## EMTALA UPDATE

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FACHE, MHA

### Why EMTALA
- Hospitals were alleged to be “dumping” patients on public medical facilities.
- Patients with emergency medical conditions were being harmed by delayed treatment.
- Patients were not receiving medically appropriate transportation when they were referred to public hospitals.
- Have things changed?

### Basic Requirements
- Provide a screening examination to any person who comes to the facility seeking emergency care.
- Provide stabilizing treatment to any person who has an emergency medical condition.
- Provide medically appropriate transfer for those persons who request transfer or for whom the facility is unable to provide care.
- Assumption that a duty to provide non-emergency care

### EMTALA Applies To
- Emergency medical conditions.
- All hospitals, with or without an organized emergency department, and some clinics.
- All practitioners who provide care at, or are on call, to the hospital (NP, PA, MD, DO).
- Hospital-owned ambulances and, more recently, all ambulances who are in transit to the hospital.
Regulation Changes to “Help You”

- Hospital clinics subject to EMTALA:
  - Held out to the public to provide “urgent” care
  - Do not require an appointment, or provide 1/3 of visits on an unscheduled basis.
- Satellite versus Hospital-based
  - Remote clinics not subject to EMTALA in all cases.
- Moving the patient to the ED
  - Regulations allow you to move the patient to appropriate treatment area.
- MSE and Transfer relief for ED located in emergency area during a national emergency

New Rules (cont.)

- Admit to inpatient care ends EMTALA process
  - Unless admission is used to avoid EMTALA requirements
- An inpatient who becomes unstable and requires transfer is covered by EMTALA
  - Transfer obligations apply
- Ambulance can divert patients to appropriate treatment settings, but contact between ambulance and ED is “comes to the hospital.”
- EMTALA MSE for newborns with emergency conditions.

Latest New Regulations

- FFY 07 Inpatient Hospital PPS
  - False Labor may be certified by nurse midwife or other practitioner authorized to do so, without physician signature
  - Specialty hospitals, even those without EDs must accept emergency transfers for services that facility offers
- Emerging Issue: Hospitals without ED, subject to EMTALA, using 911.
- Type A and B EDs. Payment differentiated
  - Type A are 24-7, Type B are part time EDs.

Community Call

- A hospital, or group of hospitals can be “on call” for certain services or for certain times if:
  - Assess community need and available docs
  - Specify area served
  - Involve EMS
  - Maintain a back up plan
  - Sign a formal plan
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<th>EMTALA Does NOT Apply To</th>
<th>Hospital Must</th>
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<td>- Persons who:</td>
<td>- Provide a screening examination for all patients who request emergency treatment.</td>
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<td>- Come to the hospital to fill prescriptions</td>
<td>- Maintain a log of all emergency room services.</td>
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<td>- Report for scheduled appointments</td>
<td>- Maintain a list of practitioners who are on site at, or on call to, the emergency room.</td>
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<td>- Do not request treatment for a medical condition (conscious)</td>
<td>- Maintain written policies, including policies that identify the medical personnel authorized to provide a screening examination.</td>
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<td>- Law enforcement blood alcohol tests</td>
<td>- Keep your policies flexible, but follow the policies you adopt.</td>
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<td>- Rural Health Clinics, Physician Offices, SNFs, Other Medicare Providers</td>
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<td>- Issue: urgent care clinic near the ED</td>
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<th>EMTALA is Satisfied When</th>
<th>Practitioners must</th>
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<td>- Person is determined not to have an emergency medical condition</td>
<td>- Provide screening examination to determine if an emergency medical condition exists.</td>
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<td>- Person is transferred (appropriately)</td>
<td>- If such a condition exists, provide stabilizing treatment, including pain management.</td>
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<td>- Person leaves against medical advice*</td>
<td>- If the facility is not able to provide required care, transfer the person to a facility who can provide the care necessary.</td>
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<td>- Person requires continued care, but does not require a transfer; or</td>
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<td>- Person’s medical condition is stabilized</td>
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Keeping the Log

- Patient log provides crucial insight to surveyors
  - Every encounter is presumed to be an emergency until MSE determines the case is not an emergency
  - You must log that the case is not an emergency, or EMTALA requirements continue
  - Log supports the circumstances about the patient encounter.

Emergency Medical Condition

- 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:
  - Placing the health of the patient in serious jeopardy;
  - Serious impairment to bodily functions;
  - Serious dysfunction of any bodily organ or part.
  - For woman having contractions, there is not time to safely transfer to another facility or transfer threatens the unborn child.

To Stabilize for Discharge

- The practitioner attending to the patient in the emergency department has determined, with reasonable clinical confidence, that the emergency medical condition has been resolved.

- The patient has reached the point where continued care could be reasonably performed as an outpatient or later as an inpatient.
  - Treatment plan/instructions required.**

Recommendations for RN Screening Protocols

- Allow the RN, when performing the screening examination, to contact the practitioner for consult and to receive orders. Contact is not the same as request to come to the facility.
- RN should be allowed to determine NO emergency condition exists. RNs should defer to the practitioner to determine that an emergency medical condition DOES exist.
- Medical Staff should periodically review problem areas, and adjust policies accordingly.
- Don’t confuse triage with medical screening examination.
To Stabilize For Transfer

- Provide such treatment 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 that the woman has delivered the child and placenta.
- Stable for transfer or discharge does not require the final resolution of the emergency medical condition.

4 Elements of Appropriate Transfer

- Transferring hospital provides treatment within its capacity that minimizes the patients’ risks;
- Receiving hospital has space/personnel for the treatment, and has agreed to accept patient;
- Transferring hospital sends medical records and transfer forms; and
- Transfer is affected through qualified personnel and equipment, as needed, including life support.

Who Decides About Transfer?

- Transferring hospital/practitioner responsible
  - Determine the emergency condition exists
  - Patient medical needs,
  - Treatment capacity and the most appropriate hospital proposed for transfer.
- Receiving hospital responsible
  - Advise about limits to capacity or services
  - Once patient is accepted, become a potential transferring hospital.
  - Don’t question decision, or condition transfer**
- Patient may request a transfer.

Transfer

- The patient must have an emergency medical condition for EMTALA regulations to apply.
  - Non-emergency transfer not under EMTALA
- The practitioner must determine the benefit of transfer outweighs the risk to the patient if no transfer occurs.
- The transfer must be “medically appropriate” for the patient’s condition.
- Contact with receiving hospital, records and forms must accompany the patient.
Transfer vs. Referral

- Many patients seek care at emergency room who do not have an emergency medical condition.
- Screening examination concludes that no emergency condition exists, EMTALA no longer applies.
- Patient with additional treatment needs, but not for an emergency condition, may be refused further care, referred to clinic or other provider. Transfer provisions do not apply.

Transfer by Personal Car

- Patients, even those with an emergency medical condition, can leave against medical advice. Hospital should try to dissuade. Document!
- Patients, even those with emergency conditions, can refuse medical transport. But, it must be offered by the Hospital.*
- Patients who are stabilized for the purpose of discharge can be referred for outpatient care without medical transport.

Hospitals, Practitioners are Not:

- Required to expand services due to EMTALA.
- Required to operate medical transportation. (They must arrange for same.)
- Required to provide any treatment beyond the screening examination to those patients who are determined not to have an emergency medical condition.
  - Can move patient from ED to hospital clinic, but not for the MSE.
  - Issue: 3 or more medical specialty equates to capacity to provide services.

Penalties

- Small Organizations
  - $25,000 per occurrence
  - Civil Money Penalties
  - Office of Civil Rights and OIG Involvement
  - Time limits
  - Statute of Limitations: 2 Years

- EMTALA versus TORT Claim
  - EMTALA does not replace malpractice claims
  - EMTALA violation does not create a TORT
How To Get In Trouble

- Patient Complaints/Patient Satisfaction
- Nurse/Practitioner Disputes: The inside job
- Receiving hospital alleges dumping or fails to allege dumping
- Patient Dumping: Bad Outcomes
- Survey and Certification
  - Technical Violations
  - Allegations of Dumping

How to Stay Out of Trouble

- Solid documentation, clear policy and procedures. Supportive medical staff.
- Clear determination of emergency condition and stabilizing treatment.
- Don’t unreasonably delay care.
- Consistent about your capacity to treat.
- **Limit the gray areas.**

Past Montana Issues

- Most Current EMTALA surveys are related to consumer complaints (currently 3 open cases in July 08)
- Patient arrested and referred for care. Hospital had no bed, transferred to facility w bed. No violation.
- Patient demand to see Physician, but not emergent
- Patient family complaint: Care appropriate, documentation could have been better.
- Receiving hospital failed to allege dumping over POV transfer, other problems
- Pt left ED over refusal to consent to care: “environment that discouraged patient from seeking care”
- Pt treatment delayed for registration activities

Recent Montana Issues

- Other violations: Practitioners
  - PA providing care by phone, not responsive to the ED
  - Physician on call refuse to come to ED, Dr claimed unaware they had call requirement Dispute over mental health transfers
  - Capacity of facility and medical staff to care for MH
  - Transfer of Patient in Active Labor
  - PA refused to provide examination on minor without parental consent
  - Parent misunderstanding of instructions for follow-up care
When the State Agency and Regional Office Disagree

SA determines no EMTALA violation, RO disagrees and issues a deficiency
- ED care followed by next day dialysis
- Hospital refused to admit, transferred to second hospital where patient better known
- Pt. served in ED, referred to surgeon for follow-up. Surgeon believed immediate need existed. RO agreed.
- RO has final say when diff of opinion

Direction to State Agencies

Requests for care that do not require a MSE
- Flu, allergy and immunization shots
- Collection of evidence for criminal law cases
- Scheduled services
- Not required to provide medications to those without emergency conditions for patient preference.
  - But, hospital must take care to document the nature of the request.
- Hospital cannot avoid EMTALA by ‘parking’ ambulance patients on stretchers, delay entry to hospital.
- SAs should not provide the hospital with their impression of the investigation.

Direction to State Agencies

Law Enforcement
- BAT: If blood draw only is requested, no MSE. If treatment for intoxication or injury plus blood draw: MSE required. Prudent layperson.
- Clearance for Incarceration: MSE required.
- Sexual Assault: Collection of evidence vs. treatment for injury: same as BAT
- Amended interpretive guides 3/08
- NOTE: SA review each case on own merit.

Response Time

CAH COP: available within 30 minutes of being called to the ED
- CAN provide telephone consultation to the RN or other providers to continue a MSE
- On call practitioner can not refuse to come to ED if summoned. Can't replace the judgement of the person at the ED
Questions