EMTALA Update 2016

Emergency Medical Treatment and Labor Act Part 1 of 2
Speaker

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- Board Member
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Proposed Changes by the OIG

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

- Clarify that on-call physicians at any participating hospital subject to EMTALA, including the hospital a patient initially presents to and the hospital with specialized capabilities or that has received a request to accept a transfer, face potential CMP and exclusion liability under EMTALA; and

- Revise the factors to clarify that aggravating circumstances include: a request for proof of insurance or payment prior to screening or treatment, patient harm, unnecessary risk of patient harm, premature discharge, or a need for additional services or subsequent hospital admission that resulted or could have resulted from the incident, and whether the individual presented with a medical condition that was an emergency medical condition.
Proposed EMTALA Changes

addition, we include the statutory language stating that the calculation of the total remuneration for purposes of an assessment does not consider whether any portion of the remuneration has a lawful purpose.

Subpart D—CMPs and Assessments for Misconduct by a Managed Care Organization

Subpart D contains the proposed provisions for penalties and assessments against managed care organizations. We propose several stylistic changes to the regulations currently listed at § 1003.103(f). We changed the verbs in this subpart from past tense to present tense to conform to the statutory language, authorities, and many other regulations in this paragraph. The proposed regulation also removes superfluous phrases, such as “in addition to or in lieu of other remedies available under law.” The proposed regulation replaces references to “an individual or entity” with “a person” because “person” is defined in the proposed section as an individual or entity. The proposed regulation also removes the phrase “for each determination by CMS.” OIG may impose CMPs in addition to, or in place of, sanctions imposed by CMS under its authorities.

We also added to the regulations an authority to impose CMPs against Medicare Advantage contracting organizations pursuant to section 1857(g)(1) of the Act and against Part D contracting organizations pursuant to section 1860D–12(b)(3) of the Act.

As discussed above, ACA amended several provisions of the Act that apply to transactions by Medicare Advantage or Part D contracting organizations. We have included these provisions in the proposed regulations. We added the change in section 6408(b)(2)(C) of ACA regarding assessment of a Medicare Advantage or Part D contracting organization when its employees, agents, or any provider or supplier it contracts with violate the law, which is effective under section 1857. We propose to add the five new violations created in ACA, and their corresponding penalties, at § 1003.410(c).

We also propose to include the new assessments, which are available for two of the five new violations, at §1003.410(c). We also propose to include the text closely mirrors that of the statute.

The violations in this subpart are grouped according to the contracting organization. Under section 1867(d) of the Act, participating hospitals and liable CMs of up to $50,000 ($25,000 for hospitals with fewer than 100 State-licensed beds) for each negligent violation of their respective EMTALA obligations. Responsible physicians are subject to exclusion for committing a gross and flagrant or repeated violation of their EMTALA obligations. OIG’s regulations concerning the EMTALA CMPs and exclusion are currently located at § 1003.102(c), 103(c) and 104(a)(4) and (d).

We propose several clarifications to the EMTALA CMP regulations. First, as part of our proposed reorganization, we have included the EMTALA authorities within a separate subsection. Further, the proposed revision removes outdated references to the pre-2001 “knowing” scienter requirement. We also propose minor revisions to clarify the CMP may be assessed for each violation of EMTALA and that all participating hospitals subject to EMTALA, including those with emergency departments and those with specialized capabilities, are subject to penalties.

As discussed above, we propose revising the “responsible physician” definition to clarify that on-call physicians at any participating hospital subject to EMTALA, including the hospital the individual initially presented to or admitted to with specialized capabilities or facilities that has received a request to accept an appropriate transfer, faces potential CMP and exclusion under EMTALA.

Section 1867(d) of the Act provides that any physician who is responsible for the examination, treatment, or transfer of an individual in a hospital participating in a health maintenance organization program, any physician on-call for the care of such an individual, and who negligently violates section 1867 may be penalized under section 1867(d). The current definition of a "responsible physician" also provides for on-call physician liability. We propose to revise the definition to clarify the circumstances when an on-call physician has EMTALA liability. An on-call physician that fails or refuses to appear in reasonable time after such physician is requested to come to the hospital for examination, treatment, or transfer purposes is subject to EMTALA liability. This includes one-
Proposed EMTALA Changes

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

- Proposed to revise responsible physician to clarify that the on-call physician at any participating hospital is subject to EMTALA

- Clarifies that this includes taking care of a patient when the hospital has received a request to accept an appropriate transfer

- Otherwise the physician can be excluded and face a fine

- Any physician, including on-call physician, who fails to exam, treat, or transfer a patient appropriately can be penalized
Proposed EMTALA Changes

- On-call physician who fails to appear within a reasonable amount of time or refuses to show up is subject to EMTALA liability.

- This includes on-call physicians at the hospital where the patient appears and the other hospital that has specialized capabilities.
  - For example: refusing to accept an appropriate transfer.

- CMS is modifying the definition of responsible physician to make it clear between the on-call physician at the hospital the patient presents and where they would send the patient.
Proposed EMTALA Changes

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

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

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

- Will you be prepared if a surveyor shows up tomorrow with an EMTALA complaint??
Access to Hospital Complaint Data

Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C3-21-16
Baltimore, Maryland 21244-1000

Center for Clinical Standards and Quality/Survey & Certification Group

DATE: March 22, 2013
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group

Ref: S&C: 13-21-ALL

Memorandum Summary

Survey Findings Posted on http://www.cms.gov: In July 2012, the Centers for Medicare & Medicaid Services (CMS) began posting redacted Statements of Deficiencies (CMS-2567s) for skilled nursing facilities and nursing facilities on Nursing Home Compare. In March 2013, CMS began posting CMS-2567s for short-term acute care hospitals and critical access hospitals (CAHs) for surveys based on complaint investigations. This memorandum describes the contents and location of those files.

Other Web-based Tools Based on These Data: At least two additional websites, provided by private parties (ProPublica and the Association for Health Care Journalists), publish information based on the CMS-2567 data. These websites are independent of CMS. CMS does not endorse or sponsor any particular private party application.

Plans of Correction (POC): The posted CMS data do not contain any POC information. State Survey Agencies (SAs) and CMS Regional Offices (RO) may see an increase in requests for both the CMS-2567 and any associated POCs.

Question & Answers: We plan to issue an update to this memorandum that will include an attachment of frequently asked questions in order to provide answers to other queries that may arise.

Background – Nursing Home Survey Findings

In July 2012, CMS began posting nursing home statements of deficiencies, derived from the Form
**Hospitals**

This page provides basic information about being certified as a Medicare and/or Medicaid hospital provider and includes links to applicable laws, regulations, and compliance information.

A hospital is an institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services. Critical access hospitals are certified under separate standards. Psychiatric hospitals are subject to additional regulations beyond basic hospital conditions of participation. The State Survey Agency evaluates and certifies each participating hospital as a whole for compliance with the Medicare requirements and certifies it as a single provider institution.

Under the Medicare provider-based rules it is possible for ‘one’ hospital to have multiple inpatient campuses and outpatient locations. It is not permissible to certify only part of a participating hospital. Psychiatric hospitals that participate in Medicare as a Distinct Part Psychiatric hospital are not required to participate in their entirety.

However, the following are not considered parts of the hospital and are not to be included in the evaluation of the hospital’s compliance:

- Components appropriately certified as other kinds of providers or suppliers, i.e., a distinct part Skilled Nursing Facility and/or distinct part Nursing Home, Home Health Agency, Rural Health Clinic, or Hospice; Excluded residential, custodial, and non-service units not meeting certain definitions in the Social Security Act; and,
- Physician offices located in space owned by the hospital but not functioning as hospital outpatient services departments

**Accredited Hospitals** - A hospital accredited by a CMS-approved accreditation program may substitute accreditation under that program for survey by the State Survey Agency. Surveyors assess the hospital’s compliance with the Medicare Conditions of Participation (CoP) for all services, areas and locations covered by the hospital’s provider agreement under its CMS Certification Number (CCN).

Although the survey generally occurs during daytime working hours (Monday through Friday), surveyors may conduct...
## EMTALA Deficiencies

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<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
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<th>I</th>
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<td>289</td>
<td>ABBOTT NORTHWESTERN HOSPITAL</td>
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<td>10/30/2012</td>
<td>Based on a review of twenty-two emergency department records, patient #1's 9/29/12 inpant obstetrical record, a review of the Transfer Reports log, and staff interview and clinical record review. It was determined that for 1 of 1 patient, there was a violation of EMTALA as the patient was transferred without a transfer form.</td>
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<td>290</td>
<td>ADVANCED HEALTHCARE MEDICAL CENTER</td>
<td>26A100</td>
<td>MO</td>
<td>36368</td>
<td>Critical Access</td>
<td>F</td>
<td>3/6/2012</td>
<td><strong>NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY</strong> Based on interviews and record reviews it was determined that the hospital failed to comply with the requirements of 42 CFR 489.24 related to failure to provide a medical staff member.</td>
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<td>88131</td>
<td>Short Term</td>
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<td>Based on review of medical records, the hospital failed to follow their policy and did not provide an adequate medical staff.</td>
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<td>Based on review of medical records, the hospital failed to ensure staff followed policies and procedures.</td>
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<td>Based on review of medical records, review of policies/procedures, and staff interview, the facility failed to enforce policies and procedures for transferring patients.</td>
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<td>63002</td>
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<td>6/4/2011</td>
<td>Based on review of the Transfer Reports log, staff interview and clinical record review, it was determined that for 1 of 1 patient, there was a violation of EMTALA as the patient was transferred without a transfer form.</td>
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<td>63002</td>
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<td>7/20/2011</td>
<td>Based on review of the Transfer Reports log, staff interview and clinical record review, it was determined that for 1 of 1 patient, there was a violation of EMTALA as the patient was transferred without a transfer form.</td>
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<td>OH</td>
<td>45005</td>
<td>Short Term</td>
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<td>5/7/2011</td>
<td>Based on review of medical records, the hospital failed to follow their policy and did not provide an adequate medical staff.</td>
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<td>AURORA MED CTR KENOSHA</td>
<td>32C 100</td>
<td>WI</td>
<td>53142</td>
<td>Short Term</td>
<td>A</td>
<td>2/8/2011</td>
<td>Based on review of medical records, the hospital failed to provide a medical staff member.</td>
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<td>10C 800</td>
<td>FL</td>
<td>32207</td>
<td>Short Term</td>
<td>A</td>
<td>4/3/2012</td>
<td>Based on review of medical records, Policies and Procedures, and staff interview, the facility failed to provide a medical staff member.</td>
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<td>38120</td>
<td>Short Term</td>
<td>A</td>
<td>4/6/2011</td>
<td>Intakes: TN 624Based on interview, the facility failed to ensure documentation of an Emergency Medical Treatment And Labor Act complaint investigation.</td>
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<td>BELTONE REGIONAL MEDICAL CENTER</td>
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<td>54012</td>
<td>Short Term</td>
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<td>10/3/2012</td>
<td>Based on review of medical records, the hospital failed to provide a medical staff member.</td>
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<td>BILLINGS CLINIC HOSPITAL</td>
<td>27C 200</td>
<td>MT</td>
<td>59101</td>
<td>Short Term</td>
<td>A</td>
<td>3/24/2011</td>
<td>On March 24, 2011, an announced on-site EMTALA (Emergency Medical Treatment and Labor Act) complaint investigation was conducted.</td>
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<td>MI</td>
<td>49048</td>
<td>Short Term</td>
<td>A</td>
<td>11/19/2012</td>
<td>Based on review of medical records, it was determined that the facility failed to comply with the requirements of 42 CFR 489.24 related to failure to provide a medical staff member.</td>
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<td>304</td>
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<td>10C 119</td>
<td>FL</td>
<td>33515</td>
<td>Short Term</td>
<td>A</td>
<td>11/2/2011</td>
<td>Based on review of medical records, the hospital failed to provide a medical staff member.</td>
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<td>305</td>
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<td>10C 119</td>
<td>FL</td>
<td>33515</td>
<td>Short Term</td>
<td>A</td>
<td>9/9/2012</td>
<td>Based on review of medical records, the hospital failed to provide a medical staff member.</td>
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<td>306</td>
<td>BRIGHAM CITY COMMUNITY HOSPITAL</td>
<td>46C 900</td>
<td>UT</td>
<td>54302</td>
<td>Short Term</td>
<td>A</td>
<td>2/6/2012</td>
<td>Based on review of a 20 patient sample of emergency department medical records, interview with facility staff members.</td>
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<td>307</td>
<td>CAMDEN CLARK MEDICAL CENTER</td>
<td>51C 800</td>
<td>WV</td>
<td>26101</td>
<td>Short Term</td>
<td>A</td>
<td>6/14/2012</td>
<td>The hospital failed to comply with the Special Responsibilities of Medicare Hospitals in Emergency Cases (42 CFR 489.24) by not providing an adequate medical staff member.</td>
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<td>CAPE CANAVERAL HOSPITAL</td>
<td>10C 701</td>
<td>FL</td>
<td>32932</td>
<td>Short Term</td>
<td>A</td>
<td>6/15/2011</td>
<td>Based on record review and interview, the facility failed to ensure the medical staff or governing body designated the qualified.</td>
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<tr>
<td>309</td>
<td>CAPE FEAR VALLEY MEDICAL CENTER</td>
<td>34C 163</td>
<td>NC</td>
<td>23302</td>
<td>Short Term</td>
<td>A</td>
<td>2/22/2012</td>
<td>Based on hospital policy review, closed medical record review, physician interview, Medical Staff Rules and Regulations review, and staff interview, the hospital failed to provide a medical staff member.</td>
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<tr>
<td>310</td>
<td>CAPE FEAR VALLEY MEDICAL CENTER</td>
<td>34C 163</td>
<td>NC</td>
<td>23302</td>
<td>Short Term</td>
<td>A</td>
<td>11/17/2011</td>
<td>Based on hospital policy review, closed medical record review, security log review, physician interviews, and closed medical record review, the hospital failed to provide a medical staff member.</td>
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<td>311</td>
<td>CAPE FEAR VALLEY MEDICAL CENTER</td>
<td>34C 163</td>
<td>NC</td>
<td>23302</td>
<td>Short Term</td>
<td>A</td>
<td>3/4/2011</td>
<td>Based on review of medical records, closed medical record review, staff and physician interviews, and Transfer Center call log review, the hospital failed to provide a medical staff member.</td>
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<td>312</td>
<td>CAROLINAS MED CENTER-MERCY</td>
<td>34C 200</td>
<td>NC</td>
<td>23020</td>
<td>Short Term</td>
<td>A</td>
<td>5/16/2012</td>
<td>Based on policy and procedure review, closed medical record reviews and staff interviews the facility failed to ensure compliance.</td>
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<td>313</td>
<td>CAROLINAS MEDICAL CENTER-LEXINGTON</td>
<td>34C 433</td>
<td>NC</td>
<td>28092</td>
<td>Short Term</td>
<td>A</td>
<td>2/18/2011</td>
<td>Based on policy and procedure review, closed medical record review, closed medical record review, medical staff bylaws review, physician interview, interview with facility staff members.</td>
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<td>CARONDELET ST MARYS HOSPITAL</td>
<td>30C 160</td>
<td>AZ</td>
<td>85745</td>
<td>Short Term</td>
<td>A</td>
<td>8/4/2011</td>
<td>Based on review of medical records, review of policies and procedures/documentation and staff interviews, it was determined that the facility failed to ensure the medical staff or governing body designated the qualified.</td>
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<td>315</td>
<td>CARRINGTON HEALTH CENTER</td>
<td>35C 100</td>
<td>ND</td>
<td>58421</td>
<td>Critical Access</td>
<td>F</td>
<td>9/19/2011</td>
<td>Based on review of medical records, review of policies/procedures, and staff interview, the Critical Access Facility (CAF) failed to ensure compliance with the EMTALA regulations.</td>
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<td>316</td>
<td>CASS COUNTY MEMORIAL HOSPITAL</td>
<td>161150</td>
<td>IA</td>
<td>50022</td>
<td>Critical Access</td>
<td>F</td>
<td>3/12/2012</td>
<td><strong>NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY</strong> Based on document review and staff interview, the hospital failed to provide a medical staff member.</td>
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<td>317</td>
<td>CATAWBA VALLEY MEDICAL CENTER</td>
<td>34C 810</td>
<td>NC</td>
<td>28802</td>
<td>Short Term</td>
<td>A</td>
<td>6/23/2011</td>
<td>An announced EMTALA complaint survey was conducted to investigate complaint numbers NC 360 and NC 617. Based on review of medical records, it was determined that there was a violation of EMTALA as the patient was transferred without a transfer form.</td>
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<td>318</td>
<td>CENTRAL FLORIDA REGIONAL HOSPITAL</td>
<td>10C 140</td>
<td>FL</td>
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<td>Short Term</td>
<td>A</td>
<td>7/12/2012</td>
<td>Based on review of medical records, policies and procedures, it was determined that the facility failed to provide a medical staff member.</td>
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<td>Tag 2400</td>
<td>Compliance with EMTALA 489.24</td>
<td>Apr 2014</td>
<td>Jan 2014</td>
<td>Nov 4 2014</td>
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<td>Tag 2401</td>
<td>Receiving Inappropriate Transfer</td>
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<td>6</td>
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<td>Tag 2402</td>
<td>Posting Signs</td>
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<td>Tag 2403</td>
<td>Maintain MR</td>
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<td>On call physician</td>
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CMS Region 4 and 5

- Posting signs regarding guidelines regarding narcotic policy might be considered to be coercive or intimidating to patients who present to the ED with painful medical conditions

- Therefore violating both the language and intent of the EMTALA statute and regulation

- Some patients with legitimate need for pain control might be unduly coerced to leave the ED before receiving an appropriate medical screening exam
  - Consider removing the ED guidelines that may be posted in your ED although no prohibition against following SOC
Posters Regarding Prescribing Pain Medication

[Image of ACEP Now website]


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ED Waiting Room Posters on Prescribing Pain Medications May Violate EMTALA

By Richard E. Wild, MD, JD, MBA, FACEP | on January 8, 2014 | 0 Comment
Uncategorized

Statement from CMS region 4 office could have far-reaching implications for EDs nationwide
Ohio Emergency and Acute Care Facility
Opioids and Other Controlled Substances (OOCS) Prescribing Guidelines

These guidelines are to provide a general approach in the prescribing of OOCS. They are not intended to take the place of clinical judgment, which should always be utilized to provide the most appropriate care to meet the unique needs of each patient.

1. OOCS for acute pain, chronic pain and acute exacerbations of chronic pain will be prescribed in emergency/acute care facilities only when appropriate based on the patient’s presenting symptoms, overall condition, clinical examination and risk for addiction.
   a. Doses of OOCS for routine chronic pain or acute exacerbations of chronic pain will typically NOT be given in injection (IM or IV) form.
   b. Prescriptions for chronic pain will typically NOT be provided if the patient has either previously presented with the same problem or received an OOCS prescription from another provider within the last month.
   c. IV Demerol (Meperidine) for acute or chronic pain is discouraged.

2. Emergency medical clinicians will not routinely provide:
   a. Replacement prescriptions for OOCS that were lost, destroyed or stolen.
   b. Replacement doses of Suboxone, Subutex or Methadone for patients in a treatment program.
   c. Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, and methadone).

3. Prior to making a final determination regarding whether a patient will be provided a prescription for OOCS, the emergency clinician or facility:
   a. Should search the Ohio Automated Rx Reporting System (OARRS) database (https://www.ohiopmp.gov/portal/Default.aspx) or other prescription monitoring programs, per state rules.
   b. Reserves the right to request a photo ID to confirm the identity of the patient. If no photo ID is available, the emergency or other acute care facility.

5. Prior to making a final determination regarding whether a patient will be provided a prescription for an OOCS, the emergency clinician should consider the following options:
   a. Contact the patient’s routine provider who usually prescribes their OOCS.
   b. Request a consultation from their hospital’s palliative or pain service (if available), or an appropriate sub-specialty service.
   c. Perform case review or case management for patients who frequently visit the emergency/acute care facilities with pain-related complaints.
   d. Request medical and prescription records from other hospitals, provider’s offices, etc.
   e. Request that the patient sign a pain agreement that outlines the expectations of the emergency clinician with regard to appropriate use of prescriptions for OOCS.

6. Emergency/acute care facilities should use available electronic medical resources to coordinate the care of patients who frequently visit the facility, allowing information exchange between emergency/acute care facilities and other community-care providers.

7. Except in rare circumstances, prescriptions for OOCS should be limited to a three-day supply. Most conditions seen in the emergency/acute care facility should resolve or improve within a few days. Continued pain needs referral to the primary care physician or appropriate specialist for re-evaluation.

8. Each patient leaving the emergency/acute care facility with a prescription for OOCS should be provided with detailed information about the addictive nature of these medications, the potential dangers of misuse and the
The Basic Concept of EMTALA

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

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

- Case ignited blitz of national coverage
- Eugene Barnes, 32 YO male brought on 1-28-85 to Brookside Hospital ED
- Had penetrating stab wound to scalp and the neurosurgeon refused to come
- Called 3 other hospitals and refused to take
- Finally sent to San Francisco General four hours after arrival but patient died
William Jenness taken to hospital in care after auto accident. Hospital asked for $1,000 deposit in advance before they would treat,

He couldn't pay so transferred to a county hospital,

It took four hours before he reached the operating room,

Six hours after the accident, he died,
Cases Congress Heard

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

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

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

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

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

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

Emergency Medical Treatment & Labor Act (EMTALA)

In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual’s ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMGs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

Downloads

CMS-1063F [PDF, 716KB]
State Operations Manual: Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases [PDF, 531KB]

Related Links

Revisions to Appendix V – Inpatient Prospective Payment System (IPPS) 2009 Final Rule
Revisions to EMTALA Regulations [Survey and Certification Letter 09-26]
Policy & Memos to States and Regions
Transmittal (11/27/2004): Payment for Emergency Medical Treatment and Labor Act (EMTALA) - Mandated Screening and Stabilization Services
CMS-1350-NC: Emergency Medical Treatment and Labor Act (Published February 2, 2012) – PDF Version
CMS-1350-NC: Emergency Medical Treatment and Labor Act (Published February 2, 2012) – Text Version
CMS-1350-ANPRM: Emergency Medical Treatment and Labor Act: Applicability to Hospital and Critical Access Hospital Inpatients and Hospitals with Specialized Capabilities (Published December 23, 2010) – PDF Version
CMS EMTALA Website

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

The Interpretive Guidelines is a tool for surveyors where the regulation is broken into regulatory citations (tag numbers), followed by the regulation language and provides detailed interpretation of the regulation(s) to surveyors.

Basic Section 1866 Commitments Relevant to Section 1867 Responsibilities – Tags A-2400/C2400 – A2405/C2405

(Rev.46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

Tag A-2400/C-2400

(Rev.46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

§489.20(l)

[The provider agrees to the following:]

(1) In the case of a hospital as defined in §489.24 (b) to comply with §489.24.
Location of CMS Hospital CoP Manuals

Medicare State Operations Manual
Appendix

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.

- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the 'Download' column to see any available file in PDF.

- To return to this page after opening a PDF file on your desktop, use the browser "back" button. This is because closing the file usually will also close most browsers

New website

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

(Rev. 60, 07-16-10)

Transmittals for Appendix V

Part I - Investigative Procedures

I. General Information
II. Principal Focus of Investigation
III. Task 1 - Entrance Conference
IV. Task 2 - Case Selection Methodology
V. Task 3 - Record Review
VI. Task 4 - Interviews
VII. Task 5 - Exit Conference
VIII. Task 6 - Professional Medical Review
IX. Task 7 - Assessment of Compliance and Completion of the Deficiency Report
X. Additional Survey Report Documentation

Part II - Interpretive Guidelines - Responsibilities of Medicare

Available at http://www.cms.gov/EMTALA/
EMTALA is Appendix V

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

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

The provisions of EMTALA apply to all individuals (not just Medicare beneficiaries) who attempt to gain access to a hospital for emergency care. The regulations define “hospital with an emergency department” to mean a hospital with a dedicated emergency department.

In turn, the regulation defines “dedicated emergency department” as any department or facility of the hospital that either –

(1) is licensed by the state as an emergency department;
(2) held out to the public as providing treatment for emergency medical conditions; or
(3) on one-third of the visits to the department in the preceding calendar year actually provided treatment for emergency medical conditions on an urgent basis.

Hospitals with dedicated emergency departments are required to take the following
Transmittals

The Centers for Medicare & Medicaid Services uses transmittals to communicate new or changed policies or procedures that we will incorporate into the CMS Online Manual System. The cover or transmittal page summarizes and specifies the changes. The transmittals for 2000 through 2003 have been archived. The archived transmittals can be accessed using the following URLs:

2003 Transmittals


2002 Transmittals


2001 Transmittals


2000 Transmittals


If you are unable to access any of the links for the archived transmittals, send a message via the CMS Feedback tool below.

Page last Modified: 04/04/2013 1:10 PM
Help with File Formats and Plug-Ins
This is a very important website

Hospitals may want to have one person periodically check this, at least once a month

This is where new interpretive guidelines are published

This is where new EMTALA memos are posted

http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage
CMS Survey and Certification Website

CMS.gov
Centers for Medicare & Medicaid Services

Survey & Certification - General Information

» Overview
» Spotlight
» CLIA
» Contact Information
» CMS National Background Check Program
» Nursing Home Quality Assurance & Performance Improvement Initiative
» Revisit User Fee Program
» Accreditation
» Policy & Memos to States and Regions

Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

Select From The Following Options:

- Show all items

- Show only (select one or more options):
  - Show only items whose is within the past
  - Show only items whose Fiscal Year is
  - Show only items containing the following word

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

Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implications Related to Ebola Virus Disease (Ebola)

Title
Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implications Related to Ebola Virus Disease (Ebola)

Memo #
15-10-Hospitals

Posting Date
2014-11-24

Fiscal Year
2015

Summary
- Ebola and EMTALA requirements. This Memorandum conveys information useful in responding to inquiries from hospitals concerning implications of Ebola for their compliance with EMTALA. • EMTALA Screening Obligation: Every hospital or critical access hospital (CAH) with a dedicated emergency department (ED) is required to conduct an appropriate medical screening examination (MSE) of all individuals who come to the ED, including individuals who are suspected of having been exposed to Ebola, and regardless of whether they arrive by ambulance or are walk-ins. Every ED is expected to have the capability to apply appropriate Ebola screening criteria when applicable, to immediately isolate individuals who meet the screening criteria to be a potential Ebola case, to contact their state or local public health officials to determine if Ebola testing is needed, and, when a decision to test is made, to provide treatment to the individual, using appropriate
EMTALA and Ebola

DATE: November 21, 2014
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group
SUBJECT: Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implications Related to Ebola Virus Disease (Ebola)

Memorandum Summary:

1. *Ebola and EMTALA requirements*: This Memorandum conveys information useful in responding to inquiries from hospitals concerning implications of Ebola for their compliance with EMTALA.

2. *EMTALA Screening Obligation*: Every hospital or critical access hospital (CAH) with a dedicated emergency department (ED) is required to conduct an appropriate medical screening examination (MSE) of all individuals who come to the ED, including individuals who are suspected of having been exposed to Ebola, and regardless of whether they arrive by ambulance or are walk-ins. Every ED is expected to have the capability to apply appropriate Ebola screening criteria when applicable, to immediately isolate individuals who meet the screening criteria to be a potential Ebola case, to contact their state or local public health officials to determine if Ebola testing is needed, and, when a decision to test is made, to provide treatment to the individual, using appropriate isolation precautions, until a determination is made whether the individual has Ebola.

3. *EMTALA Stabilization, Transfer & Recipient Hospital Obligations*: In the case of individuals who have Ebola, hospitals and CAHs are expected to consider current guidance of public health officials in determining whether they have the capability to provide appropriate isolation required for Ebola patients. Hospitals and CAHs may also need to consider the potential for increased staffing needs due to infections from EMTALA-related care.
EMTALA and Ebola

- CMS issues 4 page survey memo on November 21, 2014 and questions at hospitalSCG@cms.hhs.gov

- Every hospital, including CAHs, with a DED, must conduct an appropriate MSE on all patients coming to the ED

- This includes patients suspected of having been exposed to Ebola

- All EDs are expected to be able to apply appropriate Ebola screening

- And if necessary to isolate and notify state agency
EMTALA and Ebola

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

- CMS Issues 13 page FAQ memo on Feb 13, 2015
- CMS issued after receiving many questions on this topic
- Hospitals with specialized capabilities should accept appropriate transfers if they have capacity to provide care including those with Ebola
- The states are formally identifying hospitals that are qualified as a EVD treatment facility
- CDC’s 3 tiered system does not violate EMTALA: frontline healthcare facility, Ebola assessment hospital and Ebola treatment hospital
- Questions can be addressed to hospitalscg@cms.hhs.gov
DATE: February 13, 2015
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group
SUBJECT: Emergency Medical Treatment and Labor Act (EMTALA) and Ebola Virus Disease (EVD) – Questions and Answers (Q+A)

Memorandum Summary

EMTALA & Ebola Requirements:

- On November 21, 2014 the Centers for Medicare & Medicaid Services (CMS) Survey & Certification Group released SC 15-10-Hospitals concerning EMTALA Requirements and Implications Related to the EVD.

- The CMS has received follow-up questions regarding EMTALA and Ebola and has produced a Q+A document in response.

The CMS released S&C 15-10 on November 21, 2014 to provide guidance to hospitals and critical access hospitals (CAHs) regarding meeting EMTALA requirements in the case of individuals potentially exposed to Ebola. The memo is available via the following link:
CDC Updates List of Treatment Centers

Ebola (Ebola Virus Disease)

Hospital Preparedness: A Tiered Approach

- Preparing Frontline Healthcare Facilities
- Preparing Ebola Assessment Hospitals
- Preparing Ebola Treatment Centers
- Current Ebola Treatment Centers

Current Ebola Treatment Centers

The 55 hospitals with Ebola treatment centers as of 2/18/2015 are:

- Maricopa Integrated Health Systems, Phoenix, Arizona
- University of Arizona Health Network, Tucson, Arizona
- Kaiser Los Angeles Medical Center, Los Angeles, California
- Kaiser Oakland Medical Center, Oakland, California
- Kaiser Santa Clara Medical Center, Sunnyvale, California
ENA and Ebola

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

As the Ebola story continues to evolve, ENA would like to keep you informed with current and accurate information of the management of this health issue in the US. The current CDC guidelines on restricted movement, current as of October 29th, 2014 has been posted to the ENA Ebola resource website under Preparedness. The supportive evidence to assist you to write guidance and corresponding protocols is being developed on a daily basis. ENA recommends that emergency nurses remain informed, review information from recognized sources, and to assure appropriate communication and reassurances in your various clinical settings on how to meet this health emergency. Emergency nurses are masters of FACT not FEAR. We salute you and everything you do every day.

Get Started with our FAQs

- www.ena.org/about/media/ebola/Pages/default.aspx?utm_source=iContact&utm_medium=email&utm_campaign=Emergency%20Nurses%20Association&utm_content=10-16-14+Ebola
News

- British Nurse returns to Sierra Leone after recovery (11-19-14)
- Enhanced Airport Entry Screening to Begin for Travelers to the United States from Mali (11-16-14)
- Doctor Being Treated for Ebola in Omaha Dies (11-17-14)
- Nebraska hospital prepares for new Ebola patient (11-13-14)
- Ebola outbreak: MSF to start West Africa clinical trials (11-13-14)
- U.S. emergency physician free of Ebola (11-11-14)
- Identify, Isolate, Inform: Emergency Department Evaluation and Management for Patients Who Present with Possible Ebola Virus Disease, developed in collaboration with CDC, ACEP and ENA (10-27-14)

General Information and Disease Transmission

- ENA Topic Brief: Ebola Virus Disease
  The purpose of this topic brief is to examine EVD, discuss transmission, review prevention and containment measures, and consider future preparation strategies.
- CDC: Key Messages: Ebola Virus Disease, West Africa (11-05-14)
- CDC: About Ebola (10-03-14)
- CDC: Questions and Answers about CDC's Ebola Monitoring & Movement Guidance (11-08-14)
- CDC: Q&As on Ebola (11-09-14)
- CDC: Q&As on Disease Transmission (11-13-14)
- CDC: Review of Human-Human Transmission of Ebola Virus (10-29-14)
- CDC: 2014 Ebola Outbreak in West Africa - Case Counts and Outbreak Distribution Map (11-14-14)
Healthcare Resources for Suspected Ebola Cases

The U.S. Department of Health and Human Services’ Centers for Disease Control and Prevention (CDC) and Office of the Assistant Secretary for Preparedness and Response (ASPR) aim to increase understanding and promote preparedness of emergency departments and emergency staff concerning the Ebola hemorrhagic fever, also known as Ebola virus disease (EVD).

While countries from around the world join forces to support African communities in combating this outbreak and its spread, we want to be sure our own nation is prepared. Although ASPR, NIH, CDC and other federal agencies are working with private industry to move experimental therapies and vaccine into the earliest clinical trials, standard treatment for EVD remains supportive therapy. Early identification and appropriate isolation of Ebola cases is critical to mounting an effective response.

ACEP Ebola Expert Panel Members

Click here to learn more about the panel members

Chair:  
Stephen V. Cantrill, MD, FACEP

Panel Members:  
Deena Brecher, MSN, RN, APRN, ACNS-BC, CEN, CPEN  
Edward Etzen, MD, MPH, FACEP

Board Liaison:  
James J. Augustine, MD, FACEP

ACEP Staff:  
Marilyn Bromley, RN  
Margaret Montgomery, RN, MSN
News & Updates

- Key Messages: Ebola Virus Disease - Nov. 19, 2014
- ACEP at the White House - Nov. 13, 2014
  Video of ACEP President Dr. Mike Gerardi’s visit to discuss Ebola preparedness
  From NEJM Journal Watch
  From ACEP Now

Ebola Background & Diagnosis

- Case Definition for Ebola Virus Disease (EVD) - updated Nov. 16, 2014
- Ebola (Ebola Virus Disease) Signs and Symptoms - updated Nov. 14, 2014
- Safe Management of Patients with Ebola Virus Disease (EVD) in U.S. Hospitals - updated Nov. 16, 2014

ED Triage

- Identify, Isolate, Inform: Emergency Department Evaluation and Management for Patients Who Present with
Identify, Isolate, Inform: Emergency Department Evaluation and Management for Patients Who Present with Possible Ebola Virus Disease

**Background:** Procedures in the accompanying algorithm provide guidance on the Emergency Department (ED) evaluation and management of patients who present with possible Ebola virus disease (EVD). Guidance in this document reflects lessons learned from the recent experiences of U.S. hospitals caring for Ebola patients.

The risk of transmission of Ebola virus from a patient to a healthcare worker depends upon the likelihood the patient will have confirmed EVD combined with the likelihood and degree of exposure to infectious blood or body fluids. That risk depends on the severity of disease. Severe illness is strongly associated with high levels of virus production. In addition, close contact with the patient and invasive medical care can increase opportunities for transmission.

In general, the majority of febrile patients presenting to the ED do not have EVD, and the risk posed by patients with early, limited symptoms is lower than that from a patient hospitalized with severe EVD. Nevertheless, because early...
CDC Resources on Ebola

- [www.cdc.gov/vhf/ebola/](http://www.cdc.gov/vhf/ebola/)

2014 West Africa Outbreak

The 2014 Ebola epidemic is the largest in history, affecting multiple countries in West Africa. Two imported cases, including one death, and two locally acquired cases in healthcare workers have been reported in the United States. CDC and partners are taking precautions to prevent the further spread of Ebola within the United States.

Latest CDC Outbreak Information

Updated November 24, 2014

What’s New

- November 24, 2014: Updated Case Counts
- November 21, 2014: Information on the Survivability of the Ebola Virus in Medical Waste
- November 20, 2014: Interim Guidance for Managers and
Important Clinical Guidance

Guidance and Recommendations

- Infection Prevention and Control Recommendations for Hospitalized Patients with Known or Suspected Ebola Virus Disease in U.S. Hospitals
- Interim Guidance for Environmental Infection Control in Hospitals for Ebola Virus

Laboratory (specimen collection, transport, testing, submission)

- Interim Guidance for Specimen Collection, Transport, Testing, and Submission for Persons Under Investigation for Ebola Virus Disease in the United States

Protecting Healthcare Workers

- Guidance for Personal Protective Equipment (PPE)

Diagnosis

- Case Definition for Ebola Virus Disease (EVD)

General Information

- Ebola Virus Disease Information for Clinicians in U.S. Healthcare Settings
- Safe Management of Patients with Ebola Virus Disease (EVD) in U.S. Hospitals

Patient Transportation/Monitoring/Movement

- Interim U.S. Guidance for Monitoring and Movement of Persons with Potential Ebola Virus Exposure
- Guidance on Air Medical Transport for Patients with Ebola Virus Disease
- Interim Guidance for Emergency Medical Services (EMS) Systems and 9-1-1 Public Safety Answering Points (PSAPs) for Management of Patients with Known or Suspected Ebola Virus Disease in the United States

Communication Resources

- Radio PSAs
- Videos
- Infographics
- Factsheets
- Banners
- Posters
- Brochures/Tri-Folds

Information for Specific Groups

- Travelers
- Healthcare Workers
- Airlines, Airports, and Ports of Entry
- Parents, Schools, and Pediatric Healthcare Professionals
- Communication Resources for West African Audiences
- CDC Partners and Partner Organizations

Useful Links

- World Health Organization Global Alert and Response (CAR) Situation Report
Free Video on Donning and Doffing

Ebola: Donning and Doffing of Personal Protective Equipment (PPE)

Video Instructions From the CDC

Arjun Srinivasan, MD (CAPT, USPHS), Bryan Christensen, PhD, Barbara A. Smith, BSN, MPA

October 29, 2014

Barbara Smith, RN, BSN, MPA, CIC

OSHA Resources on Ebola


Introduction

Ebola hemorrhagic fever (EHF) (sometimes called Ebola Virus Disease, or EVD) is the disease caused by infection with an Ebola virus. It is a type of viral hemorrhagic fever (VHF) brought on by any of several strains of viruses in the Ebolavirus genus. Ebola viruses are capable of causing severe, life-threatening disease.
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

DATE: October 10, 2014
TO: State Survey Agency Directors
FROM: Director
      Survey and Certification Group
SUBJECT: Information for Hospitals and Critical Access Hospitals (CAHs) Concerning Possible Ebola Virus Disease

Memorandum Summary

• Screening for Possible Ebola Virus Disease: the U.S. Centers for Disease Control and Prevention (CDC) have issued a Health Advisory Alert on Evaluating Patients for Possible Ebola Virus Disease. The CDC has also issued additional guidance, including a checklist and algorithm for patients being evaluated for Ebola Virus Disease in the United States, as well as a hospital preparedness checklist. Links to these documents are provided.

• Hospitals and CAHs are strongly urged to review and fully adopt and implement this guidance

On October 2, 2014, the U.S. Centers for Disease Control and Prevention (CDC) issued the attached Health Advisory Alert on Evaluating Patients for Possible Ebola Virus Disease. The purpose of the Alert is to remind healthcare personnel and health officials to:
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1890

Center for Clinical Standards and Quality/Survey & Certification Group

DATE:       June 7, 2013
TO:         State Survey Agency Directors
FROM:       Director
            Survey and Certification Group
SUBJECT:    Critical Access Hospital (CAH) Emergency Services and Telemedicine:
            Implications for Emergency Services Condition of Participation (CoPs) and
            Emergency Medical Treatment and Labor Act (EMTALA) On-Call Compliance

Ref: S&C: 13-38-CAH/EMTALA

Memorandum Summary

- **The Center for Medicare & Medicaid Services (CMS) Welcomes use of Telemedicine by CAHs:** Telemedicine has great potential to expand availability of specialty care services, including emergency medicine services, to rural populations. However, misconceptions about CAH CoP and EMTALA requirements may cause unnecessary concerns about, or create barriers to, using telemedicine.

- **The CAH Emergency Services CoP does not Require a Physician to Appear On-site Whenever an Individual Comes to the Emergency Department (ED):**
  - Under 42 CFR 485.618(d), a doctor of medicine (MD), a doctor of osteopathy (DO), a physician assistant (PA), a nurse practitioner (NP), or a clinical nurse specialist (CNS), with training or experience in emergency care, must be immediately available by telephone or radio, and available on-site within 30 minutes (60 minutes for CAHs in frontier areas that meet certain conditions). Under the CAH CoPs an MD or DO is not required to be available in addition to a non-physician practitioner.
  - Under the CoP at §485.618(e), an MD or DO must be immediately available by telephone or radio contact on a 24-hours a day basis to receive emergency calls, provide information on treatment of emergency patients, and refer patients. This requirement can be met by the use of a telemedicine MD/DO as well as by an MD/DO who practices on-site at the CAH.

- **EMTALA is Not a Barrier to Using Telemedicine to Extend CAH Emergency Services:**
  - If using telemedicine for emergency and other services, a CAH is not required to include the telemedicine physicians on its physician on-call list mandated under the
EMTALA, CAH & Telemedicine

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

- CMS issues 7 page memo dated Dec 13, 2013 regarding payor requirements and collection practices

- These are covered throughout this program but every hospital should be familiar with this memo

- EMTALA is a federal law and pre-empts any inconsistent state law

- Some proposed or existing payment policies of third party payors of hospital services are in violation of the federal EMTALA law
CMS Memo Dec 13, 2013

Center for Clinical Standards and Quality/Survey & Certification Group

DATE: December 13, 2013
TO: State Survey Agency Directors
FROM: Director Survey and Certification Group
SUBJECT: Emergency Medical Treatment and Labor Act (EMTALA) Requirements & Conflicting Payor Requirements or Collection Practices

Memorandum Summary

- **EMTALA & Payor Requirements:** Some proposed or existing payment policies of third party payors of hospital services have generated confusion among providers about their EMTALA obligations. The Centers for Medicare & Medicaid Services (CMS) is clarifying for Medicare-participating hospitals and critical access hospitals (CAH) that they are required to comply with EMTALA, regardless of any conflicting requirements of third-party payors, including when those payors are State Medicaid programs.

- **Certain Hospital Collection Practices May Also Conflict with EMTALA:** It is not acceptable for a hospital or CAH to request immediate payment, by cash or other methods, for services provided to an individual who is protected under EMTALA prior to the receipt of such services. A hospital may only request on-the-spot payment after it has conducted an appropriate medical screening examination (MSE) and, if applicable, stabilized an individual’s emergency medical condition (EMC) or admitted the individual. Hospital patients are further protected under the patient’s rights Condition of Participation at 42 CFR 482.13(c)(3), which protects patients from abuse or harassment.
Hospital cannot request payment or co-pays until **after** an appropriate medical screening exam (MSE) is done and they have initiated stabilizing treatment.

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

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

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

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

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

Physicians agree to take call rotation on even basis,

We redact certain identifying information and certain potentially privileged, confidential, or proprietary information associated with the individual or entity, unless otherwise approved by the requestor.

Issued: September 20, 2007

Posted: September 27, 2007

[Name and address redacted]

Re: OIG Advisory Opinion No. 07-10

Dear [name redacted]:

OIG Advisory Opinion

- Physicians are paid a rate for each day on call
- 18 days a year are gratis
- Rate based on specialty and whether coverage is weekday or weekend, likelihood to be called, severity of illness, degree of inpatient care required
- Rates provided at fair market value
- Program open to all
Second one was concerning a 400 bed non profit general hospital and only provider in that county area for acute care services

Had many times where no one on call and had to transfer patients out

Proposed to allow on-call doctors to submit claims for services rendered to indigent and uninsured patients presenting to the ED

Signed an agreement that this was payment in full and would show up in 30 minutes
Got $100 for ED consultation, $300 per admission, $350 for primary surgeon and for physician doing an endoscopic procedure

OIG allowed finding it did not include any of the four problematic compensation structures and presented a low risk of fraud and abuse

Payments were fair market value and without regard to referrals or other business generated by the parties
Paying for On-Call Physicians

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

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

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

Office of Inspector General

OIG Supplemental Compliance Program Guidance for Hospitals

AGENCY: Office of Inspector General (OIG), HHS.

ACTION: Notice.

SUMMARY: This Federal Register notice sets forth the Supplemental Compliance Program Guidance (CPG) for Hospitals developed by the Office of Inspector General (OIG). Through this notice, the OIG is supplementing its prior compliance program guidance for hospitals issued in 1998. The supplemental CPG contains new compliance recommendations and an expanded discussion of risk areas, taking into account recent changes to hospital payment systems and regulations, evolving industry practices, relevant risk areas. Copies of these CPGs can be found on the OIG Web page at http://oig.hhs.gov.

Supplementing the Compliance Program Guidance for Hospitals

The OIG originally published a CPG for the hospital industry on February 23, 1998. (See 63 FR 8987 February 23, 1998, available on our Web page at http://oig.hhs.gov/authorities/docs/cphosp.pdf.) Since that time, there have been significant changes in the way hospitals deliver, and are reimbursed for, health care services. In response to these developments, on June 18, 2002, the OIG published a notice in the Federal Register, soliciting public suggestions for revising the hospital CPG. (See 67 FR 41433 (June 18, 2002), available on our Web page at http://oig.hhs.gov/authorities/docs/cphospitalsolicitationnotice.pdf.) After consideration of the public comments and the issues raised, the OIG published Services (the Department) publishes this Supplemental Compliance Program Guidance (CPG) for Hospitals.¹ This document supplements, rather than replaces, the OIG’s 1998 CPG for the hospital industry (63 FR 8987; February 23, 1998), which addressed the fundamentals of establishing an effective compliance program.² Neither this supplemental CPG, nor the original 1998 CPG, is a model compliance program. Rather, collectively the two documents offer a set of guidelines that hospitals should consider when developing and implementing a new compliance program or evaluating an existing one.

We are mindful that many hospitals have already devoted substantial time and resources to compliance efforts. We believe that those efforts demonstrate the industry’s good faith commitment to ensuring and promoting integrity. For those hospitals with existing compliance programs, this document...
EMTALA OIG CPG for Hospitals

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

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

- Must provide screening and treatment within full capability of hospital including staff and facilities
  - Includes on call specialist

- **On call physicians** need to be educated on their responsibilities including responsibility to accept transferred individuals from other facilities

- Must have policies and procedures

- Persons working in the ED should be periodically trained and reminded of EMTALA obligations and hospital’s P&P
CMS issued Appendix Q on Guidelines for Immediate Jeopardy on February 14, 2014

These guidelines for CMS surveyors contain an EMTALA trigger

These apply to all facilities that receive Medicare/Medicaid reimbursement including Critical Access Hospitals

### Medicare State Operations Manual

**Appendix**

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

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State Operations Manual
Appendix Q - Guidelines for Determining Immediate Jeopardy

(Rev. 102, Issued: 02-14-14)

Transmittals for Appendix Q

I - Introduction
II - Definitions
III - Principles
IV - Immediate Jeopardy Triggers
V - Procedures
VI - Implementation
VII - Documentation
VIII - Enforcement
IX - References
Attachment A
Attachment B

483(b) Requirements: Abuse
485.723 Condition: Physical Environment
485.723(a) Standard Safety of Patients
485.723(b) Standard: Maintenance of Equipment/Buildings/Grounds

Guidelines for Determining Immediate Jeopardy

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

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

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

RC.02.01.01 Conclusion reached at the termination of care in the ED

- The patient's final disposition
- Condition
- Instructions given for follow-up care, treatment, and services
CMS Regional Offices (RO)

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

e-CFR Data is current as of July 8, 2009

USER NOTICE


Browse: Select a title from the list below, then press "Go"

Title 42 - Public Health
Regional Offices

- There are 10 regional offices (ROs)
- See list at end of addresses of all ROs
- RO gives initial verbal authorization for investigation
- Then prepares Form for Request for Survey (1541A)
### REQUEST FOR SURVEY OF §489.20 AND §489.24 ESSENTIALS OF PROVIDER AGREEMENTS:

**Responsibilities of Medicare Participating Hospitals in Emergency Cases**

<table>
<thead>
<tr>
<th>1. Name and Address of State Agency</th>
<th>2. Name and Address of Hospital</th>
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<tr>
<th>3. Provider Number</th>
<th>RO Complaint Control Number</th>
<th>4. Hospital Accredited By:</th>
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<td>□ JCAHO       □ AOA       □ Nonaccredited</td>
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**DO NOT INFORM THE HOSPITAL OF THE SURVEY**

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<th>5. In Complaint Cases, Type of Emergency <em>(check all that apply)</em></th>
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<td>□ Labor            □ Other OB       □ Medical       □ Trauma       □ Psychiatric       □ Surgical       □ Other</td>
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<th>6. Source of Complaint <em>(check all that apply)</em></th>
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<tr>
<td>□ Patient or Patient’s Family       □ Quality Improvement Organization</td>
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<tr>
<td>□ Receiving Hospital                 □ Medicare Intermediary</td>
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<td>□ Transferring Hospital              □ Other <em>(specify)</em></td>
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<td>□ Congressional Inquiry</td>
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Regional Office

- RO also sends hospital Form 562 Medicare/CLIA Complaint Form (determine allegation, whether finding substantiated or not, number of complainants per allegation, source of complaint, date received etc.),

- May complete FORM 2802 Request for validation of accreditation survey for hospital (accredited by TJC, DNV Healthcare, CIHQ, AAHHS, or AOA, areas surveyed, conditions (governing board, patient rights, pharmacy) or standards

- State Agency does not notify hospital in advance
Introduction to EMTALA

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

First, the regulation is published in the federal register

Next, CMS take and adds interpretive guidelines and survey procedure

Not all sections have a survey procedure
Interpretive Guidelines

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

- Part II is the section on responsibilities of Medicare Participating Hospitals in Emergency Cases
- Includes on-call physician requirements
- Includes use of dedicated emergency departments (DEDs)
- Includes stabilization and transfer requirements
State Operations Manual
Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases

(Rev. 46, 05-29-09)

Transmittals for Appendix V

Part I- Investigative Procedures
I. General Information
II. Principal Focus of Investigation
III. Task 1 - Entrance Conference
IV. Task 2 - Case Selection Methodology
V. Task 3- Record Review
VI. Task 4- Interviews
VII. Task 5- Exit Conference
VIII. Task 6- Professional Medical Review
IX. Task 7- Assessment of Compliance and Completion of the Deficiency Report
X. Additional Survey Report Documentation

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

(Rev. 60, 07-16-10)

Transmittals for Appendix V

Part I - Investigative Procedures

I. General Information
II. Principal Focus of Investigation
III. Task 1 - Entrance Conference
IV. Task 2 - Case Selection Methodology
V. Task 3 - Record Review
VI. Task 4 - Interviews
VII. Task 5 - Exit Conference
VIII. Task 6 - Professional Medical Review
IX. Task 7 - Assessment of Compliance and Completion of the Deficiency Report
X. Additional Survey Report Documentation

Part II - Interpretive Guidelines - Responsibilities of Medicare
Tag: A-2403/C-2403

(Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

§489.20(r)

[The provider agrees to the following:]

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 transfer;

Interpretive Guidelines: §489.20(r)(1)

The medical records of individuals transferred to or from the hospital must be retained in their original or legally reproduced form in hard copy, microfilm, microfiche, optical disks, computer disks, or computer memory for a period of 5 years from the date of transfer.
EMTALA Sources of Law

- Special Responsibilities of Medicare Hospitals in Emergency Cases EMTALA is located at 42 C.F.R. 489.24

- Federal Register and CFR are available free off internet at http://www.gpoaccess.gov/fr/index.html

- Available at http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=c07ae216364917a701e2426eb3f1419c&rgn=div8&view=text&node=42:4.0.1.5.27.2.212.5&idno=42
Join or leave the FEDREGTOC-L list

This screen allows you to join or leave the FEDREGTOC-L list. To confirm your identity and prevent third parties from subscribing you to the list against your will, an e-mail message with a confirmation code will be sent to the address you specify in the form. Simply wait for this message to arrive, then follow the instructions to confirm the operation.

Please read the following: This list offers three subscription options in the form of Topics. This is a way of offering subscribers a method of controlling the format of list mail delivered to them. By default, you will receive HTML formatted e-mail from this list (TOPICS: HTML_Format). If your mail client does not understand HTML formatted e-mail, then you can choose to receive mail with the HTML file attached (TOPICS: HTML_Attached). If the e-mail client you use does not understand MIME types or if your security configuration will not allow attachments or HTML formatted e-mail, you can choose to receive a plain text version of the Table of Contents (TOPICS: Plain_Text). The options for All of the above and Other below are not necessary for you to use.

Your e-mail address:  
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Select a list:  FEDREGTOC-L Federal Register Table of Contents  
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Miscellaneous:  
- Mail delivery disabled temporarily  
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- Html_Attached  
✓ Html_Format  
- Plain_Text  
- Other (messages with unknown topic)  
- All of the above

Join the list  Leave the list  Leave all the lists

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

Back to the LISTSERV home page at LISTSERV.access.gpo.gov
Two Other Important Laws

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

www.ecfr.gov/cgi-bin/ECFR?page=browse

e-CFR Data is current as of June 27, 2014

USER NOTICE


Browse: Select a title from the list below, then press “Go”.

Title 42 - Public Health

For questions or comments regarding e-CFR editorial content, features, or design, email ecf@nara.gov. For questions concerning e-CFR programming and delivery issues, email webteam@gpo.gov.
Basic Section 2400

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

- Basic Commitment Requires the following;
- To maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition
- Must maintain medical records for five years from date of transfer
CHAPTER IV—CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)

SUBCHAPTER G—STANDARDS AND CERTIFICATION

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

Subpart A—GENERAL PROVISIONS

§489.1 Statutory basis.
§489.2 Scope of part.
§489.3 Definitions.
§489.10 Basic requirements.
§489.11 Acceptance of a provider as a participant.
§489.12 Decision to deny an agreement.
§489.13 Effective date of agreement or approval.
§489.18 Change of ownership or leasing: Effect on provider agreement.

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 CHAMPUS.
The EMTALA Sign 2400

- To post conspicuously in any emergency department, a sign specifying the rights of individuals with respect to exam and treatment for EMC and for women in labor.

- Sign must one specified by the secretary.

- Sign must say if you participate or not in Medicaid program.

- Note that more information on EMTALA sign in section 2402.
  - Make sure sign is clearly visible from a distance of 20 feet so at least 18” by 20” unless in posted in small room.
IF YOU HAVE A MEDICAL EMERGENCY OR ARE IN LABOR, YOU HAVE THE RIGHT TO RECEIVE, within the capabilities of this hospital's staff and facilities:

An appropriate Medical SCREENING EXAMINATION

Necessary STABILIZING TREATMENT (including treatment for an unborn child) and, if necessary,

An appropriate TRANSFER to another facility

Even if YOU CANNOT PAY or DO NOT HAVE MEDICAL INSURANCE

or

YOU ARE NOT ENTITLED TO MEDICARE OR MEDICAID

This hospital (DOES/DOES NOT) participate in the Medicaid Program
EN CASOS DE EMERGENCIA MÉDICA O DOLORES DE PARTO USTED TIENE EL DERECHO DE RECIBIR LOS SIGUIENTES SERVICIOS,

de acuerdo a las capacidades de los empleados del hospital y sus facilidades:

• Un EXAMEN MÉDICO apropiado,

• Un TRATAMIENTO NECESARIO de urgencia (incluyendo el tratamiento para el bebé antes de nacer), y si es necesario,

• Un TRANSFERIMIENTO apropiado a otro hospital,

aunque usted no pueda pagar o no tenga un seguro médico o no tenga derechos a Medicare o Medicaid.

Este hospital □ participa /
□ no participa en Medicaid.

Required by § 1866(a)(1)(N) of the Federal Social Security Act
Who Does EMTALA Apply To?

- Applies to hospitals who participate in the Medicare

- EMTALA is a condition of participation (CoP) just like the hospital and critical access CoPs

- Is not limited to Medicare patients and includes any individual who comes to the ED requesting care
Who Does EMTALA Apply To?

- If no verbal request is made it would include if a reasonable prudent layperson observer would conclude they need emergency care (not breathing)

- That present themselves to an area of the hospital that meets the definition of dedicated emergency department of DED

- There are three criteria to what constitutes a DED
Who Does EMTALA Apply To?

- Dedicated ED includes if licensed by state as ED, holds itself out to public as providing emergency care, or during preceding calendar year, provided at least 1/3 of its outpatient visits for treatment of EMC

- Example hospital has an emergency department (ED), or trauma center

- It covers all individuals regardless of payment source
Who Does EMTALA Apply To?

- Does not cover people on the phone
- It does cover patients in a car at the ED doors trying to access the ED
- It covers patients anywhere on hospital property seeking emergency care, for example, they come in the wrong entrance to the hospital and are looking for the ED
- Covers non-citizens of the US and minors
Hospital may not delay an appropriate MSE to inquire about the individual’s method of payment or insurance status.

CMS and OIG issue a special advisory bulletin on November 10, 1999 (Fed Reg. Volume 64, No. 217, 61353) which is still relevant today.

Every hospital should read this to understand how to meet compliance with this section.
DEPARTMENT OF HEALTH AND
HUMAN SERVICES

Office of Inspector General
Health Care Financing Administration

OIG/HCFA Special Advisory Bulletin on
the Patient Anti-Dumping Statute

AGENCY: Office of Inspector General
(OIG) and Health Care Financing
Administration (HCFA), HHS.

ACTION: Notice.

SUMMARY: This Federal Register notice,
developed jointly by the OIG and HCFA,
sets forth the Special Advisory Bulletin
addressing requirements of the patient
anti-dumping statute and the obligations
of hospitals to medically screen all
Payment Issues 2400 and 2408

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

- Hospitals can not delay a medical screening exam or stabilizing treatment to prepare an ABN (advance beneficiary notice) and obtain a beneficiary signature on this form (also 2408)

- Can collect registration information if no delay such patient is triaged and there is no bed is available but need to document to create a clear record

- The obligation to pay for emergency services under Medicare managed care contracts is based on the “prudent layperson standard”
Payment Issues

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

- Hospitals can follow reasonable registration processes
- This may include asking if individual is insured as long as does not delay screening or treatment
- Can collect demographic information and who to contact in case of an emergency
- No prior authorization from managed care
This applies equally to the receiving hospital

Hospital with specialized capability has bed and staff and must accept patient

Can not delay transfer of an unstable patient pending receipt or verification of financial information
Financial Questions from Patient

- This person must be knowledgeable about EMTALA
- This person should tell the patient that the hospital stands willing and ready to provide a MSE and stabilization
- Staff should encourage the patient to defer further discussion of financial responsibility under stabilized
- Do not give ABNs (advanced beneficiary notices) to ED patients upon arrival
Hospital may not penalize or take adverse action against a MD or qualified medical personnel (QMP) for refusing to authorize transfer of an individual with an EMC that has not been stabilized

Can not penalize a hospital employee who reports a suspected violation
Patients Who Want to Sign Out AMA

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

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

- The medical record should include a description of the risks discussed

- If the patient leaves without notifying anyone, document the fact the patient was there, what time they discovered she left while retaining all triage notes

- Source: OIG/CMS Advisory Bulletin and Tag 2407
Against Medical Advice

- CMS says the hospital will be found in violation of EMTALA for patient who leaves AMA or LWBS (Tag 2406)
- If the individual left at the suggestion by the hospital
- If the condition was an emergency, and the hospital was operating beyond its capacity, and did not attempt to transfer the patient
- There must be no coercion or suggestion
Specialized Capability  2400

- Medicare hospital are required to accept appropriate transfers of individuals with EMCs if the hospital has the specialized capabilities.

- This is when the sending or transferring hospital does not have the specialized capabilities.

- The receiving hospital must also have the “capacity.”
Specialized Capability

- The receiving hospital has a burn unit or trauma unit and the sending hospital does not.

- Does the receiving hospital have an open bed and staff to care for the transfer?

- The receiving hospital does not have to accept a patient if it does not have the capacity to stabilize the person.

- An example is if the hospital wants to transfer a suicidal patient but the hospital does not have a behavioral unit either or an obstetrical unit for the transfer of a pregnant patient.
Capacity

- Capacity means the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual.

- Capacity encompasses such things as numbers and availability of qualified staff, beds and equipment.

- The hospital's past practices of accommodating additional patients in excess of its occupancy limits.
Capacity

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

- Hospitals are required to adopt an EMTALA policy
- Policy needs to comply with all the EMTALA requirements
- Hospitals should consider EMTALA training during orientation and periodically
- Remember OIG Guidance that recommends training of all on-call physicians
Title: EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) POLICY

Original Issue Date: 3/99
Review Date: 6/00; 6/03; 2/04, 3/08, 6/09
Revised Date:

CEO Approval: ________________________________

Signature Date

MEC Approval: ________________________________

Signature Date

VP Approval: ________________________________

(Vice President, Patient Care Services) Signature Date

PURPOSE:

The purpose of this policy is to set forth the requirements of the federal Emergency Medical Treatment and Labor Act (EMTALA). This policy is to provide guidelines to ensure that patients who come to the emergency department requesting treatment will be given a medical screening exam to determine if they are in an emergency medical condition. Patients will be stabilized and transferred in accordance with this law.

This policy applies to General Hospital, the outpatient off-campus physical therapy department, and outpatient lab. Particular employees include all employees in the emergency department, obstetrics department, and behavioral health units.
**Definitions:**

- **Hospital with an Emergency Department:** A hospital with a dedicated emergency department. (§489.24(b))

- **Hospital Property:** The entire main hospital campus including the parking lot, sidewalk and driveway or hospital departments, including any building owned by the hospital that is within 250 yards of the hospital. (§413.65(a))

- **Physicians:** A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he/she performs such function or action. (This definition is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified healthcare personnel to the extent recognized under state law or a state’s regulatory mechanism). (§1861(r)(i))
Penalties

- Hospitals who are noncompliant can have CMS terminate them from the Medicare program (no more payment for Medicare patients)

- The OIG can impose fines

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

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

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

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

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

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

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

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

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

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

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

- 4-27-2010 Olive View UCLA Medical Center $25,000 settlement after 33 YO with chest pain waited over 3 hours to receive a MSE and died exiting the hospital.
Hospital San Francisco, Puerto Rico, agreed to pay $10,000 to resolve its liability for CMPs under the patient dumping statute. The OIG alleged that the hospital failed to provide an appropriate medical screening examination to a 3-year-old boy who presented to its emergency department.

The boy did not have health insurance and the OIG alleged that the admissions department requested that his mother pay a private deposit of $2,150. The mother took her son to another hospital where he was hospitalized for four days and treated for right bronchopneumonia and maxillary sinusitis.

The foregoing information is as reported on the OIG website. The settlement of a disputed case does not represent an admission of wrong-doing by the hospital or an agreement that the events occurred as stated. This settlement was reached in 2005. The date of the incident is not stated.
CA Hospital Fined $75,000 For 16 EMTALA Cases That Left Without Being Seen
Published May 1, 2010

Dameron Hospital Association (Dameron), California, agreed to pay $75,000 to resolve its liability for CMPs under the patient dumping statute. The OIG alleged that Dameron failed to provide an appropriate medical screening examination to 16 individuals that presented to its emergency department.

The individuals presented with a variety of complaints, including, chest pain, abdominal pain, vaginal bleeding, fever, vomiting, dizziness, and coughing. The individuals were triaged by a nurse and then asked to wait in the waiting area. After waiting between three and six hours, the individuals left the hospital without receiving an appropriate medical screening examinations.

The foregoing information is as reported on the OIG website. The settlement of a disputed case does not represent an admission of wrong-doing by the hospital or an agreement that the events occurred as stated. This settlement was reached in 2005. The date of the incident is not stated.
EMTALA Money Penalties

- 11-13-2012 University of Chicago Medical Center pays 50,000 for care of a man who came to ED complaining of severe jaw pain after an assault. He needed surgery and was discharged with instructions to go to another hospital for further care.

- 11-19-2012 Hackley Hospital in Michigan for failure to stabilize a woman in labor and her unborn child.

- 9-5-2012 Duke University pays 180,000 for failure to accept five transfers of psychiatric patients.

- Many cases in 2012 on OIG website, including Nashville Hospital 12-20-11 for refusing to accept a transfer for $45,000.
EMTALA Money Penalties

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

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

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

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

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

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

- 6-2-09 Plantation General Hospital in Fla paid $40,000 for failure to stabilize women in active labor. A friend drove her at high speed to the hospital where she delivered minutes after arrival.
- 3-06-09 Medical Center pays $40,000 after failed to screen patient with severe abdominal pain from an ectopic pregnancy.
- 2-25-09 Physician pays $35,000 for failure to come to the ED in patient with an open leg fracture.
The hospital must report to the Department of Health or CMS

Anytime it has reason to believe that may have received a patient who was transferred in an unstable medical condition

Hospital is required to report within 72 hours of the occurrence

If the receiving hospital fails to report then it can also lost its Medicare reimbursement
Hospitals may want to consider notifying other hospital of the breach before reporting to see if they have an appropriate explanation.

Surveyors will look to see if hospital agreed in advance to the transfer and medical records were sent with the patient.

Surveyors will make sure all transports were with appropriate staff and equipment.

Surveyors will make sure hospital had space and qualified personnel to treat the patient.
Hospital Recommendations

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

- Hospital B concurs about the EMTALA violation

- Hospital B immediately does a comprehensive plan of correction

- The physicians and Board is involved, mandatory education instituted, and new processes put in place

- CMS arrives at hospital and finds that there were out of compliance but have already resolved the problem
EMTALA Sign 2402

- Sign must be posted in any ED or in a place or places likely to be noticed by all individuals entering the emergency department

- As well as those individuals waiting for examination and treatment in areas other than traditional emergency department
  - This would include entrance, admitting area, waiting room, and treatment area
  - Note may want to post in OB, Psych, urgent care units, registration, intake areas, and walk in clinics

- See section 2400 with copy of sign as required by the Secretary of Heath and Human Services
Medical records related to the patients transferred must be kept for five years.

This date is from the date of transfer.

Medical records can be kept in hard copy, microfilm, optical disc, computer memory or any other legally producible form.
On Call Physician Issues
On Call Physicians

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

- Strategies include: enforcing hospital medical staff bylaws that require physicians to take call

- Contracting with physicians to provide coverage

- Paying physicians stipends and employing physicians

  - Study “Hospital emergency on-call coverage: Is there a doctor in the house?” Center for Studying Health System Change, http://www.hschange.com/CONTENT/956/
On Call Physicians

- 21% of deaths and permanent injuries related to ED delays due to lack of physician specialists

- National survey that 36% of hospitals pay at least one specialist to be on call, most often a surgeon

- Little Rock hospital pays trauma surgeon $1,000 a night to be on call

- Miami hospital reports paying $10 million a year for on call emergency coverage

- ACEP report cited the 2008 report
  - ACEP has practice position on EMTALA also at www.acep.org
OIG CPG for Hospitals

- Remember the Department of HHS, OIG, issued “Supplemental Compliance Program Guidance (CPG) for Hospitals, January 2005 report discussed earlier

- On call physicians need to be educated on their responsibilities including responsibility to accept transferred individuals from other facilities
On Call Physician Issues

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

- Some on call physicians should receive orientation to the hospital’s P&P on EMTALA

- For example, emergency department physicians need to be well versed on the federal EMTALA law
  - Also OB and psychiatrists

- Remember the OIG can assess money damages or exclude physicians from the Medicare program if they violate EMTALA
There were many changes to the EMTALA regulations in 2009 IPPS that significantly impact EMTALA's on-call obligations.

Referred to as the shared/community call.

Page 222 of 651 page FR PDF format (73 FR 48434), CMS issues memo on same March, 2009 and now Tag number 2404 in June 2009 edition.

Implemented some of the 55 recommendations from the EMTALA Technical Advisory Group that concluded its work in 2007.

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-09-26

DATE: March 6, 2009

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Inpatient Prospective Payment System (IPPS) 2009 Final Rule Revisions to Emergency Medical Treatment and Labor Act (EMTALA) Regulations

Memorandum Summary

- **EMTALA Regulations Revised**: The Fiscal Year (FY) 2009 IPPS final rule included EMTALA revisions, effective October 1, 2008.

- **On-Call Obligations**: The regulatory provisions have been revised and reorganized. Key changes include introduction of a shared community call (CCP) plan option and elimination of ambiguous language concerning on-call list criteria.
Final Rule Changes

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

- Revised the EMTALA regulations, section on on-call obligations, emergency waivers, and recipient hospital responsibilities

- "Community Call" program that would allow hospitals to work together to satisfy their EMTALA obligations

- The Community Call requirements include a written agreement that addresses key critical points

- Requires a written P&P
The new language reads as follows:

- An on-call list of physicians on its medical staff, who are on staff and have privileges
- At the hospital or another hospital in a formal community call plan
- Are available to provide treatment necessary after the initial examination to stabilize individuals with EMCs
- Who are receiving services required in accordance with the resources available to the hospital
The hospitals work out a plan and put it in writing such as one doctor could be on call for both hospitals.

Or EMS takes OB patients to Hospital A for first 15 days of the month and to Hospital B for the second 15 days of the month.

Hospital A is designated as the stroke hospital and all patients go there or on call for neurosurgery cases.
Shared/Community Call

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

- Hospital needs back up plan when on call physician is not available due to community call (calling in another physician, back up call, use of telemedicine, transfer agreement and send patient to another hospital)

- CMS has **removed** the italicized part of the sentence below since this phase has caused confusion.

  - There was a statement that hospitals needed to manage a list of their on-call physicians *in a manner that best meets the needs* of the hospital’s patients
Shared/Community Call

- If on call physician refuses or fails to show up physician and hospital still responsible
- Physicians can do elective surgery while on call or be simultaneously on call if permitted by the hospital
- Plan needs to specify what geographic area it covers like the city of Columbus or Franklin County
- Person from each hospital has to sign the written plan
Shared/Community Call

- Has to be a formal plan and in writing
- Does not have to be submitted to CMS but CMS may come in and look at the plan
- If paramedics bring patient to your hospital, you still have to see them and do MSE to determine if the patient is in an emergency medical condition
- Still have to keep written copy of list of which doctors are on call and include physicians on call at the other facility
On-Call Requirements 2404

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

Revised and approved by ACEP Board of Directors April 2006
Replaces policy statement entitled "Hospital, Medical Staff, and Payer Responsibility for Emergency Department Patients" approved September 1999; revised and replaced "Medical Staff Responsibility for Emergency Department Patients" approved by the ACEP Board of Directors September 1997 and "Medical Staff Call Schedule" approved as a Board Motion 1987

The American College of Emergency Physicians (ACEP) believes that:

- Hospitals, medical staff, and payers share an ethical responsibility for the provision of emergency care.
- Hospital emergency departments (EDs) require a reliable on-call system that
ACEP endorses the following principles:

- Hospitals and their medical staffs must be familiar with and comply with the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA). The American College of Emergency Physicians (ACEP).
- All patients who come to an ED requesting care must receive a medical screening examination and the necessary treatment to stabilize an emergency medical condition without unnecessary delay and without regard to the patient's ability to pay. Under most circumstances, these services are best provided by an emergency physician.
- A medical screening examination and any necessary stabilizing treatment may require the use of ancillary, consultative, or inpatient services within the capability of the hospital and its medical staff.
- All hospitals that provide emergency services must maintain a schedule of medical and surgical specialists on-call for the ED in a manner that best meets the needs of the hospital's patients who are receiving services.
- To ensure institutional compliance with the provisions of EMTALA, hospital medical staff bylaws and/or rules, and regulations must delineate the responsibilities of the on-call physician and should specify methods for monitoring and ensuring compliance.
- On-call physician services must be available within a reasonable time to provide necessary stabilizing treatment and without regard to the patient's ability to pay.
- If a hospital lacks the medical staff resources to provide on-call coverage for a given specialty, the hospital must have a plan that specifies how such referrals should be managed.
- Follow-up care should be arranged for all patients who require such care.
- Physicians who choose to assume direct on-site emergency care responsibility for their patients must be physically present in the ED and must be members of the medical staff, privileged to provide such care.
- Requests for consultative services should be made in accordance with the patient's preferences and/or health plan when feasible.
- Physician services (including medically necessary post-stabilization care), when provided in response to the request for emergency care, should be recognized as emergency services for reimbursement purposes and should be compensated in.
Appropriate Interhospital Patient Transfer

Revised and approved by the ACEP Board of Directors September 1992 titled, "Appropriate Interhospital Patient Transfer; June 1997; February 2002; and February 2009
Originally approved by the ACEP Board of Directors September 1989 as a position statement titled, "Principles of Appropriate Patient Transfer"

The American College of Emergency Physicians (ACEP) believes that quality emergency care should be universally available and accessible to the public. For patients evaluated or treated in the emergency department (ED) who require transfer from the ED to another facility, ACEP endorses the following principles regarding patient transfer.

- The optimal health and well-being of the patient should be the principal goal of patient transfer.
- Emergency physicians and hospital personnel should abide by applicable laws regarding patient transfer. All patients should be provided a medical screening examination (MSE) and stabilizing treatment within the capacity of the facility before transfer. If a competent patient requests transfer before the completion of the MSE and stabilizing treatment, these should be offered to the patient and documented. Hospital policies and procedures should articulate these obligations and ensure safe and efficient transfer.
- The transferring physician should inform the patient or responsible party of the risks and the benefits of transfer and document these. Before transfer, patient consent should be obtained and documented whenever possible.
- The hospital policies and procedures and/or medical staff bylaws should identify the individuals responsible for and qualified to perform MSEs. The policies and procedures or bylaws must define who is responsible for accepting and transferring patients on behalf of the hospital. The examining physician at the transferring hospital will use his or her best judgment regarding the condition of the patient when determining the timing of transfer, mode of transportation, level of care, and destination facility.
On-Call Requirements 2404

- Staff must be aware of who is on-call including specialists and sub-specialists

- The on-call list must be composed of physicians who are members of the MS and who have hospital privileges

- If hospital participated in community call must include the names of the physicians pursuant to this plan

- Hospitals need to provide sufficient on-call physicians to meet the needs of the community
On-Call Requirements 2404

- The plan for community call must clearly articulate which on-call services will be provided and when

- CCP does not always mean that the physician must come to the other hospital as the patient can be transferred (example stroke center)

- Consider which is best approach for the patient if physician has privileges at both hospitals

- Sending hospital must still conduct MSE and stabilize within its capability and capacity if the patient an EMC
On-Call Requirements 2404

- Hospitals participating in CCP must still accept appropriate transfers from hospitals not participating in the plan.

- All Medicare participating hospitals must fulfill their EMTALA obligation whether participating in a CCP or not.

- EMTALA does not apply to pre-hospital setting or paramedics in the field but good to educate them on this.

- Updates to the CCP plan must be communicated to EMS providers so they include the information in their protocols.
Simultaneous Call  2404

- Hospitals can permit physicians if they want to be on call at two or more facilities
- Hospitals have to be aware and agree to this
- Hospitals must have a P&P on this
- Staff will follow the written P&P if on-call is not available when called to another hospital
- Back up plan might be to transfer the patient to the next appropriate hospital
Scheduled Elective Surgery 2404

- Hospital can decide if they will allow on-call physician to do elective surgery or elective procedures

- Hospitals need to have P&P on this

- CAH that reimburse physicians for being on call may not want to do this since Medicare payment policy regulations

- Hospital must have back up plan in case on-call physician is not available
Medical Staff Exemptions

- No requirement that all the physicians on the MS must take call.

- For example, a hospital may exempt a senior physician (over 60) or physicians who have been on the staff for over 20 years.

- However, can permit physicians to selectively take call.

- Hospital needs to ensure adequate call schedule.
On-Call Requirements 2404

- Hospital must have an on-call policy
- EMTALA is the hospital’s on-call policy
- P&P must clearly delineate the responsibilities of the on-call physician to respond, exam, and treat
- P&P must address steps to follow if on-call physician can not respond due to circumstances beyond their control
  - Blizzard, flood, personal illness, transportation problems
CMS does not have a specific requirement regarding how frequent physicians have to be on call.

CMS recognizes that for safe and effective care, a hospital needs to have one physician on call every day.

There is no predetermined ratio CMS uses.

Used to use an unwritten rule of 3.

If 3 specialists are on the staff, then they need 24-hour coverage (which CMS suggested never existed).
CMS will consider all relevant factors in determining if appropriate (relevant factor test)

This would include number of physicians on the medical staff, other demands of physicians, number of times requiring stabilizing services of the on-call physician, vacations, and conferences

Hospital does a significant number of cardiac cath and holds itself out as a center of excellence so CMS would expect 24 hour coverage
On Call Physician Issues

- So what can hospitals do?
- If 1 or 2 specialists then have reasonable call schedule which includes some weekends and off hours
- May be on call 7-10 days per month
- If services needed then permissible to transfer to a facility with these services in “no coverage” periods
- P&P covers what to do such as transfer to another hospital as part of the plan
2. Q: How frequently is a hospital's medical staff of on-call physicians expected to provide on-call coverage?

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Ref.#S&C-02-34
DATE: June 13, 2002
FROM: Director, Survey and Certification Group, Center for Medicaid and Medicare Services
SUBJECT: On-Call Requirements - EMTALA
TO: Associate Regional Administrators, Division of Medicaid and State Operations,
Region I-X

The purpose of this program memorandum is to provide guidance to regional offices, state survey agency personnel and hospitals regarding the Emergency Medical Treatment and Labor Act (EMTALA). It has come to our attention that the medical community has concerns that the implementation and enforcement of EMTALA for on-call physicians is not being applied consistently across the country. We have prepared the following questions and answers based on questions we have received to clarify hospital responsibilities concerning on-call physicians.

www.acep.org/content.aspx?id=30120&terms=emtala%20on%20call
On-Call Requirements  2404

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

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

- CMS says hospitals are well advised to make physicians who are on call aware of their on-call P&P and the physician's obligation.
On-Call Requirements 2404

- If hospital A with an EMC need the specialty services of hospital B, pursuant to the CCP, then the physician is required to report to hospital B to provide the stabilization treatment.

- ED physician can call the on-call physician for consultation and on-call physician does not have to show up if not requested.

- The decision to have the physician show up is made by the ED physician who has examined the patient.
On-Call Requirements

- Remember to include in P&P and education the following
- Physicians who are on call are not representing their office practice when they are on call
- They are representing the hospital
- When they are on call they must show up within a reasonable time if requested to come to the ED
On-Call Requirements

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

- It is generally not acceptable to send ED patients to their offices for exam and treatment of an EMC.

- Exception is made when medically indicated and patient need specialized service like special equipment the hospital does not have.
On-Call Requirements 2404

- However, physician’s office must be part of hospital’s provider based system with same CMS certification number as the hospital.
- It must be clear that the transport is not done for the convenience of the physician.
- Must be genuine medical issue and all individuals with same medical condition are treated the same way.
- Appropriate medical personnel must accompany the patient to the physician’s office.
On-Call Requirements  2404

- Decision as to whether the on-call physician must respond personally or whether a non-physician can respond (PA, NP, or orthopedic tech) can be made by on-call physician.

- It must also be permitted by the hospital’s P&P

- Actually the ED physician makes the decision based on the patient’s need.

- Also, must be within scope of practice for the representative such as the PA or NP.
On-Call Requirements 2404

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

- There is no prohibition against the treating physician consulting on a case with another physician

- This physician may or may not be on the on-call list

- May consult by telephone, video conferencing, transmission of test results, or any other means of communication

- Example, patient bitten by poisonous pet snake and physician consults with expert in this area
On-Call Requirements 2404

- CMS recognized that some hospitals use telecommunication to exchange x-rays or test results with consulting doctors not on the premises.

- However, if the physician specialist is on-call and is requested by the treating physician to come to the hospital this must occur.

- Reimbursement issues are outside the scope of EMTALA enforcement but be aware of telemedicine reimbursement policy.
Telehealth or telemedicine policy is located in the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 18, Section 270

- CMS has changes to the CoP manual on telemedicine effective July 2011
  - http://www.cms.hhs.gov/Manuals/IOM/list.asp

- Also remember that EMTALA is a requirement to treat and not a requirement to pay

- On-call physician must see patient even if physician does not accept that insurance plan or patient does not have insurance
May 5, 2011 Teleradiology Standards

25550

Federal Register / Vol. 76, No. 87 / Thursday, May 5, 2011 / Rules and Regulations

have concluded this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This rule is categorically excluded, under figure 2–1, paragraph (34)(g), of the Instruction. The rule involves establishing a safety zone. An environmental analysis checklist and a categorical exclusion determination are available in the docket where indicated under ADDRESSES.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, and Wrecks.

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

1. The authority citation for part 165 continues to read as follows:


2. Add § 165.1184 to read as follows:

§ 165–1184 Safety Zone: Coast Guard Use of Force Training Exercises, San Pablo Bay, CA

(a) Location. This safety zone will apply to the navigable waters in the San Pablo Bay, and will encompass an area beginning at position 38°01′44″ N, 122°27′06″ W; 38°04′36″ N, 122°22′06″ W; 38°00′35″ N, 122°28′07″ W; 38°03′00″ N, 122°20′20″ W (NAD 83) and back to the starting point.

(b) Enforcement. The Coast Guard will notify the public via a Broadcast Notice to Mariners prior to the activation of this safety zone. The safety zone will be activated on average two times per month, but could be activated up to six times per month. It will be in effect for

Federal, State, and local officer designated by or assisting the Captain of the Port San Francisco (COTP) in the enforcement of the safety zone.

(d) Regulations. (1) Under the general regulations in § 165.23, entry into, transiting, or anchoring within the safety zone is prohibited unless authorized by the COTP or the COTP’s designated representative.

(2) The safety zone is closed to all vessel traffic, except as may be permitted by the COTP or the COTP’s designated representative.

(3) Vessel operators desiring to enter or operate within the safety zone must contact the COTP or the COTP’s representative to obtain permission to do so. Vessel operators given permission to enter or operate in the safety zone must comply with all directions given to them by the COTP or the COTP’s designated representative. Persons and vessels may request permission to enter the safety zone on VHF–16 or the 24-hour Command Center via telephone at (415) 399–5347.

Dated: March 31, 2011.

Cynthia L. Stowe,
Captain, U.S. Coast Guard, Captain of the Port San Francisco.

[FR Doc. 2011–10930 Filed 5–4–11; 8:45 am]

BILLING CODE 9100–04–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 482 and 485

[CMS–3227–F]

RIN 0938–AQ05

Medicare and Medicaid Programs: Changes Affecting Hospital and Critical Access Hospital Conditions of Participation: Telemedicine Credentialing and Privileging

This final rule will remove this undue hardship and financial burden.

DATES: Effective Date: These regulations are effective on July 5, 2011.


SUPPLEMENTARY INFORMATION:

I. Background

This final rule reflects the Centers for Medicare and Medicaid Services’ commitment to the general principles of the President’s Executive Order released January 18, 2011, entitled “Improving Regulation and Regulatory Review.” The rule revises the conditions of participation (CoPs) for both hospitals and critical access hospitals (CAHs) to:

(1) Make current Federal requirements more flexible for rural and/or small hospitals and for CAHs; and
(2) encourage innovative approaches to patient-service delivery.

CMS regulations currently require a hospital to have a credentialing and privileging process for all physicians and practitioners providing services to its patients. The regulations require a hospital’s governing body to appoint all practitioners to its hospital medical staff and to grant privileges using the recommendations of its medical staff. In turn, the hospital medical staff must use a credentialing and privileging process, provided for in CMS regulations, to make its recommendations. CMS requirements do not take into account those practitioners providing only telemedicine services to patients. Consequently, hospitals apply the credentialing and privileging requirements as if all practitioners were on site. This traditional and limited approach fails to embrace new methods and technologies for service delivery that may improve patient access to high quality care.

This final rule will permit hospitals and CAHs to implement a new...
**Memorandum Summary**

- **Telemedicine Rules Adopted for Hospitals/CAHs:** New and amended rules effective July 5, 2011 permit hospitals and CAHs to provide telemedicine services to their patients through written agreements with a distant-site hospital or a distant-site telemedicine entity.

- **Streamlined Credentialing & Privileging for Telemedicine Physicians & Practitioners.** Hospitals and CAHs may rely, when granting telemedicine privileges, upon the privileging decisions of a distant-site hospital or telemedicine entity with which they have a written agreement that meets Medicare requirements.

On May 5, 2011, the Centers for Medicare & Medicaid Services (CMS) published a final rule (76 FR 25550), effective July 5, 2011, governing the agreements under which a hospital or CAH may provide telemedicine services to its patients. “Telemedicine,” as the term is used in this rule, means the provision of clinical services to patients by physicians and practitioners from a distance via electronic communications. The distant-site telemedicine physician or practitioner provides clinical services to the hospital or CAH patient either simultaneously, for example, as in teleICU services, or non-simultaneously, as is the case with many teleradiology services.
On-Call Requirements 2404

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

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

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

- What is a reasonable time to respond?
- CMS previously required hospitals to delineate expected response time in minutes.
- Now says hospital is well-advised to establish in its P&P the maximum number of minutes what constitutes a reasonable response time.
- Generally response time for true emergencies is expected in the range of 30-45 minutes.
On-Call Requirements  2404

- Differentiate between response times on phone and physical presence

- Include what to do if they don’t show such as contact department chair or VP of MS

- If on-call physician doesn’t show up timely, take this seriously
  - Physician may also be in violation of EMTALA

- Try to get partner or another physician to come in and if hospital does this then CMS now says the hospital is not in violation of EMTALA
On-Call Requirements  2404

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

- Medical staff bylaws or P&P must define the responsibility of the on call physician for certain things.

- This would include responsibility to respond, examine, and treat patients with emergency medical condition.

- Designate in policy physician is responsible for the care of the patient when on call through the episode created by the EMC.

- Physician does not have to take patient for subsequent problems unless the physician on call at the time again.

- On call physician can not require co-pay or insurance information before assuming responsibility for the care of the patient.
The End!  Questions??

- Sue Dill Calloway RN, Esq. CPHRM, CCMSP
- AD, BA, BSN, MSN, JD
- President of the Patient Safety and Education Consulting
- Board Member Emergency Medicine Patient Safety Foundation at www.empsf.org
- 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,


- 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

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
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.
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.
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
If the hospital has to transfer a patient because the on-call MD did not show up, the sending hospital must provide the name and address of that physician to the receiving hospital.

The receiving hospital must report the violation to CMS.

This means both the hospital and physician could be surveyed and scrutinized to determine if a violation of EMTALA.
Physician Education

- Physicians, as well as hospitals, may be subject to penalties for violating EMTALA’s on-call provisions.

- Physician risks include civil monetary penalties, lose of license, termination from Medicare and other federal health programs, criminal prosecution or civil lawsuits, and medical staff suspension and can be reported to the State Medical Board by OIG.
Physician Education

- Per CMS, having an office full of patients is not an allowable excuse for not coming in timely when on call and requested by the ED physician to come to the hospital.

- EMTALA requires the name of individual physician & not the name of the physician’s group practice to be included on the on-call list.
Physician Education

- EMTALA is a requirement to treat; it is not a requirement to pay

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

- 20 Common Practices that will Get On-Call Physicians Cited at http://medlaw.com/healthlaw/EMTALA/education/20-common-practices-that-.shtml,

- The EMTALA Answer Book 2009 by Mark Moy, Aspen Publication,

Resources

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

www.thesullivangroup.com/products_services/ps_emtala_solutions.asp
EMTALA Resources

EMTALA and Healthlaw Resources for Hospitals, Physicians and Their Attorneys

BLOG
Main Resources
Publications
Services
Ask A Question
Support

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/
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.

EMTALA Resources

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

   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 online at http://www.cms.hhs.gov/medicaid/survey-cert/letters.asp.
ACEP EMTALA Resources

www.acep.org/content.aspx?LinkIdentifier=id&id=25936&fid=1754&Mo=No&acepTitle=EMTALA
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
- Ambulance Diversion
- Appropriate Interhospital Patient Transfer
- EMTALA Fact Sheet
- On-Call Specialty Shortage Resources
- Providing Emergency Care Under Federal Law: EMTALA

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

http://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

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

Robert v. Global of Virginia - The Supreme Court misses the boat on 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.

www.ihatoday.org/Resources/EMTALA.aspx
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

[Map of CMS Regional Offices showing locations in various cities across the United States, including Seattle, San Francisco, Chicago, New York, Boston, Philadelphia, Dallas, Atlanta, and others.]
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
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
Are you up to the challenge?
The End! Questions??

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Questions?