

**EMTALA OVERVIEW and
INTERPRETIVE GUIDELINE CHANGES:
HERE WE GO AGAIN!**

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Emergency Medical Treatment and Labor Act

**“EMTALA”
“Anti-Dumping Law”**

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GENERAL RULE

- If an Individual COMES TO THE EMERGENCY DEPARTMENT and a REQUEST (in the absence of such request, apply “prudent layperson observer” test) is made for examination or treatment of a Medical Condition, then
 - Hospital must provide MEDICAL SCREENING EXAM To Determine Whether an EMERGENCY MEDICAL CONDITION Exists
- If no emergency, EMTALA obligation is over! (Other laws may apply.)
- If an EMC, then must STABILIZE and/or APPROPRIATELY TRANSFER

“COMES TO THE ED”

An individual, **who is not a patient**, comes to the emergency department when he or she:

1. Presents at the hospital’s **dedicated emergency department** and requests examination or treatment (in the absence of such request, apply “prudent layperson observer” test)

“COMES TO THE ED” (Continued)

2. Presents on other **hospital property** (main campus including sidewalks, parking lots, driveway within 250 yards of hospital) and requests examination or treatment for what may be EMC (in the absence of such request, apply “prudent layperson observer” test)
3. Ambulances

HOSPITAL OBLIGATION

- Once “Comes to ED,” Hospital must provide “Emergency Medical Screening” (MSE) to determine whether an “Emergency Medical Condition” (EMC) is present.
- Hospital **may not delay** the MSE or necessary stabilizing treatment to inquire about an individual’s insurance coverage or method of payment.

“EMERGENCY MEDICAL CONDITION”

- Definition: When absence of immediate medical attention could reasonably be expected to result in:
 - Placing the health of an individual or unborn child in serious jeopardy
OR
 - Serious impairment to bodily function
OR
 - Serious dysfunction of any bodily organ or part

HOSPITAL OBLIGATIONS

- Provide for an Appropriate Medical Screening Examination (MSE) by Qualified Medical Personnel (QMP)
 - Triage ≠ Medical Screening Examination
 - Must be same MSE
- If Emergency Medical Condition exists:
 - Then Must Stabilize and/or Appropriately Transfer
- Other Obligations?

“STABILIZE”

- No material deterioration of the condition is likely to occur during the transfer.
- For women in labor, the physician/QMP has certified false labor or the woman has delivered the child and placenta.
- Psychiatric patient that is suicidal or homicidal = no longer a threat to self or others

- Once stable, EMTALA obligation is over but other State or Federal laws still apply.

WHEN CAN THE ED HOSPITAL TRANSFER?

1. NORMAL TRANSFER: Patient is stable.... No more EMC. EMTALA is over. Provide for a normal transfer.

2. EMTALA “APPROPRIATE TRANSFER”: Hospital may transfer a patient that is unstable **IF**: (a) it is an “appropriate transfer”; (b) patient/legal rep requests the transfer in writing, after being informed of the risks and Hospital’s obligations; and (c) physician certifies benefit of transfer outweighs the risk to patient (and fetus, if applicable).

**“APPROPRIATE TRANSFER”
(of unstable patient with EMC)**

- (1) Transferring hospital provides medical treatment within its capacity that minimizes risk to patient’s health (and health of fetus, if applicable).
- (2) Receiving facility: (a) has space and qualified personnel to treat patient and (b) has agreed to accept the transfer.
- (3) Transferring hospital sends all medical records at time of transfer or ASAP.
- (4) Transfer is effected through qualified medical personnel and transportation equipment, including use of life support measures during transfer, if necessary.

WHO MUST ACCEPT A REQUEST FOR TRANSFER?

- **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.**

CHANGES INCORPORATED INTO INTERPRETIVE GUIDELINES

- March 21, 2008: CMS notified State Directors of several changes/clarifications that were being incorporated into State Operations Manual App. V, Part II of the EMTALA Interpretive Guidelines For Surveyors.
- As of April 3, 2009: Although individual S&C letters are on website, CMS still had not updated its website version of this Manual.
- Changes largely were made to incorporate six (6) of CMS's 2005-2007 Survey and Certification letters into main Interpretive Guidance.
- Providers and Attorneys interpreting EMTALA may not have realized these changes were in effect.

EXAMPLE CLARIFICATIONS/CHANGES INCORPORATED

- Definition of Triage vs. MSE
- On-Call Requirements and Telemedicine
- Labor and Infant Requirements
 - Interaction of EMTALA and the Born-Alive Infants Protection Act of 2002
- “Parking” of EMS Patients
- Recipient Hospital Obligations: Specialized Capacities
- Waiver of EMTALA in Areas covered by Public Health Emergency

CHANGES/CLARIFICATIONS: MSE vs. TRIAGE

- Further clarification of Medical Screening Examination
 - Process required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an EMC or not
 - Must be appropriate to presenting signs and symptoms within capability and capacity of the Hospital
 - Not an isolated event
 - Ongoing process that begins but does not end with triage
 - On-going monitoring required
- Triage (≠ MSE)
 - Clinical assessment of individual's presenting signs and symptoms upon arrival in order to prioritize when patient will be seen by physician of other QMP

CLARIFICATION/CHANGES: ON-CALL PHYSICIAN

- March 2008 Guidance notes telemedicine consults are allowed with physician who may or may not be on the on-call list.
- However, if an on-call physician is requested by the treating physician to come in physically to the hospital, then on-call physician must come. If on the on-call list and does not come, hospital and physician could be subject to EMTALA sanctions.
- Separate issue: Is the consult billable? See Medicare Benefit Policy Manual Pub. 100-2, Ch. 18, Sec. 270.

CHANGE/CLARIFICATION: LABOR & INFANTS

- *"Labor" is defined to mean the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor, unless a physician, certified nurse-midwife, or other QMP acting within 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.*
- *An infant that is born alive is a "person" and an "individual" under 1 U.S.C. 8(a) and MSE requirement applies to "any individual" who "comes to the ED." If an infant was born alive in a dedicated ED, and a request was made on that infant's behalf for screening for a medical condition (or if a prudent layperson would conclude, based on the infant's appearance or behavior, that the infant needed examination or treatment for a medical condition), the hospital and physician could be liable for violating EMTALA for failure to provide such MSE.*
- *If an infant is born alive elsewhere on the hospital's campus (i.e., not in the hospital's dedicated ED) and a prudent layperson observer would conclude, based on the born-alive infant's appearance or behavior, that the infant was suffering from an EMC, the hospital and its medical staff are required to perform a MSE on the infant to determine whether or not an EMC exists.*
- *Whether in the DED or elsewhere on the hospital's campus, if the physician or other authorized QMP performing the MSE determines that the infant is suffering from an EMC, the hospital has an obligation under EMTALA to provide stabilizing treatment or an appropriate transfer. If the hospital admits the infant, its obligation under EMTALA ends.*

CHANGE/CLARIFICATION: Parking EMS Patients

- *Hospitals that deliberately delay moving an individual from an EMS stretcher to an ED bed do not thereby delay the point in time at which their EMTALA obligation begins.*
- *Furthermore, such a practice of "parking" patients arriving via EMS, refusing to release EMS equipment or personnel, jeopardizes patient health and adversely impacts the ability of the EMS personnel to provide emergency response services to the rest of the community.*
- *Hospitals that "park" patients may also find themselves in violation of 42 CFR 482.55, the Hospital Condition of Participation for Emergency Services, which requires that hospitals meet the emergency needs of patients in accordance with acceptable standards of practice.*
- *Does not mean that a hospital will necessarily have violated EMTALA and/or the hospital CoPs if it does not, in every instance, immediately assume from the EMS provider all responsibility for the individual, regardless of any other circumstances in ED.*

Parking (continued)

- *For example, there may be situations when a hospital does not have the capacity or capability at the time of the individual's presentation to provide an immediate MSE and, if needed, stabilizing treatment or an appropriate transfer. So, if the EMS provider brought an individual to the dedicated ED at a time when ED staff was occupied dealing with multiple major trauma cases, it could under those circumstances be reasonable for the hospital to ask the EMS provider to stay with the individual until such time as there were ED staff available to provide care to that individual.*
- *However, even if a hospital cannot immediately complete an appropriate MSE, it must still assess the individual's condition upon arrival to ensure that the individual is appropriately prioritized, based on presenting signs and symptoms, to be seen by a physician or other QMP for completion of the MSE. The hospital should also assess whether the EMS provider can appropriately monitor the individual's condition.*

CHANGE/CLARIFICATION: Recipient Hospital with Specialized Capability and Capacity

- **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.**
 - *Applies whether or not the hospital has a dedicated ED*

Recipient Hospital with Specialized Capability and Capacity (continued)

- *This assumes that, in addition to its specialized capabilities the recipient hospital has the capacity to treat the individual, and that the transferring hospital lacks that capability or capacity.*
- *A hospital with specialized capabilities or facilities that has the necessary capacity to treat an individual with an EMC may not condition, or attempt to condition, its acceptance of an appropriate transfer of an individual on the use by the sending hospital of a particular transport services instead of the transport arrangements made by the attending physician at the sending hospital.*

CHANGE/CLARIFICATION: NATIONAL EMERGENCY

- ***Waiver of certain sanctions for inappropriate transfer in national emergency***
- ***A waiver of these sanctions is limited to a 72 hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue until the termination of the applicable declaration of a public health emergency.***
- ***Need to incorporate clarifications provisions into your Disaster Plan. See Guidance.***

FEDERAL STATUTORY SANCTIONS

- Medicare Exclusion with Public Notice
- Medicaid Exclusion
- Civil Monetary Penalties
- Loss of Joint Commission Deemed Status
- Private Cause of Action by Patient

CIVIL MONETARY PENALTIES

\$25,000 < 100 Beds

\$50,000 > 100 Beds

\$50,000 - Physicians

- Penalty Applied to Each Violation

EMTALA's "D" RULES

- Don't Delay or Deny Emergency Stabilization
- Don't Discriminate in providing Emergency Treatment
- Document... Document... Document
(e.g., Don't forget to document AMAs)

Gina Ginn Greenwood is an attorney with Baker Donelson representing providers across the country from the Firm's Atlanta offices. Ms. Greenwood concentrates her practice on a wide range of health care related matters, including: fraud and abuse compliance and investigations (Anti-kickback Statute, Stark Law and False Claims Act); the Stimulus Package, HITECH Act, Health IT, electronic health records, contract drafting and general business advice; HIPAA Privacy and Security Rule compliance; EMTALA compliance, survey responses and hearings; JCAHO and licensure compliance; reimbursement issues; certificate of need matters; clinical trial research issues; regulatory surveys; corporate health care transactions (including due diligence, change of ownership and compliance issues); and many other regulatory matters pertinent to device/pharmaceutical manufacturers and health care entities (such as hospitals, hospices, skilled nursing facilities, dialysis centers, home health agencies and assisted living facilities).

Ms. Greenwood has authored numerous health care materials including HIPAA Privacy and Security policy manuals, licensure policy manuals, Internet-based employee training modules, fraud and abuse compliance programs and employee manuals. She is a frequent speaker on the topics of licensure/JCAHO compliance, avoiding medical malpractice, electronic health records, Stimulus Package, fraud and abuse, HIPAA and EMTALA compliance and various other health care topics.

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