EMTALA 2016
Emergency Medical Treatment & Active Labor Act

- Federal “anti-dumping” law enacted in 1986
- Purpose to ensure access to emergency services regardless of ability to pay
- If patient “comes to” emergency department, hospital must perform medical screening examination to determine if emergency medical condition exists
Emergency Medical Treatment & Active Labor Act

- If patient has emergency medical condition, provide stabilizing treatment
- Transfer only if: hospital does not have capacity or capability to treat patient and benefits of transfer outweigh risks; or patient requests transfer
- If no emergency medical condition exists, no further EMTALA obligations
EMTALA does not apply to:

• Inpatients of the hospital with emergency medical conditions
• Outpatients of the hospital once they are registered
• The transfer of an inpatient from one hospital to OU Medical System for emergency care, specialized services, testing, or procedures
• Individual screened and no EMC
• Individual presents at ED and requests treatment for non-emergency purpose or preventive care
Medical Screening Examinations

- Perform appropriate screening based on hospital’s capability & capacity
- Process to reach, with reasonable clinical confidence, whether patient has EMC
- May follow normal registration procedures – but cannot delay MSE or stabilizing treatment for pre-authorization or “unduly discourage” individuals from remaining for screening
Emergency Medical Condition

Acute symptoms of sufficient severity such that absence of treatment could:

- Place health of individual in serious jeopardy; or
- Cause serious impairment of bodily function; or
- Cause serious dysfunction of organ or body part.

Includes psychiatric emergencies (dangerous to self or others)

Pregnant woman having contractions (at any stage of pregnancy) has EMC if:

- Inadequate time for safe transfer before delivery; or
- Transfer poses threat to health or safety to woman or infant
If Patient Has Emergency Medical Condition . . .

• Provide necessary stabilizing treatment – medical treatment of EMC so that no material deterioration of condition is likely

• Provide for appropriate transfer – provide medical treatment within capability and capacity to minimize risks to patient

• Woman in true labor – deliver baby and placenta or transfer appropriately
If Patient Has Emergency Medical Condition . . .

- Provide necessary stabilizing treatment – medical treatment of EMC so that no material deterioration of condition is likely

- Provide for appropriate transfer – provide medical treatment within capability and capacity to minimize risks to patient

- Woman in true labor – deliver baby and placenta or transfer appropriately
**Transfers Out Permitted only ...**

- *If physician determines transfer is necessary:* physician assesses benefits & risks and determines that medical benefits outweigh risks of transfer; physician must complete and sign transfer form and obtain patient signature.

- *If patient requests the transfer:* assigned nurse will complete transfer consent form, physician explains risks and benefits, and patient signs the transfer form
Accepting Transfers

• Hospital with specialized capabilities and capacity must accept appropriate transfers

• “Capacity”
  - Beds and equipment
  - Availability of staff, including on-call
  - Not on “divert”
  - Past practices to accommodate patients
“Capacity”

- CMS considers a hospital’s past record of accommodating additional patients by:
  - Moving patients from one unit to another
  - Calling in additional staff
  - Temporarily borrowing equipment from other facilities
  - Accepting direct admissions

- Determination of capacity is case-specific
“Duty to Accept”

• Generally, a hospital with “specialized capabilities” has a duty to accept transfers from hospitals without such capabilities

• If physician at outlying facility determines that transfer is necessary – OU Medical System must accept transfer

• “Eyes on the patient” prevails in a dispute

• Hospital’s obligation to report inappropriate transfers

• OU Medical System’s protocol for transfer refusals
OU Medical System Policy

- Only the CEO, Administrator-on-Call (“AOC”), or a hospital leader who routinely takes administrative call has authority to verify that the facility does not have the capability and capacity to accept a transfer.

- Any transfer request which may be declined must first be reviewed with this hospital leader before final decision to refuse acceptance is made.

- This requirement applies to all transfer requests, regardless of whether the transfer request is facilitated by a Transfer Center representative or the facility’s CEO designee or ED physician.

- For purposes of this requirement, a Nursing Supervisor, House Supervisor or other similarly titled position is not considered equivalent to the AOC.
Related EMTALA Obligations

• A hospital cannot take adverse action against (a) physician for refusing to authorize the transfer of patient with EMC that has not been stabilized; or (b) any employee who reports a violation

• A hospital is obligated to promptly report improper transfers to CMS or State (handled through administration)

• An inappropriate transfer is not justification for refusing to accept the patient
On-Call Physicians

- Hospital must maintain on-call list
- “In accordance with resources available to the hospital”
- Physicians must be listed individually; ED physician must have direct access to on-call physicians
- If hospital offers professional service to public, should make available through call coverage
Call Policies & Procedures

• If requested by ED, on-call physician must respond in person within 30 minutes as set by your medical staff bylaws

• Policy and procedures if:
  - Particular specialty not available due to circumstances beyond his/her control

• Back-up procedures if:
  - On-call physicians schedule elective surgery
  - On-call physicians permitted to take simultaneous call
“Eyes on the patient”

• Decision maker under EMTALA is always physician with “eyes on the patient”

• If OU Medical System ED physician asks on-call specialist to respond in person, on-call specialist must do so

• Issues regarding appropriateness of on-call physician being called – must handle internally after the fact
Enforcement

- EMTALA is enforced through complaints and self-reporting
- State Department of Health, CMS (and possible referral to OIG)
- Administrative process before any sanctions
CMS Referral to OIG

- If evidence of current non-compliance
- QIO hearing

Civil monetary penalty factors:
- Degree of culpability of hospital
- Seriousness of patient’s condition
- Other EMTALA violations by hospital
- Financial condition of hospital
- Nature and circumstances of violation
Potential Sanctions - Hospital

- Negligently violates EMTALA – OIG imposes civil monetary penalty of up to $50,000 each violation
- CMS may terminate hospital’s Medicare provider agreement (very rare)
- Individual who suffers personal harm as direct result of violation may bring action against hospital
- Hospital suffers financial loss as direct result of another hospital’s violation can bring civil action
**Potential Sanctions - Physicians**

- If responsible for examination, treatment, or transfer and negligently violates EMTALA – civil monetary penalty of up to $50,000 per violation
- On-call physician who fails to respond in person or within reasonable time
- Gross, flagrant, or repeat violation – exclusion from Medicare
- Patients have no private right of action against physicians under EMTALA
Case Scenario #1

61 year old female found unresponsive in her home; initially taken to hospital and diagnosed with subdural hematoma and needed emergency surgery. ED physician telephone Medical Center call center for transfer. Medical Center transferred call to its ED; ED told transferring physician to speak to on-call neurosurgeon; call forwarded to hospitalist, who said he had to speak with on-call neurosurgeon. Spoke to on-call neurosurgeon who stated that it sounded like patient was brain dead. Transferring physician said she was not, he had medically paralyzed her to intubate. Neurosurgeon refused to accept transfer, but would be willing to consult on case. Medical Center, after finding out about its refusal, ordered neurosurgeon to accept patient, which he did. Patient had already been transferred to another hospital (patient had successful surgery).
Case Scenario #1 - Analysis

- Unreasonable delays in Medical Center’s decision to accept or not accept the patient; procedures must be in place for transferring hospital to speak to responsible physician without unreasonable delay
- Neurosurgeon was available so Medical Center had capability
- Medical Center had obligation to accept transfer if Medical Center had capacity
- Neurosurgeon’s response regarding “consulting only” is a refusal to accept a transfer & not permissible under EMTALA
- Medical Center found in violation of EMTALA for failure to accept transfer
- $40,000 penalty assessed by federal government
Case Scenario #2

University Hospital with 18 bed adult inpatient psychiatric unit. Website states it does not treat primary substance abuse-related disorders or inpatient detox.

• Only accepts transfers during certain business hours
• Outlying hospital requests transfer of patient in acute psychiatric crisis with possible substance abuse; hospital did not provide lab results indicating whether substance abuse was at issue. University Hospital did not accept transfer
Case Scenario #2 - Analysis

- EMTALA violation for University Hospital to only accept transfers of patients to business hours
- Website statement was insufficient to establish that University Hospital did not have capacity and capability to treat the patient
- Requiring transferring hospital to provide lab results, under the circumstances of this case, was an impermissible delay
- University Hospital was found to have failed to accept 5 appropriate transfers of patients (the foregoing was one of 5)
- Paid $180,000 to settle allegations of EMTALA violations
Case Scenario #3

83 year old patient comes to ED of hospital. Hospital determined patient required coronary bypass surgery at Medical Center. Medical Center’s cardiac surgeon refused to accept transfer because patient was too unstable to be transferred and would likely die.
Case Scenario #3 - Analysis

- Hospital had specialized capabilities and duty to accept patient if capacity and capability at the time
- Cardiac surgeon available, so capability met; assume that capacity also met
- Eyes on the patient prevails
- Hospital paid $20,000 settlement to resolve allegations of violation of duty to accept appropriate transfer
- Patient had successful surgery at another hospital
- Bad outcome is not necessary to have EMTALA violation
Questions Contact:

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