C. Great Expectations: CMS Enforcement of EMTALA

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Great Expectations: Government Enforcement of EMTALA

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- This presentation is based on the personal observations and opinions of the speakers, based on our experiences
Emergency Medical Treatment and Labor Act

- What Should a Medical Screening Examination Look Like?
- What Should a Hospital do When a Patient Leaves before Stabilization?
- If Hospital becomes aware of a violation, what should it do?
- Immediate Jeopardy: What is it?
- Plans of Correction: More than a checklist
- OIG Enforcement

EMTALA and Medical Screening Exams (“MSE”)

- If a hospital participates in Medicare and a patient comes to the emergency department and requests examination or treatment, it must:
  - provide for an appropriate MSE within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists
MSE: What is Provider Looking For?

- An EMC: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
  - Serious jeopardy to health;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part;
  - With respect to a pregnant woman:
    - Inadequate time to effect a safe transfer before delivery; or
    - Transfer poses a threat to the health or safety of the woman/child

- EMC: In the case of psychiatric emergencies, an individual expressing suicidal or homicidal thoughts or gestures, or determined dangerous to self or others, would be considered to have an EMC
What Is An “Appropriate” MSE?

State Operations Manual:

- An MSE is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an EMC or not. An MSE is not an isolated event. It is an ongoing process that begins, but does not end, with triage.
- The MSE must be the same MSE that the hospital would perform on any individual with those same signs and symptoms, regardless of their ability to pay.
- Doesn’t have to be right – EMTALA not malpractice suit.

What Is An “Appropriate” MSE – State Operations Manual (cont’d)

- “The medical records should contain documentation such as: medically indicated screenings, tests, mental status evaluation, impressions, and diagnoses (supported by a history and physical examination, laboratory, and other test results) as appropriate.”
What Is An “Appropriate” MSE – State Operations Manual (cont’d)

- For pregnant women:
  - Medical records should show evidence that the screening examination included ongoing evaluation of fetal heart tones, regularity and duration of uterine contractions, fetal position and station, cervical dilation, and status of the membranes, i.e., ruptured, leaking, intact.

- For individuals with psychiatric symptoms:
  - Medical records should indicate an assessment of suicide or homicide attempt or risk, orientation, or assaultive behavior that indicates danger to self or others.

What Is An “Appropriate” MSE – Federal Register

- Extent of necessary examination is generally within the judgment and discretion of qualified medical personnel performing the examination.
- Screenings should be provided to each individual commensurate with the condition that is presented.
- CMS states they are refraining from dictating to hospitals standards for medical screening examinations.
What Is An “Appropriate” MSE – Case Law

- How have courts interpreted screening requirement?
  - Majority Rule – uniformity
    - "[H]ospital satisfies the requirements...if its standard screening procedure is applied uniformly to all patients in similar medical circumstances."
  - Minority Rule – uniformity AND motive
    - "[M]ust adduce some evidence that her screening differed in some way from that given to other patients, and the difference was improperly motivated."

What Is An “Appropriate” MSE – Other Sources of Guidance

- Preamble - Vital Signs
  - Vital signs are indicators of a patient’s level of wellness and are valuable parameters
- Professional Standard of Care
- CMS Regional Offices
- State Surveyors
- QIO
Medical Screening Examination – Practical Requirements

- What are QIOs, state surveyors, and CMS looking for?
- Hospital
  - Did hospital have policies in place for complying with EMTALA?
  - Did hospital have protocols for the condition of this patient?
  - Did hospital follow its policies/protocols?
  - Was the process any different for this patient?

Medical Screening Examination – Practical Requirements

- Exhaust Capability
  - Routinely available ancillary services and equipment
  - On-call Physicians
  - Past patient history should be considered
  - If you ever “stretch” capability, you must do it uniformly
Medical Screening Examination – Practical Requirements

- How quickly does the process need to go?
  - CMS seems to consider:
    - How quickly was triage initiated?
    - Was first contact with a clinical person? Or Registration person?
    - Was waiting patient checked on regularly (and was it documented)?

- Document, Document, Document
  - Care differed slightly from written protocol? Explain in chart

Medical Screening Examination – Psychiatric Patient

- For the psych MSE, practitioners should document that they assessed the patient for risk of harm to self or to others (e.g., disorientation, aggression, suicidal/homicidal ideation)

- Much of an MSE (and some of the stabilization) is question-and-answer sessions, monitoring, and de-escalation techniques, safe room, and designated sitter/tech 1:1

- Psych Patients often come to the ED with both a psych EMC (e.g., disorientation) and a physical EMC (e.g., head contusion from falling); the hospital must provide (and document) an appropriate MSE for BOTH conditions within its capacity and capability
Medical Screening Examination – Patient Leaving AMA

- Offer individual further medical care
- Inform patient of benefits of examination and risks of withdrawal
- Take all reasonable steps to obtain written informed consent
- “[T]he burden rests with the hospital to show that it has taken appropriate steps to discourage an individual from leaving the hospital without evaluation”

Medical Screening Examination – Psych Patient Leaving AMA

- EMTALA does not expressly require that unstable psych patients be forced to remain at the facility, but hospitals generally have a duty to try and prevent an unstable psych patient from injuring or harming themselves or others
  - Know the law in your state – CMS, QIO and state surveyors seem to insist that hospitals do everything that state law permits to keep them in the ED
  - Determine if patient has capacity to sign out AMA (question of state law)
  - Document attempts to keep them in the ED
  - Contact police
Medical Screening Examination – Psych Patient Leaving AMA (cont’d)

- Initiate proceedings to obtain “psychiatric hold” if the patient is not stable for discharge
  - Some states require that hospital call police, and police initiate
- If restraining a patient, physician must document that no less restrictive/intrusive means were appropriate or available
- Restraint must meet criteria in Medicare Conditions of Participation

Medical Screening Examination – Elopement

- An elopement occurs when a patient leaves the hospital without warning before the MSE and stabilizing treatment are complete
  - Document the fact the person was there
  - What time the hospital discovered patient had left
  - Retain all triage and treatment notes
  - Have a written plan on which staff have been trained, and if the patient elopes, follow it: document attempts to locate/contact the patient (e.g., call patient’s home number, use the hospital intercom, walk the facility grounds)
- Psych patients: call police, search facility
CMS Enforcement Options

- Violations can result in either a 90-day or 23-day action to terminate the hospital’s Medicare provider agreement and issuance of a notice of deficiency (CMS 2567)
- CMS may issue 23-day (“Immediate Jeopardy”) notice if:
  - Violation poses immediate jeopardy to the health or safety of individuals who present themselves to the hospital for emergency services
  - Appendix Q of State Operations Manual

CMS Enforcement Options (cont’d)

- Explicit Discrimination based on payor status
- Repeat or Multiple Deficiencies
- Transfer because physician failed to respond
- No MSE
- Failure to provide stabilizing treatment
- Improper Transfer of unstabilized patient after no MSE
- Attitude of hospital and providers during incident
- Bad outcome: though technically irrelevant, surveyors are people, too
Plans of Correction: More Than a Checklist

- CMS receives complaint, surveyors visit, and hospital receives 2567. What does CMS need to see to accept the POC?

- First Things First: has hospital taken steps to mitigate risk of the exact thing recurring?
  - Correct any process deficiency for this particular situation (e.g., create written plan for when on-call physician fails to respond to call)
  - Train the specific physician on what they did wrong and how that situation must be handled in the future
  - Physician’s conduct reviewed by hospital staff and disciplined

(Cont’d)

- CMS wants hospitals to have culture of compliance and be proactive – treat incident as opportunity so that similar incidents don’t happen
  - Perform analysis/deep-dive on process (whatever drove this, make sure it doesn’t drive that result again)
  - Arrange for training for other physicians and staff with similar responsibilities (ED provider; specialists on call)
  - Reasonable deadline for 100% completion
  - Document 100% participation (sign-in sheets)
Plans of Correction: More than a checklist (cont’d)

- Examples of Process Changes
  - Deficiency: on-call specialist fails to respond to call
  - Process change: Update by-laws so all physicians who can take call under by-laws must undergo EMTALA training prior to appointment and re-appointment; develop/implement chain of command policy
  - Deficiency: ED physician did not speak directly with transferring physician and refused to accept transfer
  - Process change: update ED policy so that ED physician must always have doctor-to-doctor discussion before refusing to accept a transfer; assign House Supervisor to coordinate communication; review/audit all transfer refusals each week

Plans of Correction: More than a checklist (cont’d)

- What process changes did you make?
  - All plans of correction should include an audit component so that the facility can pro-actively monitor compliance going forward
  - Audit results should be reported to relevant hospital staff, C-suite, and hospital board
  - Common Deficiency: any problems/issues should be actively addressed (how are lessons actually applied/implemented?)
  - Audit results should be memorialized and maintained
HY53  Add to process change something like, develop and implement chain of command process for ED staff to alert Medical Director or Chief of Staff or Chair of specialist's department to get their help in contacting the on-call physician or a back-up.

Hillary Young, 1/17/2014
Plans of Correction: More than a checklist (cont’d)

- Document Itself
  - Each component of POC should have a specific individual assigned to its completion (use their title – not their name)
  - Each component of POC should have a specific date of completion
  - Document as an exhibit that each component is complete (e.g., sign-in sheet for all staff members for EMTALA training)
  - The plan must include the signature and title of the person responsible for implementing the acceptable plan of correction

Violation Occurs – Practical Tips

- Hospital Learns Another Hospital may have committed violation:
  - Limited Duty to Report: if receiving hospital has reason to believe a patient with an unstabilized medical condition was improperly transferred
  - 72 hours
  - Reach out to transferring hospital to learn full facts of case
  - Be sure to prepare – you’ll both get surveyed
Violation Occurs – Practical Tips

- Hospital Discovers it may have committed EMTALA violation
  - Immediately investigate to determine what happened
    - Review should include a general audit of hospital to see if any other issues exist
    - Immediately create and implement plan of correction
  - Organize into binder
  - If surveyed, surveyors may conclude there was violation but has been corrected
  - Usually at least keeps you out of the 23-day territory

CMS - Case Processing

- Enforcement of EMTALA is bifurcated between CMS and OIG
- Initial Investigation by CMS (with State surveyors and QIO)
- After CMS enforcement action, case referred to OIG (for consideration of imposing civil monetary penalties against hospitals and/or responsible physicians and potential exclusion of responsible physician)
OIG - Case Processing

- OIG reviews case to determine whether to pursue CMPs
- OIG Discretion - consider factors in regulations, including:
  - Seriousness of condition of individual
  - Culpability of hospital or doctor
  - Evidence of other instances of noncompliance with EMTALA
  - Financial condition
  - Nature and circumstances of the violation
  - Other matters as justice may require

OIG – Case Processing

- Section 1867(h) of Social Security Act provides for imposition of civil monetary penalties on hospitals and physicians responsible for the following:
  - Negligently failing to appropriately screen an individual seeking medical care;
  - Negligently failing to provide stabilizing treatment to an individual with an emergency medical condition; or
  - Negligently transferring an individual
OIG – Decision to Pursue CMPs

- OIG sends a letter to the hospital and/or physician regarding preliminary decision to pursue CMPs
- Usually give 30 days to respond
- Not a time to “litigate” case before formal administrative proceedings
- Best time to resolve case (before preparing for formal administrative hearing)