who leaves AMA or LWBS (Tag 2406)
- If the individual left at the suggestion by the hospital
- If the condition was an emergency, and the hospital was operating beyond its capacity, and did not attempt to transfer the patient
- There must be no coercion or suggestion

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**Specialized Capability 2400**

- Medicare hospital are required to accept appropriate transfers of individuals with EMCs if the hospital has the specialized capabilities
- This is when the sending or transferring hospital does not have the specialized capabilities
- The receiving hospital must also have the “capacity”

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**Specialized Capability**

- The receiving hospital has a burn unit or trauma unit and the sending hospital does not
- Does the receiving hospital have an open bed and staff to care for the transfer?
- The receiving hospital does not have to accept a patient if it does not have the capacity to stabilize the person
- An example is hospital wants to transfer a suicidal patient but the hospital does not have a behavioral unit either or an obstetrical unit for the transfer of a pregnant patient
Capacity

- Capacity means the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual
- Capacity encompasses such things as numbers and availability of qualified staff, beds and equipment
- The hospital's past practices of accommodating additional patients in excess of its occupancy limits

Capacity

- Redefined by CMS in November 2001 memo
- So test is not if the hospital has ever done it before but rather whatever a hospital customarily does to accommodate patients in excess of its occupancy limits
- This is a lower standard of care

Policies and Procedures Required 2400

- Hospitals are required to adopt an EMTALA policy
- Policy needs to comply with all the EMTALA requirements
- Hospitals should consider EMTALA training during orientation and periodically
- Remember OIG Guidance that recommends training of all on-call physicians
Hospitals who are noncompliant can have CMS terminate them from the Medicare program (no more payment for Medicare patients)

The OIG can impose fines

The civil money penalties are $50,000 if over 100 beds, $25,000 if under 100 beds, and $50,000 fine per violation for physicians
Penalties

- Exclusion of physician from any federal program if violation is gross and flagrant.
- Malpractice suit under laws of the state in which hospital is located
- The statute of limitation or time period for bring a suit under EMTALA is 2 years after date of violation
- Some medical boards and nursing boards may attempt to revoke licenses

OIG Patient Dumping

http://oig.hhs.gov/fraud/enforcement/cmp/patient_dumping.asp

EMTALA Money Penalties

- The OIG has a patient dumping website of multiple payments of physicians and hospitals.
  - 6-14-2010 University of Chicago $50,000 failure to do MSE and stabilize patients include failure to log in ambulance patients. Patient left in ED waiting area for 3 hours and found dead
  - 10-18-2013 Regional Hospital in Tenn. pays $50,000 for failure to do MSE to a patient who was refused access to the ED and told to go to a nearby hospital
  - 9-3-2013 NE Georgia MC pays $50,000 after it allegedly refused to accept an appropriate transfer who need specialized capabilities
- See additional hospitals fined for requesting payment up front
### EMTALA Money Penalties

- **11-17-2014** S Carolina Trident pays 40,000 for allegation it failed to stabilize 58 YO prisoner who had no trespass order on him

- **10-30-2014** DCH Regional MC in Alabama pays 40,000 after allegations failed to do MSE and stabilize GSW to abdomen when on call surgeon said was doing elective surgery and performed seconded elective one without evaluating the patient who died

- **9-3-2014** Springfield Hospital pays 50,000 after allegation did not do appropriate MSE

- **12-4-2013** Carolina Medical Center paid $50,000 to resolve allegation they failed to do an appropriate MSE or stabilizing treatment for a patient who needed psychiatric treatment

- **10-8-2013** Regional Medical Center in Memphis paid $50,000 regarding an allegation that a patient was refused access to the ED and told to go to a nearby hospital

- **9-03-2013** NE Georgia MC paid $50,000 regarding allegation failed to accept transfer of a patient who needed their specialized capabilities

- **August 1, 2013** Finley Hospital Iowa pays $30,000 when it delayed stabilizing treatment to a patient when transferred to another hospital

- **August 7, 2013** St Lukes Iowa pays $25,000 when allegedly failed to provide a MSE by transferring the patient to another facility based on his status as an IowaCare patient

- **July 24, 2013** Mahaska in Iowa paid $20,000 after allegations of failure to do MSE, stabilize and provide transfer to patient

- **May 1, 2010** Bessemer Carraway MC $40,000 incomplete MSE for patient with fever and chills and UTI symptoms. Triage nurse told patient to pay $85. before MSE and she left

- **4-27-2010** Olive View UCLA Medical Center $25,000 settlement after 33 YO with chest pain waited over 3 hours to receive a MSE and died exiting the hospital
EMTALA Money Penalties

- 11-13-2012 University of Chicago Medical Center pays 50,000 for care of man who came to ED complaining of severe jaw pain after assault. He needed surgery and discharged with instructions to go to another hospital for further care.
- 11-19-2012 Hackly Hospital Michigan failure to stabilize woman in labor and unborn child.
- 9-5-2012 Duke University pays 180,000 for failure to accept five transfers of psychiatric patients.
- Many cases in 2012 on OIG website- Nashville Hospital 12-20-11 $45,000 refused to accept transfer.
EMTALA Money Penalties

11-15-2011 Hospital in Michigan agrees to pay $20,000 for failure to stabilize a 15 year male who came in for treatment of medical and psychiatric emergencies.

The patient presented after a suicide attempt and he also had hypotension and an abnormal heart rhythm and transferred to facility 169 miles away.

10-04-2011 Georgia hospital pays $50,000 for failure to do a MSE and stabilization to a patient with a DVT diagnosis by family doctor. Waited 8 hours without success and left and had PE at another hospital.

EMTALA Money Penalties

9-29-09 Kaiser Foundation Hospital paid $100,000 for 2 violations failure to provide MSE and stabilize. Had 15 YO doubled over with pain and crying and discharged her and 12 YO boy with fever, pain and lethargy sent home and came back with staph sepsis.

9-10-10 Robert Wood Johnson Hospital in NJ paid $65,000 failed to provide MSE and stabilization to mom and newborn.

6-4-10 Palms West Hospital in Fla paid $55,000 for failure to accept two patients in need of specialized capabilities.

EMTALA Money Penalties

6-2-09 Plantation General Hospital in Fla paid $40,000 for failure to stabilize women in active labor. A friend drove her at high speed to the hospital where she delivered minutes after arrival.

3-06-09 Medical Center pays $40,000 after failed to screen patient with severe abdominal pain from an ectopic pregnancy.

2-25-09 Physician pays $35,000 for failure to come to the ED in patient with an open leg fracture.
Report of Dumping to CMS  2401

- The hospital must report to the Department of Health or CMS
- Anytime it has reason to believe that may have received a patient who was transferred in an unstable medical condition
- Hospital is required to report within 72 hours of the occurrence
- If the receiving hospital fails to report then it can also lose its Medicare reimbursement

Report of Dumping

- Hospitals may want to consider notifying other hospital of the breach before reporting to see if they have an appropriate explanation
- Surveyors will look to see if hospital agreed in advance to the transfer and medical records were sent with the patient
- Surveyors will make sure all transports were with appropriate staff and equipment
- Surveyors will make sure hospital had space and qualified personnel to treat the patient

Hospital Recommendations

- Paramedic brings patient to hospital A who is actually on diversion but squad did not call in
- Paramedic on arrival sees how busy the ED is and tells charge nurse he will take patient to the hospital across the street
- Charge nurse agrees
- This is an EMTALA violation and Hospital B informs Hospital A that they are required to report to CMS
Hospital Recommendations

- Hospital B concurs about the EMTALA violation
- Hospital B immediately does a comprehensive plan of correction
- The physicians and Board is involved, mandatory education instituted, and new processes put in place
- CMS arrives at hospital and finds that there were out of compliance but have already resolved the problem

EMTALA Sign 2402

- Sign must be posted in any ED or in a place or places likely to be noticed by all individuals entering the emergency department
- As well as those individuals waiting for examination and treatment in areas other than traditional emergency department
  - This would include entrance, admitting area, waiting room, and treatment area
- Note may want to post in OB, Psych, urgent care units, registration, intake areas, and walk in clinics
- See section 2400 with copy of sign as required by the Secretary of Health and Human Services

Retention of Medical Records 2403

- Medical records related to the patients transferred must be kept for five years
- This date is from the date of transfer
- Medical records can be kept in hard copy, microfilm, optical disc, computer memory or any other legally producible form
On Call Physician Issues

January 17, 2008 study found 75% of hospital EDs do not have enough specialists to treat patients, especially cardiac and neurological problems.

Strategies include:
- Enforcing hospital medical staff bylaws that require physicians to take call
- Contracting with physicians to provide coverage
- Paying physicians stipends and employing physicians
  - Study “Hospital emergency on-call coverage: Is there a doctor in the house?” Center for Studying Health System Change, http://www.hschange.com/CONTENT/956/

On Call Physicians

- 21% of deaths and permanent injuries related to ED delays due to lack of physician specialists
- National survey that 36% of hospitals pay at least one specialist to be on call, most often a surgeon
- Little Rock hospital pays trauma surgeon $1,000 a night to be on call
- Miami hospital reports paying $10 million a year for on call emergency coverage
- ACEP report cited the 2008 report
  - ACEP has practice position on EMTALA also at http://www.acep.org
### OIG CPG for Hospitals
- Remember the Department of HHS, OIG, issued “Supplemental Compliance Program Guidance (CPG) for Hospitals, January 2005 report discussed earlier
- On call physicians need to be educated on their responsibilities including responsibility to accept transferred individuals from other facilities

### On Call Physician Issues
- So what do you do to educate your on call physicians?
- Is education mandatory as a condition for being credentialed and privileged?
- Hospitals can make it simple
- Hospitals can have supplemental materials such as videotape, self assessment learning guide, or educational CD
- Sample education memo at end

### On Call Physician Issues
- Some on call physicians should receive orientation to the hospital’s P&P on EMTALA
- For example, emergency department physicians need to be well versed on the federal EMTALA law
  - Also OB and psychiatrists
- Remember the OIG can assess money damages or exclude physicians from the Medicare program if they violate EMTALA
On-Call Physicians 2404

- There were many changes to the EMTALA regulations in 2009 IPPS that significantly impact EMTALA’s on-call obligations
- Referred to as the shared/community call
- Page 222 of 651 page FR PDF format (73 FR 48434), CMS issues memo on same March, 2009 and now Tag number 2404 in June 2009 edition
- Implemented some of the 55 recommendations from the EMTALA Technical Advisory Group that concluded its work in 2007

Final Rule Changes

- Moved the physician on call requirements from the EMTALA regulation section (§ 489.24(j)(1)) to the provider agreement regulations (§ 489.20(r)(2))
- CMS backed off a plan to expand EMTALA to hospitals that receive transferred patients
- CMS said a hospital with specialized capabilities is not required under EMTALA to accept the transfer of a hospital inpatient
- Would still have to accept an unstable patient in the ED if the hospital has specialized capabilities
Final Rule Revision

- Revised the EMTALA regulations, section on on-call obligations, emergency waivers, and recipient hospital responsibilities
- "Community Call" program that would allow hospitals to work together to satisfy their EMTALA obligations
- The Community Call requirements include a written agreement that addresses key critical points
- Requires a written P&P

On-Call List 2404

- The new language reads as follows;
- An on-call list of physicians on its medical staff, who are on staff and have privileges
- At the hospital or another hospital in a formal community call plan
- Are available to provide treatment necessary after the initial examination to stabilize individuals with EMCs
- Who are receiving services required in accordance with the resources available to the hospital

Shared/Community Call

- The hospitals work out a plan and put it in writing such as one doctor could be on call for both hospitals
- Or EMS takes OB patients to Hospital A for first 15 days of the month and to Hospital B for the second 15 days of the month
- Hospital A is designated as the stroke hospital and all patients go there or on call for neurosurgery cases
### Shared/Community Call

- Need to make sure that EMS is aware of the protocol as part of annual plan
- EMS needs to know so they know where to take the patient
- Must include statement in your plan that if patient shows up at hospital not designated today that hospital must still meet EMTALA obligations.
- Annual assessment of community call plan must be done
- Questions should be addressed to Tzvi Hefner at 410 786-4487 or tzvi.hefner@cms.hhs.gov.

### Shared/Community Call

- Hospital needs back up plan when on call physician is not available due to community call (calling in another physician, back up call, use of telemedicine, transfer agreement and send patient to another hospital)
- CMS has removed the italicized part of the sentence below since this phase has caused confusion.
  - There was a statement that hospitals needed to manage a list of their on-call physicians in a manner that best meets the needs of the hospital’s patients

### Shared/Community Call

- If on call physician refuses or fails to show up physician and hospital still responsible
- Physicians can do elective surgery while on call or be simultaneously on call if permitted by the hospital
- Plan needs to specify what geographic area it covers like the city of Columbus or Franklin County
- Person from each hospital has to sign the written plan
Shared/Community Call
- Has to be a formal plan and in writing
- Does not have to be submitted to CMS but CMS may come in and look at the plan
- If paramedics bring patient to your hospital, you still have to see them and do MSE to determine if the patient is in an emergency medical condition
- Still have to keep written copy of list of which doctors are on call and include physicians on call at the other facility

On-Call Requirements 2404
- Hospital must maintain a list of physicians who are on-call
- The hospital has to keep the list of physicians who are on-call to provide necessary treatment to stabilize a patient in an EMC
- This is in the general provider agreement previously discussed
- This on-call requirement applies to hospitals without an ED if they have specialized capabilities
- ACEP has positions statements on EMTALA

ACEP has positions statements on EMTALA
www.acep.org
ACEP On-Call Physicians

- Staff must be aware of who is on-call including specialists and sub-specialists
- The on-call list must be composed of physicians who are members of the MS and who have hospital privileges
- If hospital participated in community call must include the names of the physicians pursuant to this plan
- Hospitals need to provide sufficient on-call physicians to meet the needs of the community
On-Call Requirements 2404

- The plan for community call must clearly articulate which on-call services will be provided and when
- CCP does not always mean that the physician must come to the other hospital as the patient can be transferred (example stroke center)
- Consider which is best approach for the patient if physician has privileges at both hospitals
- Sending hospital must still conduct MSE and stabilize within its capability and capacity if the patient an EMC

On-Call Requirements 2404

- Hospitals participating in CCP must still accept appropriate transfers from hospitals not participating in the plan
- All Medicare participating hospitals must fulfill their EMTALA obligation whether participating in a CCP or not
- EMTALA does not apply to pre-hospital setting or paramedics in the field but good to educate them on this
- Updates to the CCP plan must be communicated to EMS providers so they include the information in their protocols

Simultaneous Call 2404

- Hospitals can permit physicians if they want to be on call at two or more facilities
- Hospitals have to be aware and agree to this
- Hospitals must have a P&P on this
- Staff will follow the written P&P if on-call is not available when called to another hospital
- Back up plan might be to transfer the patient to the next appropriate hospital
Scheduled Elective Surgery 2404
- Hospital can decide if they will allow on-call physician to do elective surgery or elective procedures
- Hospitals need to have P&P on this
- CAH that reimburse physicians for being on call may not want to do this since Medicare payment policy regulations
- Hospital must have back up plan in case on-call physician is not available

Medical Staff Exemptions
- No requirement that all the physicians on the MS must take call
- For example, a hospital may exempt a senior physician (over 60) or physicians who have been on the staff for over 20 years
- However, can permit physicians to selectively take call
- Hospital needs to ensure adequate call schedule

On-Call Requirements 2404
- Hospital must have an on-call policy
- EMTALA is the hospital’s on-call policy
- P&P must clearly delineate the responsibilities of the on-call physician to respond, exam, and treat
- P&P must address steps to follow if on-call physician can not respond due to circumstances beyond their control
  - Blizzard, flood, personal illness, transportation problems
On-Call Requirements 2404

- CMS does not have a specific requirement regarding how frequent physicians have to be on call
- CMS recognizes for safe and effective care hospital needs to have one physician on call every day
- There is no predetermined ratio CMS uses
- Used to use unwritten rule of 3
- If 3 specialists on the staff then need 24 hour coverage (which CMS suggested never existed)

On-Call Requirements 2404

- CMS will consider all relevant factors in determining if appropriate (relevant factor test)
- This would include number of physicians on the medical staff, other demands of physicians, number of times requiring stabilizing services of the on-call physician, vacations, and conferences
- Hospital does a significant number of cardiac cath and holds itself out as a center of excellence so CMS would expect 24 hour coverage

On Call Physician Issues

- So what can hospitals do?
- If 1 or 2 specialists then have reasonable call schedule which includes some weekends and off hours
- May be on call 7-10 days per month
- If services needed then permissible to transfer to a facility with these services in “no coverage” periods
- P&P covers what to do such as transfer to another hospital as part of the plan
CMS FAQ on How Frequent to be On-call

2. How frequently is a hospital's medical staff of on-call physicians expected to provide on-call coverage?

2A: Medicare does not set requirements on how frequently a hospital's medical staff of on-call physicians is expected to provide on-call coverage. Hospitals are expected to provide services based upon the availability of physicians required to be on-call. We are aware that practice demands in treating other patients, conferences, vacations, and days off must be incorporated into the availability of staff. We are also aware that there are some hospitals that have limited financial means to maintain on-call coverage all of the time. CMS allows hospitals flexibility to comply with EMTALA obligations by maintaining a level of on-call coverage that is within their capability.

CMS FAQ on On-Call Responsibilities

Remember that if on-call physician is requested to come to the ED and refuses, it is a violation against both the physician and the hospital.

Also a violation if the physician refused to come within a reasonable time.

CMS says hospitals are well advised to make physicians who are on call aware of their on-call P&P and the physician's obligation.

On-Call Requirements

• Remember that if on-call physician is requested to come to the ED and refuses, it is a violation against both the physician and the hospital.
• Also a violation if the physician refused to come within a reasonable time.
• CMS says hospitals are well advised to make physicians who are on call aware of their on-call P&P and the physician's obligation.
On-Call Requirements 2404

- If hospital A with an EMC need the specialty services of hospital B, pursuant to the CCP, then the physician is required to report to hospital B to provide the stabilization treatment.
- ED physician can call the on-call physician for consultation and on-call physician does not have to show up if not requested.
- The decision to have the physician show up is made by the ED physician who has examined the patient.

Remember to include in P&P and education the following:

- Physicians who are on call are not representing their office practice when they are on call.
- They are representing the hospital.
- When they are on call they must show up within a reasonable time if requested to come to the ED.

Physician having an office full of patients is no excuse to not showing up when on-call and requested by the ED doctor to see the patient.

- It is generally not acceptable to send ED patients to their offices for exam and treatment of an EMC.
- Exception is made when medically indicated and patient need specialized service like special equipment the hospital does not have.
On-Call Requirements 2404

- However, physician’s office must be part of hospital’s provider based system with same CMS certification number as the hospital
- It must be clear that the transport is not done for the convenience of the physician
- Must be genuine medical issue and all individuals with same medical condition are treated the same way
- Appropriate medical personnel must accompany the patient to the physician’s office

On-Call Requirements 2404

- Decision as to whether the on-call physician must respond personally or whether a non-physician can respond (PA, NP, or orthopedic tech) can be made by on-call physician
- It must also be permitted by the hospital’s P&P
- Actually the ED physician makes the decision based on the patient’s need
- Also, must be within scope of practice for the representative such as the PA or NP

On-Call Requirements 2404

- Determination is also based on capabilities of the hospital as to whether on-call physician can send a representative
- Determination is based on MS by-laws and Rules and Regulations (R&R)
- On-call physician is still responsible for making sure the necessary services are provided to the patient
On-Call Requirements  2404

- There is no prohibition against the treating physician consulting on a case with another physician.
- This physician may or may not be on the on-call list.
- May consult by telephone, video conferencing, transmission of test results, or any other means of communication.
- Example, patient bitten by poisonous pet snake and physician consults with expert in this area.

On-Call Requirements  2404

- CMS recognized that some hospitals use telecommunication to exchange x-rays or test results with consulting doctors not on the premises.
- However, if the physician specialist is on-call and is requested by the treating physician to come to the hospital this must occur.
- Reimbursement issues are outside the scope of EMTALA enforcement but be aware of telemedicine reimbursement policy.

On-Call Requirements  2404

- Telehealth or telemedicine policy is located in the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 18, Section 270.
  - CMS has changes to the CoP manual on teledmedicine effective July 2011
  - http://www.cms.hhs.gov/Manuals/IOM/list.asp
- Also remember that EMTALA is a requirement to treat and not a requirement to pay.
- On-call physician must see patient even if physician does not accept that insurance plan or patient does not have insurance.
May 5, 2011 Teleradiology Standards

On-Call Requirements

- If physician who is on-call typically directs the individual to be transferred to another hospital when on-call, instead of making an appearance when requested

- Then the physician as well as the hospital may be found in violation of EMTALA unless higher level of care is needed

- CMS reminds that while enforcement is against the hospital but the OIG can fine the physician for a violation (remember the OIG slide previously where physicians were fined)
On-Call Requirements 2404

- What is a reasonable time to respond?
- CMS previously required hospitals to delineate expected response time in minutes
- Now says hospital is well-advised to establish in its P&P the maximum number of minutes what constitutes a reasonable response time
- Generally response time for true emergencies is expected in the range of 30-45 minutes

On-Call Requirements 2404

- Differentiate between response times on phone and physical presence
- Include what to do if they don’t show such as contact department chair or VP of MS
- If on-call physician doesn’t show up timely, take this seriously
  - Physician may also be in violation of EMTALA
- Try to get partner or another physician to come in and if hospital does this then CMS now says the hospital is not in violation of EMTALA

On-Call Requirements 2404

- However, if on-call physician does not show up and patient has to be transferred to another hospital
- The hospital is in violation of EMTALA
- Need to maintain list of on-call physicians for five years
- Need to have the name of the physician and not group practice name like OB-GYNs Incorporated
- Remember if service generally available to the public, they is available to ED patients like ultrasound
Follow Up Care and EMTALA

- Medical staff bylaws or P&P must define the responsibility of the on call physician for certain things
- This would include responsibility to respond, examine, and treat patients with emergency medical condition
- Designate in policy physician is responsible for the care of the patient when on call through the episode created by the EMC
- Physician does not have to take patient for subsequent problems unless the physician on call at the time again
- On call physician can not require co-pay or insurance information before assuming responsibility for the care of the patient

Central Log 2405

- A central log must kept on each individual who comes to the emergency department seeking assistance
- Can be paper or electronic log
- Log has to include a number of things
- Whether patient refused treatment or left AMA
- Whether patient was transferred

Central Log 2405

- Must include if admitted, stabilized, transferred or discharged
- Other things usually include diagnosis, chief complaint, age, and physician
- Purpose is to track care provided to each individual
- Must include or by reference, patient logs from other areas of the hospital considered DED (such as OB or pediatrics)
What must the hospital that has an ED do when a person "Comes to the ED"

- An appropriate MSE must be done to determine if EMC exists (heart attack, stroke dissecting aneurysm)
- It must be done within the capability of the hospital's ED
- This includes ancillary services routinely available to the ED
- Exam must be done by a qualified individual as determined by MS R&R and by-laws (called qualified medical personnel or QMP)

**Comes to the ED Means**

1. The individual has presented at a hospital's dedicated emergency department (DED) and requests examination or treatment for a medical condition, or has such a request made on his or her behalf (paramedic, family)
   - Or based on the individual's appearance they need an examination or treatment (a prudent layperson observer they need help such as patient is not breathing)

2. Has presented on hospital property, other than the dedicated ED, in an attempt to gain access to the hospital for emergency care
   - And requests examination or treatment for what may be an emergency medical condition, or has such a request made on his or her behalf
   - Or based on the individual's appearance a prudent layperson observer would believe they have an EMC and need an examination or treatment (not breathing, having a seizure, delivering a baby)
**Comes to the ED Means**

3. Is in an ambulance owned (ground or air) and operated by the hospital for presentation for examination and treatment for a medical condition at a hospital's dedicated ED
   - Even if the ambulance is not on hospital grounds
   - Does not apply if part of communitywide EMS protocol that direct transport to another hospital

4. Is in a non-hospital-owned (air or ground) ambulance on hospital property for presentation for examination and treatment for a medical condition at a hospital's DED
   - If the ambulance is not on property, can refuse even if squad contacts staff by phone or telemetry if in diversionary status

**Comes to the ED Means**

- If you are on diversion squad can still disregard denial and if they show up EMTALA obligations attach to the patient
  - If the squad is on hospital property it is too late to divert
  - One state passed a law that hospitals could not go on diversion so states can be more stringent if they want

**You have to read the definitions in the EMTALA law because they mean things you may not realize it from a common understanding**

http://ecfr.gpoaccess.gov at 42 CFR 489.24
Subpart B—ESSENTIALS OF PROVIDER AGREEMENTS

§489.20 Basic commitments.
§489.21 Specific limitations on charges.
§489.22 Specific provisions applicable to prepayment requirements.
§489.23 Specific limitation on charges for services provided to certain enrollees of fee-for-service FEHB plans.
§489.24 Special responsibilities of Medicare hospitals in emergency cases.
§489.25 Special requirements concerning CHAMPUS and CHAMPVA programs.
§489.26 Special requirements concerning veterans.
§489.27 Beneficiary notice of discharge rights.
§489.28 Special capitalization requirements for RHBAs.

Special requirements concerning beneficiaries served.
Hospital Property Means

- The entire main hospital campus and includes:
  - Parking lot
  - Hospital campus (which includes the 250 yard rule)
  - Sidewalk and driveway

**DOES NOT INCLUDE** areas of the hospital’s main building that are not part of the hospital such as physician offices, skilled nursing facilities, shops, restaurants.
Hospital Campus 250 Yard Rule

- Is defined to mean the physical area immediately adjacent to the provider's MAIN building.
- And other structures that are not strictly contiguous to the main building but are located within 250 yards of the main building, and
- Other areas that are determined on an individual case basis by CMS Regional Office (RO).

EMTALA and Outpatients

- If an individual is registered as an outpatient and present on hospital property, other than to the DED.
- The hospital does not have an obligation to provide a MSE even if the patient suffers EMC.
- This is if the patient have begun to receive a course of treatment for outpatient care.
- This patient is protected in the hospital CoPs to protect patient's health and safety.

Medical Screening Examination Definition

- A MSE means a physical (and mental when necessary) health evaluation used to determine if they have an emergency medical condition (EMC).
- EMC could include things such as seizure, life threatening injury, pain, extensive bone or soft injury, vascular or nerve damage, psychiatric disturbance, or symptoms of substance abuse.
- If a EMC does not exist then EMTALA does not apply.
Moving Patient to Another Department

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

Example is patient with eye injury needs the special equipment in the eye clinic like the slit lamp

Movement is not considered a transfer since moved to another hospital owned facility or department

Can not move patients to a location off campus such as a satellite clinic or urgent care center for their MSE

Patient Shows Up at Off-Campus Location

- What if the hospital owns an off campus department (like a physical therapy department) and a patient shows up at the wrong location
- The off campus location does not have an ED and does not meet definition of DED
- Sending the patient to the main campus (main hospital ED) is not a transfer
- If a request is made for emergency services the staff should use whatever they have in place and call 911
Off Campus

- The off campus facility must have P&P in place so staff know what to do.
- In a true emergency, staff may want to send to the closest ED.
- The P&P should state that the facility will provide initial treatment within its capability and capacity.
- If all the off campus Physical Therapy department had was a cart, blanket, and oxygen then need to use it when indicated.
- Include in your orientation of new employees.

MSE 2406

- MSE is an ongoing process.
- Triage is not generally considered to be a MSE.
- It is a system of prioritizing when the patient will be seen by the physician or QMP (PA, NP).
- MSE will be different depending on signs and symptoms.
- Patient with chest pain, difficulty breathing, and diaphoresis is assessed differently than the patient who got bit by her bird.

Medical Screening Examination

- The MSE must be adequate and appropriate (again will vary based on the patient’s condition, complaints and history except for pregnant women).
- This means the same screening exam as all others presenting to the ED (same standard of care).
- Request for MSE or treatment can be made by anyone, family member, squad, police, or bystander.
Medical Screening Examination

- Includes ancillary services routinely available to the ED
- Example could include CT scans and ultrasound
- “MSE is the most complex and far-reaching of the EMTALA mandates”

Source: Bitterman, Robert, pg. 23, Providing Emergency Care Under Federal Law; EMTALA, Published by ACEP, 1 800 798-1822.

MSE of Pregnant Patients

- For pregnant women having contractions, MSE includes at a minimum;
- Ongoing evaluation of FHTs
- Observation and recordation of the regularity and duration of uterine contractions
- Including fetal position and station
- Including cervical dilation, status of membranes (leaking, intact, ruptured)

ACOG PRACTICE BULLETIN

CLINICAL MANAGEMENT GUIDELINES FOR OBSTETRICIAN-GYNECOLOGISTS

NUMBER 156, JUNE 2000

Intrapartum Fetal Heart Rate Monitoring: Nomenclature, Interpretation, and General Management Principles

The Practice Bulletin is developed by the ACOG Committee on Practice Bulletins with the assistance of a writing panel. The writing panel is charged with developing recommendations appropriate for obstetrician-gynecologists and their patients, in light of the current state of medical knowledge. The ACOG Executive Committee, with advice from the Board of Directors and the Council of Members, approves the final content of the Practice Bulletin. The organizational form of this Practice Bulletin is in accordance with the requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
MSE for Pregnant Patients

- Most emergency departments direct women over 20 weeks gestation with pregnancy related complaints to LD
- Any doubt about the nature of the complaint, then can have ED nurse triage
- Acceptable to CMS
- If pregnant trauma patient, OB nurse should go to the ED to evaluate the patient
- Make sure hospital has P&P and all staff in the ED and OB know the policy

Labor Defined 2406

- Labor is the process of childbirth beginning with the latent or early phases of labor and continuing through the delivery of the placenta
- A woman is experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other QMP, acting within his or her scope of practice, as defined in the hospital MS bylaws and State law
- Certifies that, after a reasonable time of observation, the woman is in false labor

Certification of False Labor

- Physician or QMP have to examine patient to determine if EMC exists
- True labor is an EMC? (never defined in original statute as an EMC)
- This means if the physician or QMP diagnoses that the woman is in false labor, then the MD, QMP or nurse midwife is required to certify diagnosis before discharge
- Woman experiencing contractions are in true labor unless MD, certified nurse midwife or QMP acting within their scope of practice certifies that... woman is false labor after a reasonable time of observation
Certification of False Labor

- If woman is in false labor, the MD, QMP or nurse midwife is required to certify diagnosis before discharge
- And one of these individuals must complete the certification of false labor
- Can use stamp, sticker, or form
- Can use CMS Memos to draft form (Sept 26, 2006 Memo, S&C-06-32 and earlier memo January 16, 2002 S&C-02-14)

Certification of False Labor Sample Form

CMS requires the certification of false labor.

- Section 489.24(B) defines what constitutes labor.
- Labor is defined to mean the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta.
- A woman is experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical personnel acting within his or her scope of practice, as defined in the hospital medical staff bylaws and State law.
- Certifies that, after a reasonable time of observation, the woman is in false labor.

Certification of False Labor Sample Form

- I hereby state that the patient has been examined for a reasonable time of observation and certify that the patient is in false labor.
- Name and title___________________
- Date_________ Time______________
**Born Alive law**

- Born-Alive Infants Protection Act of 2002, and CMS added to EMTALA interpretive guidelines under Tag 2406
- CMS Issued April 22, 2005, Reference S&C-05-26, bulletin that advises state survey agencies that violations of this Act should be investigated as potential EMTALA violations

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**Born Alive Law**

- Infant born and hospital would have to be resuscitate if request made for MSE on infant’s behalf
- Infant is deemed an individual
- ED and L&D meets the definition of DED and EMTALA applies
- If born else where on campus and the lay person standard that infant had EMC
- http://pediatrics.aappublications.org/cgi/content/full/116/4/e576
**Born Alive Law**

- In complaint manual, has section updated 2013
- Tells surveyor how to handle a complaint
- Definition of person and individual under 1 USC 8(a) it is clear that EMTALA is applicable to infant born alive
- Does say if request was made on infant’s behalf or based on infant’s appearance that infant needed examination and treatment

*At http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/itemdetail.asp?filterType=dual,%20date&filterValue=2|yyyy&filterByDID=3&sortByDID=4&sortOrder=ascending&itemID=CMS060362&NumPerPage=10

**Minor Child 2406**

- Remember that the federal EMTALA law preempts state law on informed consent
- A minor child can request an examination or treatment for an EMC
- The hospital is required by law to conduct a MSE on the infant to determine if it is an EMC
- Hospitals should not delay by waiting for parental consent
- If no EMC exists after the MSE, staff can wait for parental consent before proceeding

**MSE On-Campus Provider Based Entity**

- Hospital with off-campus department such as rural health clinic or physician offices can not move patients for MSE when on-campus
- First, hospitals should know if they are a freestanding entity or a provider based entity and many small hospitals can meet the definition of a provider based entity
- Billing is different based on your status
- CMS issues transmittal A-30-030 to help explain this and to describe the criteria and procedure to determine if you are a provider based entity
**Ambulance**
- If patient is not on hospital property then EMTALA does not apply and not deemed to have come to the ED
- If patient in an ambulance owned by the hospital then the patient is deemed to have come to the ED and EMTALA applies even if ambulance is five miles out
- If patient in non-hospital owned ambulance is on the property of the hospital then EMTALA applies (too late to divert)

**Telemetry 2406**
- If patient is in non-owned ambulance and hospital contacted by telemetry, patient is not deemed to have come to the ED
- Unless the ambulance is on the hospital's property already
- Hospitals contacted by telephone or telemetry communication can still divert if on diversionary status
- If hospital owned ambulance may only divert if pursuant to community wide EMS protocol
  - Patient needs level 1 trauma center or pursuant to a community call program

**Diversionary Status**
- A hospital can be in diversionary status because it does not have staff or beds to accept additional patients (either ED beds or can divert critical care patients if no critical care beds)
- If the ambulance disregards the hospital's instructions and brings the patient on to hospital grounds, it can not deny access
- Don't direct the ambulance to another facility unless on diversion for one of these two reasons (remember Arrington v. Wong problem, US District Ct of Appeals)
**Diversionary Status**

- Furthermore, in June 29, 2009 IG, CMS said a hospital that is not in diversionary status, fail to accept a telephone or radio request for transfer or admission.
- The refusal could represent a violation of other federal or state laws like Hill-Burton.
- Many states have state EMTALA laws.
- Hill Burton Act is also called the Hospital Survey and Construction Act which was passed in 1946 to provide grants and loans to improve physical plants of hospitals.

**Parking of Patients  2406**

- CMS issued a Memo to Region IV Hospitals on the "Parking of EMS Patients in Hospitals" on December 12, 2005, a memo April 27, 2007 and CMS included section in Tag number 2406.
- States CMS has learned several hospitals prevent EMS staff from transferring patients from their stretchers to ED cart.
- Some staff believe that unless hospital takes responsibility for them, hospital is not obligated to provide care.

**Parking of Patients**

- Hospitals can not deliberately delay moving a patient from the EMS stretcher to the bed to delay the point where their EMTALA obligations begin.
- Patient is presented when arrives on hospital grounds and within 250 yards of the main hospital building.
- Can not delay MSE by not allowing EMS to leave the patient.
Parking of Patients

- However, this does not mean that in every instances, there must immediately resume all responsibility.
- There might be some situations where the hospital does not have the capacity or capability at the time.
- Example is when squad brings in a patient while occupied with major trauma case.
- Still need to assess patient’s condition upon arrival to determine priority and if physician or QMP need to see right away.

Parking of Patients 2007 Memo 2406

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Washington, DC 20201

妍: April 27, 2007
TO: State Survey Agency Directors
FROM: Survey & Certification Group
SUBJECT: ENFELA Issues Related to Emergency Transport Services

Memorandum

- Hospital may not request transfer of a patient from one emergency department to another if
- SAC 90-11 should not be interpreted to mean that a patient cannot be transferred to an
- SAC 90-11 should not be interpreted to mean that a patient cannot be transferred to an

Parking of Patients 2006 Memo

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Washington, DC 20201

DATE: July 16, 2006
TO: State Survey Agency Directors
FROM: Survey & Certification Group
SUBJECT: “Parking” of Emergency Medical Service Providers in Hospitals

Letter

- The Centers for Medicare & Medicaid Services (CMS) has received reports from hospital emergency departments of emergency medical service providers being blocked from entering the hospital and parking their ambulances in emergency department parking lots.
- This situation has caused problems and concerns for hospital emergency departments and
- Parking ambulances at the hospitals' emergency departments may

The Centers for Medicare & Medicaid Services (CMS) has learned that several.
Helipad 2406
- Helicopters and ambulances that enter the hospital grounds just to access the helipad to tertiary hospitals does not trigger an EMTALA obligation
- However, if medical crew or ground crew requests medical assistance then EMTALA obligation occurs
- Remember the exception is if the hospital owns the air transport, the patient is deemed to have come to the ED

State Plans 2406
- State plans can not preempt the federal EMTALA law
- State plans for indigent patients, psychiatric, or obstetrical patients can not disregard EMTALA
- Example is a state can not tell the ED to send the suicidal patient off-campus to have their MSE done
- Hospitals can not discharge a patient who has not been screened
MSE Cases

- Perception of the MD at the time of the MSE that governs the scope and appropriateness of the MSE
- In Summers v. Baptist Medical Center, 1996, patient fell out of tree while deer hunting, complained of back and chest pain, no CXR but thoracic and LSS x-rays, discharged and two days later found to have fractured sternum, rib, and vertebra. MD did not perceive chest symptoms sufficient to warrant x-rays.

MSE Cases

- Failure to follow your own policies and procedures (rules) will be an EMTALA violation
- PA dismissed 9 month old child with fever without involvement of ED MD. Violation since protocol required consult with MD an all children under 1
- In 1998 Bohannon case, patient involved in motorcycle accident and had C-spine films and discharged before reviewed by ED MD. Violated own policy.

Who is Qualified to be a QMP? 2406

- MSE must be conducted by a QMP
- Must be qualified by hospital by-laws and R&R
- Must meet the requirements of 482.55 which is the CoP for emergency services
- ED must be supervised by qualified member of the medical staff
- Board should approve the document about QMPs
QMP

• It may be prudent for hospitals to require a MD to conduct the screening exam if one is on the premises
• CMS notes there may not always be a MD present in the hospital especially in rural areas
• It should be the someone who is qualified by education and training such as a PA and NP
• Must be capable of ordering any necessary diagnostic procedures without exceeding the scope of their professional license

QMPs

• This person must have access to all the hospital's resources including ancillary services
• RNs without advance training or resources generally do not meet this criteria
• An exception is that in some hospitals experienced OB nurses have been deemed QMPs or the ED nurse for non-emergencies like BP checks or giving flu shots

OB Nurses as QMPs

• If hospital uses RNs to conduct limited MSE (i.e. obstetrical nurses) then specific P&P should be adopted addressing the education and training under which a RN must consult with a physician
• Note that only a MD can make a transfer decision or determine whether a pregnant woman having contractions is in false labor
Inpatients

- CMS says the EMTALA obligations end when the patient has been admitted for inpatient hospital services
- CMS says even if the patient has not been stabilized (although you still want to stabilize to best of your ability)
- CMS says EMTALA does not apply to hospital inpatients

Definition of Inpatient

- Inpatient is an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital care
- Expectation that he will remain at least overnight and occupy a bed
- Even though the situation later develops that the patient can be discharged or transferred
- And does not actually use the bed overnight
- Can not be a sham and must be in good faith

Inpatient 2406

- What about observation patients?
  - They are not inpatients and EMTALA still applies to them (2411)
  - Also if the case ends up in the court room the result might be different
  - The case of Moses v. Providence Hospital and Medical Centers, Inc held that the liability of EMTALA does not end when the patient was admitted
    - Recall in part 1 CMS decided not to make any changes
The Moses Case

- The Sixth Circuit stuck to its interpretation that EMTALA imposes an obligation on a hospital beyond simply admitting a patient with an EMC to an inpatient care unit.
- The Court noted that the statute requires “such treatment as may be required to stabilize the medical condition,” and forbids the patient’s release unless the patient’s emergency condition has “been stabilized.”
- Moses v. Providence Hospital and Medical Centers, Inc., No. 07-2111 (6th Cir. April 2009).

The Moses Case

- The court overruled CMS’s regulation that EMTALA ended when the hospital admitted the patient in good faith.
- The Court stated that the rule was contrary to EMTALA’s plain language.
- This requires a hospital to “provide . . . for such further medical examination and such treatment as may be required to stabilize the medical condition.”
The Moses Case

- Can non-patient have standing to sue under EMTALA?
- EMTALA’s civil liability provision reads as follows:
  - “Any individual who suffers personal harm as a direct result of a participating hospital’s violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located…”
- Court allowed non-patient (family member) to sue the hospital but not the physician

The Moses Case

- This case creates an enormous expansion of hospital liability under the federal law
- Especially if this interpretation is accepted in other district courts
- All inpatient ‘premature discharge’ claims would become federal ‘failure to stabilize before transfer’ claims under EMTALA
- The hospital would be directly liable for any negligence of the admitting/discharging physician

Inpatient Admission and EMTALA

- Admission does not end EMTALA
- Hospital still liable for discharging an unstable patient even after he had been admitted to the hospital
- Remember also that any discharge home from the ED is defined by EMTALA as a transfer so want to be sure all discharged patients are stable when they leave
- Inpatients admitted for elective services are not covered by EMTALA but by hospital CoPs
Waiver of Sanctions 2406

- Sanctions can be waived for an inappropriate transfers during a national emergency
- Or for the MSE at an alternate location
- On 9-11 when 400 people came to the closest hospital in New York there was no way to triage and do a MSE on all these individuals
- Also includes if a pandemic occurred
- Waiver is limited to 72 hours during the emergency period
- This section amended July 16, 2010

Non-Emergencies in the ED 2406

- If person comes to the ED and request is made for exam or treatment
- However, the nature of the request makes it clear that is not an emergency
- Hospital is only required to do such screening as appropriate
- It could be a request to have a blood alcohol test, sexual assault exam, or a blood pressure checked

Request for Medications

- If a patient comes to the ED and requests medications
- The hospital has an EMTALA obligation
- Surveyors are instructed to ask probing questions
- Was it likely by the request that the patient had an EMC
- Hospitals are not required to provide medications because a patient who does not have an EMC is unable to pay or does not wish to get them from a retail pharmacy
Blood Alcohol Tests (BATs) 2406

- It is important to determine from the patient’s condition if a MSE is needed when there is request for a BAT
- If patient only requests a BAT then a MSE may not be necessary
- If patient is intoxicated and a prudent lay person observer would not believe the individual needed an exam
- If person involved in MVA and may have sustained injuries a MSE would be indicated

Blood Alcohol Tests (BATs) 2406

- Surveyors will evaluate each case on the merits
- You want to make sure patient is competent to make a decision
- Many hospital personally offer a MSE even if patient came for a BAT
- Hypoglycemia, cerebral hypoxia, strokes, head injury, metabolic abnormalities, and ingestions of toxins can mimic alcohol intoxications

ACEP Blood Alcohol

**Blood Alcohols, Labs and Minor Treatments in the ED: Is a Medical Screening Exam Required by EMTALA?**


By Robert A. Bittner, MD, JD, FACEP

Hospital emergency departments serve many functions other than the evaluation and treatment of patients with true medical emergencies by emergency physicians. The emergency department (ED) is often used by police to draw blood alcohol levels on allegedly intoxicated drivers, physicians obtain breath tests on a 12-year-old driver, and hospitals provide urine drug screens on injured workers, prescription refill, allergy shots, vaccine vaccinations on blood transfusions. The question is whether federal law, the Emergency Medical Treatment and Active Labor Act (EMTALA), requires the hospital to perform a medical screening examination in each of these scenarios. To determine if a patient is suffering from an emergency medical condition, the statutory language of EMTALA requires the hospital to provide a medical screening examination. The question is whether the patient is suffering from an emergency medical condition.
If a person has an emergency medical condition (EMC) the hospital must provide further exam and treatment to stabilize the medical condition.

Patient comes in with chest pain, radiates down left arm, and difficulty breathing and diagnosis of MI is made.

This is considered an EMC and hospital stabilizes with IV, oxygen, monitor, CCU admission, thrombolytics, aspirin, etc.

**Definition of EMC**

- EMC defined to mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbance, symptoms of substance abuse).
- Such that the absence of immediate medical attention could be reasonably expected to result in placing the health of the individual in serious jeopardy (or to the mother and infant for a pregnant woman).
- Serious impairment to bodily functions or serious dysfunction of any organ.
EMC of Pregnant Women

- With respect to the pregnant women with contractions that there is inadequate time to effect a safe transfer to another hospital before delivery or
- That transfer may pose a threat to the health or safety of the woman or the unborn child

OB Patients

- Should have P&P for screening pregnant patients
- Elements of exam should be completed in all cases, parity, gestational age, nature, frequency, duration, and intensity of contractions
- FHT, station, dilation, presentation, VS, etc.

Necessary Stabilization Treatment

- When patients come to the ED and the hospital determines they have a EMC, further medical exam and treatment must be provided
- Such treatment must be given as necessary to stabilize the medical condition within the capabilities and capacity
- Capabilities of a facility means that there is physical space, equipment, supplies, and specialized services that the hospital provides
Stabilization  2407

- Such as surgery, obstetrics, psychiatry, pediatrics, trauma care, or intensive care
- Capabilities of the staff mean the level of care the hospital can provide within the training and scope of their professional license
- Need to treat all individuals with similar conditions consistently and regardless of whether the patient is in a managed care plan
- If the patient refuses care, they must be informed of the risks and benefits and discussed in the earlier section on AMA

Stabilization  2407

- And if lack capability, there is a transfer of the patient and the facility must follow transfer rules
- Must stabilize the patient before discharge or transfer
- Capacity includes what the hospital does to accommodate a patient in excess of occupancy limits
- Like moving patients to other units, calling in additional staff, or borrowing equipment

Definition of Stabilization of EMC

- Means that no material deterioration of the condition is likely to occur
- Within reasonable medical probability
- To result from or during the transfer or with respect to an EMC
- Until the woman has delivered the child and placenta
Stabilization

- After the MSE is done, the MD should document the absence or presence of an EMC.
- Also document when the patient is stable.
- Again, stabilization and transfer only kick in if the patient has an EMC.
- When stable, EMTALA obligation is over.

Stabilization

- The hospital has to have actual knowledge that an EMC exists which is a subjective standard.
- However, the definition of stabilized is an objective standard, whether the MD knew or should have known.
- If the patient actually deteriorates, this issue will come up.

Discharge Home with Follow Up Instructions

- Individual is considered stable and ready for discharge home.
- Within reasonable clinical confidence.
- It is determined that the patient has reached the point where his care and treatment.
- Could be performed later as an inpatient or on an outpatient basis.
- EMC that caused the problem must be resolved.
Stabilization Case Law

- Much litigation in the area of allegations of failure to stabilize
- Child with diagnosis of ear infection and dies from meningitis, could be a malpractice case not EMTALA since MD did not know this
- No legal duty to stabilize the child
- Federal courts also uniformly agree that the MD or hospital must have actual knowledge that the EMC existed before liability for failure to stabilize, (Vickers v. Nash General Hospital, Inc. 78 F.3d 139 (4th Cir. 1996))

Definition of Transfer

- Transfer means the movement (including discharge)
- Of a patient outside a hospital’s facilities
- At the direction of any person employed by (or affiliated or associated, directly, or indirectly) with the hospital
- Doesn’t include person declared dead (DOA) or
- Person who leaves the facility without permission (AMA)

Transfer General Rule 2409

- The general rule is that if an individual at a hospital has an EMC, the patient may not be transferred
- There are exceptions to the rule on when a transfer will be appropriate
  - A hospital may not transfer an unstable patient unless the patient is informed of the hospital’s obligations under this law
  - And the risks of the transfer in writing (use the transfer form)
Transfer General Rule

- And the physician signs a certification (in writing) that the benefits reasonably expected outweigh the risks, to the individual or unborn child, or (have the person consents in writing to the transfer)
- If a physician is not present in the ED at the time of transfer, a QMP can sign the certification after consultation with the physician, and
- The physician must later countersigns the certificate and
- The certification must contain a summary of the risks and benefits upon which the certification is based
- And the transfer must be an appropriate transfer

What Is an Appropriate Transfer? 2409

- The transferring hospital provides medical care within its capacity that minimize the risk to the patient or unborn child
- The receiving facility has space and qualified personnel to care for the patient
- The receiving facility has accepted the transfer
- The transferring hospital sends all medical records including history, observations, preliminary diagnosis, test results, copy of certification
- Records not available must be sent as soon as practicable

What Is an Appropriate Transfer?

- This must include the name and address of any on call MD who refused or failed to show up within a reasonable amount of time
- There are qualified personnel and appropriate transportation equipment including the use of life support measures
- Physician of sending hospital determines what is appropriate mode of transport and equipment and who should be in attendance
- If the patient refuses to consent, the risks and benefits must be documented,
- Take all reasonable steps to ensure it is a written informed refusal
Transfers 2409

- Transfers may be made at the request of the patient
- The patient or their legal guardian must be informed of the hospital’s obligation to provide stabilizing treatment regardless of ability to pay
- Patient must be informed of the risks of transfer and sign the transfer certification

Psychiatric Patients 2407

- Psychiatric patients are considered stable when they are protected and preventing from injuring or harming themselves or others
- Administration of medications or physical restraints may stabilize a patient for a period of time for purposes of transferring an individual to another facility
- But the underlying condition may persist and patient may experience exacerbation of EMC
- Use great care in determining medical condition is stable after administering drugs or using restraints

CMS has given guidance on what constitutes an EMC

CMS has not given guidance on what needs to be done to stabilize the psych EMC

Physician must use their best judgment

If no psychiatric EMC may discharge

May transfer if facility does not capability to stabilize patient like an inpatient unit
Transfer of Psychiatric Patients

- CMS views the following as psychiatric EMC
- History of drug ingestion in comatose or impending comatose condition
- Depression with feeling of suicidal hopelessness
- Delusions, severe insomnia and hopelessness
- History of recent suicidal attempt or suicidal ideation

Psychiatric EMCs by CMS

- History of recent assaultive, self-mutilate or destructive behavior
- Inability to maintain nutrition in a person with altered mental status
- Impending DT's or acute detox
- Seizures (withdraw of toxic)
- List is not exclusive

Psychiatric Patients

- Hospitals with specialized psychiatric capabilities must accept patients if sending hospital does not have capability (unless transfer from outside the country)
- And if they have capacity (staff, available beds, equipment etc.
- Patient may refuse treatment but must be competent to make informed decision
- Physician should determine if patient lacks understanding or capacity to communicate regarding exam and treatment
Psychiatric Patients

- If surrogate decision maker (parent, guardian or DPOA) then discuss with them
- Consent is presumed in the event of an emergency
- Remember involuntary admission procedure in each state
- Behavioral Hospital of Lutcher (La.), formerly known as St. James Psychiatric Hospital, paid $30,000 for allegedly failing to appropriately accept transfers of two patients suffering psychiatric emergencies (see OIG dumping cases previously discussed)

Transfer Certification 2409

- This is a legal written document and it must filled out completely
- Most facilities have transfer forms and checklists
- Certification must state the reason for the transfer along with benefits
- Hospitals not capable of handling high risk deliveries have written transfer agreements with level 3 facilities

Transfer of Woman with Contractions

- Limited circumstances to transfer
- Woman in labor is transferred if she requests it or physician
- Or Examining MD certifies in writing the benefits outweigh risks to mom and child
- Can not cite state law or practice as basis for transfer
Woman with Contractions

- Delivery is expected to be highly complex and needs specialized ob services
- Arrange appropriate transfer and must send everything along that could possibly be needed (Pitocin drip, warm blankets, ob nurse, neonatal nurse FH monitor and maybe even an ob doctor)

Transfer Certification  2409

- This form should state that
- “Based on the information available to me at the time of this transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to the individual and, in the case of labor, to the unborn child from effecting the transfer.”
Ca Hospitals Make Sure Contact Notified

December 30, 2013


TO: 
General Acute Care Hospitals

SUBJECT: 
Patient Transfer from Non-acute Reasons: Notification

AUTHORITY: 
Health and Safety Code (HSC) Section 1317.2
and Civil Code (CC) 1550.2

This Act amends Patient Transfer from Non-acute Reasons: Notification. Existing law prohibits the transfer of a person needing emergency services from one hospital to another who may not be able to provide the services needed to stabilize the person. Existing law also provides that the transferring hospital must provide the receiving hospital with the name, date of birth, and other identifying information of the person to be transferred, the diagnosis or reason for the transfer, the admitting service, and the type of treatment needed by the person. This Act amends Patient Transfer from Non-acute Reasons: Notification. Effective January 1, 2014, HSC 1317.2 sets forth that the transferring hospital must provide the receiving hospital with the name, date of birth, and other identifying information of the person to be transferred, the diagnosis or reason for the transfer, the admitting service, and the type of treatment needed by the person. Hospitals will additionally be required to document any attempt to contact a preferred receiving hospital or next of kin in the patient’s medical record.

The information in this Act is a brief summary of AB 1374. Facilities are responsible for following all applicable law. The California Department of Public Health (CDPH) has developed this act and guidance to assist hospitals in understanding this Act. Facilities must follow all applicable law and regulations. Hospitals and healthcare providers must ensure that policies and procedures reflect this information and applicable law and regulations. Facilities must ensure that this information is reflected in all educational materials and provided to all healthcare providers. These requirements do not relieve facilities in their responsibility for following all law and for having all such written materials up to date. Facilities should also refer to the full text of the Act and Safety Code Sections 1317.2 and Civil Code 1550.2 to ensure compliance.

Specialized Capabilities 2411

- There is a duty of hospitals with specialized capabilities to accept patient
- Hospital A does not have a trauma unit and Hospital B is a level 1 trauma unit
- Hospital B has staff and beds and so must accept the unstable trauma patient
- Includes facilities such as burn units, shock-trauma units, or neonatal ICUs
- Hospitals that are rural regional referral centers may not refuse to accept appropriate transfer requiring specialized services (under 42 CFR 412.96)
Specialized Capabilities 2411
- This assumes the sending hospital does not have specialized capabilities
- This includes the requirement to accept if you have specialized capabilities even if your hospital does not have an ED
- This was done to level the playing field with specialty hospitals
- Do not have to accept transfers outside the US

Lateral Transfers 2411
- Lateral transfers are those between facilities of comparable resources
- Hospital A has a burn unit and so does Hospital B
- Transfers are not required by EMTALA
- Benefits of transfer do not outweigh risks except when a hospital has a serious capacity problem or other problem like flooding or lost of power

Consultation with QIOs
- QIO is Qualified Improvement Organization
- Every state has one which is under contract by CMS
- If medical opinion is necessary to determine a MD’s or hospital’s liability
- CMS requests the appropriate QIO to review the allegation
Consultation with QIO

- CMS needs to give the QIO all the information relevant to the case
- CMS, in consultation with the OIG, provides the QIO with a list of relevant questions to which the QIO must respond in its report
- Must give hospital/MD reasonable notice of its review
- And opportunity to submit additional information

Consultation with QIOs

- If the QIO determines after a preliminary review
- That there was an appropriate MSE and the individual did not have an EMC
- Then the QIO may, at its discretion, return the case to CMS
- CMS may release a QIO assessment to the physician and/or hospital, or the affected individual, or his or her representative, upon request

Round Trip Transfers

- Transfers to another hospital with the intention of returning to the original hospital
- Sent to get test such as CT-scan, MRI or angiography
- EMTALA compliance with transfer requirements must occur
- Ensure documentation, certification, and acceptance by the receiving hospital
- Implementing an appropriate transfer back to the sending hospital is not necessary
Important Tag Numbers

- May look at the following important documents:
  - EMTALA policy TAG 2400
  - EMTALA signs TAG 2402
  - Medical records and make sure they are maintained for five years 2403
- List of on call physicians 2404
- Central log 2405

Important Tag Numbers and Deficiencies

- Appropriate MSE 2406
- Stabilizing treatment 2407
- No delay in exam 2408
- Appropriate transfer 2409
- Whistle blower protection 2410
- Recipient hospital responsibilities 2411

Beneficiary & Family Centered Care QIOs

- Beneficiary and Family Centered Care (BFCC)-QIOs will manage:
  - All beneficiary complaints,
  - Quality of care reviews,
  - EMTALA,
  - And other types of case reviews
- To ensure consistency in the review process while taking into consideration local factors important to beneficiaries and their families
KEPRO and Livanta QIOs

Beneficiary and Family Centered Care - Quality Improvement Organizations (BFCC-QIOs)

- **Area 1 – Livanta**
  
  9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701
  
  Toll-free: 866-815 5440
  
  www.BFCCQIOAREA1.com

- **Miayan/Dr Brian Murphy EMTALA**

- **Area 2 – KEPRO**
  
  5201 W. Kennedy Blvd., Suite 900
  
  Tampa, FL 33609
  
  Toll-free: 844-455-8708 X7330

- **Chuck Hester/Dr Ferdinand Richards**
  
  www.keproqio.com

- **Area 3 – KEPRO**
  
  5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131
  
  Toll-free: 844-430-9504
  
  www.keproqio.com

- **Area 4 – KEPRO**
  
  5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609
  
  Toll-free: 855-408-8557
  
  www.keproqio.com

- **Area 5 – Livanta**
  
  9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701
  
  Toll-free: 877-588-1123
  
  www.BFCCQIOAREAS.com
QIP Manual 68 Pages Anti-Dumping

Quality Improvement Organization Manual

Chapter 9 - Sanction and Abuse Issues

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(Rev. 12, 10-03-03)


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9000 - Citations and Authority
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9125 - QIO Action on Final Finding of a Violation
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9160 - Appeal Rights of the Suspended Practitioner or Other Person

ANTIDUMPING

9110 - Statutory Background
9110 - Hospital Requirements
9110 - Hospital Requirements for Nonprofit

The End! Questions??

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sdill1@columbus.rr.com
Questions?

EMTALA
- Are you up to the challenge?
- Sample educational memo for physician follows this slide
- List of regional offices follows this
- EMTALA resources

Resources
- The EMTALA Answer Book 2013 by Mark Moy, Aspen Publication,
- 20 Common Practices that will Get On-Call Physicians Cited at http://medlaw.com/healthlaw/EMTALA/education/20-common-practices-that-.shtml,
20 Common Practices Article

- Article by Stephen Frew JD

- When asked to come to the ED physician responds to admit and will see the patient later. EMTALA requires a reasonable response time.

- When asked to come to the ED to see patient physician debates the necessity of coming in. Response is not negotiable or debatable.

- When asked to come in refuses and orders patient sent to another facility.


- When asked to come to the ED physician declines saying patient needs exceeds their scope of practice. Physician must render care within their privileges and not their usual scope of practice.

  - Physician must come in and justify any transfers.

- When covering more than one hospital and physician asks patient be sent where physician is currently seeing patients instead of the patient’s location.

  - Unless an emergency and it is done to meet the needs of the patient.

- When asked to come to the ED physician responds patient was previously discharged from their practice for non compliance or non payment.

- When asked to come to the ED the on-call physician responds not interested because patient is aligned with another physician who is unavailable or declined to come in.

- Declining a requested transfer from a hospital without the capability to deal with the patient’s needs and regardless of the ability to pay.
20 Common Practices Article

- On-call physician refuses to accept a patient because a specialist at the first hospital was not available.
- Refusing to participate in the call list which then leads gaps in the list but expecting to be called for your patients and patient for whom you are covering.
- Listing your PA or NP on the call rooster instead of the on-call physician.
- Not signing the transfer form prior to the transfer.

Physician Education Memo

- The following lists important elements that a hospital could use to provide a memo to physician to educate them on EMTALA.
- Also make sure they know how to complete an EMTALA transfer form.
- Include a sample of a completed one for reference.

Physician Education

- On Call Memo for your physicians on EMTALA might include the following points.
  - The hospital has a legal duty to provide on-call physicians for emergency patients under the federal EMTALA law.
  - Whenever you are on-call, you are representing the hospital and not your office practice.
Physician Education

- It is the treating Emergency Department physician who makes the final decision regarding which on-call individual to contact and whether or not that physician must come to the hospital.
- The ED physician can do a phone consult or may require the physician to come to the Department to actually see the patient.

Physician Education

- The ED physician may agree, if it is appropriate for the physician's PA, NP, or orthopedic tech to come and see the patient or whether the physician needs to come.
- Under the federal EMTALA law, if you are on-call you must show up within a reasonable time when called and requested to show up.

Physician Education

- The rule of thumb that has been used by CMS surveyors for a patient covered by EMTALA is 30-60 minutes, absent extenuating circumstances (e.g. in surgery, weather, etc.).
- Federal law requires the hospitals to have a time specified in our policy which for a true emergency is ___ minutes.
Physician Education

• If the hospital has to transfer a patient because the on-call MD did not show up, the sending hospital must provide the name and address of that physician to the receiving hospital.
• The receiving hospital must report the violation to CMS.
• This means both the hospital and physician could be surveyed and scrutinized to determine if a violation of EMTALA.

Physician Education

• Physicians, as well as hospitals, may be subject to penalties for violating EMTALA’s on-call provisions.
  • Physician risks include civil monetary penalties, lose of license, termination from Medicare and other federal health programs, criminal prosecution or civil lawsuits, and medical staff suspension and can be reported to the State Medical Board by OIG.

Physician Education

• Per CMS, having an office full of patients is not an allowable excuse for not coming in timely when on call and requested by the ED physician to come to the hospital.
• EMTALA requires the name of individual physician & not the name of the physician’s group practice to be included on the on-call list.
Physician Education

- EMTALA is a requirement to treat; it is not a requirement to pay
- The on-call physician must respond whether or not the patient belongs to a Managed Care Organization in which that physician participates, is a Medicaid or Medicare patient, or whether the patient has no insurance

Resources

- 20 Common Practices that will Get On-Call Physicians Cited at http://medlaw.com/healthlaw/EMTALA/education/20-common-practices-that-.shtml,
- The EMTALA Answer Book 2009 by Mark Moy, Aspen Publication,

Resources

- Surgeons Violate Sherman Act by Refusing On Call Emergency Care Duty, Hospital Says, Health Law Reporter, Vol 15, Number 2, January 12, 2006
Regional Offices

- Region I: Boston Regional Office
  States served: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

- Health Standards & Quality
  Center for Medicare Services
  JFK Federal Building, Room 2325
  Boston, MA 02203
  617-565-1298
  fax 617-565-4835

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Regional Offices

- Region II: New York Regional Office
  States and territories served: New Jersey, New York, Puerto Rico, Virgin Islands

- State Operations Branch (NY)
  Center for Medicare Services
  26 Federal Plaza, Room 3811
  New York, NY 10278-0063
  212-264-3124; fax 212-861-4240

- State Operations Branch (NJ, PR & VI)
  Center for Medicare Services
  26 Federal Plaza, Room 3811
  New York, NY 10278-0063
  212-264-2583; fax 212-861-4240

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Regional Offices

- Region III: Philadelphia Regional Office

- States and territories served: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia

- Division of Medicaid and State Operations
  Center for Medicare Services
  Suite 216, The Public Ledger Bldg.
  150 S. Independence Mall West
  Philadelphia, PA 19106
  215-861-4263
  fax 215-861-4240
Regional Offices

Region IV: Atlanta Regional Office
States served: Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi, Tennessee

Health Standards & Quality
Center for Medicare Services
61 Forsythe Street, SW, #4T20
Atlanta, GA 30301-8909
404-562-7458
fax 404-562-7477 or 7478

Regional Offices

Region V: Chicago Regional Office
States served: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin

Health Standards & Quality
Center for Medicare Services
233 N. Michigan Ave, Suite 600
Chicago, IL 60601
312-353-8862
fax 312-353-3419

Regional Offices

Region VI: Dallas Regional Office
States served: Arkansas, Louisiana, New Mexico, Oklahoma, Texas

State Operations Branch (TX)
Center for Medicare Services
1301 Young St., 8th Floor
Dallas, TX 75202
214-767-6179
fax 214-767-0270
### Regional Offices

<table>
<thead>
<tr>
<th>Region</th>
<th>Office</th>
<th>States Served</th>
<th>Address</th>
<th>Phone</th>
<th>Fax</th>
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<tbody>
<tr>
<td>Region VII</td>
<td>Kansas City Regional Office</td>
<td>Iowa, Kansas, Missouri, Nebraska</td>
<td>Richard Bolling Federal Building, 601 E. 12th St., Room 235, Kansas City, MO 64106-2808</td>
<td>816-426-2408</td>
<td>816-426-6769</td>
</tr>
<tr>
<td>Region VIII</td>
<td>Denver Regional Office</td>
<td>Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming</td>
<td>Health Standards &amp; Quality, Center for Medicare Services, 1600 Broadway, Suite 700, Denver, CO 80202</td>
<td>303-844-2111</td>
<td>303-844-3753</td>
</tr>
</tbody>
</table>
Regional Offices

- Region IX: San Francisco Regional Office
  States and territories served: American Samoa, Arizona, California, Commonwealth of Northern Mariana Islands, Guam, Hawaii, Nevada

  Health Standards & Quality
  Center for Medicare Services
  75 Hawthorne Street, 4th Floor
  San Francisco, CA 94105-3903
  415-744-3753
  fax 415-744-2692

Regional Offices

- Region X:
  Seattle Regional Office
  States served: Alaska, Idaho, Oregon, Washington

  Health Standards & Quality
  Center for Medicare Services
  2201 Sixth Ave.
  Mail Stop RX40
  Seattle, WA 98121-2500
  206-615-2410
  fax 206-625-2435

Questions?
EMTALA

- Are you up to the challenge?
- Sample educational memo for physician follows this slide
- List of regional offices follows this
- EMTALA resources

The End! Questions??

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Questions?