

EMTALA Update 2016

Emergency Medical Treatment and Labor Act Part 2 of 2



Speaker



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Deficiencies

May 13, 2016

**Tag 2400 Compliance with
EMTALA 489.24**

756

Tag 2401 Receiving
Inappropriate Transfer

10

Tag 2402 Posting Signs

140

Tag 2403 Maintain MR

30

Tag 2404 On call physician

126

Deficiencies

May 13, 2016

Tag 2405	ED Log	256	
2406	MSE	591	
2407	Stabilization Treatment	258	
2408	Delay in Exam	60	
2409	Appropriate Transfer	327	
2410	Sp Capability & Lateral Transfers	0	
2411	Recipient Hospital Responsibility	104	Total 2,667

Central Log 2405

- A central log must be 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)

Special Responsibilities 2406

- 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)

Comes to the ED Means

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

Comes to the ED Means

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

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Subpart B--ESSENTIALS OF PROVIDER AGREEMENTS

- [§489.20](#) Basic commitments.
- [§489.21](#) Specific limitations on charges.
- [§489.22](#) Special 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 HHAs.
- Special requirements concerning beneficiaries served

Basic Commitment Section

conditions and women in labor; and

(2) To post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital or rural primary care hospital participates in the Medicaid program under a State plan approved under title XIX.

(r) In the case of a hospital as defined in §489.24(b) (including both the transferring and receiving hospitals), to maintain—

(1) Medical and other records related to individuals transferred to or from the hospital for a period of 5 years from the date of the transfer;

(2) An on-call list of physicians who are on the hospital's medical staff or who have privileges at the hospital, or who are on the staff or have privileges at another hospital participating in a formal community call plan, in accordance with §489.24(j)(2)(iii), available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services required under §489.24 in accordance with the resources available to the hospital; and

(3) A central log on each individual who comes to the emergency department, as defined in §489.24(b), seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged.

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

(a) *Applicability of provisions of this section.* (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must—

(i) Provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction; and

(ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.

(2)(i) When a waiver has been issued in accordance with section 1135 of the Act that includes a waiver under section 1135(b)(3) of the Act, sanctions under this section for an inappropriate transfer or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department if the following conditions are met:

(A) The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period.

(B) The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan.

- (C) The hospital does not discriminate on the basis of an individual's source of payment or ability to pay.
- (D) The hospital is located in an emergency area during an emergency period, as those terms are defined in section 1135(g)(1) of the Act.
- (E) There has been a determination that a waiver of sanctions is necessary.
- (ii) A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided under section 1135(e)(1)(B) of the Act.

(b) *Definitions.* As used in this subpart—

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 and the hospital's past practices of accommodating additional patients in excess of its occupancy limits.

Comes to the emergency department means, with respect to an individual who is not a patient (as defined in this section), the individual—

(1) Has presented at a hospital's dedicated emergency department, as defined in this section, and requests examination or treatment for a medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition;

Hospital includes a critical access hospital as defined in section 1861(mm)(1) of the Act.

Hospital property means the entire main hospital campus as defined in §413.65(b) of this chapter, including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the hospital's main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities.

Hospital with an emergency department means a hospital with a dedicated emergency department as defined in this paragraph (b).

Inpatient means an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services as described in §409.10(a) of this chapter with the expectation that he or she will remain at least overnight and occupy a bed even though the situation later develops that the individual can be discharged or transferred to another hospital and does not actually use a hospital bed overnight.

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

Participating hospital means (1) a hospital or (2) a critical access hospital as defined in section 1861 (mm)(1) of the Act that has entered into a Medicare provider agreement under section 1866 of the Act.

Patient means—

provide a report on its findings in accordance with paragraph (h)(2)(iv) and (v) of this section. CMS provides to the QIO all information relevant to the case and within its possession or control. CMS, in consultation with the OIG, also provides to the QIO a list of relevant questions to which the QIO must respond in its report.

(2) Notice of review and opportunity for discussion and additional information. The QIO shall provide the physician and hospital reasonable notice of its review, a reasonable opportunity for discussion, and an opportunity for the physician and hospital to submit additional information before issuing its report. When a QIO receives a request for consultation under paragraph (h)(1) of this section, the following provisions apply—

(i) The QIO reviews the case before the 15th calendar day and makes its tentative findings.

(ii) Within 15 calendar days of receiving the case, the QIO gives written notice, sent by certified mail, return receipt requested, to the physician or the hospital (or both if applicable).

(iii)(A) The written notice must contain the following information:

(1) The name of each individual who may have been the subject of the alleged violation.

(2) The date on which each alleged violation occurred.

(3) An invitation to meet, either by telephone or in person, to discuss the case with the QIO, and to submit additional information to the QIO within 30 calendar days of receipt of the notice, and a statement that these rights will be waived if the invitation is not accepted. The QIO must receive the information and hold the meeting within the 30-day period.

(4) A copy of the regulations at 42 CFR 489.24.

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 of not part of the hospital such as **physician offices**, skilled nursing facilities, shops, restaurants

Hospital Property & 250 Yard Rule 2406

If an individual who is not a hospital patient comes elsewhere on **hospital property** (that is, the individual comes to the hospital but not to the dedicated emergency department), an EMTALA obligation on the part of the hospital may be triggered if either the individual requests examination or treatment for an **emergency** medical condition or if a prudent layperson observer would believe that the individual is suffering from an **emergency** medical condition. The term “hospital property” means the entire main hospital campus as defined in [§413.65\(a\)](#), including the parking lot, sidewalk and driveway or hospital departments, including any building owned by the hospital that are within **250** yards of the hospital).

If an individual is registered as an outpatient of the hospital and they present on hospital

Hospital Campus 250 Yard Rule

- Is defined to mean the physical area immediately adjacent to the providers 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 2406

- 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 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

Moving Patient to Another Department

- 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 106, JULY 2009

Replaces Practice Bulletin Number 70, December 2005

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

This Practice Bulletin was developed by the ACOG Committee on Practice Bulletins with the assistance of George A. Macones, MD. The information is designed to aid practitioners in making decisions about appropriate obstetric and gynecologic care. These guidelines should not be construed as dictating

In the most recent year for which data are available, approximately 3.4 million fetuses (85% of approximately 4 million live births) in the United States were assessed with electronic fetal monitoring (EFM), making it the most common obstetric procedure (1). Despite its widespread use, there is controversy about the efficacy of EFM, interobserver and intraobserver variability, nomenclature, systems for interpretation, and management algorithms. Moreover, there is evidence that the use of EFM increases the rate of cesarean deliveries and operative vaginal deliveries. The purpose of this document is to review nomenclature for fetal heart rate assessment, review the data on the efficacy of EFM, delin-

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
- Available at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter05-26.pdf>

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-05-26

DATE: April 22, 2005

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Interaction of the Emergency Medical Treatment and Labor Act (EMTALA) and the Born-Alive Infants Protection Act of 2002

Letter Summary

- The Born-Alive Infants Protection Act of 2002 (Pub. L. 107-207) adds to the United States Code a definition of the term “individual” to include every infant who is born alive, at any stage of development; it also adds a definition of the term “born alive.”

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&intNumPerPage=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
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-20

Date: April 27, 2007

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: EMTALA Issues Related to Emergency Transport Services

Memorandum Summary

- Hospitals may not condition their acceptance of an Emergency Medical Treatment and Labor Act (EMTALA)-related transfer upon the sending hospital's agreement to use a specific transport service designated by the receiving hospital.
- S&C 06-21 should not be interpreted to mean that a hospital cannot ever ask Emergency Medical Services (EMS) staff to stay with an individual transported by EMS to the

Parking of Patients 2006 Memo

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-06-21

DATE: July 13, 2006
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group
SUBJECT: EMTALA - "Parking" of Emergency Medical Service Patients in Hospitals

Letter Summary

- The Centers for Medicare & Medicaid Services (CMS) has received reports from hospital emergency departments concerning patients being left on stretchers for extended periods of time with emergency medical service personnel in attendance, possibly in violation of the Emergency Medical Treatment and Labor Act.
- CMS recognizes the enormous strain and crowding many hospital emergency departments face every day; however, this practice is not a solution.
- "Parking" patients in hospitals impacts the ability of the emergency medical service personnel to provide emergency services to the rest of the community.

The Centers for Medicare & Medicaid Services (CMS) has learned that several hospitals

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

Helipad 2406

- If hospital is sending a patient then they must have conducted a MSE prior to transporting the patient to the helipad
- Sending hospital must still implement stabilizing treatment if sending a patient to the helipad
- Hospital with helipad is not required to perform MSE when helipad is used as point of entry by the squad or other hospitals

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).

File Name: 09a0137p.06

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

JOHNELLA RICHMOND MOSES, Personal
Representative of the Estate of MARIE MOSES
IRONS, deceased,

Plaintiff-Appellant,

v.

PROVIDENCE HOSPITAL AND MEDICAL
CENTERS, INC. and PAUL LESSEM,

Defendants-Appellees,

CHRISTOPHER WALTER HOWARD,

Third-Party Defendant.

No. 07-2111

Appeal from the United States District Court
for the Eastern District of Michigan at Detroit.
No. 04-74889—Anna Diggs Taylor, District Judge.

Argued: December 5, 2008

Decided and Filed: April 6, 2009

Before: CLAY and GIBBONS, Circuit Judges; STAMP, District Judge.*

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?

ACEP News - July 1998

▪ www.acep.org/emtala/

By Robert A. Bitterman, 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 lab tests or x-rays during off-hours, and hospitals provide urine drug screens on injured workers, prescription refills, allergy shots, rabies vaccinations or 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 the patient is suffering from an emergency medical condition.

The statutory language of EMTALA requires the hospital to provide a medical screening examination (MSE) to anyone who "comes to the emergency department" and "requests

[Feedback]

EMC and Stabilization 2407

- 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 a 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

Definition of EMC

- 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 2407

- 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

Psychiatric Patients

- 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 Litcher (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 be 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.”

Emergency Medical Condition (EMC) Identified: (Mark appropriate box(es), then go to Section II)

I. MEDICAL CONDITION: Diagnosis _____

<input type="checkbox"/> No Emergency Medical Condition Identified: This patient has been examined and an EMC has not been identified.
<input type="checkbox"/> Patient Stable - The patient has been examined and any medical condition stabilized such that, within reasonable clinical confidence, no material deterioration of this patient's condition is likely to result from or occur during transfer.
<input type="checkbox"/> Patient Unstable - The patient has been examined, an EMC has been identified and patient is not stable, but the transfer is medically indicated and in the best interest of the patient.
<i>I have examined this patient and based upon the reasonable risks and benefits described below and upon the information available to me, I certify that the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to this patient's medical condition that may result from effecting this transfer.</i>

II. REASON FOR TRANSFER: Medically Indicated Patient Requested _____

On-call physician refused or failed to respond within a reasonable period of time.

Physician Name _____ Address _____

III. RISK AND BENEFIT FOR TRANSFER:

Medical Benefits: <input type="checkbox"/> Obtain level of care / service NA at this facility. Service _____ <input type="checkbox"/> Benefits outweigh risks of transfer	Medical Risks: <input type="checkbox"/> Deterioration of condition en route _____ <input type="checkbox"/> Worsening of condition or death if you stay here. <small>There is always risk of traffic delay/accident resulting in condition deterioration.</small>
---	--

IV. Mode/Support/Treatment During Transfer as Determined by Physician - (Complete Applicable Items):

Mode of transportation for transfer: BLS ALS Helicopter Neonatal Unit Private Car Other _____

Agency _____ Name/Title accompany hospital employee _____

Support/Treatment during transfer: Cardiac Monitor Oxygen - (Liters) _____ Pulse Oximeter IV Pump

IV Fluid _____ Rate _____ Restraints - Type _____ Other _____ None

Radio on-line medical oversight (if necessary): Transfer Hospital Destination Hospital Other _____

V. Receiving Facility and Individual: The receiving facility has the capability for the treatment of this patient (including adequate equipment and medical personnel) and has agreed to accept the transfer and provide appropriate medical treatment.

Receiving Facility / Person accepting transfer _____ Time _____

Receiving MD _____

Transferring Physician Signature _____ Date/Time _____

VI. ACCOMPANYING DOCUMENTATION – sent via: Patient/Responsible Party Fax Transporter

Copy of Pertinent Medical Record Lab/ EKG/ X-Ray Copy of Transfer Form Court Order

Advance Directive Other _____

Report given (Person / title) _____

Time of Transfer _____ Date _____ Nurse Signature _____ Unit _____

Vital Signs Just Prior to Transfer T _____ Pulse _____ R _____ BP _____ Time _____

VII. PATIENT CONSENT TO "MEDICALLY INDICATED" OR "PATIENT REQUESTED" TRANSFER:

I hereby **CONSENT TO TRANSFER** to another facility. I understand that it is the opinion of the physician responsible for my care that the benefits of transfer outweigh the risks of transfer. I have been informed of the risks and benefits upon which this transfer is being made.

I hereby **REQUEST TRANSFER** to _____. I understand and have considered the hospital's responsibilities, the risks and benefits of transfer, and the physician's recommendation. I make this request upon my own suggestion and not that of the hospital, physician, or anyone associated with the hospital.

The reason I request transfer is _____

Signature of Patient Responsible Person _____ Relationship _____

Witness _____ Witness _____

TRANSFER FORM

White: Receiving Facility; Yellow: Medical Record; Pink: QA

Patient Name:

Date of Birth:

Medical Record Number:

Ca Hospitals Make Sure Contact Notified

December 30, 2013

www.cdph.ca.gov/certlic/facilities/Documents/LNC-AFL-13-37.pdf

AFL 13-37

TO: General Acute Care Hospitals

SUBJECT: Patient Transfer: Non-Medical Reasons: Notification

AUTHORITY: Health and Safety Code (HSC) Section 1317.2
and Civil Code (CIV) 56.1007

This All Facilities Letter (AFL) letter is being sent to notify general acute care hospitals (GACHs) of new requirements which take effect January 1, 2014. Assembly Bill (AB) 974 (Chapter 711, Statutes of 2013) amends Health and Safety Code Section 1317.2 relating to patient transfer for non-medical reasons and notification to their preferred contact or their next of kin.

Existing law prohibits the transfer of a person needing emergency services from one hospital to another for any non-medical reason unless prescribed conditions are met. Effective January 1, 2014, HSC 1317.2 will also require that prior to a transfer of a patient for a non-medical reason, the hospital ask the patient if there is a preferred contact person to be notified, and make a reasonable attempt to contact the person and alert him or her about the proposed transfer, and if the patient is not able to respond, require that the hospital make a reasonable effort to ascertain the identity of the preferred contact person or the next of kin and alert him or her about the transfer. Hospitals will additionally be required to document any attempt to contact a preferred contact person or next of kin in the patient's medical record.

The information in this AFL is a brief summary of AB 974. Facilities are responsible for following all applicable laws. The California Department of Public Health's (CDPH) failure to expressly notify facilities of legislative changes and/or statutory and regulatory requirements does not relieve facilities of their responsibility for following all laws and for being aware of all legislative changes. Facilities should refer to the full text of Health & Safety Code Sections 1317.2 and Civil Code 56.1007 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 Quality Improvement Organization
- Every state has one which is under contract by CMS
 - 2 BFCC ones for Livanta and KePRO
- 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/physician 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

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)

▪ www.qionews.org/articles/july-2014-special-focus/beneficiary-and-family-centered-care-quality-improvement-orga



Area 1 - Livanta Area 2 - KEPRO Area 3 - KEPRO
Area 4 - KEPRO Area 5 - Livanta

Beneficiary & Family Centered Care 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.BFCCQIOAREA5.com

EMTALA KEPRO

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EMTALA

We are the Medicare Quality Improvement Organization, working to improve the quality of care for Medicare beneficiaries. Our site offers beneficiary and family-centered care information for providers, patients, and families. Welcome!

KEPRO conducts a five-day medical advisory review upon request from the appropriate Centers for Medicare & Medicaid Services (CMS) regional office. KEPRO's physician conducts a medical assessment of a potential [Emergency Medical Treatment and Labor Act \(EMTALA\)](#) violation case as specified in [Part 9 of the QIO Manual \(Attachment J-4\)](#). The five-day review is not mandated by the federal statute and regulations. However, the regional office may use this review as a resource in making a compliance determination, rather than simply determining the merits of the complaint.

Under sections 1867(d)(3) of the Act and 42 CFR §489.24(g), KEPRO is required to conduct a 60-day review upon receipt of a completed EMTALA case sent to the Office of the Inspector General for possible civil monetary penalty or exclusion sanction as outlined in Part 9 of the QIO Manual.

QIO Manual 68 Pages Anti-Dumping

Quality Improvement Organization Manual

Chapter 9 - Sanction and Abuse Issues

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(Rev. 12, 10-03-03)

[www.cms.gov/Regulations
-and-
Guidance/Guidance/Manu
als/downloads/qio110c09.
pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c09.pdf)

SANCTIONS

- 9000 - Citations and Authority
- 9005 - Identification of Potential Violations
- 9010 - Meeting With a Practitioner or Other Person
- 9015 - QIO Finding of a Violation
- 9020 - QIO Action on Final Finding of a Violation
- 9025 - QIO Report to Office of the Inspector General (OIG)
- 9030 - Imposition and Notification of Sanctions
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- 9040 - Reinstatement After Exclusion
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ANTI-DUMPING

- 9100 - Statutory Background
- 9110 - Hospital Requirements
- 9120 - Hospital Penalties for Noncompliance
- 9130 - Regional Office Responsibilities

9100 - Statutory Background

(Rev.12, 10-03-03)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), PL 99-272, revised §1866, "Agreements with Providers of Services," of the Social Security Act (the Act), and added §1867, "Examination and Treatment for Emergency Medical Conditions and Women in Active Labor." This section prohibited hospitals with emergency departments from turning away or transferring patients without screening for emergency medical conditions, and stabilizing such conditions or determining that transfer is in the best interest of the patient. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89), PL 101-239, further refined the requirements of §1154, "Functions of Peer Review Organizations," §§1866 and 1867 of the Act, and deleted the word "Active" from the title of §1867.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90), PL 101-508, added §1867(d)(3). This section, titled "Consultation with Peer Review Organizations," is implemented by 42 CFR 489.24(g). These regulations require that, unless the delay would jeopardize the health or safety of individuals, or when there was no screening examination, CMS will request Quality Improvement Organizations (QIOs) to review cases where a medical opinion is necessary to determine a physician's or hospital's liability under §1867(d)(1) of the Act. The QIO will provide a report on their findings before the OIG may impose a Civil Monetary Penalty (CMP) against a physician or hospital or an exclusion sanction against a physician. The QIO must also offer the involved physician(s) and hospital(s) an opportunity to discuss the case and an opportunity to submit additional information before OIG may impose sanctions (except in cases where the delay would jeopardize the health or safety of individuals or when there was no screening examination).

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

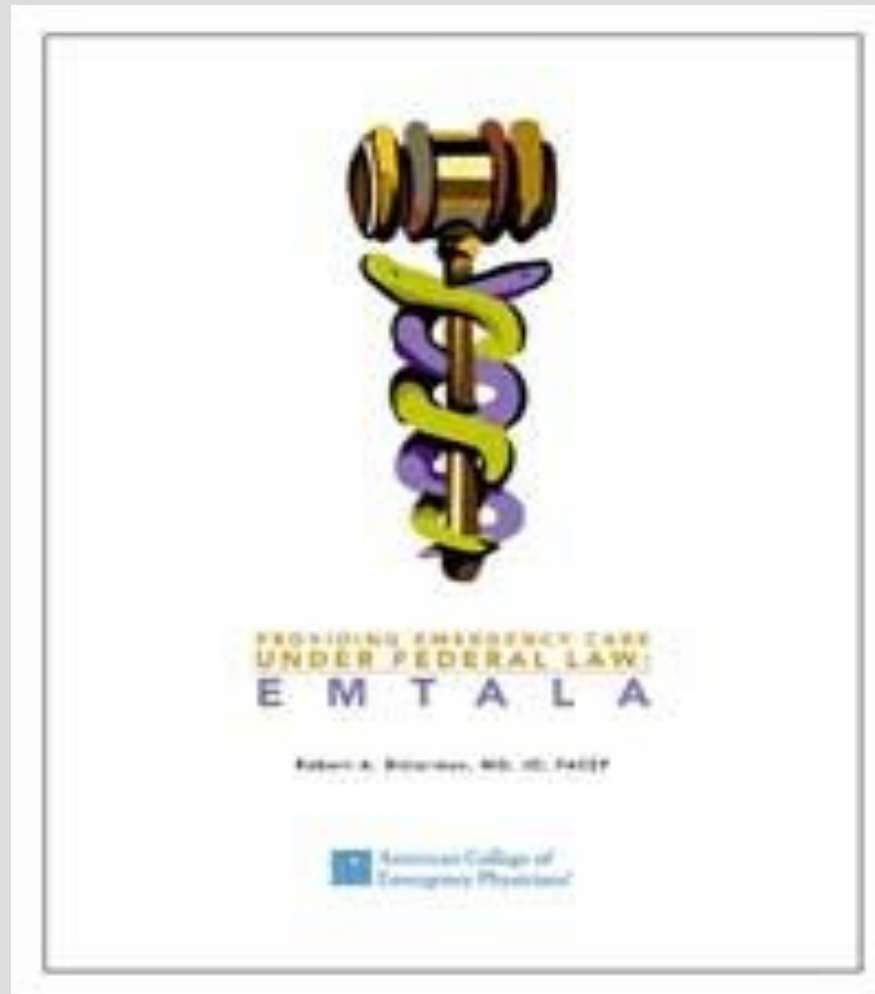
- Appropriate MSE 2406
- Stabilizing treatment 2407
- No delay in exam 2408
- Appropriate transfer 2409
- Whistle blower protection 2410
- Recipient hospital responsibilities 2411

The End! Questions??



- Sue Dill Calloway RN, Esq. CPHRM
- AD, BA, BSN, MSN, JD
- President of the Patient Safety and Education Consulting
- Board Member
Emergency Medicine Patient Safety Foundation at www.empsf.org
- 5447 Fawnbrook Lane
- Dublin, Ohio 43017
- 614 791-1468
- 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,
- Bitterman, Robert A, MD, JD. Providing Emergency Care Under Federal Law- EMTALA, American College of Emergency Physicians. 2001. Supplement 2004
- 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
 - <http://www.medlaw.com/healthlaw/EMTALA/education/20-common-practices-that-.shtml>

20 Common Practices Article

- 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

20 Common Practices Article

- 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 physicians 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 emergencies 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

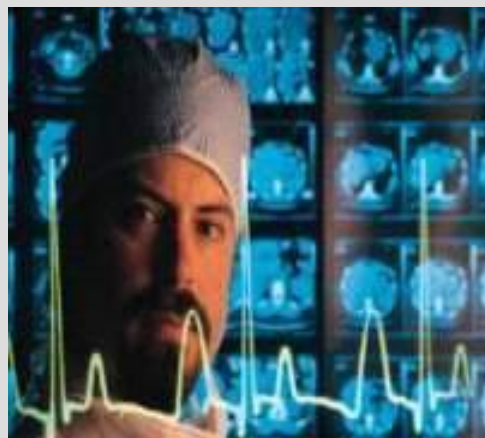
Physician Education

- 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,
- Bitterman, Robert A, MD, JD. Providing Emergency Care Under Federal Law-EMTALA, American College of Emergency Physicians. 2001. Supplement 2004.

Resources



- On Call Specialist Coverage in ED, ACEP Survey of ED Directors, Sept 2004, and 2006 ACEP Survey
- Surgeons Violate Sherman Act by Refusing On Call Emergency Care Duty, Hospital Says, Health Law Reporter, Vol 15, Number 2, January 12, 2006

Resources Case Reporter

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EMTALA Resources

Dr. Sullivan is a leading national authority on EMTALA. He has provided many educational offerings and has published extensively in this area. TSG offers several courses on EMTALA ranging from a comprehensive offering to a more limited course specifically for physicians on call for the emergency department. Several of the nation's largest health care organizations look to TSG for web-based EMTALA education.

Today more than ever it is critical that medical staff in the emergency department, urgent care facilities, labor and delivery, physicians on call for the emergency department, and hospital administrators understand EMTALA and related issues. The failure to understand this law and its regulations will inevitably result in violations of the law, and expose you to liability. Additionally, the hospital is at risk for substantial fines and loss of participation in the Medicare program.

TSG web-based education is enjoyable, interactive, and provides CME and CE credit. The courses are accredited through the American College of Emergency Physicians, the American College of Osteopathic Emergency Physicians, and the Emergency Nurses Association.

- [EM Risk Initiative](#)
- [E-Learning](#)
- [ED Audit & Reporting Tools](#)
- [TSG PowerDoc™](#)
- [Risk & Safety Overlay for EDIS](#)
- [EMTALA Resources](#)
 - [EMTALA Case Reporter](#)
 - [CMS Reporter](#)
 - [EMTALA Quiz](#)
 - [View EMTALA Brochure](#)
- [Brochures](#)

Call us for more information
1-800-455-4555 Med-Risk

[EMTALA : Resources](#)

- [CMS Addresses Swine Flu: August 14, 2009](#)
- [CMS Final Rule: Revisions to EMTALA March 6, 2008](#)

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www.thesullivangroup.com/products_services/ps_emptala_solutions.asp

EMTALA Resources



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Announcements

Main Resources

The Main Resources segment of this site contains all material posted to this website prior to January 1, 2011. The software used to maintain this segment of the website is no longer supported by the manufacturer. We have elected to maintain this information online for your use.

Our Blog

Effective January 1, 2011, all new items will be posted to our blog.

www.medlaw.com/

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EMTALA Resource Center

Set forth below are the statutes, regulations and other documentation regarding the Emergency Medical Treatment and Active Labor Act requirements.

[Sixth Circuit Court of Appeals Extends EMTALA Protection to Certain Inpatients and as a result](#)

[CMS to Revisit Rules on EMTALA Application to Inpatients](#)

January 2011

CMS recently issued an Advance Notice of Proposed Rulemaking stating that it is considering revising the EMTALA rules regarding the application of EMTALA to hospital inpatients.

Federal Statutes

[Emergency Medical Treatment and Active Labor Act 42 U.S.C. 1395dd](#)

Full text of the EMTALA statute.

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www.bricker.com/services/resource-details.aspx?resourceid=188

EMTALA Resources

The screenshot displays the Essent Healthcare website's compliance program page. The top navigation bar includes links for HOME, QUALITY COMMITMENT, CAREERS, PHYSICIAN OPPORTUNITIES, COMPLIANCE PROGRAM, HEALTH RESOURCES, and CONTACT US. A search bar is located in the top right corner. The left sidebar contains a menu with the following items: Code of Conduct, Compliance Policies, Contact Compliance Officer, EMTALA, EMTALA Resources, Handbooks, HIPAA Privacy, HIPAA Security, Reporting Hotline, Resources Links, and Secure e-mail. The main content area is titled "COMPLIANCE PROGRAM" and features a large red sign with a white arrow pointing left and the word "Emergency" in white text. Below the sign, the text "Compliance Reporting Hotlin 1-800-472-886" is displayed in red. Under the heading "Links to EMTALA Resources", a list of links is provided: Essent Healthcare EMTALA Training Presentation, Essent Employee Guide to EMTALA, EMTALA Interim Guide from CMS, EMTALA On-Call Requirements from CMS, EMTALA Interpretive Guidelines from CMS, Special Advisory Bulletin on Patient Dumping, and EMTALA and ARNs.

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COMPLIANCE PROGRAM

← Emergency


Compliance Reporting Hotlin
1-800-472-886

Links to EMTALA Resources

- [Essent Healthcare EMTALA Training Presentation](#)
- [Essent Employee Guide to EMTALA](#)
- [EMTALA Interim Guide from CMS](#)
- [EMTALA On-Call Requirements from CMS](#)
- [EMTALA Interpretive Guidelines from CMS](#)
- [Special Advisory Bulletin on Patient Dumping](#)
- [EMTALA and ARNs](#)

www.essenthealthcare.com/page.cfm?page_id=642

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www.aaem.org/emtala/resources.php

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Position Statements

Accountable Care Organizations

Critical EM & Practice Issues

Legal

Practice Guidelines and Statements

Regulatory Issues

EMTALA

CMS News

Resources

EMTALA Resources and References

Statute, Regulations, and Government Interpretive Guidelines.

1. 42 USC 1395dd (EMTALA statute)
2. 42 CFR 489.24; 42 CFR 489.20 (EMTALA regulations)
3. 68 Fed. Reg. 53,221-53264 (2003): the new final EMTALA regulations on EMTALA published by CMS in the Federal Register on September 9, 2003. The new regulations became effective November 10, 2003. A copy of the new EMTALA rules can be found though the Federal Register Online GPO Access at:
http://www.access.gpo.gov/su_docs/fedreg/a030909c.html under "Separate parts in this issue."
4. CMS's Interpretive Guidelines (issued in May 2004) for state surveyors and CMS regional offices regarding the enforcement of EMTALA under the new regulations is available on line at <http://www.cms.hhs.gov/medicaid/survey-cert/letters.asp>.

ACEP EMTALA Resources

The screenshot displays the ACEP website interface. At the top, the ACEP logo and navigation menu are visible. The main content area features a 'News Media' banner with a microphone background. Below this, a sidebar on the left lists various resources, and the main content area displays an advertisement for ACEP and a section titled 'EMTALA' with a 'Main Points' heading. A URL is overlaid on the page, and a small advertisement for the Emergency Medicine Foundation is visible on the right side.

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www.acep.org/content.aspx?LinkIdIdentifier=id&id=25936&fid=1754&Mo=No&acepTitle=EMTALA

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EMTALA

Main Points

- The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law

Emergency Medicine Foundation
Making a Difference
www.emfoundation.org

ACEP Position Statements

The screenshot displays the ACEP website's 'ACEP Policy Statements' page. At the top, the ACEP logo is visible with the tagline 'ADVANCING EMERGENCY CARE'. The navigation menu includes 'Clinical & Practice Management', 'Continuing Education', 'Professional Development', 'Meetings & Events', 'Advocacy', 'Membership', and 'Bookstore'. The current page is 'ACEP Policy Statements', with a breadcrumb trail: 'Clinical & Practice Management > ACEP Policy Statements'. A search bar is present, and there are links for 'Print', 'Email', and 'Share This'. The main content area features a large image of a hand holding a stethoscope, with the text 'Clinical & Practice Management' overlaid. Below this, the 'ACEP Policy Statements' section includes a search bar with the text 'Search Policy Statements:' and a 'Search' button. A paragraph of text follows: 'ACEP board-approved policy statements highlight the scope of issues being addressed in emergency medicine. New policies are initially distributed to ACEP members via Annals of Emergency Medicine and posted here. In addition, the ACEP Board of Directors...'. To the right, a 'Related Links' section lists 'Policy statements' with sub-links: 'Alternative Methods to Vascular Access in the Emergency Department' and 'Definition of an Emergency'.

www.acep.org/policystatements/

Clinical & Practice Management

ACEP Policy Statements

Search Policy Statements:

ACEP board-approved policy statements highlight the scope of issues being addressed in emergency medicine. New policies are initially distributed to ACEP members via Annals of Emergency Medicine and posted here. In addition, the ACEP Board of Directors...

Related Links

Policy statements

- » Alternative Methods to Vascular Access in the Emergency Department
- » Definition of an Emergency

Medical-Legal: EMTALA

Links to other sites:

- [CMS Regional Offices for Reporting EMTALA Violations](#)
- [Interpretive Guidelines - Responsibilities of Medicare Participating Hospitals in Emergency Cases](#)

Links to ACEP Resources

www.acep.org/emtala/

[Ambulance Diversion](#)

[Appropriate Interhospital Patient Transfer](#)

[EMTALA Fact Sheet](#)

[On-Call Speciality Shortage Resources](#)

[Providing Emergency Care Under Federal Law: EMTALA](#)

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 ACEP Members

[Blood Alcohols, Labs and Minor Treatments in the ED: Is a Medical Screening Exam Required by EMTALA?](#)

★★★★★

[Emergency Medical Treatment and Labor Act \(EMTALA\) Interim Guidance](#)

★★★★★

[CMS Letter to State Survey Agency Directors](#)

★★★★★

EMTALA Resources

emtala.com

A resource for current information about the Federal Emergency Medical Treatment and Labor Act, also known as COBRA or the Patient Anti-Dumping Law. EMTALA requires most hospitals to provide an examination and needed stabilizing treatment, without consideration of insurance coverage or ability to pay, when a patient presents to an emergency room for attention to an emergency medical condition.

[Statutes/Regulations](#) | [FAQ](#) | [News](#) | [History](#) | [Enforcement](#)

Frequently Asked Questions

<http://emtala.com/>

We have prepared a compilation of [Frequently Asked Questions](#) about EMTALA. The format has been updated.

Reference information

[Statute and regulations](#) - This section also includes the materials relating to the State Operating Manual and the Interpretive Guidelines used by CMS in doing hospital compliance surveys.

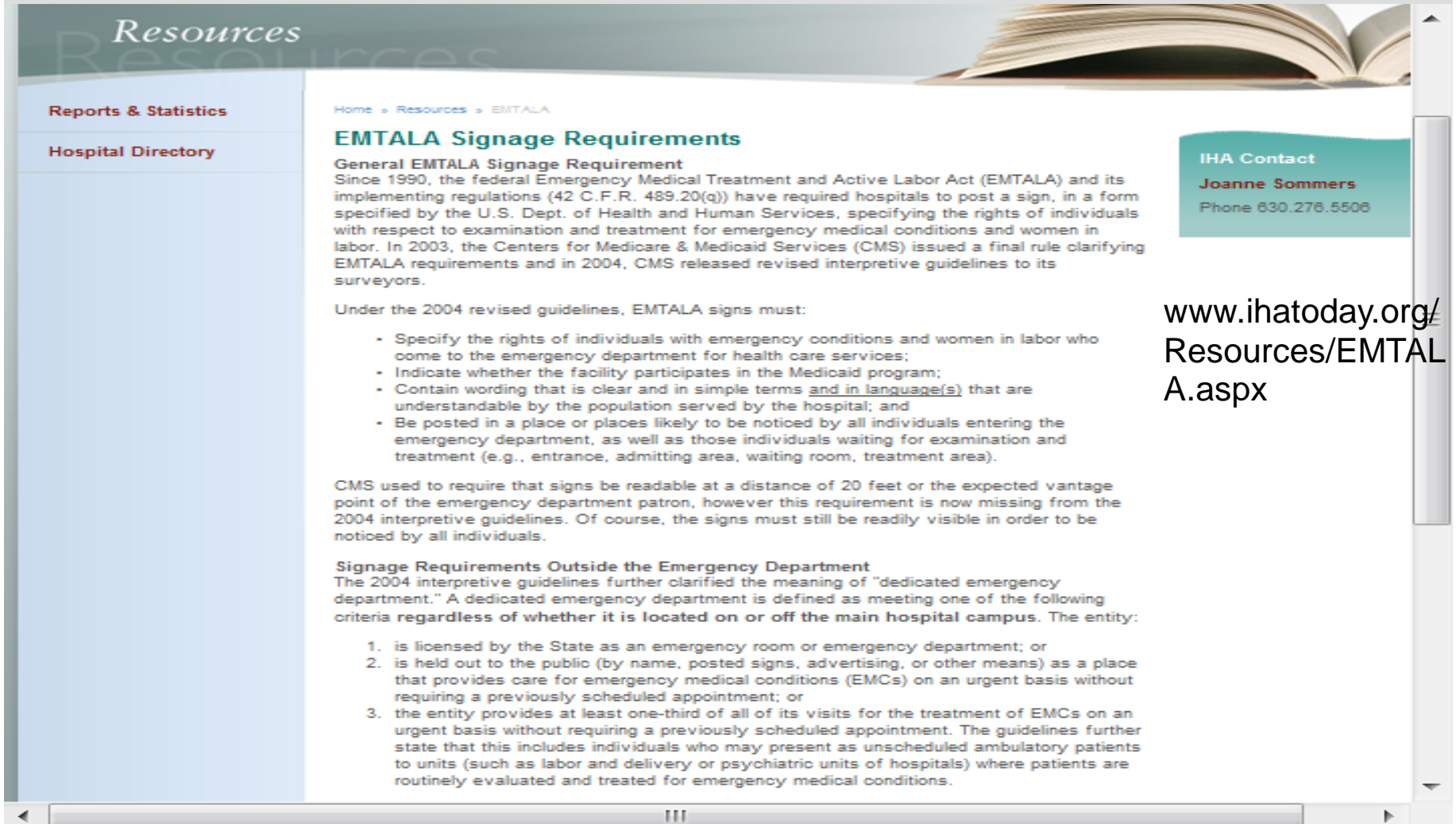
News on EMTALA - See our [news items](#) page.

Cases on EMTALA - We have prepared a listing and short description of several [judicial decisions](#) issued on EMTALA. This page also provides links to the short articles and commentary that we have posted regarding key cases.

Our writeups - Short articles on selected cases

[Roberts v. Galen of Virginia](#) - The Supreme Court misses the boat on EMTALA

EMTALA Sign



The screenshot shows a web browser window displaying a page from the IHA website. The page title is "EMTALA Signage Requirements". The left sidebar contains navigation links for "Reports & Statistics" and "Hospital Directory". The main content area includes a breadcrumb trail "Home > Resources > EMTALA", a sub-header "EMTALA Signage Requirements", and several paragraphs of text explaining the EMTALA signage requirements. A list of requirements is provided, followed by a note about CMS changes and a section on signage requirements outside the emergency department. A contact box on the right lists "IHA Contact" as Joanne Sommers with phone number 830.276.5506. The URL "www.ihatoday.org/Resources/EMTALA.aspx" is displayed on the right side of the browser window. The browser's address bar and navigation buttons are visible at the bottom of the screenshot.

Resources

Reports & Statistics

Hospital Directory

Home > Resources > EMTALA

EMTALA Signage Requirements

General EMTALA Signage Requirement

Since 1990, the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and its implementing regulations (42 C.F.R. 489.20(q)) have required hospitals to post a sign, in a form specified by the U.S. Dept. of Health and Human Services, specifying the rights of individuals with respect to examination and treatment for emergency medical conditions and women in labor. In 2003, the Centers for Medicare & Medicaid Services (CMS) issued a final rule clarifying EMTALA requirements and in 2004, CMS released revised interpretive guidelines to its surveyors.

Under the 2004 revised guidelines, EMTALA signs must:

- Specify the rights of individuals with emergency conditions and women in labor who come to the emergency department for health care services;
- Indicate whether the facility participates in the Medicaid program;
- Contain wording that is clear and in simple terms and in language(s) that are understandable by the population served by the hospital; and
- Be posted 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 (e.g., entrance, admitting area, waiting room, treatment area).

CMS used to require that signs be readable at a distance of 20 feet or the expected vantage point of the emergency department patron, however this requirement is now missing from the 2004 interpretive guidelines. Of course, the signs must still be readily visible in order to be noticed by all individuals.

Signage Requirements Outside the Emergency Department

The 2004 interpretive guidelines further clarified the meaning of "dedicated emergency department." A dedicated emergency department is defined as meeting one of the following criteria regardless of whether it is located on or off the main hospital campus. The entity:

1. is licensed by the State as an emergency room or emergency department; or
2. is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions (EMCs) on an urgent basis without requiring a previously scheduled appointment; or
3. the entity provides at least one-third of all of its visits for the treatment of EMCs on an urgent basis without requiring a previously scheduled appointment. The guidelines further state that this includes individuals who may present as unscheduled ambulatory patients to units (such as labor and delivery or psychiatric units of hospitals) where patients are routinely evaluated and treated for emergency medical conditions.

IHA Contact
Joanne Sommers
Phone 830.276.5506

www.ihatoday.org/
Resources/EMTALA.aspx

American Health Lawyers Association



[www.healthlawyers.org/Resources/Health%20Law%20Wiki/Emergency%20Medical%20and%20Labor%20Treatment%20Act%20\(EMTALA\).aspx](http://www.healthlawyers.org/Resources/Health%20Law%20Wiki/Emergency%20Medical%20and%20Labor%20Treatment%20Act%20(EMTALA).aspx)

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Emergency Medical and Labor Treatment Act (EMTALA)

Overview of Issue

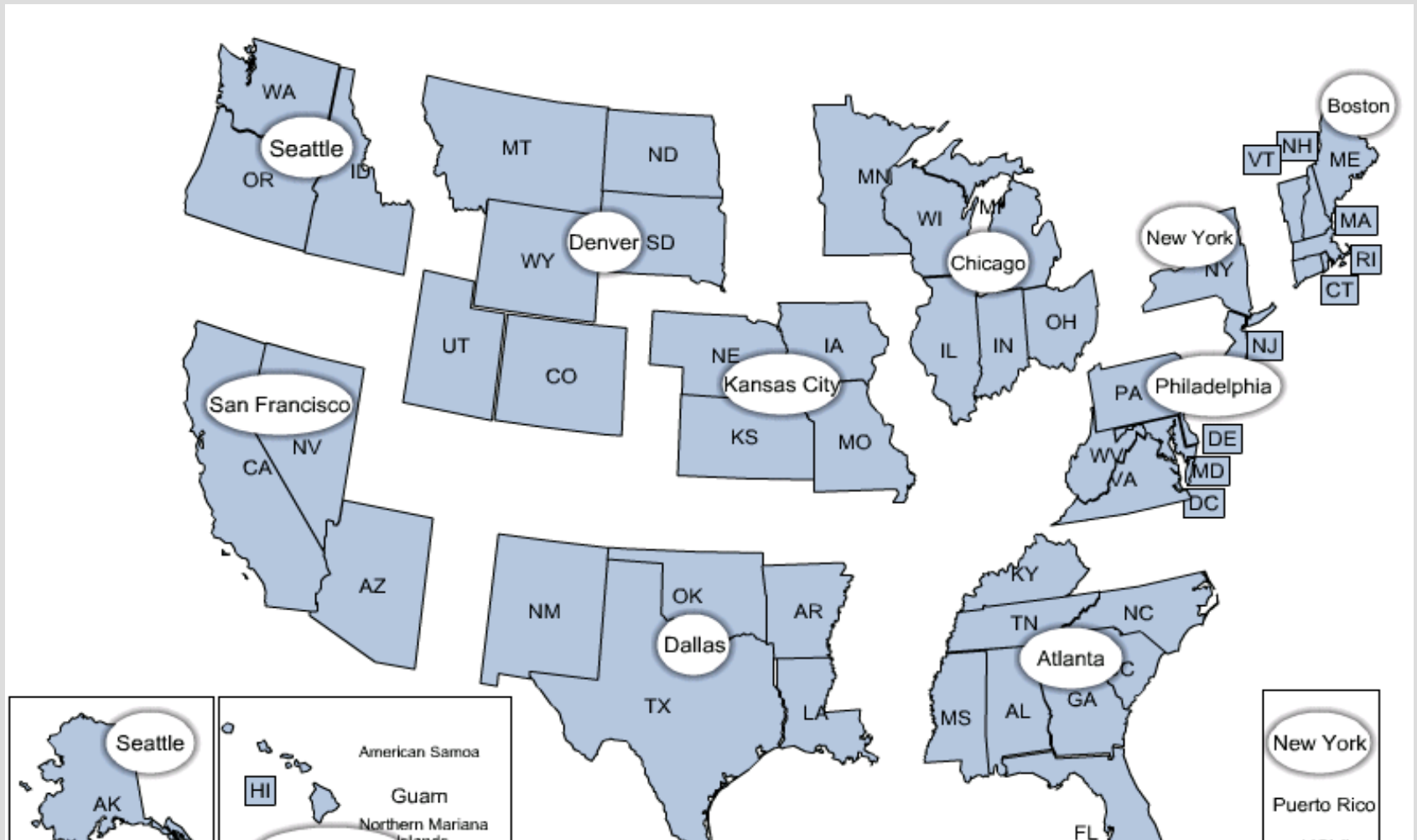
The Emergency Medical Treatment and Active Labor Act (EMTALA), also known as the "Patient Anti-Dumping" statute, is a Federal statute intended to prevent Medicare-participating hospitals with dedicated emergency departments from refusing to treat people based on their insurance status or ability to pay. The core objective of EMTALA is to protect patients seeking emergency care who might otherwise go untreated and be left without a remedy. Although EMTALA's focus is upon preventing disparate treatment of patients who cannot pay for treatment, EMTALA applies to all patients whether or not eligible for Medicare benefits. (42 U.S.C. § 1395dd (a)). The specific requirements of the statute are detailed in regulations that have been the subject of frequent regulatory action and court decisions.

Policy

EMTALA was enacted in 1986 under Section 1867 of the Social Security Act. (42 U.S.C. § 1395dd). EMTALA was passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Pub. L. 99-272). Congress enacted EMTALA in response to wide spread concerns that hospitals were denying emergency care to indigent and uninsured patients, and shunting them ("dumping") to another facility for care, or to no facility at all, by discharging the patient after a cursory inadequate medical examination.

Authority

CMS Regional Offices



Regional Offices

- Region 1: 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

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

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

- State Operations Branch (OK, NM)
Center for Medicare Services
1301 Young St., 8th Floor
Dallas, TX 75202
214-767-3570
fax 214-767-0270
- State Operations Branch (AR, LA)
Center for Medicare Services
1301 Young St., 8th Floor
Dallas, TX 75202
214-767-6346
fax 214-767-0270

Regional Offices

- Region VII: Kansas City Regional Office
States served: Iowa, Kansas, Missouri, Nebraska
- Center for Medicare Services
Richard Bolling Federal Building
601 E. 12th St., Room 235
Kansas City, MO 64106-2808
816-426-2408
fax 816-426-6769

Regional Offices

- Region VIII: Denver Regional Office
States served: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
- Health Standards & Quality
Center for Medicare Services
1600 Broadway, Suite 700
Denver, CO 80202
303-844-2111
fax 303-844-3753

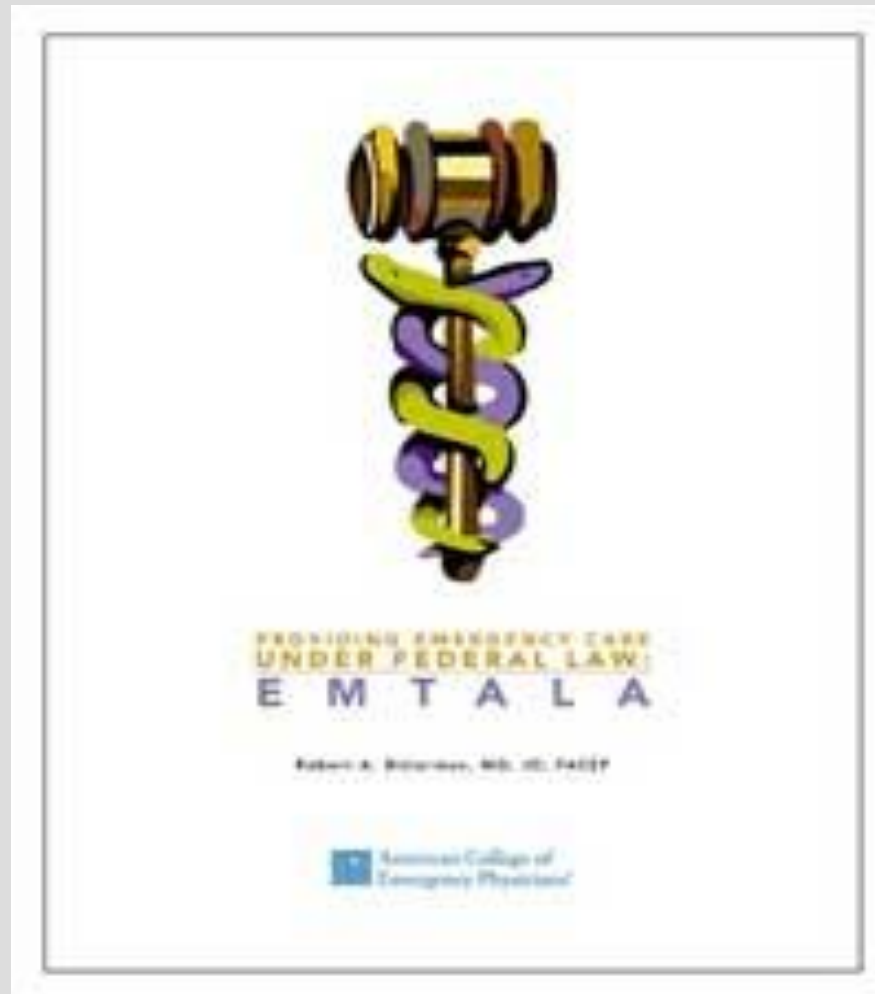
Regional Offices

- Region IX: San Francisco Regional Office
States and territories served: American Samoa, Arizona, California, Commonwealth of Northern Marianas 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

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

The End! Questions??



- Sue Dill Calloway RN, Esq. CPHRM
- AD, BA, BSN, MSN, JD
- President of the Patient Safety and Education Consulting
- Chief Learning Officer for the Emergency Medicine Patient Safety Foundation at www.empsf.org
- 5447 Fawnbrook Lane
- Dublin, Ohio 43017
- 614 791-1468
- sdill1@columbus.rr.com