EMTALA Webinar Series Part Two

Nancy M. Ruzicka B.S., RPh., MBA, MJ, CHC
Iowa Hospital Association
July 1, 2020

1

1

Speaker

Nancy M Ruzicka B.S. RPh., MBA, MJ, CHC
Ruzicka Healthcare Consulting LLC

Over 30 years experience teaching and assisting hospitals and other healthcare facilities in understanding applicable Federal and State laws, rules, regulations and interpretative guidelines.

Previous experiences include:
-Director of Integrity & Compliance, Privacy Official at Mercy Medical Center, Des Moines
-Director of Regulatory Compliance, UnityPoint Health, West Des Moines
-Twenty years with Iowa Department of Inspections and Appeals

2

Part Two
Learning Objectives

- Describes what constitutes an adequate medical screening exam for behavioral health, obstetric and other patients
- Describe what constitutes an appropriate certification of false labor
- Review what language is required on EMTALA signage and where must be located
- Illustrate what an appropriate transfer entails and what must be included on the transfer form

3

3

EMTALA Week One
Quick Review

4

What are the EMTALA regulations?

Emergency Medical Treatment and Labor Act
Enacted in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA)
Known as the anti-dumping statute

In response to the practice of some hospitals of refusing to see or transferring the poor and uninsured

Purpose was to ensure every patient who comes to the emergency room receives appropriate medical screening, stabilizing treatment and (if necessary) appropriate transfer to another facility

5

EMTALA Requirements vs. Conditions of Participation

- EMTALA requirements part of hospital/CAH provider agreement
- Violation of EMTALA requirements may result in hospital and physician fines
- Violation of EMTALA requirements require demonstration of correction prior to revisit, not just a plan of correction
- EMTALA investigation is always complaint driven and not conducted as part of any routine survey

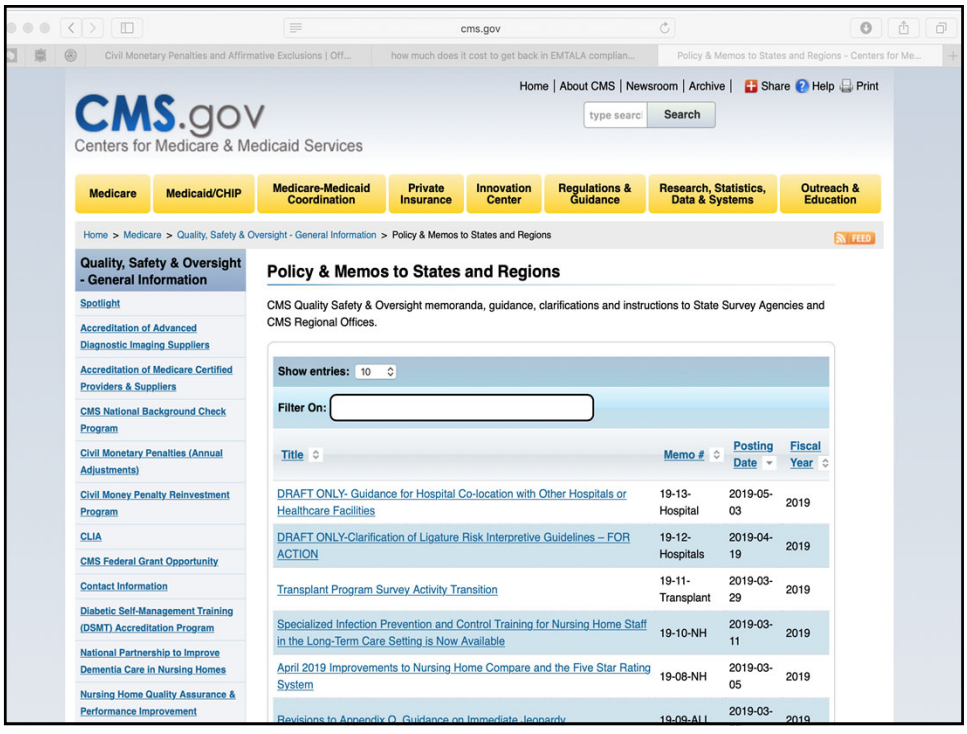
6

EMTALA Resources

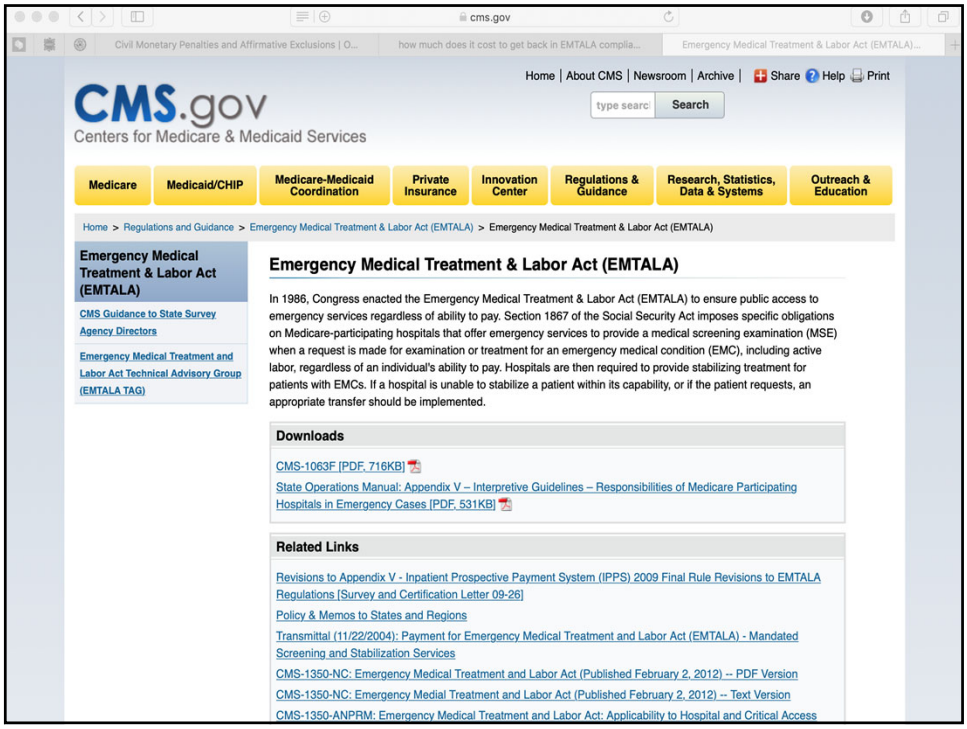
- https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/policy-and-memos-to-states-and-regions.html
- This website contains the latest directions to the surveyors
- New interpretative guidelines posted here prior to CMS republishing the entire document

- https://www.cms.gov/regulations-and-guidance/legislation/emtala/
- This website contains all information related to EMTALA

7



8



9

Where and Who Does EMTALA Apply To Within Hospital/CAH?

10

EMTALA Applies To?

- Any individual who comes to the Dedicated Emergency Department and requests examination or treatment for ANY medical condition
- Any individual who comes to the hospital (other than DED) and requests examination or treatment for what may be an emergency medical condition (labor, chest pain)
- Prudent layperson standard
- Individual does not have to be Medicare beneficiary

11

Who Does EMTALA NOT Apply To?

- Scheduled Outpatients-even when EMC develop AFTER outpatient services begin
- Persons clearly requesting non-emergency services (ie., physician office sent patient over for non-emergency lab services)
- Inpatients-
  - Hospitals can not circumvent EMTALA stabilization and treatment by simply admitting individuals with EMC and then discharging short time later from hospital

12

What about Individual in Observation Status?

- Individuals who are placed in observation status are not inpatients, even if they occupy a bed overnight.
- Placement in an observation status of an individual who came to the hospital's DED does not terminate the EMTALA obligations of that hospital or a recipient hospital toward the individual.
- Therefore all requirements of EMTALA apply including ongoing monitoring AND ALL transfer requirements if transfer is necessary

13

If EMTALA Applies, What Next?

- Conduct a Medical Screening Examination based upon clinical signs and symptoms by a physician (MD/DO) or a Qualified Medical Person to determine whether or not an Emergency Medical Condition (EMC) exists
- If EMC exists, the hospital/CAH must either provide treatment to resolve the EMC OR transfer the individual in accordance with the transfer requirements

14

Medical Screening Examination Regulations and Requirements

15

A2406/C2406
42 CFR 489.24
Special Responsibilities of Hospitals in Emergency Cases

- Must provide an appropriate medical screening exam within hospital ED capability including ancillary services routinely available to determine whether EMC exists or not
- Exam must be conducted by individual who is determined qualified by hospital bylaws, rules and regulations
- Second most frequently cited EMTALA regulation in 2020
  - 70% General Acute
  - 10% CAH
- Lack of compliance results in the majority of fines

16

A2406/C2406 Interpretative Guidelines

- EMTALA obligation triggered when
  - Person presents to the hospital's dedicated emergency department and requests treatment or exam for any medical condition
  - Person comes elsewhere on hospital property and requests examination or treatment for what might be an emergency condition
  - IF "prudent lay person" believes the person is suffering from emergency medical condition when on hospital property
  - IF person in a ground or air ambulance owned and operated by the hospital for purposes of examination and treatment for a medical condition at a hospital's dedicated emergency department, even if the ambulance is not on hospital grounds.
  - IF person is on hospital property in non-hospital owned ground or air ambulance for purposes of examination or treatment at the hospital

17

1135 Waiver and Screening Locations

- May set up alternate sites on campus to perform MSE
- Wherever seen still must log
- Do not present first to ED
- If present to ED first, may still be redirected to on-campus screening location
- May also redirect to off-campus location as long as not inconsistent with state emergency plan
- Remember, these waivers will disappear once pandemic declared to no longer exist or hospital's emergency plan no longer active

18

If Triggered, What Constitutes an Adequate Medical Screening Examination

- It depends—
- At a minimum it includes a physical (and mental when necessary) evaluation to determine if there is an emergency medical condition by physician or Qualified Medical Person
- Must be based upon individual's presenting signs and symptoms and capability/capacity of hospital
- Provides all necessary testing and on-call services available within hospital's capability
- MSE represents a spectrum ranging from simple process such as H/P to a complex process requiring ancillary studies and procedures including: lumbar punctures, CT scans, lab or other diagnostic testing
- Ongoing monitoring required until patient is stabilized, admitted or transferred
- Must be non-discriminatory-not based upon payment sources, race, national origin, disability, age, sex

19

Medical Screening Exam

- More than triage which only determines order in which patients seen
- Must be ongoing process
- Will be different depending upon clinical signs and symptoms
- Individual with chest pain and difficulty breathing will be triaged different than an individual bit by their pet guinea pig
- Same screening exam for all who present with same symptoms (same standard of care)
- Can occur via telehealth if clinically appropriate
- Process required to reach, within reasonable clinical confidence, the point at which it can be determined whether an EMC exists

20

MSE and COVID

- Can hospitals conduct MSE if patient remains in car?
  - Maybe –depending upon what the individual is presenting for
- If individual is solely requesting COVID testing, what is required for MSE
  - MSE not required unless complaining or exhibiting any symptoms of medical condition

21

Who Can Perform a MSE?

- Left to hospital discretion
- Must be qualified by state licensure
- Qualifications must be described in written document approved by governing body
- Generally includes:
  - MD/DO
  - Mid-level practitioners (PA or ARNP) within scope of practice and as defined by individual hospital and licensure
  - Certified Nurse Mid-Wives (only for labor/delivery)
  - Obstetrical Nurses with Physician Consultation

22

Qualified Medical Person

- QMP must be capable of ordering necessary diagnostic procedures and testing without exceeding scope of professional license or hospital privileges
- RNs without advance training generally do not meet this criteria
  - 1135 FAQ (page 5 #4) indicate that RN trained to perform MSE if within state scope and approved by governing body
  - 1135 individual hospital may request waiver
- Exception can include experienced OB nurses in consultation with MD/DO
  - Hospital needs to adopt specific P/P addressing the education and training of the OB nurse
  - Must also address physician consultation requirements

23

Medical Screening Exam and Hospital Off-Campus Locations

- Must have P & P in place for staff to know what to do in event of medical emergency
  - Include in employee orientation
- In true emergency, staff may need to send patient to closest ED
- P & P need to address that the location will provide initial treatment within its capability and capacity
- Varies depends upon services provided at location
  - If off-campus PT department, services provided may be lesser than if off-campus location provided cardiac rehabilitation

24

MSE and Moving Patient to Another Department

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

25

Minor Child and Medical Screening Exam

- A minor child can request an examination or treatment for an EMC
- Hospital is required by law to conduct the examination if requested by an individual or on the individual's behalf to determine if an EMC exists.
- Hospital personnel should not delay the MSE by waiting for parental consent.
- If after screening the minor, it is determined no EMC is present, the staff can wait for parental consent before proceeding with further examination and treatment.

26

OIG and MSE Fines

27

The Cost of "Dumping"

- Fines-- up to $111,597 per each negligent violation for hospitals over 100 beds. And up to $55,800 per each negligent violation for hospitals under 100 beds (adjusted effective January 1, 2020)
- Up to $111,597 per negligent violation for physicians if violation occurs in hospital over 100 beds. And up to $55,800 for negligent violation for physicians occurring in hospitals under 100 beds.
- If physician violation is gross and flagrant or repeated, the physician faces exclusion from Medicare
- Private lawsuits for money damages
- Costs of compliance depend on hospital size but range from $50,000--over $150,000 in both direct and indirect costs including lost productivity
- Termination from the Medicare program
- Increased surveillance by CMS and State Survey Agency

28

28

OIG Fines and Inadequate MSE

On April 20, 2020, DeKalb Medical Center, Inc. (DeKalb), Decatur, Georgia, entered into a $260,000 settlement agreement with OIG. The settlement agreement resolves allegations that, based on OIG's investigation, DeKalb violated the Emergency Medical Treatment and Labor Act (EMTALA), when it failed to provide an adequate screening examination and stabilizing treatment for twenty-one individuals. The following are examples of such incidents.

Patient N.R.A., a 25-year-old female, presented to DeKalb's Emergency Department (ED) on January 18, 2015, with complaints of acute gastric pain, nausea, and vomiting. The medical records also listed possible pregnancy as her chief complaint. N.R.A. had a prior history of peptic ulcer disease and gastric ulcers. The medical records indicated that N.R.A. was seen by a registered nurse and was triaged using an emergency severity level index at level 4 (indicating a non-urgent patient). The triage nurse recorded N.R.A.'s vital signs and marked "no" next to nine questions on a non-patient specific checklist. Within six minutes of the nurse starting the triage process, N.R.A. was discharged from DeKalb's ED.

In the incident (and 19 more) described above, DeKalb's ED was capable of providing an appropriate medical screening examination to determine whether the patients had an emergency medical condition and providing stabilizing treatments OIG contends that DeKalb failed to do so.

29

OIG Fines and Inadequate MSE

On February 10, 2020, Maryland General Hospital, Inc. d/b/a UM Medical Center Midtown Campus (UMMC), Baltimore, Maryland, entered into a $106,965 settlement agreement with OIG. The settlement agreement resolves allegations that, based on OIG's investigation, UMMC violated the Emergency Medical Treatment and Labor Act (EMTALA), when it failed to provide an adequate medical screening examination and stabilizing treatment for a 22-year old female patient.

Specifically, the patient presented to UMMC's Emergency Department (ED) on January 9, 2018, via ambulance. The patient was diagnosed with a contusion of the face and lip abrasion, and was discharged. The patient refused to sign the discharge forms, stated that she was homeless, and refused to exit the premises. The patient was escorted by security off of UMMC's property wearing only a hospital gown and socks. The following day, the patient retuned to UMMC's ED via ambulance after a bystander called 911. The bystander found the patient at a bus stop outside the hospital in 30-degree weather. A nurse told the patient that she would need to go to a shelter if she did not have a place to stay. The patient was then discharged without receiving a medical screening examination or being stabilized.

30

OIG Fines and Inadequate MSE

On November 22, 2019, Rockdale Medical Center (RMC), Conyers, Georgia, entered into a $70,000 settlement agreement with OIG. The settlement agreement resolves allegations that, based on OIG's investigation, RMC violated the Emergency Medical Treatment and Labor Act (EMTALA) when it failed to provide a medical screening examination, stabilizing treatment or proper transfer to a 79-year-old female. Specifically, the patient presented to RMC's Emergency Department (ED) by ambulance after being involved in a motor vehicle crash with multiple injured individuals. EMS contacted RMC's ED for guidance about disposition of the injured individuals and the ED physician at RMC directed that the patient be taken to a trauma center. When one of the ambulances arrived in RMC's ambulance bay with the patient, a hospital nurse approached the ambulance and told the driver that the patient was supposed to go to the trauma center. The ambulance then transported the patient to the trauma center without the patient receiving a medical screening examination. During the transport, the patient's condition deteriorated, and she ultimately died at the receiving hospital

31

MSE and Pregnant Woman

32

Appropriate Medical Screening Exam for Pregnant Woman

- Most general emergency department will direct women who are over 16-20 weeks gestation with pregnancy related complaints to Labor/Delivery for examination (this makes labor/delivery area a dedicated emergency department)
- Any doubt about nature of complaint then can have ED nurse triage (per facility policies)
- If pregnant woman has experienced trauma (car accident), the OB nurse can go to the ED to evaluate the woman if needed
- Make sure hospital has P & P and all staff in ED and OB know the policy

33

Labor Defined

- Process of childbirth beginning with latent or early phase of labor and continuing through the delivery of the placenta
- Woman experiencing contractions is in true labor unless a physician, certified nurse-midwife or other qualified medical person acting within scope of practice as defined by medical staff bylaws; CERTIFIES after a reasonable time of observation, the woman is in false labor

34

Appropriate Medical Screening Examination of Pregnant Women

- For pregnant women having contractions, a MSE must include at a minimum
  - Ongoing evaluation of Fetal Heart Tones (FHT)
  - Observation and recording of the regularity and duration of uterine contractions
  - Includes fetal position and station
  - Includes cervical dilation status of membranes (leaking, intact, ruptured)

35

Medical Screening Exam of Woman Experiencing Contractions

- ACOG recommends that a woman experiencing contractions be observed for a period of 1-2 hours before it can be determined the woman is or is not in labor
- Other suggested criteria include:
  - Gestation of 20 weeks or greater but less than 37 weeks
  - Persistent uterine contractions (4 q 20 minutes or 8 q 60 minutes) AND
  - Documented cervical change OR
  - Cervical effacement of 80% or greater OR
  - Cervical dilation of greater than 1 cm

36

Certification of False Labor

- Physician or QMP have to examine patient to determine if Emergency Medical Condition
- All women in true labor are considered to have an Emergency Medical Condition and are considered unstable
- If physician, nurse mid-wife or QMP diagnoses that the woman is in false labor, then they are required to certify the diagnosis PRIOR to discharge
- Written/electronic documentation must include that the woman has been examined for a reasonable time of observation and the individual is certifying that the woman is in false labor
  - Include the name and title of the person conducting the exam
  - Include the date and time of certification
- False labor can not be presumed simply based upon discharge home

37

Born Alive Infants Protection Act of 2002

- CMS reissued 2005 guidance in 2019 as reminder
- An infant that is born alive is a person and an individual and is entitled to a medical screening examination
- If the infant is born alive in the hospital's dedicated ED (either traditional ED or labor/delivery area that is defined as a dedicated ED) and a request is made for screening OR prudent layperson believes an exam is needed based upon appearance or behavior, the hospital has an EMTALA obligation
- BORN ALIVE IS DEFINED AS :
  - At any stage of development who after such expulsion or extraction breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, cesarean section or induced abortion.

38

How Does BIPPA interact with EMTALA?

- If an infant was born alive in the DED (traditional ED or labor/delivery) AND a request made on infant's behalf for screening of a medical condition OR based upon the infant's appearance or behavior that the infant needed exam or treatment based upon a prudent layperson standard AND the hospital failed to provide such an exam or failed to resuscitate, the hospital and physician could be liable under EMTALA

39

OIG Fines and MSE of Pregnant Woman

40

OIG Fines and MSE of Pregnant Woman

On December 26, 2019, San Mateo Medical Center (San Mateo), a small hospital in San Mateo, California, entered into a $20,000 settlement agreement with OIG. The settlement agreement resolves allegations that, based on OIG's investigation, San Mateo violated the Emergency Medical Treatment and Labor Act (EMTALA), when it failed to provide an appropriate medical screening examination, stabilizing treatment, and transfer for a 23-year old pregnant woman.

On August 24, 2016, the patient presented to San Mateo's Emergency Department (ED) complaining of abdominal pain for about four hours, with some vaginal discharge and bleeding. She was approximately 25 weeks pregnant. San Mateo did not perform a vaginal exam and did not determine if the patient was in labor. San Mateo's ED physician arranged for the patient to be transferred to another hospital for a higher level of care. The ED physician was informed that it would take 45 minutes for ambulance transport to arrive at San Mateo's ED, so he recommended that the patient be transferred by private vehicle. The patient delivered her baby in her car on the way to the receiving hospital and the patient self-diverted to a different hospital, where she arrived 26 minutes later. The baby was not breathing upon arrival to the hospital and the Neonatal Intensive Care Unit was unable to resuscitate the baby.

41

OIG Fines and Inadequate MSE of Pregnant Women

On December 12, 2018, Hartford Hospital (Hartford), Hartford, Connecticut, entered into a $50,000 settlement agreement with OIG. The settlement agreement resolves allegations that Hartford violated the Emergency Medical Treatment and Labor Act when it failed to provide an appropriate medical screening examination to a woman who was 23.5 weeks pregnant when she presented to Hartford's Emergency Department with symptoms of preeclampsia, an emergency medical condition.

42

OIG Fines and Inadequate MSE of Pregnant Woman

East Texas Medical Center Carthage (ETMC Carthage), Texas, agreed to pay $20,000 to resolve its liability for Civil Monetary Penalties under the patient dumping statute. The OIG alleged that ETMC Carthage violated the requirements of the patient dumping statute when it failed to provide an adequate medical screening examination to a patient who was 24 weeks pregnant. The patient presented to ETMC Carthage with complaints of uterine contractions and abdominal pain. The patient was told to seek care in Henderson Texas because ETMC Carthage did not have obstetrical (OB) service and did not have an OB doctor on staff. The patient then left ETMC Carthage by private vehicle.

43

OIG Fines and Inadequate Medical Screening

On March 8, 2018, Paulding County Hospital (PCH), Paulding, Ohio, entered into a $50,000 settlement agreement with OIG. The settlement agreement resolves allegations that PCH violated the Emergency Medical Treatment and Labor Act when it failed to provide an adequate medical screening and effectuate an appropriate transfer for a patient. The patient, a 33-week pregnant woman, presented to PCH's Emergency Department (ED) complaining of leaking fluids, pelvic pain, and vomiting. A nurse at PCH's ED brought the patient to an examination room. The nurse told the patient that the hospital did not have an obstetrician on-site, and that the patient could either start treatment at PCH and be transferred later, or that her male companion could drive her immediately to another hospital, where her obstetrician practiced. After being told this, the patient left PCH by private vehicle to another hospital, a thirty-minute drive. PCH never provided the patient or her unborn child a medical screening examination. At the receiving hospital, the patient underwent an emergency C-Section and delivered a male infant without a heartbeat. The receiving hospital's efforts to revive the infant were unsuccessful.

44

MSE of Patients Exhibiting Psychiatric or Behavioral Health Issues

45

Medical Screening Examination of Individual Experiencing Psychiatric Disturbances

- Most difficult and most risk prone of ED patients to manage
- CMS appears to place the care provided to patients in ED with psychiatric conditions as one of their highest priorities
- When patients present to ED with medical issues, many hospitals are not providing a mental health type of screening when patient also exhibits symptoms of psychiatric issue.

46

Demand for Psychiatric Services Greatly Exceeds Supply

- Community hospitals are seeing more and more patients with mental illnesses.
- A study published in Health Affairs in 2016 found:
  - A 55% jump nationally in ED visits related to mental health from 2002 to 2011, from 4.4 million to 6.8 million, whereas,
  - The number of inpatient psychiatric beds available nationally to serve these patients plummeted nearly 80% from 1970 to 2010, from about 500,000 to 114,000.
- CMS believes if you have an ED you can provide a basic level of service for the mentally ill.

47

Appropriate MSE for Psychiatric Patients

- Who will perform MSE?
  - ED physician alone
  - ED physician with assistance of telemedicine
  - ED physician along with internal or external behavioral health specialists (LISW or others)
  - Other QMP as designated by hospital
- Supervising ED physician ultimately responsible for MSE in the ED
- Are there other resources available to hospital?

48

Appropriate MSE for Psychiatric Patients

- MSE should include:
  - For patient with known psychiatric disease presenting with symptom exacerbation
    - Full medical and psychiatric history
    - Targeted physician exam and mental status exam
    - Urine toxicology screening and non urine drug screen lab testing should not be routinely performed.
  - Additional screening tests may be valuable for patients with:
    - New onset psychiatric symptoms who are over 65 years
    - Immunosuppressed patients
    - Patients with concomitant medical disease

Medical Screening of Mental Health Patients in the Emergency Department: A Systematic Review. J Emerg Med. 2018 Dec;55(6):799-812. doi: 10.1016/j.jemermed.2018.09.014. Epub 2018 Oct 10.

https://www.ncbi.nlm.nih.gov/pubmed/30316619

49

Appropriate MSE for Psychiatric Patient

- Should include assessment of whether the individual is suicidal, homicidal or "gravely disabled"
  - The phrase "gravely disabled" has been used by CMS to imply a danger to oneself due to an inability appropriately care for oneself, including refusal to take necessary medicine.
- Hospitals may used "contracted services" to assist with psychiatric MSE as long as clinicians are appropriately credentialed by hospital

Take threats of suicide or homicide very seriously because hospital's evaluation will be scrutinized very closely

50

Appropriate MSE for Psychiatric Patient

- CMS appears to hold every hospital and CAH responsible for providing an appropriate MSE for psychiatric patients
- CMS requires a hospital to consider and use all of its available resources to provide an appropriate MSE for a patient that may suffer from a psychiatric condition
- Appropriate MSE must be provided even if the hospital does not provide inpatient psychiatric service

51

Medical Patients with Possible Psychiatric Issues

- Not every patient requires a psychiatric evaluation as part of an MSE, however, a physician should listen and observe patients for cues of instability.
- If a patient appears depressed or speaks of depression, evaluate for mental health issues.
- If a patient with no psychiatric history threatens a homicidal or suicidal act, evaluate for mental health issues.
- If a patient seems psychiatrically unstable in any way, evaluate for mental health issues.

52

Psychiatric Patient Leaves ED Before Receiving MSE

- Be careful as to how a psychiatric patient is "triaged" given that they may be at higher risk of leaving prior to receiving MSE
  - Where do you place these individuals awaiting MSE?
- CMS will look closely at the condition and needs of the patient upon presentation to ED and what did the hospital do to ensure that the patient received timely MSE

53

OIG Fines Relating to Inadequate MSE of Individuals Exhibiting Psychiatric Symptoms

54

OIG Fines and Psychiatric Condition MSE

On April 2, 2018, Southeastern Regional Medical Center (SRMC), Lumberton, North Carolina, entered into a $200,000 settlement agreement with OIG. The settlement resolves allegations that, based on OIG's investigation, SRMC violated the Emergency Medical Treatment and Labor Act (EMTALA) when it failed to provide an appropriate medical screening exam, stabilizing treatment, and/or an appropriate transfer for four individuals.

Specifically, in the following two instances, SRMC failed to provide an appropriate medical screening examination and/or stabilizing treatment. The second patient, a 49-year-old male, presented to SRMC's ED on August 27, 2015, with lethargy and overdose of multiple medications. The patient said he was depressed and expressed suicidal ideations. The ED physician ordered blood and urine tests, an EKG, and a head CT, and noted the patient had a history of depression and chronic back pain. The patient was placed on suicide precaution watch, but no psychiatric evaluation was ordered. The patient was discharged about 4.5 hours later with diagnoses of polypharmacy and asthenia with discharge instructions for near-syncope and weakness. Four days later, the patient died due to a self-inflicted gunshot wound to the head.

55

OIG Fines and Psychiatric Condition MSE

On October 17, 2017, Southeast Missouri Hospital (SEM), Cape Girardeau, Missouri, entered into a $100,000 settlement agreement with OIG. The settlement agreement resolves allegations that SEM violated the Emergency Medical Treatment and Labor Act when it failed to provide an adequate medical screening examination and stabilizing treatment for two patients who presented to SEM's Emergency Department (ED) in 2011. OIG alleged that instead of being properly evaluated and treated, the patients were discharged with unstabilized emergency medical conditions to the custody of police pursuant to a hospital policy: if a patient had a blood alcohol level (BAL) above 100, the patient was given to local law enforcement and taken to jail. The first patient was 25 years old when she called a crisis hotline and an ambulance was dispatched to her residence. She was transported to SEM's ED for evaluation of a possible suicide attempt by overdose. The patient's BAL was 422 and the ED physician discharged her into the custody of local law enforcement where she was detained in jail and expected to see a counselor. The second patient was 41 years old when he presented to SEM after attempting suicide by overdose. The patient was depressed, had a history of psychiatric problems, and had recently been admitted for electroconvulsive therapy. The patient's BAL was 288 and he was discharged into the custody of local law enforcement and taken to jail. The next day the patient was seen by a counselor in jail and then released from custody. The patient returned to SEM that evening after again attempting suicide by overdose. The patient had slurred speech, was lethargic and had a flat affect and was admitted to the intensive care unit in guarded condition.

56

OIG Fines and Psychiatric Condition MSE

On September 18, 2017, North Shore Medical Center (NSMC), Lynn, Massachusetts, entered into a $60,000 settlement agreement with OIG. The settlement agreement resolves allegation that NSMC violated the Emergency Medical Treatment and Labor Act when it failed to provide an appropriate medical screening examination for a fourteen-year-old patient and inappropriately transferred her to another hospital. The patient arrived at NSMC's Union Hospital emergency department by ambulance, secured to a stretcher and under police escort, for psychiatric evaluation after combative behavior at home and banging her head against a wall. Upon arrival at NSMC Union Hospital the patient was placed in a room, still secured to the stretcher. NSMC Union Hospital's emergency department physician came into the room and told the paramedics that the patient should be transported to NSMC's Salem Hospital emergency department for pediatric psychiatric evaluation. Before recommending transfer, NSMC failed to provide the patient with a medical screening exam. On route to NSMC Salem Hospital, the police instructed the ambulance to take the patient to a different hospital where her mother was waiting.

57

Required EMTALA Signage Regulations and Requirements

58

A2402/C2402
42 CFR 489.20(q)
Hospital agrees to:

- Post required signage in ANY ED or places likely to be noticed by persons entering ED as well as individuals waiting for exam and treatment in areas other than ED
  - Entrances
  - Admitting areas
  - Waiting rooms
  - Treatment areas
- Sign must specify rights of individuals to exam and treatment of emergency medical conditions and women in labor
- Sign must indicate whether the hospital participates in Medicaid program

59

A2402/C2402
Interpretative Guidelines

- Signage must be visible at 20 feet—Minimum of 18 x 20 inches
- Must specify individual rights under EMTALA
- Wording must be clear and simple
- Wording must also be understandable by population served by hospital
- Must be in all areas of hospitals specified in regulations

60

IT'S THE LAW

IF YOU HAVE A MEDICAL EMERGENCY OR ARE IN LABOR, YOU HAVE THE RIGHT TO RECEIVE, within the capabilities of this hospital's staff and facilities:
An appropriate Medical SCREENING EXAMINATION
Necessary STABILIZING TEATMENT (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

61

Frequency of Signage Citations

- General Acute Hospitals-14% in FFY2018 and 20% in 2019 and 13% in FFY 2020 to date
- Critical Access Hospitals- 7% in FFY 2018 and 4% in FFY2019 and 3.8% in FFY 2020 to date

62

Common Reasons for Sign Citation

- Missing signage
  - OB/Labor treatment areas where women are being evaluated
  - Signage taken down during remodeling/renovation
- Signage covered up
- Signage not of appropriate size or unable to be seen

63

Transfer Requirements and Transfer Forms

64

A2409/C2409
42 CFR 489.24 (e)
Restricting Transfer Until Individual is Stabilized

- May not transfer individual with EMC that has not been stabilized UNLESS
  - Appropriate transfer per regulations OR
  - Individual requests transfer in writing indicating reasons for request and awareness of risks and benefits of transfer OR
  - **Physician** Certification that Benefits outweigh Increased Risks

65

Written Physician /QMP Certification

- Expected clinical medical benefits outweigh the increased risks of the transfer
- Must specify reason
- Specific to the condition of patient upon transfer
- If physician not present in ED at time of transfer, QMP must sign the certification AFTER a physician has been consulted with AND agrees with certification. Physician must countersign the certification

66

Appropriate Transfer Requirements

- Transferring hospital provides medical treatment within capacity to minimize risk of transfer
- Receiving hospital has agreed, has space and personnel
- Qualified personnel and equipment during transfer
- All medical records sent with patient and
  - Written consent or certification
  - Other records as soon as practicable
  - Name and address of on-call physician, if failed to appear and this caused the transfer to occur

67

A2409/C2409 Interpretative Guidelines

- Transfer with Physician Certification
  - If transferring pregnant woman in labor, physician must certify the expected benefits outweigh risk to both mom and the unborn child
- Physician countersignature on certification(if not present) must be obtained within timeframe specified by hospital
- Date and time the physician or QMP completed certification should closely match date and time of transfer
- Certification must be in writing. Can not be implied by findings in medical record

68

Transfer at Request of Individual

- Individual with EMC may request transfer
- Hospital must inform of EMTALA obligations
  - Provide stabilizing treatment within capability and capacity regardless of ability to pay
- Must assure the individual has been advised of the **medical** risks
- Request must be in writing
  - Must include reason for request
  - Must include acknowledgement of risks/benefits

69

Consent to/or Request for Transfer Form Documentation

- Must provide patient with Notice of Hospital Responsibilities
  - Brief statement of hospital's obligations under the statute. Obligations include:
    - Right to receive medical examination or treatment within the the capabilities of the hospital to stabilize an emergency medical condition OR if necessary be transferred to another medical facility
    - Right to be informed of the risks of the transfer and benefits of the transfer
    - Right to refuse the examination, treatment or transfer.
    - Care and treatment for your EMC is offered even if you cannot pay, do not have medical insurance or are not entitled to Medicare or Medicaid

70

Consent to/or Request for Transfer Form Documentation

- Benefits outweigh risks certification by physician
- Must be clinical in nature
- Benefits can include:
  - Need for diagnostic equipment/services (need to specify exactly what is needed) not available
  - Need for higher level of care or service not available (be specific—need for ICU, burn unit)
  - Do not leave it ambiguous
- Risks of Transfer—clinical based upon patient—bleeding/shock, maternal/fetal complications
- Certification must include whether patient is stable or unstable (in EMC)—Remember all Women in Labor are Unstable
- Patient signature indicating have consent to the transfer

71

Consent to/or Request for Transfer Form Documentation

- Following must also be on the form
  - Patient Name
  - Transferring hospital and transferring physician name
  - Receiving hospital name—include town hospital is located in as many hospitals have similar/same names
  - Receiving name and title of individual who accepted
  - Mode of transfer-including personnel sent and equipment
  - Date and time of Acceptance of patient by receiving hospital
  - Vital signs close to the time of Transfer
  - What records sent
  - If utilize QMP, have place for both QMP and physician countersignature

72

OIG Fines and Transfers

73

Frequency of Citation

- General Acute Hospitals-Ranges from 23 %-30% during the period of October 1, 2017 through current
- Critical Access Hospitals—Ranges from 3.5%-6.4% during the period of October 1, 2017-current

74

OIG Fine and Transfer

- On December 26, 2019, San Mateo Medical Center (San Mateo), a small hospital in San Mateo, California, entered into a $20,000 settlement agreement with OIG. The settlement agreement resolves allegations that, based on OIG's investigation, San Mateo violated the Emergency Medical Treatment and Labor Act (EMTALA), when it failed to provide an appropriate medical screening examination, stabilizing treatment, and transfer for a 23-year old pregnant woman. On August 24, 2016, the patient presented to San Mateo's Emergency Department (ED) complaining of abdominal pain for about four hours, with some vaginal discharge and bleeding. She was approximately 25 weeks pregnant. San Mateo did not perform a vaginal exam and did not determine if the patient was in labor. San Mateo's ED physician arranged for the patient to be transferred to another hospital for a higher level of care. The ED physician was informed that it would take 45 minutes for ambulance transport to arrive at San Mateo's ED, so he recommended that the patient be transferred by private vehicle. The patient delivered her baby in her car on the way to the receiving hospital and the patient self-diverted to a different hospital, where she arrived 26 minutes later. The baby was not breathing upon arrival to the hospital and the Neonatal Intensive Care Unit was unable to resuscitate the baby.

75

OIG Fines and Transfer

On November 4, 2019, Hospital Authority of Valdosta and Lowndes County d/b/a South Georgia Medical Center (SGMC), Valdosta, Georgia, entered into a $40,000 settlement agreement with OIG. The settlement agreement resolves allegations that, based on OIG's investigation, SGMC violated the Emergency Medical Treatment and Labor Act (EMTALA) when it failed to provide examination and treatment by its on-call urologist for a 27-year old male. Specifically, on June 18, 2014, the patient presented to SGMC's Emergency Department (ED) complaining of pain from an episode of priapism lasting five days. He was seen by an ED physician who contacted SGMC's on-call urologist. The urologist, however, did not come in to the ED to further examine or treat the patient. Instead, the urologist requested that the patient be transferred to another hospital for treatment. The transfer did not take place for more than eight hours and was to a hospital approximately 150 miles away. Priapism is a serious medical condition and delaying proper treatment can lead to penile injury, necrosis, or loss. The patient's transfer was medically inappropriate and put the patient at further risk by delaying needed medical treatment.

76

OIG Fines and Transfer

On April 2, 2018, Southeastern Regional Medical Center (SRMC), Lumberton, North Carolina, entered into a $200,000 settlement agreement with OIG. The settlement resolves allegations that, based on OIG's investigation, SRMC violated the Emergency Medical Treatment and Labor Act (EMTALA) when it failed to provide an appropriate medical screening exam, stabilizing treatment, and/or an appropriate transfer for four individuals.

SRMC also failed to meet its EMTALA obligations when it failed to re-evaluate the patient at the time of transfer to determine whether: (1) the benefits to each patient continued to outweigh the risks, (2) the previous arrangements for appropriate personnel and transportation equipment were appropriate given the patient's deterioration, and (3) additional medical treatment was needed to minimize the risks to the individual's health, and in the case of a woman in labor, the health of the unborn child.

The patient, a 44-year-old female, presented to SRMC's ED on February 28, 2014 at 3:38 p.m. for evaluation of an altered mental status when she was found unresponsive with an empty bottle of butalbital beside her. A CT scan revealed an extensive acute subarachnoid hemorrhage with possible artery aneurysm bleed. At 9:30 p.m., the ED physician certified that the medical benefits of neurosurgery at a hospital over 122 miles away outweighed the risks of transfer. However, the patient was not transferred until 2:16 a.m. the following day, when her condition had significantly deteriorated.

77

Recipient Hospital

78

A2411/C2411
42 CFR 489.24(f)
Recipient Hospital Responsibilities

- All transfer patients MUST be accepted
  - If the receiving hospital has capabilities and capacity to treat AND
  - If patient has an EMC AND
  - If the receiving hospital has specialty services not available at the sending hospital
  - AND if the patient had not been previously an inpatient at the transferring hospital
- ONLY applies when patient is coming from another hospital and NOT nursing home, physician office or jail
- Applies to any patient transfer from within the United States boundaries

79

Recipient Hospitals Responsibilities Guidelines

- Applies to all Medicare participating hospitals with specialized services even if hospital has no dedicated emergency department (psychiatric hospitals)
- Requirement to accept does not apply to acceptance of inpatients (may be asked if individual is already an inpatient)
- Requests to transfer should generally not be made over great distances due to patient stability during transfer; however may be necessary (psychiatric)
- May not condition acceptance of patient based upon mode of transport
- Lateral transfers are not required-benefits do not outweigh risks
- CMS does not define specialized capabilities or facilities

80

Citations and OIG Fines Related to Lack of Acceptance of Patient Transfer

81

Frequency of Citation

- General Acute Hospitals-Ranges from 5-10% during the period of October 1, 2017 through current
- Critical Access Hospitals-No Cited during this period of time.

82

OIG Fines and Lack of Acceptance of Transfer

On January 10, 2018, Clarksville Health System, f/k/a Gateway Medical Center (CHS), entered into a $40,000 settlement agreement with OIG. The settlement agreement resolves allegations that CHS violated the Emergency Medical Treatment and Labor Act when it failed to accept an appropriate transfer. A 13-year-old presented to a hospital Emergency Department (ED) complaining of testicular pain. An ultrasound indicated no evidence of blood flow in the right testicle and a large amount of fluid surrounding the testicle. In order to access the needed specialized services of a urologist, which that hospital did not have, the ED requested that CHS accept the patient for transfer. CHS's on-call urologist, however, refused to accept the transfer of the patient, recommending instead that the patient be transferred to another facility. OIG alleged that CHS declined to accept the appropriate transfer when it had both the capability and capacity to stabilize the patient's emergency medical condition.

83

OIG Fines Due and Lack of Acceptance of Transfer

On December 26, 2017, Phoebe Putney Memorial Hospital (Phoebe Putney), Albany, Georgia, entered into a $50,000 settlement agreement with OIG. The settlement agreement resolves allegations that Phoebe Putney violated the Emergency Medical Treatment and Labor Act when it failed to accept an appropriate transfer. A 54-year-old man presented to another hospital's Emergency Department (ED) suffering from a subdural hematoma. A CT scan showed that this subdural hematoma was on top of a previous hematoma. The patient needed to be evaluated by a neurosurgeon, which was not available at that hospital. Accordingly, the ED physician at the transferring hospital attempted to transfer the patient to Phoebe Putney for neurosurgical services. Phoebe Putney treated the patient approximately one week earlier for the previous hematoma. Phoebe Putney refused to accept the transfer when it had both the capabilities and capacity to treat the patient. Subsequently, the patient was transferred to another hospital and immediately admitted to its neuro ICU, where he remained for several days before being discharged.

84

OIG Fines and Lack of Transfer Acceptance

On February 9, 2015, Palms West Hospital (Palms), a Loxahatchee, Florida hospital, agreed to pay a maximum penalty of $50,000 in a settlement agreement with OIG. The agreement resolves allegations that Palms refused to accept the transfer of a toddler who had ingested Drano. The mother of an 18-month old toddler brought her daughter to a hospital emergency department (ED) for ingestion of an unknown quantity of Drano. Poison control recommended that the toddler be treated by a pediatric gastroenterologist (GI), which that hospital did not have. The ED physician contacted the Hospital Corporation of America's Transfer Center (TC) to arrange a transfer of the patient. As protocols required, TC had a copy of Palms' on-call list. TC called Palms to confirm that pediatric GI services were available and to arrange for the transfer of the toddler. The ED physician at Palms accepted the transfer, but later rescinded the acceptance believing that she had made a mistake about on-call coverage. As a result, the toddler was transferred to another hospital. Palms, however, did have a pediatric GI available on call when the request was made to transfer the toddler. TC failed to check on the transfer request in a timely manner and learned of the refusal after the patient had been transferred to another facility.

85

Resources for Pattern of Deficiencies and Civil Monetary Penalties

https://qcor.cms.gov/main.jsp

This site details substantial deficiencies and deficiency patterns and trends

https://oig.hhs.gov/fraud/enforcement/cmp/cmp-ae.asp

This site details all CMP and Affirmative Exclusions

86

EMTALA Overview

Patient comes to the dedicated emergency department requesting exam or treatment for any medical condition or is on hospital property requesting treatment for an emergency medical condition

↓

Hospital provides triage

↓

Hospital provides Medical Screening Examination

- Reveals no emergency medical condition → Hospital discharges patient with or without treatment → Patient's EMC is resolved and patient is stable – may be admitted to hospital for continued care or transferred.
- Reveals emergency medical condition
  - Hospital provides treatment to stabilize emergency → Patient's EMC is resolved and patient is stable for discharge home if reasonable to get continued care as outpatient or later as inpatient. Patient receives plan for follow-up care with discharge instructions
  - Hospital unable to stabilize emergency condition → Hospital provides unstable patient with an "appropriate transfer."

87

87

Questions?

88

Speaker

Nancy M Ruzicka B.S. RPh., MBA, MJ, CHC
Ruzicka Healthcare Consulting LLC

Contact Information
Address: 2210 Ridgewood Dr.
Altoona, IA 50009
Email: nancy@ruzickaconsulting.com
Phone: 515/360-2086

89