Advanced Decision Making for EMTALA

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CHA Web Seminar

Welcome and Program Overview

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California Hospital Association
Faculty: David Perrott, MD, DDS

Dr. Perrott is senior vice president and chief medical officer for CHA. His responsibilities include all clinical issue areas, including the Center for Hospital Medical Executives, Healthcare Quality Committee, the Medication Safety Committee, and the Joint Committee on Accreditation and Licensing. He is actively involved in the California Hospital Patient Safety Organization, and was recently appointed to The Joint Commission (TJC) Board of Commissioners. Prior to joining CHA, he was senior vice president/CMO at Salinas Valley Memorial Healthcare System, a TJC hospital surveyor, and maintained a part-time practice.

Faculty: CDR Kelly Valente, PharmD

CDR Kelly Valente, PharmD is pharmacist surveyor and EMTALA lead for Centers for Medicare & Medicaid Services, Region IX. As team leader on EMTALA, CDR Valente is responsible for determining hospitals’ compliance with EMTALA, and to that end works closely with state surveyors and CMS’ Quality Improvement Organization. She has served as CMS EMTALA trainer and presented information on EMTALA to CHA membership and other associations, as well as and state government.
M. Steven Lipton, JD is a partner in the San Francisco office of Hooper, Lundy & Bookman, PC and the author of CHA’s manual, *EMTALA — A Guide to Patient Anti-Dumping Laws*. A noted expert on patient anti-dumping laws, he has worked extensively with hospitals on EMTALA civil sanction matters and on compliance interpretation, policy development and education.

**Overview**

- Quick review of the basics — EMTALA 101
- Six case scenarios that address:
  - Behavioral health
  - Transfers
  - Capacity and capability
  - And more
- Open Q and A
Disclaimers

- This presentation assumes basic knowledge of EMTALA
- We do not have all the answers …

(Please, don’t shoot the messenger!)

EMTALA 101 — The Basics!

- When does EMTALA begin?
- What is an appropriate medical screening examination (MSE)?
- What is an emergency medical condition (EMC)?
- What stabilizing treatment is required?
- What is an appropriate transfer?
- When must a hospital accept a transfer?
When does EMTALA begin?

Four Paths to EMTALA —

- Individual presents to “dedicated emergency department” (ED/OB) seeking/in need of examination or treatment for a medical condition
- Individual presents elsewhere on hospital property seeking/in need of examination or treatment for potential emergency condition
- Individual in a hospital-owned/operated ambulance that is not operating under emergency medical services (EMS) direction
- Individual in a non-hospital owned/operated ambulance on hospital property

EMTALA — Core Obligations

- Medical screening examination
- Further examination and stabilizing treatment for an emergency medical condition
- On-call coverage
- Transfer/discharge of patients
- Acceptance of patients with unstabilized emergency conditions requiring a higher level of care
- No delay of required services, including transfers, for insurance or payment reasons
What is an Appropriate MSE?

CMS — “an MSE is the process to reach, within reasonable clinical confidence, the point at which it can be determined whether the individual has an EMC or not”

- Triage is not an MSE
- Designation of staff to perform MSEs
- Consistency/non-discriminatory — the MSE must be the same MSE performed on any other individual presenting with the same signs and symptoms
- Rules for OB are the same as ED
- Includes any request in the ED for pharmacy services
- Documentation

What is an EMC?

- Medical condition (including severe pain, psychiatric disturbances or chemical dependency abuse) manifesting itself by acute symptoms of sufficient severity so that the absence of immediate medical attention could reasonably be expected to result in —
  - Placing the health of the patient (or an unborn child) in serious jeopardy; or
  - Serious impairment of bodily functions; or
  - Serious dysfunction of any bodily organ or part
- A pregnant woman having contractions if there is inadequate time for a safe transfer to another facility or the transfer will pose a threat to the health of the mother or the unborn child
When is Further Examination and Stabilizing Treatment Required?

If an emergency medical condition exists

- Must provide further examination and stabilizing treatment within the capability and resources of the hospital, including on-call coverage and response
- Further examination and treatment is subject to a patient’s right to make an informed refusal of care

Stabilization of an EMC

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)
- **Interpretive Guidelines**: an emergency condition is not stabilized until the condition, within reasonable medical confidence, is “resolved”
- **WARNING** — disputes or misunderstandings arise when “stable” is used to describe a patient who has an unstabilized emergency medical condition
Inpatients

- The EMTALA obligations are terminated when 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”
- Inpatient status includes admitted patients who are “boarded” in the ED waiting for a bed.
- EMTALA obligations are also terminated when a mother has delivered her baby and the placenta.

What is an Appropriate Transfer?

A transferring hospital must meet the following standards for making an “appropriate” transfer under EMTALA:
- A receiving hospital/physician has accepted the transfer.
- Medical records are sent to the receiving facility.
- The patient has an EMC that has not been stabilized and the resources needed to do so are not available at the treating hospital.
- A physician has certified that the clinical benefits of the transfer outweigh the risks or the patient has made informed request for the transfer.
- An appropriate level of transport (including personnel and equipment) is selected.
When Must a Hospital Accept a Transfer?

A hospital is required to accept an “appropriate” transfer from a transferring hospital if all of the following exist:

- The patient presented to the sending hospital seeking or in need of emergency care and treatment
- The patient has an EMC that is not stabilized
- The sending physician has determined that the patient requires further examination and treatment in order to stabilize the EMC
- At the time of transfer, the sending hospital does not have the capability/capacity to stabilize the EMC
- The receiving hospital has the capability and capacity to stabilize the patient’s EMC

Do Not Forget …

EMTALA applies only to emergency patients who have an EMC —

- Inpatient transfers are not covered by EMTALA!
- An emergency patient with a stabilized EMC, as determined by the sending physician, is not covered by EMTALA
Sticky Issue — Registration

- EMTALA — hospitals may follow reasonable registration processes, including asking for insurance, so long as the inquiry does not delay screening or treatment.
- California law — “Emergency services and care shall be rendered without first questioning the patient or any other person as to his or her ability to pay therefor.”
- Which law prevails? EMTALA does not preempt state laws that do not directly conflict with EMTALA.

CMS warning (May 9, 2012) — “aggressive debt collection”
- “We would have serious concerns with the legality of any hospital policy or procedure that may discourage individuals from seeking emergency care, such as demanding that emergency department patients pay before receiving treatment.”
- May not delay screening or stabilizing treatment to inquire about payment or insurance status.
Who Enforces EMTALA?

Scenarios:
EMTALA and Behavioral Health
Scenario 1

- Patient A presents to Hospital X under a 5150 custodial hold written by a police officer
  - Hospital X is not an Lanterman Petris Short Act (LPS)-designated hospital
  - Hospital X does not provide psychiatric services
  - The ED physicians at Hospital X are not designated by the county to write a 5150 hold
  - The presenting complaint is that Patient A appears to be suicidal based on her reported ingestion of a drug overdose

Scenario 1

- ED physician determines that Patient A is “medically clear” (there is no drug overdose)
- ED physician examines Patient A for suicidality and monitors Patient A for six hours
- ED physician concludes that Patient A’s psychiatric condition, within reasonable clinical probability, is “stabilized”
Scenario 1

ED physician is not authorized to release the hold; what can ED physician do?

- Discharge the patient?
- Transfer the patient to a designated facility?
  - Is this an EMTALA transfer?
- Call the law enforcement agency that wrote the hold?
- Call the County and ask for assistance?

Scenario 1 — EMTALA Obligations

- EMTALA regulations define an emergency medical condition as including “psychiatric disturbances”
- EMTALA Interpretive Guidelines
  - In the case of psychiatric emergencies, if an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered to have an EMC
Scenario 1 — California Law

“Psychiatric emergency medical condition” means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

a) An immediate danger to himself or herself or to others; or

b) Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder

Stabilization of Psychiatric EMC

- **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

- **California law**: same as EMTALA regulations
Types of Custodial Holds

5150 Hold vs. 24-Hour Hold

- **5150 hold** — detain involuntarily a person who is a danger to self/others, or gravely disabled, in order to transport the person to a designated facility for evaluation and treatment

- **24-hour hold** — immunity statute for hospitals and physicians to hold a person who is a danger to self/others, or gravely disabled, in order to arrange for behavioral health services

Custodial Holds — 5150 Process

Steps in the pre-hospitalization process

- Custodial hold by an authorized person (5150)
- Assessment by an authorized person at a designated facility for admission (5151)
- Admission to a designated facility for up to 72 hours for evaluation and treatment (5152)
Custodial Holds — 5150 Process

When any person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, member of the attending staff, as defined by regulation, of an evaluation facility designated by the county, designated members of a mobile crisis team ..., or other professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody and place him or her in a facility designated by the county and approved by the State Department of Mental Health as a facility for 72-hour treatment and evaluation.

Parsing section 5150 —

- “… mental disorder”
- “… take, or cause to be taken, the person into custody”
- “… place him or her in a facility designated by the county”
- “… application”
- Time limits of a 5150 hold …
1) Hospital staff, ED physician, or appropriate licensed mental health professional, has documented repeated unsuccessful efforts to find appropriate mental health treatment

2) Patient cannot be safely released from the hospital because, in the opinion of the treating physician, or certain psychologists, the person, as a result of a mental disorder, presents a danger to self, others or is gravely disabled

3) The person is not detained beyond 24 hours

A person detained under a 24-hour hold must be credited for the time detained in the event he/she is admitted to a designated facility for treatment up to 72 hours
### 5150 vs. 24-Hour Holds — Who May Initiate a Hold

<table>
<thead>
<tr>
<th>5150 Hold</th>
<th>24-Hour Hold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peace officer</td>
<td>Treating physician</td>
</tr>
<tr>
<td>Attending staff</td>
<td>Clinical psychologist with medical staff privileges</td>
</tr>
<tr>
<td>County-designated mobile crisis team member</td>
<td>Clinical psychologist with clinical privileges</td>
</tr>
<tr>
<td>Other county-designated professionals</td>
<td>Certain state hospital psychologists</td>
</tr>
</tbody>
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### EMTALA and Involuntary Holds

- There is nothing in the EMTALA statute that addresses involuntary holds
  - This is a state process
- The EMTALA investigation can use the involuntary hold as a variable in patient determination of an emergency medical condition
**What’s on the CMS Radar Screen?**

- Screening of patients with behavioral health complaints
- Further evaluation and monitoring of behavioral health patients
- Elopement of behavioral health patients
- Transfers and discharge of behavioral health patients
- Acceptance of transfers of behavioral health patients — requests for insurance information

**Scenario 1 — Issues**

If the custodial police officer is not present at the hospital:

- Is the patient still on a 5150?
- What are the police obligations to the patient?
- What are the hospital/physician obligations to the patient?
- How long can the hospital hold the patient if he/she wants to leave the facility?
Scenario 1 — More Issues

- Is a 5150 hold an EMC?
  - Does it matter whether the hold was placed by law enforcement or a crisis team?
- Is an EMTALA-compliant transfer required if the patient is on a hold even if the ED physician believes the patient does not have a psychiatric emergency condition?
  - Must a designated facility accept the patient?

Scenario 2

Patient A presents to Hospital X
- Hospital X is a county-designated, Medicare participating, LPS facility
- ED physician determines that Patient A is “medically clear”
- ED physician also determines that Patient A has a psychiatric emergency medical condition and meets the criteria for a 5150 hold (which he/she is authorized to write)
- ED physician starts stabilizing treatment and continued monitoring and evaluation in the ED
Scenario 2

After a period of six hours —
- ED physician consults with staff psychiatrist
- Consensus that Patient psychiatric EMC is “stabilized,” but the 5150 hold should not released
- Hospital X has determined that Patient A is a member of Health Plan Z
  - Hospital X is not a Health Plan Z contract hospital
- Hospital X has capacity and capability to admit Patient A for evaluation and treatment

Scenario 2 — The Issues

- Must Hospital X contact Health Plan Z?
- If yes, can Hospital X transfer Patient A to hospital aligned with Health Plan Z?
  - If Health Plan hospital accepts Patient A, is this an EMTALA transfer?
- Must Hospital X admit Patient A since it has the capability and capacity to treat Patient A?
Scenario 2 — EMTALA

- Psychiatric patients are “considered stable when they are protected and prevented from injuring him/herself or others”
- Chemical or physical restraints may be administered for the purpose of a transfer, so long as the transferring physician —
  - Determines that the psychiatric condition is stabilized after administering restraints; and
  - Considers the time and distance of the transfer in the continued effectiveness of the restraints

Scenario 2 — California Law

- A hospital may transfer a patient with an emergency psychiatric condition if the condition is stabilized
- If a hospital has identified that the patient is a health plan member, the hospital must contact the health plan or contracting provider to arrange a transfer
Scenario 2 —
The Issues Revisited …

- Must Hospital X contact Health Plan Z?
- If yes, can Hospital X transfer Patient A to hospital aligned with Health Plan Z?
  - If Health Plan hospital accepts Patient A, is this an EMTALA transfer?
- Must Hospital X admit Patient A since it has the capability and capacity to treat Patient A?
EMTALA and Recipient Hospital Responsibilities (A2411, 489.24(f))

- 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 U.S. an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.
- This is regardless of whether the hospital has a dedicated emergency department and does not apply to inpatients.

Scenario 3

Patient A presents to Hospital X located in the Central Valley.
- Hospital X is Medicare participating and not a designated LPS facility.
- ED physician determines that Patient A has a psychiatric emergency condition.
- A county mental health worker writes a 5150 hold on Patient A.
- Hospital X calls multiple hospitals from Bakersfield to Stockton; all of the hospitals state that they do not have capacity or capability to accept Patient A.
Scenario 3

- Hospital X calls Hospital Y in the Bay Area seeking acceptance of the transfer
- Hospital Y has capacity and capability to accept the transfer, but the representative stated, “it is too far”
- Hospital X calls CMS to complain that Hospital Y refused to accept a patient determined to have an unstabilized psychiatric condition
- Does this warrant an investigation?

Scenario 3

- YES!
- Under EMTALA, no hospital with capacity or capability can refuse to accept a patient based solely on location and where this hospital “thinks” the sending hospital should send the patient
- Hospital Y will be investigated for A2411, Recipient Hospital Responsibilities
Scenario 3.5

- Same facts as Scenario 3, except —
  - The ED physician believes that Patient A may benefit from 23-hour crisis stabilization rather than an inpatient admission up to 72 hours
  - Hospital X calls a crisis stabilization unit (CSU) to arrange for the transfer of Patient A

- Is a transfer to a CSU permitted under EMTALA?

CMS Letter (11/12/2009)

- An appropriate transfer under EMTALA does not require in all cases that the receiving facility must be a hospital
- A transfer to a CSU or other non-hospital facility is not automatically a violation of EMTALA
- However …
**CMS Letter (11/12/2009)**

However —

- The transferring physician, in certifying the transfer, must have a reasonable clinical confidence that the CSU has the capability to stabilize the patient’s behavioral emergency.
- If the sending physician does not have the clinical confidence that the CSU can stabilize the condition, the CMS suggests that the physician should arrange a transfer to a level of care higher than the CSU (e.g., a psychiatric health facility (PHF) or an acute unit/facility).

**CMS Letter (11/12/2009)**

Are PHFs and CSUs subject to EMTALA?

- CSUs — No, unless the unit is part of an acute hospital or psychiatric hospital.
- PHFs — maybe, but mostly not!
  - Most PHFs are not certified by Medicare as an acute psychiatric hospital.
  - A few PHFs have obtained certification, and are therefore subject to the EMTALA accepting hospital obligation.
Scenario 4

- Hospital Y, located in Los Angeles, accepts the transfer from Hospital X in the Central Valley of Patient A, a cardiac patient with an emergency medical condition
- Hospital Y finds that Hospital X had called only one other hospital in the Central Valley to arrange the transfer, which declined the transfer

Scenario 4

- Hospital Y feels there were many hospitals from Fresno to Bakersfield that could have accepted Patient A
  - Hospital Y also feels that the 100+ mile transfer was not in the best medical interest of Patient A
- Hospital Y calls CMS requesting an investigation of the transfer and Hospital X
- Does this warrant an investigation of Hospital X?
Scenario 4

- No!
- Unless Hospital Y has proof that a closer hospital had the capability and capacity for this patient and that Hospital X called them and they refused, then there is no basis for an investigation.

Scenario 4

Obligation to Report an EMTALA Violation

- A basic commitment to a provider agreement
- Reasonable belief that a hospital has received a patient from another hospital in violation of EMTALA
- May call CMS or CDPH
- Report should be made within 72 hours
Scenario 4.5 (Bonus)

- Hospital Y receives a call from Hospital X seeking to transfer Patient A with an unstabilized EMC
- ED physician at Hospital X requests admission of Patient A to an ICU bed
Scenario 4.5 (Bonus)

- Hospital Y has an unoccupied bed in the ICU and has the capability to stabilize Patient A’s EMC; however (take your pick) —
  - The open bed is reserved for a patient in surgery who will need the bed after post-op
  - The open bed is temporarily reserved for an inpatient who may need to be upgraded to ICU
  - The open bed is reserved if a trauma patient presents to the ED

Capacity and Capability

CMS has defined both terms at 42 CFR 489.24(b)

- **Capacity** means the ability of the hospital to accommodate the treatment of the transferred individual; it encompasses number and availability of qualified staff, beds and equipment and the hospital’s past practices of accommodating patients in excess of its occupancy limits
- **Capability** means that there is physical space, equipment, supplies and specialized services that the hospital provides, and level of care the personnel can provide, including on-call rosters
Scenario 4.5 (Bonus)

- The open bed is reserved for a patient in surgery who will need the bed after post-op
  - This can be looked at as a committed bed
- The open bed is temporarily reserved for an inpatient who may need to be upgraded to ICU
  - This can be looked at as a committed bed
- The open bed is reserved if a trauma patient presents to the ED
  - This is an open bed

Scenario 4.5 (Bonus)

- The surveyors will be looking at your historical practice in regards to bed space
- What is your policy?
Scenario 5

- Sunset Hospital is a small hospital that has general surgery, orthopedics, and OB and general medicine medical staff available
  - Patient A is a 550-pound, morbidly obese 38-year-old female who has a preliminary diagnosis of “acute appendicitis” and requires surgery

- Sunset wishes to transfer Patient A to another facility for the following reasons:
  - It cannot complete all the studies (CT scan) that the general surgeon believes are needed due to the size of Patient A
  - The Sunset staff feel that they do not have the capability to manage the patient while in the hospital due to her size (beds, operating room)
Scenario 5

- Sunrise Hospital is 30 miles away, and has a full bariatric program with all the necessary equipment and facilities to address this population of patients.

Scenario 5

- Does the transfer implicate EMTALA?
- What is Sunset’s responsibility to meet the needs of this patient?
- Does Sunrise have to accept this patient?
Capacity and Capability

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- **Capacity** means the ability of the hospital to accommodate the treatment of the transferred individual; it encompasses number and availability of qualified staff, beds and equipment and the hospital’s past practices of accommodating patients in excess of its occupancy limits.

- **Capability** means that there is physical space, equipment, supplies and specialized services that the hospital provides, and level of care the personnel can provide, including on-call rosters.

Scenario 5

- Does Sunset have the capability and capacity to treat Patient A?
  - What are the limitations of Sunset’s capability and capacity?
  - Are the limitations clinically significant?
  - How has Sunrise managed similar patients in the past?
Scenario 6

Flat Land Hospital is a 60-bed community hospital with a general surgery service and general surgeon on call

- Flat Land has a GI lab, with a specialist present for consults and procedures, including endoscopic retrograde cholangiopancreatography (ERCPs) on Monday, Wednesday and Friday
- A GI specialist accepts call M, W and F during lab hours, but does not take call on other days or at night and weekends

Scenario 6

University Hospital is a 380-bed, Level II trauma center with a full scope of services —

- University has a GI on-call service
- The GI service performs ERCPs during weekday hours and for emergent cases on weekends
On a Wednesday morning at 2 a.m., University Hospital receives a call from Flat Land seeking to transfer a 63-year-old male patient with acute cholecystitis.

- The ED physician says that the patient needs an ERCP and the GI physician will not be in until 7 a.m.
- University has the service available, but is 3+ hours away, depending on weather and traffic conditions.

Flat Land feels that this is a transfer to a facility of a higher level of care.

The on-call GI physician at University feels that this is a lateral transfer since there is time to hold the patient until the 7 a.m. arrival of the GI physician at Flat Land.

Based on the facts, who is correct in its characterization of the transfer?
Scenario 6

- A “lateral transfer” is a transfer between facilities of comparable resources and capabilities
  - Lateral transfers are not covered by EMTALA until the sending facility does not have then existing capability or capacity to provide stabilizing treatment
- Is this a lateral transfer?
  - What are the limitations of Flat Land’s capability and capacity?
  - How has Flat Land managed similar patients in the past?
  - Who decides if the patient can wait until 7 a.m.?

Thank you

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Questions

Online questions:
Type your question in the Q & A box, hit enter

Phone questions:
To ask a question hit 14
To remove a question hit 13

EMTALA Manual

2009 Edition Available

- Covers several interpretations of the EMTALA obligations affecting:
  - On-call physicians
  - Medical screening exams
  - Dedicated emergency departments
  - Stabilization and transfer
- Includes new information on EMTALA in disaster situations
2012 Publications

- California Hospital Survey Manual (New publication)
- California Hospital Compliance Manual
- Consent Law
- Principles of Consent and Advance Directives
- Minors and Health Care Law
- Mental Health Law (Available July 2012)
- California Health Information Privacy Manual (Available Summer 2012)

Learn more at www.calhospital.org/publications

Upcoming Programs

- Disaster Planning for California Hospitals
  October 15 - 17, 2012, Sacramento
- Behavioral Health Care Symposium
  December 3 - 4, 2012, Huntington Beach
- Post-Acute Care Conference
  January 31 - February 1, 2013, Huntington Beach
- Rural Health Care Symposium
  March 13 - 15, 2013, Sacramento
Thank You and Evaluation

Thank you for participating in today’s program. An online evaluation will be sent to you shortly.

For education questions, contact Liz Mekjavich at (916) 552-7500 or lmekjavich@calhospital.org.