The Emergency Medical Treatment and Labor Act (EMTALA)

Presentation to the 2016 Nurse Leaders in Native Care Conference

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The information provided in this presentation is only intended to be general summary information. It is not intended to take the place of statute, regulations, or official CMS policy.

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This presentation will discuss basic EMTALA requirements for hospitals and critical access hospitals (CAHs).

At the end of the presentation, the participants will be able to:

• Identify EMTALA requirements for hospitals and CAHs
• Better understand compliance with EMTALA by reviewing scenario-based examples
EMTALA requires Medicare-participating hospitals (including CAHs) to provide:

1. Medical screening examinations to any individual who presents to the emergency department (regardless of insurance or ability to pay),
2. Stabilizing treatment for emergency medical conditions, and
3. Appropriate transfers to hospitals with specialized capabilities
EMTALA requirements apply to Medicare-participating hospitals and CAHs:

• With emergency departments (ED):
  – Licensed as ED
  – Held out to the public as providing ED services
  – 1/3 of visits in prior year provided treatment for emergency medical conditions on an urgent basis

• Without EDs but with specialized services and capabilities
EMTALA Statute:
• Section 1866 – Agreements with Providers of Services; Enrollment Processes
• Section 1867 – Examination and Treatment for Emergency Medical Conditions and Women in Labor

EMTALA Regulations:
• 42 CFR 489.24
• 42 CFR 489.20 (related requirements)
Accrediting Organizations

- Hospitals/CAHs may choose to be accredited by one of the four hospital AOs with deeming authority for participation in Medicare
- Majority of hospitals are deemed
- Some, but not majority of CAHs, are deemed
- AOs assess compliance with the hospital and CAH Conditions of Participation (CoP)
- AOs have no authority over EMTALA
EMTALA Enforcement

- Complaint-driven process
- Investigations authorized by CMS Regional Office (RO)
- **All** EMTALA requirements are assessed
  - Regardless of focus of complaint
- Non-compliance may lead to termination of provider agreement and/or imposition of civil monetary penalties (CMP)
  - HHS Office of Inspector General imposes CMPs
EMTALA Enforcement (2)

- RO makes final determination based on surveyor input and Quality Improvement Organization (QIO) expert physician review
- Only current non-compliance is cited
- However, identification of past non-compliance as well as current non-compliance may be forwarded to HHS Office of Inspector General for review and possible imposition of CMPs
• Policies and procedures which address anti-dumping provisions
• Reporting inappropriate transfers
• EMTALA signage
• Transfer records
• Physician on-call list
• ED logs
EMTALA Requirements (2 of 2)

- Medical screening examinations
- Stabilizing treatment
- Delays in examination or treatment
- Appropriate transfers
- Whistleblower protections
- Recipient hospital responsibilities
The hospital must provide a medical screening examination (MSE) to any individual who “comes to the ED” for care:

1. Presents to the ED (including L & D) requesting an examination of a medical condition
2. Is outside the ED but on hospital property
3. Is not on hospital property but in a hospital-owned and operated ambulance
4. Is in a non-hospital-owned ambulance that has arrived on campus

***Regardless of Native American - Indian status***
Medical Screening Examinations 2

• Exam must be performed by a qualified medical professional:
  – Physician, mid-level practitioner
    • On occasion may be a RN
  – Determined qualified by bylaws, rules and regulations
  – Meets personnel requirements in the hospital emergency services CoP

• Purpose of MSE is to determine if an emergency medical condition exists
Emergency Medical Condition

- A medical condition manifesting itself by acute symptoms (including severe pain, psychiatric disturbances, substance abuse) that in the absence of immediate medical intervention could result in:
  - Placing the health of the individual or the unborn child in serious jeopardy
  - Serious impairment to bodily functions
  - Serious dysfunction of any bodily organ or part

- Pregnant woman who is having contractions:
  - There is inadequate time to effect a safe transfer before delivery
  - The transfer may pose a threat to the health and safety of the woman or unborn child
Triage alone does not meet the requirements of a MSE. It is a process to:

- Collect information
- Assess signs and symptoms
- Determine priority

The MSE must be appropriate to presenting signs and symptoms:

- May be simple or complex utilizing the capabilities of the hospital
- Similar to the MSE provided to any other individual who presents with similar symptoms
- Regardless of financial status, race, sex, color, national origin or disability
Hospitals may follow normal registration procedures as long as they doesn’t delay the MSE
• Gather demographic data, emergency contact, etc.
• Ask for insurance information, if applicable

However, hospitals must not ask for payment, co-pays or deductibles, or seek insurance authorization prior to completing the MSE and providing stabilizing treatment for any emergency medical condition.

*These actions place the hospital at risk of violating EMTALA.*
• If the MSE determines an emergency medical condition exists, the hospital must provide stabilizing treatment or arrange for an appropriate transfer.

• If the MSE determines there is no emergency medical condition, EMTALA no longer applies.
Stabilizing Treatment 1

The hospital is required to stabilize any emergency medical conditions:

• Within the capabilities and capacity of the hospital, including inpatient admission
• Treating individuals with similar medical conditions consistently
• Utilizing the physician on-call list, as needed
An individual will be deemed stabilized if the treating physician or QMP attending to the individual in the ED/hospital has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.

- “Clinically stable” or “stable for transfer” does not necessarily mean the emergency medical condition has been stabilized.

*Note: underlying medical conditions may persist*
Stabilizing Treatment 3

• If unable to stabilize, then appropriately transfer
• Provide ongoing examination and treatment within hospital capabilities until the transfer occurs
  – Including if there are delays in transfer until placement is found (e.g. psych patients)
The hospital cannot transfer the patient with an unstabilized emergency medical condition unless:

- The patient requests a transfer in writing
  - You must inform the patient of the risks of transfer
- The physician certifies in writing that the medical benefits of transfer outweigh the risks
- A non-physician practitioner consults with an MD and the MD agrees with the transfer
Additionally:
1. The sending hospital must provide care within its capabilities prior to transfer
2. The recipient hospital agrees to the transfer and has capabilities and capacity to treat
3. The sending hospital sends all records
4. Qualified personnel and equipment are used for transportation, as determined by sending hospital
Scenario 1

A 56 year old man with a history of hypertension, diabetes and elevated cholesterol comes to your ED complaining of chest pain and shortness of breath.

• What do you do?

Your hospital doesn’t have a cardiologist on staff, a cath lab or any other cardiac services. The man doesn’t have a primary care provider but uses the health center in town for medical services.

• Who do you call?

The ED doc determines the patient is having an acute MI and needs to be urgently transferred to a hospital with cardiac services.

• What do you need to do before the transport team arrives?
Scenario 2

Your hospital doesn’t have a labor and delivery department or any obstetricians on staff. A pregnant woman walks into your ED waiting room and says her water just broke.

- This is her first pregnancy
- She has had prenatal care but is visiting from out of town
- Her contractions are coming 5-6 minutes apart
- After 25 minutes in the ED, she wants to push...
Scenario 3

A patient is in a motor vehicle accident and paramedics bring him to your ED. X-rays show he has a pelvic fracture. You contact the orthopedic surgeon on-call who reviews the films and says she isn’t able to repair this type of fracture. She instructs you to transfer the patient to a trauma center.

While waiting for the patient to be transferred, what are your responsibilities?

• Is the on-call specialist required to come to the ED?
• Do you provide treatment before the patient departs your ED?
• Have you arranged an “appropriate transfer” per EMTALA?
Scenario 4

A suicidal patient has been in your ED for 4 days awaiting placement at a psychiatric hospital. The social worker reaches out to the psych hospital on a daily basis to try and arrange a transfer but they haven’t had any available beds.

In the meantime... security is monitoring the patient and he is getting meals and daily showers. The nurses take vital signs and document an assessment every shift. He hasn’t had any additional examinations by the ED practitioners and is not receiving his routine medications.

*Is this potentially an EMTALA violation?*
**EMTALA Requirements**

**Brief overview of EMTALA requirements covered today**

<table>
<thead>
<tr>
<th>What can you do to avoid an EMTALA violation?</th>
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<tr>
<td>Monitor with QAPI</td>
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<td>Train your staff, ALL staff</td>
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<td>Don’t ask for financial information before MSE underway</td>
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<td>Accept transfers if you have capability and capacity</td>
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<td>Maintain logs (arrivals and transfers) and on-call schedules</td>
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<td>Post EMTALA signs</td>
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The objectives for this presentation were to:

- Identify *basic* EMTALA requirements for hospitals and CAHs
- Better understand compliance with EMTALA by reviewing scenario-based examples
Questions
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