New EMTALA Regulations
Six Months Later

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The History of EMTALA

- 1986: EMTALA enacted as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA)
  - EMTALA designed to prevent hospitals from refusing to treat emergency patients or transferring them to charity or public hospitals due Medicaid or other economic reasons
- 1988/89: Amendments to EMTALA
- 1994: Final EMTALA rules issued
- 2000: EMTALA rules amended
- Nov. 2003: EMTALA rules amended
The New Rules of the Road

- EMTALA relates to individuals who present to a “dedicated emergency department”
- EMTALA only applies to off-campus facilities and departments that are a “dedicated emergency room”
- EMTALA does not apply to outpatients during the course of their treatment (even if an emergency occurs)
- EMTALA does not apply to individuals who are inpatients
- The on call obligations for physicians have changed
- EMTALA does not apply to hospital owned ambulances operating under EMS direction
- Guidance on prior authorization and managed care patients
The Old Rules of the Road

What has not changed in the 2003 EMTALA regulations:

- Definition of an “emergency medical condition”
- Documentation of patient refusal of treatment or transfer
- Definitions of stabilization, stable for transfer, stable for discharge
- Requirements for an appropriate transfer
- Obligations to accept patient transfers
- Signage
- Central Log
- Maintenance of Medical Records
- Reporting EMTALA violations
- Private lawsuits for damages
- Sanctions
The New Rules of the Road

Who is Covered by EMTALA -- Four Instances:

- Presentation to “dedicated emergency department” for examination or treatment for a medical condition
- Presentation on hospital property for examination or treatment for what may an emergency medical condition
- Individual in a hospital-owned/operated ambulance not under EMS direction
- Individual in a non-hospital owned/operated ambulance on hospital property
Patients Presenting to a DED

The EMTALA obligations begin when an individual presents to a DED of a hospital and either:

- **Requests examination or treatment for a “medical condition;”** or
- **Has a request made on his/her behalf;** or
- **A prudent layperson observer would believe, based on the individual’s appearance or behavior, that the individual needs examination or treatment for a “medical condition”**
The Dedicated Emergency Department

A “dedicated emergency department” is:

- A licensed emergency department; or
- Held out to the public (advertising, signs, marketing material, websites, etc.) as a place that providers care for emergency medical conditions on an urgent care basis without requiring a previously scheduled appointment; or
- A department/facility that provides 1/3 of its visits to patients on an urgent basis without requiring a scheduled appointment
What is a DED?

Dedicated Emergency Departments include:

- Labor & Delivery
- Psychiatric Units
- Crisis Assessment Centers
- Urgent Care Centers
- Ambulatory clinics that advertise or routinely accept drop-in patients

DEDs must comply with all requirements of EMTALA
What is a DED?

Compliance Issue: **How do you hold out your services to the public**

- Website
- Advertising and other promotional materials
- Patient education/ information brochures
- Yellow pages listings
- Marketing statements
- Statements by other hospital personnel on the availability of services (“we see patients without an appointment”)
DEDs – Compliance Questions

- Does EMTALA apply to a hospital that does not operate a DED?
- Does EMTALA apply to a hospital that operates an off-campus DED (e.g., urgent care), but does not operate a DED on its main campus?
- Is a hospital-operated service that meets the definition of DED considered a DED if it is not treated as a provider-based department (e.g., occupation medicine)?
- What are the on-call requirements for a DED that is not a typical emergency department?
DEDs – Compliance Questions (cont.)

- Can a hospital post a “no emergency services” if it operates a drop-in clinic that is a DED, but not an organized emergency service?
- If a hospital operates a part-time drop-in urgent care clinic that is a DED, is the hospital subject to EMTALA when the clinic is closed?
- Are drop-in clinics that are open part-time for specific medical conditions (e.g., senior care or AIDS) a DED?
- Does EMTALA apply to patients with scheduled appointments in a DED (e.g., routine labor checks)?
EMTALA and Hospital Property

EMTALA applies to an individual who has presented on “hospital property,” other than a DED, and

- Requests examination or treatment for what may be an emergency medical condition
- Has such a request made on his/her behalf; or
- A prudent layperson observer would believe, based on the individual’s appearance or behavior, that the individual needs emergency examination or treatment
EMTALA Coverage Depends on Location

- Patient in Dedicated ED, EMTALA applies if-
  - Request for examination or treatment for a medical condition; or
  - Prudent layperson would believe that individual needs examination or treatment for a medical condition

- Patient in other hospital department or on-campus, EMTALA applies if-
  - Request for examination or treatment for an emergency condition; or
  - Prudent layperson would believe that individual needs examination or treatment for an emergency condition
Hospital Property

- “Hospital property” is defined by the 250-yard test for describing the hospital campus under the provider-based rules:
  - The main hospital building(s)
  - 250 yards of the main buildings
  - Other areas that CMS may determine are part of the campus on a case-by-case determination
- Includes driveways, sidewalks, parking lots
Hospital Property (cont.)

Hospital property does not include -

- Rural health clinics (regardless of location)
- Skilled Nursing Facilities
- Home Health Agencies
- Private Physician Offices
- Privately-Owned Business
- Private Residences
Hospital Property – Compliance Issues

Are the following “hospital property?”

- **Common areas in hospital-owned medical buildings**
- **Hospital administrative, support or supply buildings on the hospital campus (i.e., non-clinical buildings)**
- **Public streets**
- **Hospital parking lots and other property more than 250 yards from the main facility**
- **Hospital property surrounding an off-campus DED?**
Hospital Property – Compliance Issues

Adopt policies for providing emergency services outside of the DED –

- Define what’s on your hospital property
- Establish procedures for responding to emergency situations in the main hospital, other on-campus buildings and on the hospital grounds and parking lots
- Establish procedures for moving patients to the DED or calling 911 (when appropriate)
- Inservice! Inservice! Inservice!
- Quality improvement reviews of responses to emergency situations on the hospital campus - learn from your errors!
EMTALA and Outpatients

- The EMTALA obligations do not apply to an outpatient during the course of his/her “encounter” (that is not an encounter that triggers the EMTALA obligations)

- An “encounter” is a “direct personal contact” between a patient and a physician/caregiver who may order or furnish hospital diagnostic or treatment services

- **NOTE:** EMTALA applies before or after the encounter if the individual requests or is need of emergency services
EMTALA and Outpatients

- If the outpatient develops an emergency condition during the outpatient encounter, the hospital’s response is governed under the Medicare Conditions of Participation, not EMTALA (even if the patient is moved to a dedicated emergency department for follow-up examination and stabilizing treatment)

Compliance Issues: Must have policies and procedures to respond to emergency situations in outpatient departments

Question: If you call 911 to transport the patient to the Emergency Department does the EMS transport become an intervening factor which results in EMTALA obligations?
EMTALA and Inpatients

The Final Ruling -

✓ The EMTALA obligations are terminated once an individual is admitted for inpatient care
✓ An “inpatient” is “a person who is has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services.” (Medicare Hospital Manual)
✓ Inpatient status includes admitted patients who are “boarded” in the E.D. waiting for an available bed
EMTALA -- Other Persons on Campus

- EMTALA applies to individuals on hospital property for other than outpatient or inpatient services who may request or be in need of emergency services -
  - Visitors and guests
  - Vendors
  - Hospital employees (are they going off-site for assessment of on-the-job injuries?)
EMTALA – Off-Campus Departments

All EMTALA obligations apply to a hospital off-campus, provider-based DED

Compliance Issues:

✓ Do off-campus DEDs have compliant EMTALA policies – signage, central log, etc.
✓ Do all patients receive an MSE?
✓ Are off-campus DED staff designated to perform MSEs
✓ Is there any on-call coverage for your off-site DED?
✓ Does the DED have transfer agreements?
✓ Inservice! Inservice! Inservice!
✓ Is the off-campus DED on the quality improvement radar screen
EMTALA – Off-Campus Departments

- Off-campus departments that are not a DED are subject to the Medicare conditions of participation, and must appraise emergencies and refer patients when appropriate.

Compliance Issues:
- Is there a policy and procedure for staff response to emergency situations?
- Is there documentation of emergency situations?
- Use 911
The New Rules of the Road

EMTALA does NOT apply to the following:

- Outpatients in the course of treatment
- Inpatients
- Off-campus departments that are not dedicated emergency departments
- Buildings and services on or off hospital property that are not part of the hospital for Medicare purposes -- e.g., private physician offices, skilled nursing facility, home health agency, non-hospital owned businesses, private residences
EMTALA and Hospital-Owned Ambulances

- New Rules: EMTALA does not apply to hospital-owned air or ground ambulances if:
  - The ambulance is operated under community-wide emergency medical service protocols that direct it to transport the individual to a hospital other than the hospital that owns the ambulance (for example, the closest available hospital); or
  - The ambulance is operated at the direction of a physician who is not employed or affiliated with the hospital that owns the ambulance.
EMTALA and Non-Hospital Owned Ambulances

- New EMTALA rules-
  - Add air ambulances
  - May “direct the ambulance to another facility” when on diversion

- New Rules do not address the Arrington v. Wong decision (9th Circuit) applying EMTALA to a non-hospital owned ambulance enroute to a hospital that apparently was not on diversion
Medical Screening Examinations

The fundamental requirements have not changed:

- **Triage is not medical screening**
- **The MSE is to determine, within reasonable clinical confidence, the presence or absence of an emergency medical condition**
- The MSE must be provided by a qualified medical personnel in a manner that is non-discriminating to all patients presenting with same or similar signs and symptoms within the capabilities of the hospital
- **The MSE must be performed by a qualified medical personnel designated by the hospital**
Medical Screening Examinations (cont.)

- What is new for the MSE?
  - If an individual comes to an dedicated emergency department and the nature of the request is clear that the condition is not of an emergency nature, “the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.”
Medical Screening Examinations - Compliance Issues

Patients presenting to a DED --

- for injections and other pharmaceutical therapy (including drug refills)
- with physician orders for non-pharmaceutical treatment
- to see their own personal physician in the DED
- in the custody of law enforcement personnel for blood/alcohol tests, pre-jail medical clearance or rape/sexual assault
- for pre-employment or school physicals
- for preventive health services (e.g., blood pressure checks)

Can DED patients still be redirected to other hospital departments (that are not a DED) for the MSE?
Medical Screening Examinations - Compliance Issues

Rules for Labor and Delivery and other DEDs are the same as the typical emergency department

- **Non-physician personnel performing MSEs must be designated by the hospital/medical staff and perform the MSE within applicable state laws and hospital policies/protocols/procedures**
- **Only a physician can certify false labor**
- **If a patient presents with a medical condition beyond the competency of a QMP, patient must be seen by a physician**

Behavioral assessments must be conducted and documented by a physician and/or other hospital personnel (cannot rely solely on non-hospital crisis evaluation teams)
On-Call Obligations - New Rules

- Hospitals must have an on-call roster that-
  - Best meets EMTALA patient needs
  - In accordance with available resources
  - Including the availability of on-call physicians
- Required frequency of coverage-
  - No federal requirement, but must consider availability of physicians, including patient care obligations, conferences, vacations, etc.
  - A call schedule must list physicians by name; hospital cannot list the name of a medical group on the call schedule
- May exempt senior staff from coverage, but must meet the needs of EMTALA patients
On-Call Obligations - New Rules

- A hospital may permit an on-call physician to schedule elective surgery or provide simultaneous coverage to two or more hospitals if the hospital has policies and procedures to provide that emergency services are available to meet patient needs.

- Qualifications --
  - These exceptions do not apply to critical access hospitals.
  - CMS expects that an on-call surgeon will have a planned back-up for call when in surgery.
  - Hospital should know when physician has simultaneous call obligations.
On-Call Obligations - New Rules

CMS Comments to New Rules

- Services offered to the public must be available through on-call coverage; but CMS declined to make this a regulation.
- Physicians who are visiting their own patients should not be considered to be “on call” unless they are listed on the call roster for that day.
- The practice of refusing to be listed on the call roster, but taking calls selectively violates EMTALA.
On-Call Obligations - New Rules

Two additional comments from CMS to consider:

- Disagreements between the treating and on-call physicians regarding the need to come to the hospital “must be resolved by deferring to the medical judgment of the emergency physician or other practitioner who has personally examined the individual and is currently treating the individual.”

- A physician “who is in a narrow subspecialty may, in fact, be medically competent in his or her general specialty, and in particular may be able to promptly contribute to the individual’s care by bringing skills and expertise that are not available to the emergency physician...”
On-Call Obligations – Compliance Issues

- How do you balance the needs of your EMTALA patients with the limited numbers of specialists who will take call?
- Need to document decision-making process for call coverage (especially in unusual case or special arrangements)
- Expect state survey agencies/ CMS to second-guess the judgment of the hospital and the medical staff (especially in the absence of written documentation of the rationale behind the staffing schedule)
EMTALA – Patient Registration

- **Prior Authorization**: a hospital may not seek prior authorization for emergency services until completion of the MSE and initiation of stabilizing treatment.

- **Registration**: a hospital may follow reasonable registration processes for emergency patients, including requests for insurance status, **but cannot delay or “unduly discourage” patients from remaining for emergency services**.

- **Consultation**: the treating physician may consult with an off-site or plan physician at any time to seek advice on the patient’s history and needs, **but cannot inappropriate delay required emergency services**.
EMTALA – When is an Emergency Condition Stabilized?

Emergency Medical Condition Exists

- **Must provide further examination and stabilizing treatment within the capability and resources of the hospital.**

When is an Emergency Condition Stabilized?

- **EMTALA regulations:** when no material deterioration is likely, within reasonable medical probability, to result from or occur during the transfer of the patient to another medical facility (or woman having contractions has delivered the baby/placenta)

- **Nov. 2003 Guidance:** An emergency condition is not stabilized until the condition, within reasonable medical confidence, is “resolved”
EMTALA -- What is an Appropriate Transfer?

Standards for an Appropriate Transfer have not changed:

- The Transferring Hospital has provided treatment to the individual with an **emergency medical condition** within capacity of hospital
- The Transferring Hospital has obtained agreement to accept the patient from Receiving Hospital, including identifying a Physician to accept the patient
- The Transferring Hospital has provided sufficient data, including medical records, X-rays, lab reports as available, to the Receiving Hospital to facilitate continuing evaluation and treatment
- The Transferring Physician has certified the transfer and arranged for the use of appropriate mode of transportation, personnel and equipment

The judgment of the Transferring Physician takes precedence as to the existence of an EMC and the appropriateness of a Transfer
EMTALA – Receiving Hospital

Obligations

- EMTALA requires hospitals with the specialized capabilities, capacity and resources needed by a patient with an unstabilized emergency medical condition that are not available at the Transferring Hospital to accept that patient in transfer.

- EMTALA does not require hospitals to accept a patient who does not require the specialized capabilities of the hospital whether or not the patient has an emergency medical condition.

- Under current law, a hospital’s obligation to accept a patient under EMTALA does not apply to inpatient transfers.
The Top EMTALA Rules to Remember

- Log in every patient who presents, together with complaint/diagnosis and disposition. A patient has “presented” when he/she is on the campus (i.e., 250 yard zone around the hospital), “provider based” remote sites and ambulances owned by the hospital without regard to means or ability to pay.
- Triage patients per protocol to establish the order in which patients receive MSE.
- Provide a medical screening examination, following triage, to all patients who present to a dedicated emergency department. The MSE must be the same for all patients presenting with like signs and symptoms.
The Top EMTALA Rules to Remember (cont.)

- Do NOT call for prior authorization before the MSE or initiation of stabilizing treatment
- Do NOT delay the MSE or attempt to secure verification from third party payor, nor attempt to influence the patient by drawing payor status issues to the patient's attention prior to completion of MSE and initiation of stabilizing care
- Provide necessary testing, including on-call services, as needed to exclude the presence of a legally defined emergency medical condition (does NOT equate to emergent patient)
The Top EMTALA Rules to Remember (cont.)

- Provide an MSE, by either a physician (or a QMP who has been credentialed through the Interdisciplinary Practice Committee to provide MSEs)
- For transfers, document on the Transfer Form the acceptance from the receiving hospital, with the name of the accepting physician/hospital representative and time
- For transfers, provide medically appropriate vehicles, personnel and equipment; private vehicles should not be without an informed written refusal of an ambulance
The Top EMTALA Rules to Remember (cont.)

- The transferring physician must document a physician certification with clearly stated risks and benefits of transfer the transfer.
- The transferring hospital must provide medical records, labs, reports and consultation records to accompany the patient on all EMTALA transfers.
- The transferring hospital/physician must document on the Transfer Form the name of any on-call physician who refused to respond or failed to make a timely response of any EMTALA patient transferred as a result of that refusal or lack of timely response.
- Document the reassessment of a transfer patient immediately prior to departure.

Send records:
- Exam record
- Test results
- x-rays
- consents
- transfer form
- certificate for transfer
The Top EMTALA Rules to Remember (cont.)

• Document a written refusal of services from a patient, including the risks of refusal associated with the individual case, or document the reasonable efforts by the hospital to obtain written refusal.

• Obtain and document on the Transfer Form written consent to transfer from the patient or responsible party, or document reasonable justification for not obtaining the written consent.

• Report any possible violations of EMTALA by another facility within 72 hours of receipt of the patient to a designated hospital department.
The Top EMTALA Rules to Remember (cont.)

✓ **For each EMTALA patient** --
  ✓ obtain and document full vitals including pain assessment on all presenting patients
  ✓ maintain documented vitals at appropriate frequency during the stay, and
  ✓ in ALL CASES obtain and document vitals or vitals at the time of discharge or transfer

✓ **Post EMTALA signs in all public entrances, waiting areas, registration and care areas**

✓ **Complete the central log in a timely and complete manner**
EMTALA...the Potential Punishment for Failure to Follow the Regulations

- Termination from Medicare and Medicaid
- Potential fine of up to $50,000 per violation
- Potential lawsuit for civil damages
- Potential civil rights violations
- Physician can also be fined up to $50,000 per incident
- Publicity of the violation and penalty
Questions and Answers