EMTALA Update and Enforcement Data
MS Hospital Assn.

Madison, MS
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Presentation Overview

- Review & Clarify EMTALA Law and Regulations (agency regulatory perspective)
- Updates and clarifications: Recipient Hospital Responsibilities,
- Community Call Option
- Physician to Physician (Mis)Communications
- EMTALA Waivers in Public Health Emergency
- Regulatory Compliance and Enforcement
- Questions?
Key Point: Patient focus
Individual Case, complaint driven

Terminology and definitions are as defined by:
Law and regulation: Social Security Act Section 1867
(42 USC 1395 dd), enacted 1985)
Regulations: 42 CFR 489.24

Term’s meaning may be somewhat different than in common medical parlance.
(ex. “stable” vs. “stabilized”)
Basic EMTALA Flow Chart

An individual comes to ED for a medical condition

Must be provided an appropriate medical screening exam (MSE) by qualified medical personnel (QMP) within the capability (staff and facilities available at the hospital) routinely available to the ED

MSE is to determine whether an emergency medical condition (EMC) exists.
Define: Emergency Medical Condition

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

(i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part; or-
Define: Emergency Medical Condition

(or)-

(2) With respect to a pregnant woman who is having contractions-

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery;

or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.”

42 CFR 489.24
Define: Labor

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

Does an Emergency Medical Condition (EMC) Exist?

If No, no further obligation under EMTALA. (might still have liability for failure to dx, rx, or any other type of medical liability)

If Yes, (or if EMC not ruled out) then must either Stabilize, Admit, or appropriately Transfer.
Define: Medical Screening Exam

Appropriate MSE: Based on and appropriate to presenting signs and symptoms, reasonably calculated to determine whether an emergency medical condition (EMC) exists.

Without delay to inquire about payment. And without disparity of exam between different sources of payment or nonpayment, disability, diagnosis (e.g. labor, pregnancy, psychiatric, AIDS), race, ethnicity, immigration status, etc.
Define: Medical Screening Exam

MSE is a process, may involve multiple steps and reassessment over time (including lab, radiology, CT, EKG, procedures, e.g. lumbar puncture, and even consultation and exam by other staff specialty physicians).
Federal Pre-emption of conflicting state law

“The existence of a State law requiring transfer of certain individuals to certain facilities is not a defense to an EMTALA violation for failure to provide an MSE or failure to stabilize an EMC therefore hospitals must meet the Federal EMTALA requirements or risk violating EMTALA”

SOM, Interpretive Guidelines 489.24(a)

Issue: Federal Pre-emption of conflicting state law, includes conflicting state court orders, TROs, no-contact orders, restraining orders, psychiatric care referral protocols, etc.
Mob attacks hospitals for alleged denial of treatment: Accident victims did not get emergency care:

• PHOTO: SUSHANTA PATRONOBISH

Date: 14/04/2010 URL: http://www.thehindu.com/2010/04/14/stories/2010041456601300.htm

The Kolkata hospital ransacked on Tuesday for allegedly refusing emergency care to victims of a road accident.
TRIAGE is NOT an MSE

Triage is NOT an MSE

TRIAGE is NOT an MSE

(repeat 3 X, after me)

Triage merely determines the order, or priority of the MSE by qualified medical personnel.
Appropriate MSE

There is only one standard for an MSE.

Appropriate or not appropriate.

Will be determined after the fact based on the individual’s presenting signs and symptoms.
Aviation or Health Care?
Define: Qualified Medical Personnel

QMP- must be designated and approved in writing in a document by the governing board of the hospital (rules and regulations or hospital bylaws) not by informal personnel appointments. (source-SOM)

Must be acting within the scope of their (State) professional license.
Define: Qualified Medical Personnel

Must demonstrate specific competency and training to conduct an appropriate medical screening exam (not just a triage exam).

In the event of an EMTALA complaint, QMP will be subject to an after-the-fact determination as to whether the MSE was appropriate and whether the QMP was qualified or competent to conduct the MSE based on the clinical presentation of the individual whose case is under investigation.
No different standard for an adequate MSE based on type of professional’s license, training, or credentials. (i.e. the standard will be the same for an RN, NP, PA, or an MD, DO, board certified or not board certified).
Define: “Transfer”

Transfer- “the movement (including the discharge) of an individual outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include the movement of an individual who …leaves the facility without the permission of any such person.”

42 CFR 489.24(b)

CAUTION: document mental competency, leaving AMA vs. elopement vs. economic “coercion” or “suggestion”
42 CFR 489.24

To Stabilize - “means with respect to an “emergency medical condition”…to provide such medical treatment of that condition necessary to assure within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to an “emergency medical condition” as defined…that a woman has delivered the child and the placenta”
“Stable” vs “Stabilized”

Distinguish between “stable” for transfer between facilities and “stabilize” the medical/psychiatric condition before discharge (defined as a “transfer” by the law).
Psychiatric Emergencies

In the case of psychiatric emergencies, if an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered to have an EMC-(“emergency medical condition”).

State Operations Manual (SOM)
Interpretive guideline 489.24(d)(2)(i)
“Stable” Psychiatric Patients

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

SOM - interpretive guidelines

Does the writing of an involuntary commitment order “stabilize” the patient with a psych EMC? Answer: NO. Only treatment, (inpatient), until the patient no longer danger to self or others.
CAUTION:
The administration of chemical or physical restraints for purposes of transferring an individual from one facility to another may stabilize a psychiatric patient for a period of time and remove the immediate EMC but the underlying medical condition may persist and if not treated for longevity the patient may experience exacerbation of the EMC.
Caution:
Practitioners should use great care when determining if the medical condition is in fact stable after administering chemical or physical restraints.

SOM- interpretive guideline
Psychiatric Emergencies

Caution:

Remember that behavioral or psychiatric symptoms may be the manifestation of severe underlying medical and metabolic conditions which may be life threatening.

Hence the need for a careful history and medical screening exam to determine the cause of the behavioral symptoms.
Psychiatric Emergencies

Caution:

The psychiatric patient may be the victim of occult trauma, intoxication, or have an additional active emergency medical condition which requires stabilization before transfer.
Recipient Hospital Responsibilities

Source: 42 CFR 489.24(f)
SOM Appendix V, (ref S&C 06-32, and S&C 08-15)
- Tag A-2411/C-2411

§ 489.24(f) Recipient Hospital Responsibilities

- A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual. This requirement applies to any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.
Duty to Report

Sec 1866 Social Security Act, 42 CFR 489.20(m)

Hospital Conditions of Participation Agreement:

Hospital agrees …to report to CMS or the State Survey Agency ANY TIME IT HAS REASON TO BELIEVE IT MAY (emphasis added) have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of ..489.24(e)
Duty to Report

CMS Guidance (SOM) App.V (Rev46, 05-29-09)

“A hospital that SUSPECTS (emphasis added) it MAY HAVE receive an improperly transferred…unstable individual with an emergency medical condition is required to promptly report the incident to CMS or the State Agency within 72 hours of the occurrence. **If the recipient hospital fails to report an improper transfer, the hospital may be subject to termination of its provider agreement.**” (emphasis added)
Duty to Report

Whistleblower protection: (SSA 1867, 42USC1395dd)

“A participating hospital may not penalize or take adverse action against a qualified medical person or a physician because...refuses to transfer ...(pt with unstabilized EMC)... or against any hospital employee because the employee reports a violation of ... this section.”
Recipient Hospital Responsibilities: A hospital with specialized capabilities is not required under EMTALA to accept the transfer of a hospital inpatient who presented to the admitting hospital under EMTALA.
The FY 2009 IPPS Final Rule clarified EMTALA obligations for hospitals with specialized capabilities with the addition of the following language at §489.24(f)(2):

- The provisions of this paragraph (f) do not apply to an individual who has been admitted to a referring hospital under the provisions of paragraph (d)(2)(i) of this section.
Recipient Hospital Responsibilities

This applies once an individual is admitted in good faith to the admitting hospital.

Admission means inpatient admission, does not include placing in observation status who are still considered as outpatients (as opposed to admission to hospital as inpatient).

Please notify CMS regional office if problems with this section arise.
Community Call Plan (CCP) Option

- The IPPS FY 2009 final rule added a provision at 42 CFR.489.24(j)(2)(iii) that permits hospitals to participate in a formal CCP to share their on-call responsibilities. Participation by hospitals in a CCP is entirely voluntary. CMS is simply making this option available to hospitals that wish to pursue it. (See S&C 09-26)
Community Call Plan

The regulation establishes several elements that must be present in any formal CCP (continues on next slide):

• A clear delineation of on-call coverage responsibilities; that is, when each participating hospital is responsible for on-call coverage (for a specific time period, or for a specific service, or both);

• A description of the specific geographic area to which the plan applies;

• A signature by an appropriate representative of each hospital in the plan;

• Assurances that any local and regional EMS system protocol formally includes information on community on-call arrangements;
CCP requirements, continued

• A statement specifying that even if an individual arrives at a hospital that is not designated as the on-call hospital, that hospital still has an obligation under 42 CFR 489.24 to provide a medical screening exam and stabilizing treatment within its capability, and that hospitals participating in the community call plan must abide by the regulations under §489.24 governing appropriate transfers; and

• An annual assessment of the community call plan by the participating hospitals.
Physician to Physician 
(Mis)Communications

• Pitfalls for initial (transferring) hospital:
  - ER physician with own hospital on call physician.

Pitfalls for recipient hospital:
Transferring hospital ER physician to recipient hospital on call staff (or designee).

On Call “bullying”, “Kabuki dances”, or “passive aggressive-telephone tag games” will not be considered a defense for refusal to see or accept a patient. (Both parties will go to the “principal’s office”).
Links to CMS S&C documents


EMTALA Waivers in Public Health Emergencies

Very limited in scope:
EMTALA Waivers apply in only two (2) situations:

Transfer of individuals who have not been stabilized.

Redirection or relocation of an individual by a hospital to alternative location to receive medical screening exam.

Transfer must be necessitated by the circumstances of the (public health) emergency.
Prerequisites for EMTALA Waivers

HHS Secretary must declare a public health emergency. President must issue a declaration under the Stafford Act or National Emergencies Act.
Secretary must invoke her waiver authority including 48 hour advance notice to Congress and must define the scope and duration of sec. 1135 waivers.
State must activate its emergency preparedness plan or pandemic preparedness plan.
Hospital must activate its own disaster protocol.
Hospital must request waiver from CMS Regional Office.
References on EMTALA Waivers


Also: http://www.cms.hhs.gov/H1N1/

for downloads on CMS guidance pertaining to: Fact Sheet on ASC in pandemics, guidelines on requesting an 1135 waiver, and Q & A, etc.
EMTALA Enforcement
2006-2007

Regional and National Perspectives

Frances R. Jensen, MD
EMTALA Technical Leader
Division of Acute Care Services
CMS/CMSO/SCG
**EMTALA SUMMARY FY04-07**

*CY04: 9 Mos.*  
FY05-07: 12 Mos. (07 lacks some unclosed investigations)

<table>
<thead>
<tr>
<th></th>
<th>CY04</th>
<th>FY05</th>
<th>FY06</th>
<th>FY07</th>
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<tbody>
<tr>
<td># Complaints</td>
<td>658*</td>
<td>738</td>
<td>744</td>
<td>699</td>
</tr>
<tr>
<td># Surveys</td>
<td>616*</td>
<td>649</td>
<td>642</td>
<td>626</td>
</tr>
<tr>
<td>% Violations</td>
<td>30*</td>
<td>38</td>
<td>40</td>
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## Regional Complaint Volume

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<thead>
<tr>
<th>Region</th>
<th>FY06</th>
<th>FY07</th>
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<tbody>
<tr>
<td>RO1 Boston</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>RO2 New York</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>RO3 Philadelphia</td>
<td>34</td>
<td>16</td>
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<tr>
<td>RO4 Atlanta</td>
<td>329</td>
<td>286</td>
</tr>
<tr>
<td>RO5 Chicago</td>
<td>64</td>
<td>65</td>
</tr>
<tr>
<td>RO6 Dallas</td>
<td>131</td>
<td>124</td>
</tr>
<tr>
<td>RO7 Kansas City</td>
<td>64</td>
<td>89</td>
</tr>
<tr>
<td>RO8 Denver</td>
<td>52</td>
<td>54</td>
</tr>
<tr>
<td>RO9 San Fran</td>
<td>24</td>
<td>38</td>
</tr>
<tr>
<td>RO10 Seattle</td>
<td>22</td>
<td>10</td>
</tr>
<tr>
<td><strong>National</strong></td>
<td><strong>744</strong></td>
<td><strong>699</strong></td>
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</table>
## Regional Complaint Rates

<table>
<thead>
<tr>
<th>Region</th>
<th>FY06</th>
<th>FY07</th>
</tr>
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<tbody>
<tr>
<td>RO1</td>
<td>4.2 %</td>
<td>1.0 %</td>
</tr>
<tr>
<td>RO2</td>
<td>3.2</td>
<td>3.2</td>
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<tr>
<td>RO3</td>
<td>6.8</td>
<td>2.9</td>
</tr>
<tr>
<td>RO4 Atlanta</td>
<td>28.7</td>
<td>23.5</td>
</tr>
<tr>
<td>RO5</td>
<td>6.0</td>
<td>5.7</td>
</tr>
<tr>
<td>RO6 Dallas</td>
<td>12.0</td>
<td>9.8</td>
</tr>
<tr>
<td>RO7</td>
<td>12.3</td>
<td>16.5</td>
</tr>
<tr>
<td>RO8</td>
<td>15.0</td>
<td>14.2</td>
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<tr>
<td>RO9</td>
<td>4.1</td>
<td>5.2</td>
</tr>
<tr>
<td>RO10</td>
<td>9.4</td>
<td>3.7</td>
</tr>
<tr>
<td><strong>National</strong></td>
<td><strong>12.1 %</strong></td>
<td><strong>10.2 %</strong></td>
</tr>
</tbody>
</table>
What Does This Data Tell Us About Enforcement Consistency?

- Regional rates relatively stable over time, except for ROs with fewer hospitals.
- Within regions, State complaint rates vary more over time (but Florida has the most).
- Since EMTALA enforcement is complaint-driven, a major source of regional variation is beyond CMS control.
- Regional and State variation in the rate of EMTALA complaints causes different levels of enforcement activity.
Who is filing EMTALA complaints?
## Source of Complaints

<table>
<thead>
<tr>
<th>Source</th>
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<th>FY07</th>
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<tbody>
<tr>
<td>Pt/Family/Friend</td>
<td>36.0%</td>
<td>34.2%</td>
</tr>
<tr>
<td>Self</td>
<td>8.7%</td>
<td>9.8%</td>
</tr>
<tr>
<td>Providers (hospitals)</td>
<td>32.1%</td>
<td>34.8%</td>
</tr>
<tr>
<td>Hospital Staff</td>
<td>1.9%</td>
<td>1.7%</td>
</tr>
<tr>
<td>CMS</td>
<td>0.8%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Other*</td>
<td>20.5%</td>
<td>18.4%</td>
</tr>
</tbody>
</table>
Large number of patient/family/friends
Large number of other providers (transferring or recipient hospitals)
Large number of others
- SAs, physicians, media, none specified, ombudsmen, Congress, QIOs
Selection of Complaints to be Surveyed

- Is there any evidence of variation among the regions in authorizing surveys in response to EMTALA complaints?
## % of Authorized Surveys

<table>
<thead>
<tr>
<th>Region</th>
<th>FY06</th>
<th>FY07</th>
</tr>
</thead>
<tbody>
<tr>
<td>RO1</td>
<td>91</td>
<td>33*</td>
</tr>
<tr>
<td>RO2</td>
<td>92</td>
<td>93</td>
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<tr>
<td>RO3</td>
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<td>RO4</td>
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<td>RO5</td>
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<td>RO6</td>
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<td>RO7</td>
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<td>RO8</td>
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<td>RO9</td>
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<td>RO10</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>National</td>
<td>86</td>
<td>90</td>
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</tbody>
</table>
What Does This Data Tell Us About Enforcement Consistency?

• Most regions authorize surveys for most complaints; in some regions small numbers of complaints skew the numbers
## % of Surveys with Violations

<table>
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<tr>
<th>Region</th>
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<th>FY07</th>
</tr>
</thead>
<tbody>
<tr>
<td>RO1</td>
<td>40</td>
<td>33</td>
</tr>
<tr>
<td>RO2</td>
<td>83</td>
<td>56</td>
</tr>
<tr>
<td>RO3</td>
<td>38</td>
<td>38</td>
</tr>
<tr>
<td>RO4</td>
<td>26</td>
<td>37</td>
</tr>
<tr>
<td>RO5</td>
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<td>RO6</td>
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<td>RO7</td>
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<td>RO8</td>
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<td>RO9</td>
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<td>66</td>
</tr>
<tr>
<td>RO10</td>
<td>68</td>
<td>53</td>
</tr>
<tr>
<td><strong>National</strong></td>
<td><strong>40</strong></td>
<td><strong>41</strong></td>
</tr>
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</table>
### Substantiation % over Time

<table>
<thead>
<tr>
<th>Region</th>
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<th>FY05</th>
<th>FY06</th>
<th>FY07</th>
</tr>
</thead>
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<td>17</td>
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<td>RO4</td>
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<td>RO9</td>
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<tr>
<td>RO10</td>
<td>16</td>
<td>70</td>
<td>68</td>
<td>53</td>
</tr>
</tbody>
</table>

*Italics < 30 surveys*
Regions with larger numbers of surveys affect the national data (a function of the denominator); some regional rates may be misleading as highest volume ROs have the lowest substantiation rates.
What subtypes of complaints are being alleged and/or violated?
# Subtype Distribution FY06-07

<table>
<thead>
<tr>
<th>Subtype</th>
<th>Allegations FY06 (n=1349)</th>
<th>Allegations FY07 (n=1255)</th>
<th>Violations FY06 (n=473)</th>
<th>Violations FY07 (n=475)</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-call</td>
<td>6.2%</td>
<td>7.3%</td>
<td>6.3%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Screening</td>
<td>26.2%</td>
<td>26.5%</td>
<td>30.4%</td>
<td>29.9%</td>
</tr>
<tr>
<td>RHR</td>
<td>8.2%</td>
<td>7.8%</td>
<td>8.7%</td>
<td>8.8%</td>
</tr>
<tr>
<td>Stabilizing Rx</td>
<td>20.0%</td>
<td>17.4%</td>
<td>13.3%</td>
<td>12.8%</td>
</tr>
<tr>
<td>Delay</td>
<td>5.5%</td>
<td>7.2%</td>
<td>3.0%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Transfer</td>
<td>17.9%</td>
<td>15.2%</td>
<td>16.1%</td>
<td>16.6%</td>
</tr>
<tr>
<td>Signage</td>
<td>0.9%</td>
<td>0.3%</td>
<td>1.1%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Log</td>
<td>2.3%</td>
<td>4.5%</td>
<td>3.6%</td>
<td>5.5%</td>
</tr>
</tbody>
</table>
What Does This Data Tell Us About Enforcement Consistency?

• Distribution of types of violations generally correlates with the distribution of allegations
  – Reinforces that EMTALA enforcement is complaint-driven

• Screening, stabilizing treatment and transfer are the big problems areas
  – CMS enforcement is not focused on administrative violations.
Mob attacks hospitals for alleged denial of treatment: Accident victims did not get emergency care:

The Kolkata hospital ransacked on Tuesday for allegedly refusing emergency care to victims of a road accident.
Thank You

Applications?

Questions??