Emergency Medical Treatment and Labor Act (EMTALA) Update
Promoting Patient Safety through EMTALA Compliance

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Objectives

At the conclusion of this presentation the participant will be able to describe:

- The basic requirements of the Emergency Medical Treatment and Labor Act (EMTALA)
- The interpretations given to the requirements of EMTALA by the courts
- Ways in which compliance with EMTALA can be improved
- Ways in which compliance with EMTALA can improve patient safety
Introduction

Guarantees the right of access to emergency care
  • At hospitals that participate in Medicare

Closest that we have to universal health coverage
  • Although we have yet to see what health care reform will bring for the industry and for EMTALA

Courts are beginning to understand it
  • But they are continuing to find new ways to construe it

But regulators are not content with it
All medical malpractice cases must arise out of a duty of care, and the breach of that duty

Before EMTALA, hospitals had no duty to persons unless they had formed a provider/patient relationship with them

- Hospitals could turn people away with impunity, because they had no duty to them

EMTALA imposes that duty on hospitals with respect to persons with emergency medical conditions

- EMTALA also defines that duty
Basic Rule

Any person who comes to a hospital emergency department (ED) seeking examination or treatment for a medical condition

- Must be screened for such condition
- If an emergency medical condition is detected
  - Must be stabilized within the capability of the hospital
  - May be transferred to another facility
    - If the other facility has the capability to stabilize the condition
    - If the other facility accepts the transfer
    - If appropriate equipment is used to transfer patient
      - A transfer is a movement between facilities with different provider numbers
      - Movement within a facility with a single provider number is not subject to EMTALA

42 CFR §489.24(b)
Two Basic Duties

Duty to screen
• Arises when
  – Someone comes to a hospital
  – With an emergency medical condition
  – Seeking treatment for the emergency medical condition
  – ABSOLUTE obligation

Duty to stabilize
• Arises when
  – Hospital has actual knowledge that patient has an emergency medical condition
  – Conditional obligation

42 CFR §489.24(b)
EMTALA is not a substitute for a medical malpractice action

- State law governs medical malpractice
  - Based on negligence
    - Must have a duty to the person
    - Must breach the duty
    - Must suffer injury as a result of the breach
- EMTALA is a federal statute
  - Lawsuits are based on violations of the statute
    - Patient needs to have suffered an injury as a result of violation
  - Not on whether or not the providers were negligent
Who and What is Covered?

Inpatients are not subject to EMTALA

• If admitted in good faith
  – i.e. not for the purpose of circumventing the requirements of EMTALA
    ➢ EMTALA still applies if admission was a subterfuge
• They are covered by the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation
• “Golden window” present in the ED

Does not apply to outpatients who have begun the episode of outpatient care

• Conditions of Participation (COP) govern these patients
• Does not mean there is no obligation to screen/treat if need arises

Interpretive Guidelines, 42 CFR §489.24(b)
What does it Mean to Come to an Emergency Department?

Presentation at

- ED (according to regulations)
- Dedicated Emergency Departments (DED)
- Certain areas within 250 yards of hospital campus

Any department of the hospital, whether on campus or off, can be a Dedicated Emergency Department, if:

- It is licensed as an emergency department
- It holds itself out as a place that treats emergency patients
- In the last year at least 1/3 of its patients were treated on an unscheduled basis for emergency medical conditions
  - Based on a representative sample

42 CFR §489.24(b)
What Does it Mean to Come to an Emergency Department?

Hospital property also includes:

• Ambulances owned by the hospital
  – May not apply if ambulance is subject to the direction of the community-wide Emergency Medical System (EMS)

• Non-owned ambulances, if electronic communication made with the hospital, unless hospital is in diversionary status
  – *Arrington v. Wong* 237 F. 3d 1066 (9th Cir. 2001)
  – *Morales v. Sociedad Espanola De Auxilio Mutuo Y Beneficencia*, 524 F.3d 54 (1st Cir. 2008)

• Any ambulance on hospital property is deemed to have come to the hospital
  – Unless it is merely for transfer to helicopter

42 CFR §489.24(b)
Comes To The Emergency Department

Estate of Kundert v. Illinois Valley Community Hospital, No. 3-11-0007 (Ct. App. Ill. January 10, 2012)
- This was not an EMTALA case – the issue was whether a telephone call to the ED gave rise to a duty of care
  - The court ruled that it did not

Miller v. Medical Center of Southwest Louisiana, 22 F.3d 626 (5th Cir. 1994)
- Telephone call to ED by a physician did not give rise to liability when transfer was refused
What is an Emergency Medical Condition (EMC)?

If the patient is not pregnant:

- An EMC is a condition manifesting itself by acute symptoms of sufficient severity
  - E.g., severe pain, psychiatric disturbances, symptoms of substance abuse
- Such that absence of immediate medical attention could result in:
  - Placing the health of the individual in serious jeopardy
  - Serious impairment to bodily functions
  - Serious dysfunction of any bodily organ or part
- The EMC must be present during the episode of care
  - *Reynolds v. MaineGeneral Health*, 218 F. 3d 78 (1st Cir. 2000)
- Acute psychiatric conditions are emergency conditions
Comes To The Emergency Department

EMTALA does not apply if a patient comes to DED and requests treatment and the nature of the request makes it clear that it is not a medical condition (e.g., suture removal)

- In the absence of a request, a request will be deemed to have been made if a prudent layperson would feel that the person requires examination or treatment for a medical condition

Direct admits do not need to go through the ED

Interpretive Guidelines 42 CFR §489.24(a)(1)(i)
What is an Emergency Medical Condition?

Non-Emergency Conditions

- Requests for blood alcohol levels by law enforcement will continue to be problematic
  - CMS will evaluate on a case-by-case basis
  - Intoxicated person’s statement may not be credible
  - EMC may be difficult to determine upon brief interview and casual inspection
  - If you can’t screen everyone brought in for a blood alcohol, be sure to screen the patient if there is any indication that a medical condition may be present (MVA, trauma, alcohol toxicity, etc.)

- Clearance for incarceration will require an MSE

Interpretive Guidelines 42 CFR §489.24(c)
What is an Emergency Medical Condition?

Non-Emergency Conditions (cont’d)

• Probably should be restricted to:
  – Suture removal
    ➢ Should be assessed by licensed personnel to ensure no complications
  – Preventive care (e.g., flu or allergy shots)
  – Other clearly non-emergent conditions

• Medication administration on order of personal physician may indicate medical condition, therefore is subject to EMTALA

• Caveat:
  – Any time you rely on this without screening you may be doing so at your peril
What is an Emergency Medical Condition?

If the patient is pregnant and having contractions

• EMC exists if there is insufficient time to transfer the woman safely before delivery
• EMC exists if transfer would pose a threat to the health or safety of the woman or the unborn child
• EMTALA may not distinguish between non-viable pre-term labor and term labor
• 42 CFR §489.24(b)

There may be a duty to stabilize women in pre-term labor

• Pregnant + contractions = emergency medical condition
What is a Medical Screening?

Medical screening is different than triage

- Triage sets priority for examination and treatment
- Screening must be reasonably intended to determine whether an EMC exists
- That is not, however, to say that triage may not be part of a screening

Screening is performed by qualified medical personnel

- Who is “qualified?”
  - Determination must be made by Hospital Board, consistent with state licensure
    - If a physician is available, those are usually the screeners
  - Specified in hospital policies/procedures or rules/regulations
What is a Medical Screening?

Medical screening must be “appropriate”

- “Appropriate” means all patients with same symptoms get the same screening – the screenings are not disparate
- “Appropriate” does not mean “non-negligent”
  - It can miss an EMC and still be appropriate
  - Appropriate means that the screening is not different (disparate) than screening other patients received
- Policies should address what is appropriate for given conditions

A minor can request a screening, which should not be delayed to obtain parental consent if emergency exists

- Stabilization, without parental consent, can be provided if EMC is found

42 CFR §489.24(b)
What is “Appropriate”? In the absence of protocols or policies, courts have been giving plaintiffs access to the records of other patients who presented with similar conditions

• How can the plaintiff prove his screening was disparate unless he can see how other patients were screened?

Risk management tip: general guidance on the minimum screening which should be given to ALL patients with similar complaints should be developed

• Tee sheets, or similar documents, can perform this function
• Forms can be developed for L&D and mental health
What Is An “Appropriate” Medical Screening?

• Plaintiff must prove that screening was disparate, and cannot do so by reference to hospital policy

Gonzalez v. Choudhary, Civil No. 08-0076-JHR-AMD (D. N.J. April 15, 2009)  
• Plaintiff given access to records of other similarly situated patients

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What Is An “Appropriate” Medical Screening?

- Plaintiff given access to records of other similarly situated patients

**Guzman v. Memorial Hermann Hospital System**, No. 09-20780 (5th Cir. February 1, 2011)
- Plaintiff must show more than a minimal deviation from policy for EMTALA action

- Past practices (patient had been seen for same complaint multiple times) may dictate what is an appropriate screening
What is a Medical Screening?

Generally includes:

- Review of chief complaints/symptoms
- Assessment of vital signs
- Assessment of general appearance
- Assessment of pain level
- Assessment of mental status
- Assessment of hydration status
- If pregnant, assessment of gestational status
- Other tests necessary to ascertain whether an EMC exists

NOT specifically defined by the regulations

- Statute only specifies that “the hospital must provide for an appropriate medical screening examination … to determine whether or not an emergency medical condition exists”

42 U.S.C. §1395dd(a)
What is a Medical Screening?

Timing

• MSE cannot be delayed while checks on payer status are made
  – Includes pre-authorization for care
  – But hospital can ask insurance company for past history

• Screening cannot be unduly delayed, denied or discouraged
  
  ➢ Scruggs v. Danville Regional Medical Center, No. 4:08CV00005 (W.D. Va. Sept. 5, 2008)
  – If patient leaves before screening is completed, it may be a violation of EMTALA if the wait time has been long
  
  ➢ Correa v. Hospital San Francisco, 69 F. 3d 1184 (1st Cir. 1995)
What if an EMC is found?

The hospital has three choices:

- Admit the patient in good faith
- Transfer or discharge the patient after stabilization
- Transfer the patient without stabilization
  - The hospital must do everything within its capabilities to stabilize the patient prior to transfer

Hospital can seek payment information after stabilization has begun, as long as necessary stabilizing care is not delayed
What If An EMC Is Not Found?


- Court held that, in some cases, it was not necessary that an EMC be diagnosed, if one clearly existed
  - Mr. Gray was paraplegic, in severe pain, was vomiting blood, and had an above normal respiratory rate, highly elevated white cell count, below normal red cell count, below normal lymph percentage, increased hematocrit, and below normal urine output and density.
If the Patient is Transferred without Stabilization

Transferring hospital MUST have provided care within its capacity to provide treatment
  • What does it normally do to accommodate patients?
  • Can you run at 110% of occupancy, at least for a short period?

Receiving hospital must agree to accept patient
  • If it has the capacity to treat the patient (space and available staff)
  • May be liable for “reverse dumping” if it inappropriately refuses transfer
    – *St. Anthony Hospital v. DHHS*, 309 F.3d 680 (10th Cir. 2002)

Be aware that there is currently a window of opportunity in the ED that may close if the patient is admitted

Interpretive Guidelines: 42 CFR §489.24(e)
If the Patient is Transferred without Stabilization

All available medical records must accompany the patient, including:

- Available history
- Records relating to EMC
- Observations of signs and symptoms
- Results of diagnostic studies
- Preliminary diagnoses
- Any consents
- Transfer certification

42 CFR §489.24(e)
If the Patient is Transferred without Stabilization

May transfer patient if the transfer is requested

- Must provide explanation of:
  - Risks and benefits of transfer
  - Risks and benefits of treatment at transferring hospital

- Request for transfer must be documented and signed by patient

42 CFR §489.24(e)
If the Patient is Transferred without Stabilization

Transfer must be by use of qualified staff and appropriate equipment

- Includes the use of medically appropriate life support during transfer
- It is virtually never appropriate to put an unstable patient back in a personal vehicle for transport to another facility
  - *Burrows v. Redbud Cnty. Hosp. Dist.*, No. 00-17119, 01-15115 (9th Cir. May 6, 2002)

  Ø Criminal charges brought against ED physician in addition to EMTALA claims

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42 CFR §489.24(e)
If the Patient is Transferred without Stabilization

Physician must sign/countersign transfer certification that:

• Medical benefits of transfer outweigh the increased risk to the individual
  – Must include a summary of risks and benefits
• A non-physician qualified medical person may complete the certification after a physician has made the appropriate determination
  – Physician must then countersign later

42 CFR §489.24(e)
What does Stabilization Require?

In the case of a pregnant patient

- Condition is stabilized when the woman has delivered both the infant and the placenta
- May also require products of conception be delivered for spontaneous abortions

In the case of other patients

- The term "to stabilize" means to provide such medical treatment of the condition as may be 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
What Constitutes a Transfer?

Any movement outside a hospital’s facilities having been directed by a person affiliated with the hospital, including discharges

- Does not include patients who leave without permission
  - However, leaving after a 2-hour delay in screening has been considered a constructive discharge subject to EMTALA

  ➢ *Correa v. Hospital San Francisco*, 69 F. 3d 1184 (1st Cir. 1995)

Does not include movement within hospital (same provider number), except that proper equipment and staff should still be used
Obligations of Receiving Hospitals

Receiving hospitals are obligated to accept a patient if they have specialized capabilities and available capacity

- e.g., burn units, shock-trauma units, or neonatal intensive care units
- Which is a "regional referral center" in a rural area

Probably applies to all hospitals with specialized services

✓ If the specialist on call for the tertiary facility refuses to accept the patient, but the hospital and the physician have the capacity to accept him, the specialist and the hospital have probably violated EMTALA

42 CFR §489.24(f)
Specialist On-call Panels

CMS has given hospitals “flexibility” in dealing with this issue

Basic requirements:
- Must maintain an on-call list
- Must “best meet the needs” of the hospital’s patients
  - As long as the provision of care is not adversely affected
- On-call capabilities must be “in accordance with the resources available to the hospital, including the availability of on-call physicians”
- The “rule of 3” never existed
  - This held that the hospital had to require 24X7X365 coverage if it had 3 or more specialists in a given specialty on staff

Interpretive Guidelines, 42 CFR §489.24(j)
Hospitals must have written policies and procedures to respond to situations when:

- The particular specialty is not available
- The on-call physician cannot respond due to circumstances beyond his/her control
- The on-call physician is involved in scheduled elective surgery (if permitted by hospital)
  - Not permitted if specialist is being compensated for taking call at a critical access hospital
- The on-call physician is simultaneously taking call at another hospital (if permitted by hospital)

May enter into a community call arrangement

Interpretive Guidelines, 42 CFR §489.24(j)
Specialist On-call Panels

“Selective call” may be a violation

- e.g., specialist takes call for his/her own patients, or those of another practitioner by private arrangement, but not for unassigned patients
- May be a violation of EMTALA if the hospital’s call coverage is inadequate at that time
  - Especially if provider is selective in seeing unassigned patients (will see insured patients, etc.)

Interpretive Guidelines, 42 CFR §489.24(j)
Specialist On-call Panels

Factors that CMS will evaluate to determine whether a hospital’s call coverage is reasonable

• Number of physicians on staff
• Other demands on the physicians
• Frequency with which the hospital’s patients require the services of a specialist
• Provisions a hospital has made to manage patient care when a specialist is unavailable

Interpretive Guidelines, 42 CFR §489.24(j)
Specialist On-call Panels

If a specialist refuses to come in when on call and ED physician determines the specialist should come in
- Hospital is not in violation if it manages the situation appropriately
- Specialist is in violation

Specialist may not direct the patient to come to his/her office to be seen
- This is an ED physician decision
- May be done if specialist’s office is on-site and appropriate staff/equipment used
  – Otherwise, probably not acceptable

Interpretive Guidelines, 42 CFR §489.24(j)
Specialists’ Duty to Patients

- On-call specialist was unavailable when his services were required
- Court held he could be liable for damages caused by delay in treatment (death in this case)

- On-call status plus medical advice equals physician/patient relationship
Follow Up Care

Hospital Bylaws should specify that on-call specialists will provide some level of follow up care, especially if they do not come in to see the patient.

  - In this case, the on-call specialist refused to see the patient for a genitourinary issue on the day after the ED visit
  - Hospital was dismissed because the issue was the quality of care provided by the specialist
  - But the hospital still got sued
What, exactly does all this mean?

- CMS will apply a “reasonableness” test to whatever plan a hospital implements
  - Who determines what is reasonable?
- The hospital’s on-call scheme needs to be a reasonable reflection of the resources available to the hospital
- It will undoubtedly not be reasonable:
  - To not have a call schedule
  - To have specialists who do not take call
    - Unless legitimately exempted according to Bylaws
  - To expect a physician to be continuously on call
Advance Beneficiary Notification (ABN)

ABN must be given if services are to be rendered for which Medicare will not reimburse the hospital.

Hospitals have a duty to provide ABNs:
- Best practice is to wait until after screening and stabilization.
- Should not be given while hospital has obligations under EMTALA to patient.
- Must not be given while patient is under duress.

Cannot give blanket ABN:
- Must have reasonable belief the particular service is not covered.
Record Keeping Requirements

Must retain records for no less than 5 years
  • Obligation is on both transferring and receiving hospitals

Must also maintain a list of specialists on call
Record Keeping Requirements

Must maintain a central log, including:

- Whether patient refused treatment
- Whether patient was refused treatment
- Disposition of patient
  - Transferred, admitted, discharged
- Status at disposition
  - Stable or unstable
- Avoid logging potentially discriminatory information

42 CFR 489.20(r)
Signage Requirements

Must post signs conspicuously

- Wherever patients are present for emergency treatment
  - Best advice: no one should be able to gain access to the DED without passing a sign
- Must be readable from 20-feet away
  - May be smaller in smaller areas

Need to avoid signs that may conflict with required sign

- e.g., signs mentioning insurance information, acceptance of credit cards, payment expected at time of service, etc.

✔ This may be the most common failing in all of EMTALA compliance

- Make it a point to visit all public entrances to the ED and OB to make sure signs are prominently displayed

42 C.F.R §489.20(r)
Civil Monetary Penalties

Hospitals with >100 beds
  • Up to $50,000 per violation

Hospitals with <100 beds
  • Up to $25,000 per violation

ED physicians and specialists on call
  • Up to $50,000 per violation
  • May be excluded from federally funded health insurance program if violation was gross and flagrant

Penalties are not covered by insurance

42 U.S.C. §1395dd(d)
Hospitals are liable for civil damages if EMTALA is violated and the patient is injured
  • Not a substitute for medical malpractice action
    – No requirement that the provider be negligent
  • Liability is essentially strict liability

Statute of limitations is 2 years
  • Hard cap regardless of state law

State law caps on damages usually apply
  • State law notice requirements may or may not apply
  • State law caps may not apply to screening claims
Liability for Damages

Physicians are not liable for civil damages for violations of EMTALA, only penalties

  - Physicians may not be brought in on an indemnification action by hospital

  - Claims for conspiracy by physicians to violate EMTALA not dismissed on motion to dismiss
Conclusion

The jurisprudence of EMTALA is continuing to evolve.

The courts are not necessarily in agreement with CMS on interpretation.

There are still ambiguities in the cases and the law.

EMTALA may be a community issue.

*When in doubt, comply with EMTALA*
Emergency Medical Treatment and Active Labor Act, 42 U.S.C. §1395dd

Implementing regulations
- 42 C.F.R §413.65 (definition of campus)
- 42 C.F.R §489.20 (signage requirements)
- 42 C.F.R §489.24 (main set of regulations)
- 42 C.F.R §489.24j (medical staff call provisions)

Interpretive Guidelines

State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases
Thank You for Your Attendance and Participation!

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