AHC Media

October 29, 2015

EMTALA from A to Z

Part 1

1

Your Speaker

Joseph P. McMenamin, MD, JD, FCLM

McMenamin Law Offices, PLLC

joe.mcmenamin@venebio.com

804-921-4856

Joseph P. McMenamin is the Principal at McMenamin Law Offices in Richmond, VA. He assists clients on an array of regulatory and reimbursement issues, licensure, informed consent, contract matters, risk management, and privacy. Previously, Dr. McMenamin practiced emergency medicine at hospitals in Pennsylvania and Georgia.

Dr. McMenamin graduated summa cum laude from Washington and Lee with a BS in chemistry in 1974, with an MD from the School of Medicine at the University of Pennsylvania in 1978, and with a JD from the School of Law at the same institution in 1985. He trained in internal medicine at Emory University and Grady Memorial Hospital in Atlanta from 1978-81.

2

Disclaimers

- The views expressed are my own, and not necessarily those of clients of McMenamin Law Offices or of my consultancy, MDJD, LLC, or of AHC.
- Theories of liability are discussed for educational purposes only and do not reflect a concession that any is valid in general or in a particular case.
- As used here, “MD” is an abbreviation for “physician.”
- No claim of copyright in clip art or in state or federal law.

3

Objectives

- Briefly describe hospital and healthcare provider duties as defined by the Emergency Medical Treatment & Labor Act.
- Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.
- Evaluate compliance requirements and penalties.

 4

Outline

- Historical background
- EMTALA overview
- Screening
- Stabilization
- Transfer
- Public health emergencies
- No delay in examination or treatment
- Enforcement
- Defenses
- Whistle blower protections
- What the investigator will request
- What a hospital with a DED must do

 5

Part 1, 10/29/15

- Historical background
- EMTALA overview
- Screening

 6

No Duty at Common Law

- Private hospitals have no duty to accept or treat patients
  - *Smith v. Richmond Mem'l Hosp.*, 416 S.E.2d 689 (Va. 1992)
- Before MD accepts patient, there is no doctor-patient relationship, so physician has no duty either
  - *Root v. Liberty Emergency Physicians, Inc.*, 68 F. Supp. 2d 1086 (W.D. Mo. 1999), *aff'd*, 209 F.3d 1068 (8th Cir. 2000)
- For refusals, then, no remedy at state law existed
  - *Hoffman v United States* (2009, E.D. Va.) 593 F.Supp. 2d 873
  - ∴ EMTALA "fills a lacuna"
    - *Hardy v. N.Y.C. Health & Hosp. Corp.*, 164 F.3d 789 (2d Cir. 1999)
- EMTALA created a new cause of action
  - *Perry v. Owensboro Health, Inc.*, 2015 U.S. Dist. LEXIS 93688 (W.D. Ky. 2015)

Pre-EMTALA Exceptions

- Common law theories of reliance and abandonment
  - *Brooks v. Md. Gen. Hosp., Inc.*, 996 F.2d 708, 710 (4th Cir. 1993)
- **Reliance**: *Wilmington Gen'l Hosp. v. Manlove*, 3 Del. 338, (1961), *aff'd* 54 Del. 15, 25 (1961)
  - Must prove emergency, custom, and reliance on custom
- **Abandonment**: *Le Juene Rd. Hosp., Inc. v. Watson*, 171 So. 2d 202, 203 (Fla. Dist. Ct. App. 1965)
- Pre-EMTALA **state statutes** (~1/2 of states)
  - Fines, imprisonment (Tex., Ill.); misdemeanor (NYC)
  - Without direct conflict, EMTALA does not preempt

Example: Mass. Statute

- Every patient or resident of a facility [has] the right:
  - (k) to **prompt life saving treatment in an emergency** without discrimination on account of economic status…

...

  - (n) if refused treatment because of economic status or the lack of a source of payment, to **prompt and safe transfer** to a facility which agrees to receive and treat...
    - ALM GL ch. 111, § 70E: 70E

Medicare Prospective Payment System (1983)

- Blows to fee-shifting:
  - Reimbursement turned on diagnosis related groups (DRGs)
    - Capped the upper end for charges
  - Managed care: contracted with providers to reimburse at a certain percentage above Medicare
- Barred:
  - Discounting non-Medicare business
  - Discounting patient portion of Medicare fees without corresponding discount on government's share
    - 42 CFR 1001.701(a)(1)
  - Amended: greater leeway in providing discounts to the poor

 10

EMTALA Enactment (1986): Rationale

- So "individuals," "regardless of…**ability to pay**, receive adequate emergency medical **care**."
  - *Bryant v. Adventist Health Sys./W.,* 289 F.3d 1162, 1165 (9th Cir. 2002) (quoting *Jackson v. E. Bay Hosp.*, 246 F.3d 1248, 1254 (9th Cir. 2001))
    - EMTALA protects all, not just the poor
      - *Mazurkiewicz v. Doylestown Hosp.*, 305 F. Supp. 2d 437 (E.D. Pa. 2004)
  - **Anti-"dumping"**: "either refusing to provide emergency medical treatment or transferring patients before their conditions were stabilized."
    - *Id.*, *quoting Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1255 (9th Cir. 1995). *Leimbach v. Haw. Pac. Health*, 2015 U.S. Dist. LEXIS 95397 (D. Haw. 2015)

 11

Outline

- Historical background
- EMTALA overview
- Screening
- Stabilization
- Transfer
- Public health emergencies
- No delay in examination or treatment
- Enforcement
- Defenses
- Whistle blower protections
- What the investigator will request
- What a hospital with a DED must do

 12

Part 1

- Historical background
- EMTALA overview
- Screening

EMTALA's Reach

- All hospitals having a 1.) Medicare contract and 2.) an ED
  - 42 U.S.C. § 1395dd(e)(2); § 1395cc(a); 42 C.F.R. § 489.24
  - ED: means "a hospital that offers services for emergency medical conditions . . . within its capability to do so."
    - 42 C.F.R. § 489.24(b)
    - Since enactment, some hospitals have closed or downsized EDs
- **Individual** need not be a beneficiary or Medicare eligible
  - 42 USC § 1395dd(a), (e)(2)
- Not covered: Hospitals that do not accept Medicare funds
  - Some Veterans Administration hospitals
  - U.S. Public Health Service-run Indian reservation hospitals
  - A few private (generally psychiatric) hospitals

EMTALA Under Obamacare

- "[N]othing in this Act shall be construed to relieve any health care provider from providing emergency services as required by … law, including … EMTALA."
  - Patient Protection and Affordable Care Act, 42 U.S.C. § 18023(d)

EMTALA Duties, in Brief

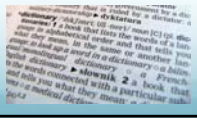
- To provide "an appropriate medical screening examination."
  - 42 U.S.C. § 1395dd(a)
- To "stabilize" any emergency medical conditions detected by the medical staff before transferring or discharging the patient. Id. § 1395dd(b)."
  - *Leimbach v. Haw. Pac. Health*, 2015 U.S. Dist. LEXIS 95397 (D. Haw. 2015)

EMTALA Duties, Expanded

- 1. Appropriate **MSE** to anyone who comes to ED
- 2. **Stabilize** individual with an EMC or in labor
- 3. Appropriately **transfer** individual if either she so requests or hospital lacks capability to stabilize (or to admit)
- 4. **Don't delay** exam and/or treatment to inquire about insurance or payment status
- 5. If pt refuses, get written **informed refusal** of exam, treatment (or try) or an appropriate transfer
- 6. Take **no adverse action** against MD or qualified medical personnel who refuse to transfer an individual with EMC, or against an employee who reports a violation
  - State Operations Manual, Appendix V – Interpretive Guidelines

Definitions: Dedicated Emergency Department ("DED")

- **Dedicated ED**: specially equipped and staffed area of the hospital…used a significant portion of the time for the initial evaluation and treatment of outpatients for EMCs, as defined in 42 CFR §489.24(b), and located either:
  - (1) on the main hospital campus; or
  - (2) off the main campus and treated by Medicare under §413.65(b) [Provider-based determinations] as a department



DED: Operational Definition

- Any department or facility of the hospital that either
  - (1) Is **licensed** by the state as an ED; or
  - (2) Is **held out** to the public as providing treatment for EMCs; or
  - (3) On **1/3** of the visits to the department in the preceding calendar year actually provided **treatment for EMCs** on an urgent basis **without** requiring an **appointment**
    - Based on a representative sample
      - CMS, Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 (174) FR 53222-53264 (2003) ("**Clarifying Policies**"); State Operations Manual, Appendix V – Interpretive Guidelines
  - Probable: L&D, psych departments, urgent care centers

DED: Counted in the Estimate

- Patients who suffer an unexpected EMC after they arrive for an outpatient visit but before they begin an outpatient encounter and
- Patients whose appearance or behavior would cause a prudent lay observer to believe they need exam or treatment for an EMC
  - Clarifying Policies

Definitions: EMC

- **Emergency medical condition**:
- **(A)** 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—
  - **(i)** placing the **health** of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in **serious jeopardy**, or
  - **(ii)** serious impairment to **bodily functions**, or
  - **(iii)** serious **dysfunction of any bodily organ or part**; or
- **(B)** with respect to a **pregnant** woman who is having **contractions**—
  - **(i)** that there is **inadequate time** to effect a safe **transfe**r to another hospital before delivery, or
  - **(ii)** that **transfer** may pose a threat to the **health or safety** of the woman or the unborn child

"Hospital": An Institution that

- (1) Is primarily engaged in providing, by or under [physician] supervision, to inpatients
  - (A) diagnostic…and therapeutic services for…diagnosis, treatment, and care…or
  - (B) …services for the rehab of: injured, disabled, or sick persons;
- (2) Maintains clinical records on all patients;
- (3) Has [medical staff] bylaws;
- (4) [Requires] that every patient with respect to whom payment may be made…must be under [a doctor's]…care…;
- (5) Provides 24-hour nursing service rendered or supervised by a[n RN], and has a[n LPN or [RN] on duty at all times ...;

Hospital, 2: Institution that

- (6) Has in effect a hospital
  - (A) UR plan…and
  - (B) a discharge planning process…;
- (7) [Where applicable]
  - (A) Is licensed pursuant to [state] law or
  - (B) Is approved, by the [licensing] agency of such State or localities meeting the [licensing] standards…
- (8) Has in effect an overall plan and budget…
- (9) Meets such other requirements as the Secretary finds necessary….
  - 42 U.S.C. § 1395x(e); *Rivera v Medical & Geriatric Admin. Servs*., 254 F. Supp. 2d 237, 240, 241 (D. P. R. 2003)
- "Hospital" includes critical access hospitals
  - State Operations Manual, Appendix V – Interpretive Guidelines

Not "a Hospital," so EMTALA N/A

- An outpatient surgery center with ER
  - *Rodriguez-Perez v Caribbean Med. Ctr. Pueblo Int'l, Inc.,* 380 F. Supp. 2d 19 (D. Puerto Rico 2005)
- PR's *Centros de Diagnostico y Tratamiento*: 24 hour ER services, but in Puerto Rico a diagnostic and treatment center is not a "hospital"
  - *Rodriguez v Am. Int'l Ins. Co*., 402 F3d 45 (1st Cir. 2005)

Not "a Hospital," so EMTALA N/A, 2

- Diagnostic and Treatment Center that
  - (1) Did not provide services to inpatients
  - (2) Did not provide required 24-hour nursing service
    - 42 USCS § 1395x(e)
  - (3) Was a diagnostic and treatment center, which Puerto Rican law distinguishes from hospitals
  - (4) Was not licensed by Puerto Rico as hospital
    - SO: Center could not, and did not, have "hospital ED" as required and described in 42 USCS § 1395dd(a)
      - *Rivera v Medical & Geriatric Admin. Servs.*, 254 F. Supp. 2d 237 (D. P. R. 2003)(refusal to care for uninsured patient)

Definitions: "Hospital with an ED"

- "Hospital with an ED": term of art from section 1867 of the [Social Security] Act [EMTALA] separately included in the definitions under 42 CFR §489.24(b) ["Special responsibilities of Medicare hospitals in emergency cases"] to mean generally "a **hospital** that **offers services for emergency medical conditions**."
  - Clarifying Policies
- Simpler: a hospital with a DED
  - State Operations Manual, Appendix V – Interpretive Guidelines

Definitions: "Hospital Property"

- Hospital property: "the entire main hospital **campus** as defined at §413.65(b) [Requirements for a Determination that a Facility or an Organization has Provider-based Status] of this chapter, including the **parking lot, sidewalk**, and **driveway**, but **excluding** other areas or structures of the hospital's main building that are not part of the hospital, such as **physician offices, RHCs, SNFs**, or other entities that participate separately in Medicare, or restaurants, shops, or other nonmedical facilities."
  - Clarifying Policies

Definitions: "Inpatient"

- Individual admitted for bed occupancy for inpatient care, with the **expectation** he will remain **at least overnight** and **occupy a bed** even if the situation changes and he can be discharged or transferred without occupying a bed
  - 42 CFR 489.24; see, 42 CFR 409.10(a)

 28

Definitions: "Patient"

- Patient:
  - (1) An individual who has begun to **receive outpatient services** as part of an encounter, as defined in §410.2, other than an encounter that EMTALA obliges the hospital to provide or
  - (2) An individual **admitted** as an inpatient
    - 42 CFR 489.24; Clarifying Policies

 29

Definitions: Qualified Medical Person ("QMP")

- An individual determined by the hospital bylaws or rules and regs to be qualified and practicing within the scope of licensure
  - Obstetric triage unit: might include CNMs, NPs, and RNs with requisite competencies
- During regular operating hours, **off-campus departments** must have **at least one designated QMP**
  - 42 CFR 489.24(i)(2)(i)
- CMS reserves the right to **override hospital's choice** of QMP
  - *Williamson v. Roth*, 120 F. Supp. 2d 1327 (M.D. Fla. 2000)(where hospital's own policy required MD to examine patient in labor before discharge, mother of IUFD infant could sue hospital whose nurse, at doctor's direction, discharged abruptio case)

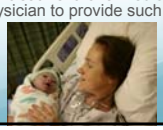
 30

Definitions: Stabilize

- **Stabilize**: "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that **no material deterioration** of the condition is likely to result from or occur during the transfer of the individual"
- **Labor**: ends with delivery of **child** and **placenta**
  - 42 U.S.C. 1395dd(e)(4)(B)); 42 C.F.R. 489.24(b)

Stabilize: OB

- A woman experiencing **contractions** is in **true labor** unless a physician, CNM, or other QMP, acting within his scope of practice under State law and hospital bylaws, **certifies** that, after a reasonable time of observation, the woman is in **false labor**.
  - 42 CFR 489.24(b); 73 (161) Fed. Reg. 48655 (8/19/08)
- Labor includes contractions associated with IUFD
  - *Morin v. E. Me. Med. Ctr.*, 779 F. Supp. 2d 166 (D. Me. 2011).
- An infant born alive is a "person" and an "individual"
  - 1 U.S.C. 8(a)
- If an **infant is born alive in a DED**, and a **request** is made on that infant's behalf for **screening** for a medical condition (or if a prudent layperson would conclude, based on the infant's appearance or behavior, that the infant needs examination or treatment for a medical condition), EMTALA requires hospital and physician to provide such a MSE
  - Interpretive Guidelines §489.24(a)(1)(i)



Undefined Under EMTALA:

- "Appropriate medical screening"
- "Comes to the Emergency Department"
- "Individual"
- "Direct result"
- "Medical condition"
- "Personal harm"
- "Report"

Outline

- Historical background
- EMTALA overview
- Screening
- Stabilization
- Transfer
- Public health emergencies
- No delay in examination or treatment
- Enforcement
- Defenses
- Whistle blower protections
- What the investigator will request
- What a hospital with a DED must do

 34

Part 1

- Historical background
- EMTALA overview
- Screening

 35

Medical Screening Examination ("MSE")

- In the case of a hospital that has a hospital ED, if any individual (whether or not eligible for benefits under this subchapter) **comes to** the ED and a **request** is made on the individual's behalf **for exam or treatment** for a **medical condition**, the hospital must provide for an **appropriate MSE within the capability of the hospital's ED**, including ancillary services routinely available to the ED, **to determine whether** or not an **EMC**…exists.

 36

Screening Exam Details

- Non-disparate treatment
  - "Commensurate with the condition that is presented"
- Screening obligation is implicated in one of two ways:
  - (1) Individual can present at the hospital's **DED** and request examination or treatment for a **medical condition**;"
    - *Cruz-Vázquez v. Mennonite Gen. Hosp., Inc.*, 717 F.3d 63, 2013 U.S. App. LEXIS 10790, 2013 WL 2322016 (1st Cir. P.R. 2013)

OR

  - (2) "the individual can present **elsewhere on hospital property** (that is, at a location that is on hospital property but is not part of a DED), and request examination or treatment for an **emergency** medical condition."
- EMTALA obligations end once individual is **admitted**
  - 42 CFR §§413, 482, 489.24

 37

Covered and Not

- Presentations to a DED that meet other EMTALA applicability criteria are subject to EMTALA if there is a **request** by or on behalf of the individual for exam or tx for a medical condition, **or** the **appearance or behavior** of the individual would cause a **prudent lay observer** [next slide] to believe that the individual needed such exam or treatment and that she would so request were she able to do so
  - Rely on the **prudent layperson** standard only where the individual is **unable** to request exam or treatment herself
- **Pharmaceutical services** in DED: may be for medical conditions, so are subject to EMTALA
  - Clarifying Policies

 38

Prudent Layperson

- Standard applies to presentations both inside and outside DED
  - Inside: prudent lay observer would believe, based on the individual's appearance or behavior, that MSE is needed
  - Outside: prudent layperson would believe the individual needs examination or treatment for an **emergency medical condition** (emphasis in original)
    - Clarifying Policies

 39

Covered and **Not**

- Presents to dedicated ED but requests services that are **not exam or tx** for a medical condition
  - Preventive care, e.g.
  - Police requests (blood alcohol level without evidence of trauma, e.g.)

Triage is Not Enough

- Triage is **not equivalent** to a MSE
  - Merely determines the "order" in which patients will be seen, not presence or absence of EMC
  - If MSE is appropriate and does not reveal an EMC, the hospital has no further obligation under §489.24
    - Clarifying Policies

Triage is Not Enough

- Hospital screening policies relevant; triage policies not
  - *Stiles v. Tenet Hosps. Ltd*., 494 Fed. Appx. 432, 2012 U.S. App. LEXIS 20894, 2012 WL 4762212 (5th Cir. Tex. 2012)(severe headache following surgery for subdural hematoma)

Locus of the MSE

- DED to which individual presents need not necessarily be the one to do EMTALA screening and stabilization
  - Example: man with a medical condition seeking treatment in the OB/GYN department rather than in ED
    - Hospital may have an EMTALA obligation
    - Hospital may transport the man to its general ED for screening and, if medically indicated, stabilization
      - Clarifying Policies

 43

Non-Doctor May Screen

- Non-physician ED staff may screen
- If no EMC, may refer individual to her physician's office for further treatment
- Any non-physician (ER RN, e.g.) who performs such screening should be a designated "qualified medical person" for purposes of appropriate transfer certification
  - §489.24(e)(1)(ii)(c); Clarifying Policies

 44

VS May Not be Required

- ED's P&P, or QMP, or both may require taking VS
  - VS: Indicate level of wellness; valuable parameters to assist HCPs to make medical decisions re: patient's health needs
    - Patient's medical condition and practitioner's discretion determine need for VS monitoring
- But taking VS **not required** for every presentation to DED
  - Where EMC unlikely, individual's statement that she is not seeking emergency care, plus brief questioning by QMP, generally suffices to establish: no EMC
    - Hospital's EMTALA obligation thereby satisfied
      - Clarifying Policies

 45

EMTALA N/A Outpatients

- EMTALA N/A any individual who, **before** she presents to the hospital for examination or treatment for an **EMC**, has begun to receive outpatient services as part of an encounter, as defined in 42 CFR 410.2, other than an encounter that EMTALA obligates hospital to provide
  - Clarifying Policies
- **Encounter**: a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or CAH staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient.
  - 42 CFR 410.2

EMTALA N/A Outpatients, 2

- *Torretti v. Main Line Hosps*., Inc., 580 F.3d 168 (3d Cir. 2009), *amended by* 586 F.3d 1011 (3d Cir. 2009)(an "individual" "comes to the ED" only if she is not already a "patient." 42 C.F.R. § 489.24(b). EMTALA N/A expectant mother without recognized EMC who came to hospital for pre-natal appointment)
- Nor to inpatients transferred for **hospice** care
  - *Smith v. Albert Einstein Med. Ctr*., 378 Fed. Appx. 154 (3d Cir. Pa. 2010)

Kids

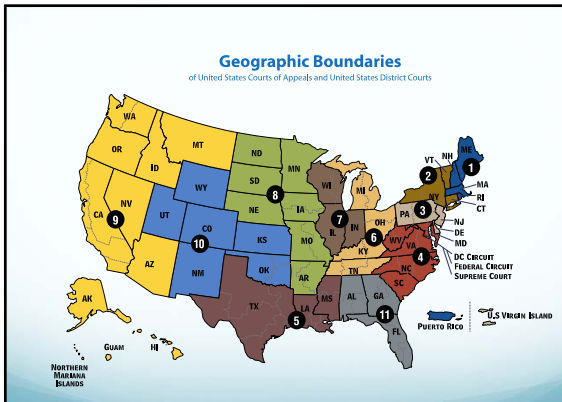
- A minor (child) can request an exam or treatment for an EMC
  - Hospital must conduct the exam if requested by an individual or on the individual's behalf to determine if an EMC exists
  - Do not delay MSE to await parental consent
- If screening the minor determines than no EMC is present, staff can wait for parental consent before proceeding with further examination and treatment
  - Interpretive Guidelines §489.24(a)(1)(i)

Judging the Screening Exam

- "Appropriate": what have been provided to **paying patient**
  - *Romine v. St. Joseph Health Sys.*, 541 Fed. Appx. 614, 2013 U.S. App. LEXIS 21926, 2013 FED App. 0917N (6th Cir.)
  - Disparate treatment necessary
    - *Lugo v. Hosp. Matilde Brenes Inc.*, 2014 U.S. Dist. LEXIS 175811 (D.P.R. Nov. 7, 2014)(transfer after failure to detect ruptured uterus and IUFD in patient with sudden onset abdominal and pelvic pain)
  - But may not suffice
    - *Moore v. Grand View Hosp.*, 2014 U.S. Dist. LEXIS 164875 (E.D. Pa. 2014)(that a "typical" pre-eclamptic gets a biophysical profile was not sufficient to show departure from protocol in patient who didn't)

Judging the Screening Exam, 2

- Need but perform MSE "**within the capability**" of own ED
  - No comparison with other hospitals
- "Depending on the individual's presenting signs and symptoms," an appropriate screening "can involve a wide **spectrum** of actions, ranging from a simple process involving only a **brief** history and physical examination to a **complex** process that also involves performing ancillary studies and procedures."
- "Ancillary studies and procedures" could include
  - Lumbar punctures
  - Clinical laboratory tests
  - CT scans
    - CMS State Operations Manual 36-37



MSE Majority View: Circuits 6, 8, 10, 11, & DC

- Hospital must screen, examine, and treat its patients in a **non-disparate manner** within that hospital's capabilities
  - *Cleland v. Bronson Health Care Group, Inc*., 917 F.2d 266, 271 (6th Cir. 1990)
  - Test: whether screening procedure
    - "is designed to identify an 'EMC' manifested by 'acute' and 'severe' symptoms"
    - **Not** "was adequate as judged by the medical profession."
      - *Eberhardt v. City of LA*, 62 F.3d 1253, 1258 (9th Cir. 1995)(alleged failure to identify patient's suicide risk)
- Courts look to legislative intent and to EMTALA's plain language in determining a subjective standard for an "appropriate medical screening examination"
  - *Cleland* at 268

Summary of Actionable MSE Claims (8th Cir.)

- (1) Dumping a patient
- (2) Improper discriminatory screening of patients
- (3) Failure to screen patients at all; and
- (4) Screening patients differently from others perceived to have identical conditions
  - *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1139 (8th Cir. 1996) (*en banc*)(negligent failure to obtain CXR on trauma patient was not a failure to screen, even though "Baptist agrees that patients complaining of pain in the front of their chest (*sic*), or of snapping or popping noises when breathing, would normally be given a chest x-ray.")
    - How is 2 different from 4?

MSE: Minority View Circuits 1, 9

- "A hospital fulfills its statutory duty to screen patients in its emergency room if it provides for a screening examination **reasonably calculated to identify critical medical conditions** that may be afflicting symptomatic patients **and** provides that level of screening **uniformly** to all those who present substantially similar complaints."
  - *Correa v. Hospital San Francisco*, 69 F.3d 1184, 1192 (1st Cir. 1995)(**delay tantamount to failure to screen** chest pain patient)
  - *But see*, *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1257 (9th Cir. 1995)(**MSE of heroin OD was adequate** even though it failed to detect patient's likely suicide: pt promised to get f/u and did not suicide for 30 h. "EMTALA does not require physicians to detect medical conditions that are *not* manifested by acute and severe symptoms, nor those that do not require immediate medical attention to prevent serious bodily injury.")

MSE: Minority View Circuits 1, 9

- A hospital meets its obligation to provide an "appropriate medical screening" if it:
  - "Provides a patient with an examination **comparable to the one offered to other patients presenting similar symptoms**, unless the examination is so **cursory** that it is "not designed to identify acute and severe symptoms that alert the physician of the need for immediate medical attention to prevent serious bodily injury."
    - *Baker v. Adventist Health, Inc.*, 260 F.3d 987, 995 (9th Cir. 2001); *see also Jackson v. East Bay Hosp.*, 246 F.3d 1248, 1256 (9th Cir. 2001); *Eberhardt*, 62 F.3d at 1257-59. *Leimbach v. Haw. Pac. Health*, 2015 U.S. Dist. LEXIS 95397

 55

Eberhardt v. City of Los Angeles (9th Cir. 1995)

- "…Congress's refusal to impose a national standard of care does not mean that a hospital can discharge its duty under the EMTALA by not providing **any** screening, or by providing screening at such a **minimal** level that it properly cannot be said that the screening is "appropriate." *See Baber*, 977 F.2d at 879 n.7 (hospital's standard may be so low 'that it amounts to no 'appropriate medical screening'). The touchstone is whether, as § 1395dd(a) dictates, the procedure is **designed to identify** an "emergency medical condition," that is manifested by "acute" and "severe" symptoms"
  - 62 F.3d at 1258 (**dicta**)

 56

Eberhardt's Progeny

- "A hospital fulfills its…duty to screen…if it provides for a screening exam **reasonably calculated** to identify critical medical conditions that may be afflicting symptomatic patients and provides that level of screening **uniformly** to all those who present substantially similar complaints." *Id.; see also Jackson v. East Bay Hosp*., 246 F.3d 1248, 1256 (9th Cir. 2001) ("[A] hospital satisfies EMTALA…if it provides a patient with an exam **comparable** to the one offered to other patients presenting similar symptoms, **unless** the exam is so **cursory** that it is not 'designed to identify acute and severe symptoms that alert the physician of the need for immediate medical attention to prevent serious bodily injury.'" (quoting *Eberhardt*)).
  - *Del Carmen Guadalupe v. Negron Agosto*, 299 F.3d 15, (1st Cir. P.R. **2002**)(Despite pt's death, MSE for pneumonia was appropriate b/c procedures were "were reasonably calculated to identify the pt's critical medical condition;" no evidence that hospital had **ability** to provide the O_2 sats and radiologist's reading of CXR that P's expert called for)(DICTA)

 57

Eberhardt's Progeny, 2

- "[A] reasonable jury could conclude that the screen performed was so **cursory** that it was not designed to identify acute and severe symptoms and thus did not meet the requirements…In its brief, Schneck barely argues [ERP] Reisert's screen was more than cursory. Schneck argues only that Reisert did something and found Lewellen had a normal neurological exam. Defendants claim: "Based upon his examination, Dr. Reisert brought to bear on the case his medical judgment and concluded Mr. Lewellen could be safely discharged."
  - *Lewellen v. Schneck Med. Ctr.*, 2007 U.S. Dist. LEXIS 60358 (S.D. Ind. 2007)(evaluation for less than one hour of drunk (nurse anesthetist) MVA patient complaining of LBP, and **failure to examine lumbar and cervical films before discharge**, failed to satisfy screening duty)

Eberhardt's Progeny, 3

- "[A] showing of uniformity may not be sufficient to fulfill a hospital's duties under the screening provisions…if the screening that the plaintiff received is so **delayed** or **paltry** as to amount to **no screening at all**…[A]n egregious and unjustified **delay** in attending a patient can amount to an effective **denial** of a screening examination . . . [T]he Court can find that no screening at all was provided to the patient."
  - *Marrero v. Hospital Hermanos Melendez*, 253 F. Supp. 2d 179, 194 (D.P.R. 2003) (internal citations omitted)
  - *See also, Byrne v. Cleveland Clinic*, 684 F. Supp. 2d 641 (E.D. Pa. 2010) (alleging delay of **2 hours** or more in evaluation of **CP** patient sufficed to state screening claim)

Successful Screening Claim, First Circuit

- Where patient presented evidence that both of her treating physicians were aware of and had identified her symptoms of vaginal bleeding during her 3d trimester yet failed to perform tests called for by hospital's "Gravid with 3rd Trimester Bleeding" protocol, trial court erred in awarding summary judgment to hospital
  - *Cruz-Vazquez v. Mennonite Gen. Hosp., Inc.*, 717 F3d 63 (1st Cir 2013)

Screening Claims: What P Must Prove

- [1] that the screening examination he received . . . was **inferior** to the procedures used for similarly situated patients, or [in Circuits **1, 9**:]
- [2] that the procedure was **not designed** to identify acute and severe symptoms that alert the physician to the need for immediate medical attention.
  - *Hands v. Sonoma Valley Hosp.*, 1999 U.S. Dist. LEXIS 15316 (N.D. Cal. 1999)(med mal + EMTALA); *Eberhardt*, 62 F.3d at 1258; *Leimbach v. Haw. Pac. Health*, 2015 U.S. Dist. LEXIS 95397 (D. Haw. 2015)
- A "failure to screen" claim is, in effect, a strict liability claim: **motive need not be shown**
  - *Stevison v. Enid Health Sys's,* 920 F.2d 710, 713 (10th Cir. 1990)(But see, discussion below)

MSE: No Liability

- Unconscious plaintiff's supervisor instructed defendant hospital's ambulance driver to take patient to a different hospital
  - No request to D hospital for treatment or exam
    - *Hernandez v. Starr County Hosp. Dist*. 30 F. Supp.2d 970, 972 (S.D. Tex. 1999)
- Patient may withdraw her request for treatment, but hospital has burden of proving she did so
  - *Stevison v. Enid Health Sys*., 920 F.2d 710, 713-14 (10th Cir. 1990) (Appellate court rev'd D's successful MSJ because trial court shifted burden of proof to P on question whether P had requested tx)

Med Mal ≠ EMTALA Failure to Screen

- Misdiagnosis does not establish a claim
  - *Money v. Health*, 2012 U.S. Dist. LEXIS 49922 (D. Nev. 2012) (fatal cardiac arrest 2° MI; patient admitted after two doctors and one nurse examined)
- EMTALA establishes liability for **failure to treat;** does not duplicate preexisting legal protections
  - *Leimbach v. Haw. Pac. Health*, 2015 U.S. Dist. LEXIS 95397 (D. Haw. 2015) (necrotizing fasciitis in patient s/p cut, mosquito bites)
  - **Med mal claims remain available**
    - *Bryant*, 289 F.3d at 1168-69
- EMTALA is not to improve standard of care, but so hospitals do not refuse essential emergency care because of patient's inability to pay
  - *Eberhardt*, 62 F.3d at 1258 (citing H.R. Rep. No. 241, 99th Cong., 1st Sess. (1986))
  - No national standard of care
    - *Bryant*, 289 F.3d at 1166 (citing *Baker v. Adventist Health, Inc.*, 260 F.3d 987, 993 (9th Cir. 2001))

Failure to Diagnose is for State Tort Law

- Spinal cord contusion mistaken for muscle spasm
  - *Johnson v. Bishof*, 2015 Ill. App. (1st) 131122, 33 N.E.3d 624, 392 Ill. Dec. 823 (Ill. App. Ct. 1st Dist. 2015)("…that, in retrospect, the examinations might have been incomplete or resulted in a misdiagnosis does not determine whether a medical screening examination satisfies EMTALA.")
- Missing alleged aspirin overdose
  - *Jones v. Sunrise MountainView Hosp.*, 2015 U.S. Dist. LEXIS 67183 (D. Nev. 2015)
- Missing likely suicide
  - *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1255 (9th Cir. 1995)(suicidal tendencies not shown to be "acute" or "severe")

EMTALA: Not for Mere Misdiagnosis

- "EMTALA is implicated only when individuals who are **perceived** to have the **same medical condition** receive **disparate** treatment; it is not implicated whenever individuals who turn out in fact to have had the same condition receive disparate treatment…As a result, when an exercise in medical judgment produces a given diagnosis, the decision to prescribe a treatment responding to the diagnosis cannot form the basis of an EMTALA claim of inappropriate screening."
  - *Vickers v. Nash Gen' l Hosp.*, 78 F.3d 139 (4th Cir. 1996), cited with approval in *Summers v. Baptist Medical Center Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996), *Sykora v. Douglas County*, 2009 U.S. Dist. LEXIS 110440 (D. Neb. 2009) at 9-11

Need Stabilize only Those with a **Detected** EMC

- *Macamaux v. Day Kimball Hosp.*, 2011 U.S. Dist. LEXIS 105449 (D. Conn. 2011)
- *Torretti v. Paoli Mem. Hosp.*, 2008 U.S. Dist. LEXIS 6263 (ED Pa 2008)
- *Lopes v. Kapiolani Med. Ctr.*, 410 F. Supp. 2d 939, (D. Haw. 2005)
- *St. Joseph Healthcare, Inc. v. Thomas*, 2013 Ky. App. Unpub. LEXIS 1011 (2013)

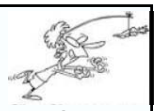
Hospital's Capability

- Hospital must provide a screening "within [its] capabilities"
  - 42 U.S.C. § 1395dd(a)
  - Varies with hospital
    - *Phillips v Hillcrest Med. Ctr.*, 244 F.3d 790 (10th Cir. 2001, *cert den* 535 U.S. 905 (2002), *reh den* 535 US 1043 (2002)
- Hospital must treat individual within the capabilities of hospital **as a whole**, not necessarily in terms of the particular department at which the individual presented
  - Clarifying Policies
- "[P]recludes resort to a malpractice or other objective standard of care as the meaning of the term 'appropriate.'" (quoting § 1395dd(a))
  - *Cleland*, 917 F.2d at 272

Hospital's Capability, 2

- When MRI machine is down, using it is not within hospital's capability
  - *Leimbach v. Haw. Pac. Health*, 2015 U.S. Dist. LEXIS 95397 (D. Haw. 2015)
- Where screening was beyond hospital's capabilities, EMTALA permitted calling in county mental health department crisis worker to screen patient for psychiatric emergency
  - *Baker v Adventist Health, Inc.*, 260 F3d 987 (9th Cir. 2001)

Motive and the 6th Cir.: Screening Claims



- "[T]he terms of the statute, specifically referring to a MSE by a hospital 'within its capabilities' precludes resort to a malpractice or other objective standard of care as the meaning of the term 'appropriate.' Instead, 'appropriate' must more correctly be interpreted to refer to the **motives** with which the hospital acts. If it acts in the same manner as it would have for the usual **paying patient**, then the screening provided is 'appropriate' within the meaning of the statute."
  - *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 272 (6th Cir. 1990)
  - *Perry v. Owensboro Health, Inc.*, 2015 U.S. Dist. LEXIS 93688 (W.D. Ky. July 16, 2015)(SJ/Ds for no showing of disparate treatment nor any showing of improper motive)

Cleland's Two-Part Test of Screening

- 1.Did hospital "act[] in the **same manner** as it would have for the usual paying patient"?
  - If so, screening was appropriate; court ignores part 2
    - *Cleland*, 917 F.2d 266, 272 (6th Cir. 1990)
- 2. If the hospital provides a **disparate** screening, then did it do so **because of** the patient's sex, race, ethnic group, occupation, politics, personal prejudice, condition (e.g., drunkenness, AIDS), inability to pay, etc.
  - Id.

 70

Screenings: Motive and the 6th Cir.

- An EMTALA screening plaintiff must "adduce some evidence that her screening differed in some way from that given to other patients, and the difference was **improperly motivated**."
  - *Romine v. St. Joseph Health Sys*., 541 F. App'x 614, 620 (6th Cir. 2013)
  - *Perry v. Owensboro Health, Inc*., 2015 U.S. Dist. LEXIS 93688 (W.D. Ky. 20I5)
  - *Estate of Lacko v. Mercy Hosp., Cadillac*, No. 11-12361, 2011 WL 5301775, at 4 (E.D. Mich. Nov. 3, 2011)
  - *Broughton v. St. John Health Sys*., 246 F. Supp. 2d 764 (E.D. Mich. 2003)

 71

Motivation **Outside** 6th Cir.

- Ps did "not allege that their financial condition or lack of health insurance contributed to [ERP's] decision not to treat their son."
  - *Nichols v. Estabrook*, 741 F. Supp. 325 (D.N.H. 1989)(defendants' motion to dismiss granted; parents failed to assert hospital transferred infant for **economic reasons**)
- Failure to do 12-lead EKG on CP pt w/o a showing of economic motivation: summary judgment for defense
  - *Evitt v. University Heights Hospital*, 727 F. Supp. 495 (S.D. Ind. 1989)(7th Cir.)
  - Accord, *Stewart v. Myrick*, 731 F. Supp. 433, 436 (D. Kan. 1990)(10th Cir.)

 72

No Need to Show Improper Motive

- ER discharged patient diagnosed two days later with meningitis. D's MSJ denied. Act "nowhere mentions either indigency, an inability to pay, or the hospital's motive as a prerequisite to statutory coverage," so Act is not limited to instances of patient dumping despite legislative history
  - *Deberry v. Sherman Hospital Ass'n*, 741 F. Supp. 1302 (N.D. Ill. 1990)
  - *Accord, Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1138 (8th Cir. 1996)
  - *Correa v. Hosp. S.F.*, 69 F.3d 1184, 1193-94 (1st Cir. 1995)

No Need to Show Improper Motive, 2

- *Power v Arlington Hosp. Ass'n*, 42 F.3d 851 (4th Cir. 1994)(P need not prove an improper motive for the hospital's treatment or discharge decision)
  - *See also*, *Vickers v. Nash General Hospital, Inc.*, 78 F.3d 139 (4th Cir. 1996)(that MD did not test head laceration case for intracranial injury does not show violation, as MD failed to detect EMC)
- *Phillips v. Hillcrest Med. Ctr.*, 244 F.3d 790 (10th Cir. 2001), *cert den* 535 US 905 (2002)
- *Brodersen v. Sioux Valley Mem'l Hosp.*, 902 F. Supp. 931, 947 (N.D. Iowa 1995)
- *Byrne v. Cleveland Clinic*, 684 F. Supp. 2d 641 (E.D. Pa. 2010)

Roberts v. Galen of Virginia, Inc., 525 U.S. 249 (1999)

- Did *Roberts* overrule *Cleland*?
- *Roberts* addressed "stabilization," § 1395dd**(b)**, **not** screening, § 1395dd**(a)**
  - To recover under § 1395dd(b)(1)(A), P need not allege that improper motive caused hospital's failure to stabilize: "Unlike the provision of EMTALA at issue in *Cleland*, § 1395dd(a), the provision at issue in this case, § 1395dd(b), contains no requirement of appropriateness").
    - Footnote: 6th Circuit's § 1395dd(a) requirement of "improper motive" is in the minority
  - But: "the correctness of the *Cleland* court's reading of § 1395dd(a)'s 'appropriate medical screening' requirement is not before us, and we express no opinion on it here." 253
    - *Owensboro Health, Inc.*, 2015 U.S. Dist. LEXIS 93688 (W.D. Ky. 2015)

"**Comes to** the ED": 42 U.S.C. 1395dd(a)

- "In the case of a hospital that has a hospital ED, if any individual (whether or not eligible for benefits under this subchapter) **comes to** the ED and a request is made on the individual's behalf for examination or treatment…the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department…
- Competing interpretations:
  - (1) Literal interpretation: physical presence in ER mandatory v.
  - (2) Mere physical presence on hospital property generally is enough

 76

"Comes To": Literal Interpretation

- Person must actually present himself **at ED**
  - *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 884 (4th Cir. 1992) (rejecting P's claim that requested treatment anywhere in hospital is EMTALA-protected; EMTALA N/A to patient transferred not to ED but directly **to psychiatric ward**)
  - Accord, *McIntyre v. Schick*, 795 F. Supp. 777, 780 (E.D. Va. 1992)(OB case); *James v. Sunrise Hosp.*, 86 F.3d 885 (9th Cir. 1996)(N/A **inpatient** whose AV shunt for hemodialysis clotted)
- Phone request insufficient
  - *Miller v. Med. Ctr. of Southwest La.*, 22 F.3d 626 (5th Cir. 1994)(Doctor calls local hospital requesting admission for child injured in MVA. Boy lacked insurance, so hospital declined. EMTALA N/A because boy never physically **came to** the hospital; his doctor's phone request did not satisfy the "comes to" requirement)

 77

Literally "Coming to" ED May Not be Enough

- PCP sent pt for 2d opinion to MD who happened to work in ED. On entering ED, P stopped to ask directions to admissions. He was refused admission for insurance reasons, and claimed an EMTALA violation. Merely walking through ED while *en route* to another hospital area was not "coming to" the ED
  - *Rios v. Baptist Mem'l Hosp. Sys.*, 935 S.W.2d 799 (Tex. App. 1996)
- Individuals who have **begun to receive** outpatient services during an encounter, or who present to a provider-based, off-campus department that is not a DED with undetected emergency conditions, are **not protected under EMTALA** if they are later found to have an EMC, even if then transported to DED
  - Protected by: Medicare hospital CoPs and relevant State law
    - Clarifying Policies

 78

HHS Interpretation: Comes to the ED

- An individual can "come to the ED"…in one of two ways:
  - The individual can present at a hospital's DED and request examination or treatment for a medical condition; or
  - She can present elsewhere on hospital property (that is, at a location on hospital property but not part of a dedicated ED), and request examination or treatment for an **EMC**
    - Clarifying Policies

Applying the Broader Interpretation

- EMTALA applied to stroke pt transferred immediately from ER to ICU. After 21 days, released because no rehab center would accept her. Condition deteriorated; claimed EMTALA violation. DICTA: "hospitals may not circumvent the requirements of the Act merely by admitting an ER patient to the hospital then immediately discharging that patient."
  - *Thornton v. Southwest Detroit Hospital*, 895 F.2d 1131, 1135 (6th Cir. 1990)
- EMTALA applies where patient was admitted to hospital by his personal MD instead of through ED
  - *Reynolds v. Mercy Hosp*., 861 F. Supp. 214 (W.D.N.Y. 1994)(pre-arranged esophageal dilatation)

Broader Interpretation, 2

- That hospital's alleged failure to screen newborn baby occurred in hospital's **birthing center** instead of ER did not defeat plaintiffs' failure to screen claim; baby born in birthing center has "come to emergency department" for purposes of hospital's duty to provide medical screening examination
  - *Preston v Meriter Hosp., Inc.,* 2005 WI 122, 284 Wis. 2d 264, 700 N.W.2d 158 (2005)

Off-Campus Departments

- If emergency services are provided at the hospital but are not provided at one or more off-campus departments of the hospital, the governing body of the hospital must assure that the medical staff have written **P&P** in effect with respect to the off-campus department(s) for **appraisal of emergencies and referral when appropriate**.
  - 42 CFR §482.12(f)(3); Clarifying Policies

 82

"Comes To" and Communications

- A patient whose only contact with Hospital A is a referral to Hospital B from A's telemetry communications to the ambulance paramedics has not "come to" A's ED
  - *Johnson v. Univ. of Chicago Hosp.*, 982 F.2d 230 (7th Cir. 1992)
- Phone call between MD and hospital ER that refused to accept MD's patient for lack of health insurance does not violate EMTALA; patient never "came to" ER
  - *Miller v. Med. Ctr. of Southwest La.*, 22 F.3d 626 (5th Cir. 1994)
- Ambulance's phone contact with ERP did not trigger EMTALA liability
  - *Arrington v. Wong*, 19 F. Supp. 2d 1151, 1155 (D. Hawaii 1998)

 83

"Comes To" and Communications, 2

- Independently-owned ambulance en route to hospital with infant called hospital telemetry nurse who diverted patient to another hospital farther away. Infant died; mother sued base station hospital under EMTALA
  - No violation. Infant never "came to" the hospital or ED
  - Hospital-operated **telemetry system was distinct from its ER**. Infant never arrived on hospital grounds. Hospital was legally allowed to divert patients if they never reached hospital property
    - *Johnson v. University of Chicago Hospitals*, 982 F.2d 230, 231 (7th Cir. 1993)

 84

"Comes To" and Communications, 3

- ERP's radio communication with ambulance personnel advising them to take patient in respiratory distress to more distant hospital
  - Held: not actionable, as patient did not "come to" emergency room before being discharged or transferred as required by statute
    - *Arrrington v Wong,* 19 F. Supp. 2d 1151 (D. Hawaii 1998), *revd, remanded,* 237 F.3d 1066 (9th Cir. 2001), 2001 CDOS 579, 2001 Daily Journal DAR 765

Communications: *Contra*

- P carrying nonviable ectopic pregnancy developed abdominal pain and vomiting. Ambulance, neither owned nor staffed by the hospital, set out for Hospital 1, where P's OB practiced. Crew called ahead; spoke to director, who on learning P was uninsured "abruptly terminated the call." Believing this to be a denial of care, crew took P to Hospital 2, where she was treated. No claim that Hospital 1 was on diversion
- Court dismissed suit: [P] never "came to" Hospital 1's ED
- Appeal, **reversed**: "…fact finder could conclude that [P] had come to the Hospital's ED within the purview of EMTALA; that a **request** for examination or treatment had been **rendered on her behalf**; and that the request had been rebuffed because of her uninsured status." Policy rationale for EMTALA – Defined "comes to" to mean "on the way"
  - *Morales v. Sociedad Espanola de Auxilio Mutuo y Beneficencia*, 524 F.3d 54, 55 (1st Cir. 2008)

Christopher Sercye's Case and its Aftermath

- Shot in Chicagoland gang violence, May 1998
- Friends brought him within ½ block of ED when pt collapsed
- Friends asked ED for help
- Under hospital policy, staff refused to go
  - Dangerous neighborhood
  - Recommended: call 911; we'll treat on arrival
- Died soon after arrival
- CMS imposed $ 40,000 fine; threatened to revoke Medicare participation unless hospital changed its policy

The 250 Yard Rule

- "'Campus' means the physical area immediately **adjacent** to the provider's main buildings, other **areas and structures** that are not strictly contiguous to the main buildings but are located **within 250 yards** of the main buildings, and any other areas determined on an **individual case basis**, by the HCFA regional office, to be part of the provider's campus."
  - 42 CFR 413.65
  - **Excluded**: physician offices, RHCs, SNFs, or other entities that participate separately in Medicare, or restaurants, shops, or other nonmedical facilities
    - Clarifying Policies

CMS Position: Broad Interpretation

- EMTALA applies to:
  - **Any facility offering emergency services**;
  - "All individuals who attempt to gain access to the hospital for emergency care. An individual may not be denied services simply because [she] failed to enter the facility's designated ED."
    - 59 Fed. Reg. 32101, codified at 42 C.F.R. § 489.24(b)
- **Lack of an established ED is not an indication that emergency services are not provided**. If a hospital offers emergency services for medical, psych or substance abuse emergencies, it must, within its capability and capacity, comply with all EMTALA requirements
  - 42 CFR §§489.20 and 489.24

CMS Position: Broad Interpretation, 2

- Most **psych hospitals** are accredited by the Joint Commission and **have an ED** that provides reasonable care in determining whether an emergency exists, renders life saving first aid, and makes appropriate referrals to the nearest organizations that are capable of providing needed services. The ED must have a mechanism for providing physician coverage at all times.
  - Interpretive Guidelines: §489.24(a)

Regulatory Resolution: 42 C.F.R. 489.24(b)

- Pt "comes to" the hospital if he:
  - Is on hospital property
    - Includes hospital-owned and -operated ambulances, even if not on hospital grounds OR
  - Is in a non-hospital-owned ambulance on hospital property
- "Campus" includes the 250 yards concept in its definition; therefore, by referencing §413.65(b) in the definition of "hospital property" under EMTALA, we are already including the concept of 250 yards.
  - Requirements for a Determination that a Facility or An Organization has Provider-based Status; Clarifying Policies

 91

"Comes To" and Ambulances

- Pt does NOT "come to the hospital" if she is
  - In a non-hospital-owned ambulance off hospital grounds
    - Even if squad member contacts hospital by phone or telemetry and informs hospital that squad wants to transport pt to hospital for exam
      - So hospital may deny access if it is in "diversionary status"
        - If squad disregards instructions and transports her on to hospital property anyway, she has "come to" the ED
      - If the ambulance is owned by the hospital, the diversion of the ambulance is appropriate **only** if the hospital is being diverted pursuant to **community-wide EMS protocols**
        - Interpretive Guidelines §489.24(a)(1)(i)

 92

Ambulances, "Coming To" and Courts

- Ambulance transports gunshot victim to the Emergency Care Center at D.C. General. Before taking patient out of ambulance, nurse directs ambulance to hospital #2. Patient died while undergoing surgery at #2. Held:
  - Once the ambulance arrived on hospital property, patient had "come to" ED
  - Hospital failed to provide MSE in response to request to treat
    - *McLaurin v. District of Columbia*, No. CIV.A. 92-2742-NHJ/DAR, 1993 WL 547193, at 1 (D.D.C. Oct. 21, 1993)
- Subsection (a) applies where patient is in hospital-owned ambulance
  - *Hernandez v. Starr County Hosp. Dist.*, 30 F. Supp.2d 970, 972 (S.D. Tex. 1999)
  - *Madison v. Jefferson Parish Hosp. Serv.*, 1995 WL 396316 at *2 (E.D. La. 1995) (same)

 93

Ambulances, "Coming To" and Courts, 2

- West Jefferson Hospital ambulance transports burn patient. Although West Jefferson was closest, the ambulance brought patient to Charity Hospital, which then transferred him to the burn unit at Baton Rouge General
  - Held: since hospital owned and operated the ambulance, WJH was liable because the patient "came to" its emergency department
    - *Madison v. Jefferson Parish Hospital Service Dist. No. 1*, No. CIV.A. 93-2938, 1995 WL 396316 (E.D. La. 1995)

 94

Ambulances, "Coming To" and Courts, 3

- Starr County Memorial Hospital ambulance arrived at accident scene where Hernandez, injured in a work-related accident, was unconscious. Pt's employer told Starr County Memorial paramedic to take pt to a more distant hospital. Ambulance complied. Hernandez sued Starr County Memorial Hospital under EMTALA
  - Held: Under *Madison*, patient "came to" ED, because Starr owned the ambulance
    - *Hernandez v. Starr County Hosp. Dist.*, 30 F. Supp. 2d 970, 971-72 (S.D. Tex. 1999)

 95

Ambulances, "Coming To" and Courts, 4

- Hospital turns away a nonhospital-owned ambulance and tells it to go elsewhere
  - Held: Unless hospital is on diversionary status, upon receiving paramedics' call, Reg's "plain language" forbids it to turn away non-hospital-owned ambulance
  - Court: DHHS gave an "expansive approach" to the meaning of "comes to"
    - A nonhospital-owned ambulance has arrived at the hospital when it is on the hospital's premises
    - Absent a "valid treatment-related reason" why it should not, diversionary status, e.g., hospital must accept patient being transported towards it in a nonhospital-owned ambulance.
      - *Arrington v. Wong*, 237 F.3d 1066, 1069 (9th Cir. 2001)

 96

Ambulances, "Coming To" and Courts, 5

- Under **community-wide protocols** requiring transportation to hospital other than defendant hospital/ambulance owner's ER, i.e. nearest hospital, plaintiffs, laboring mother and her son, had **not** "come to" defendant hospital
  - *Beller v Health & Hosp. Corp*., 703 F.3d 388 (7th Cir 2012)
    - Same principle would apply to **state-wide protocols**
      - Clarifying Policies

Ambulances, "Coming To" and Courts, 6

- Plaintiffs' failure to facilitate transfer claim did not state EMTALA violation because hospital and ambulance company were separate entities, hospital could not have been responsible for company's allegedly profit-driven disregard for minor's medical needs, and company did not have duty to transfer minor because **company was not a hospital**
  - *Kenyon v. Hosp. San Antonio, Inc.,* 951 F. Supp. 2d 255 (DPR 2013)

Requirement to Transport to **Nearest** Hospital

- Exception to rule requiring EMTALA applicability to hospitals that own and operate ambulances:
  - N/A if ambulance is operating under a **communitywide EMS protocol** that requires it to transport the individual to a hospital other than the hospital that owns the ambulance
    - When he is brought **onto property** of hospital he is transported to, pt has "come to" its ED
  - "Hospital-owned ambulances **operating under medical command**": destination determined not by ambulance personnel but by a physician in radio contact with ambulance
    - Clarifying Policies; §489.24(b)

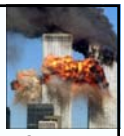
Nearest Hospital, 2

- Patient has not "come to the hospital" if hospital owning ambulance does not employ MD providing medical command nor is otherwise affiliated with him
  - If medical command is provided subject to communitywide protocols that require pt be transported to a hospital other than the hospital that owns the ambulance, such as the closest appropriate hospital, the hospital is operating under **communitywide protocols**
- Where hospital EMS personnel on board determine that transporting to owner hospital would endanger patient's life or safety, EMTALA permits transport to closest hospital able to treat pt
  - Cases can best be identified and resolved case-by-case basis
- Applies to air ambulances as well
  - Clarifying Policies; §489.24(b)

Helicopters and Helipads

- Local ambulance services or other hospitals use a hospital's helipad to transport individuals to tertiary hospitals: If before transport sending hospital conducted MSE to R/O EMC, EMTALA does not oblige the helipad hospital to do MSE before individual's continued travel to recipient hospital
- If, however, while at helipad, individual's condition deteriorates, the helipad hospital must provide another MSE and stabilizing treatment within its capacity if requested by medical personnel accompanying the individual
  - Interpretive Guidelines §489.24(a)(1)(i)

National Emergencies



- During a national emergency, EMTALA sanctions for an inappropriate transfer **do not apply** to a hospital with a DED located in an emergency area
  - §1135(g)(1) of the Act
- In the event of such a national emergency, CMS will issue appropriate guidance to hospitals.
  - Clarifying Policies; §489.24(a)(2)

Hospital P&P and Other Internal Documents

- Courts may see P&P as "parameters for an appropriate screening.'"
  - *Cruz-Vázquez v. Mennonite Gen. Hosp., Inc.*, 717 F.3d 63 (1st Cir. 2013)(hospital did not perform testing required in its "**Gravid with 3d Trimester Bleeding**" protocol); *Battle ex rel. Battle v. Mem'l Hosp. at Gulfport*, 228 F.3d 544, 558 (5th Cir. 2000)(**febrile babies** protocol); *Adams-Erazo v. Hosp. San Gerardo*, 2015 U.S. Dist. LEXIS 97147 (D PR 2015)(**GSW** protocol)
- "Slight deviation[s]" or "*de minimus* variations" from a hospital's standard screening policy "do not amount to a violation of hospital policy," and do not violate EMTALA
  - *Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519, 523 (10th Cir. 1994) cited in *Leimbach v. Haw. Pac. Health*, 2015 U.S. Dist. LEXIS 95397 (D. Haw. 2015; *Kilroy v Star Valley Med. Ctr*. 237 F.Supp.2d 1298 (D. Wyo. 2002)

P&Ps Defeat Summary Judgment for Hospital

- ED "**Nursing Care Standards**" stated that "'infants and elderly are usually hospitalized if no definitive source for fever/infection' is determined"
  - *Battle v. Mem'l Hosp. at Gulfport*, 228 F.3d 544, 558 (5th Cir. 2000).
- Policy that **Triage Nurse be notified** of any individual seeking treatment
  - *Abney v. Univ. Med. Ctr. of S. Nev.*, No. 2:09-cv-02418-RLH-PAL, 2011 WL 468349, at 7 (D. Nev. Feb. 4, 2011)
- Policy that radiology department "must" take **x-rays revealing portions of the spine**; it failed to redo plaintiff's faulty films
  - *Macamaux v. Day Kimball Hosp.*, No. 3:09-CV-164 JCH, 2011 WL 4352007, at 2, 6 (D. Conn. Sept. 16, 2011)

P&Ps Defeat Summary Judgment, 2

- Policy required nurses to measure **BP** during initial assessment and take **VS q2h**. Treating MDs contended that "they had all of the information they needed … to complete an appropriate…screening."
  - *Bode v. Parkview Health Sys., Inc.*, No. 1:07-CV-324, 2009 WL 790199, at 7-10 (N.D. Ind. 2009)
- MD failure to **R/O bacterial process**
  - *Hoffman v. Tonnemacher*, 425 F. Supp. 2d 1120 (E.D. Cal. 2006)
- Patient's **assignment to Category IV**, not II, despite chest pain
  - *Cruz-Queipo v Hosp. Espanol Auxilio Mutuo De P.R.*, 417 F3d 67 (1st Cir. 2005) (quoting *Correa v. Hosp. San Francisco*, 69 F.3d 1184 (1st Cir.1995)

Rx: Bag P&P?

- EMTALA imposes no duty to create P&P
  - *Nolen v. Boca Raton Cmty. Hosp.*, 373 F.3d 1151 (11th Cir. 2004); *Summers v. Baptist Med. Ctr. Arkadelphia,* 91 F.3d 1132, 1140 (8th Cir. 1996); *Guzman v. Mem'l Hermann Hosp. Sys.*, 637 F. Supp. 2d 464 (S.D. Tex. 2009), *aff'd,* 409 F. App'x 769 (5th Cir. 2011)
    - Hospital need not show it had a uniform or written screening procedure. *See Marshall*, 134 F.3d at 319; *Williams v. Birkeness*, 34 F.3d 695, 697 (8th Cir. 1994)
- Regs require emergency service "P&P" but do not necessitate that they be **written or detailed**
  - 42 C.F.R. § 482.55
- Policies result in **disputes** about their **meaning**
  - *Cunningham v. Fredonia Reg'l Hosp.*, No. 95-3350, 1996 WL 584917 (10th Cir. 1996) (P: hospital should have followed its "Initial E.R. Care For Patient With Chest Pain" policy **instead of** its "Determination of Valid Emergency Illness/Injury" policy; text of CP policy was ambiguous)

Discovery of P&P: Privilege

- Hospital director's testimony on whether MD breached standard was relevant only to malpractice claim, so was protected by peer-review privilege AND
- Fed. R. Evid. 501, requiring application of state privilege law to element of claim or defense as to which state law supplied rule of decision, defeated P's claim that her EMTALA case mandated application of federal privilege law
  - *Bennett v. Kent County Mem. Hosp.*, 623 F. Supp. 2d 246, 79 Fed. Rules Evid. Serv. 1185 (D.R.I. 2009); R.I. Gen. Laws §§ 23-17-25(a) and 5-37.3-7(c)
  - *See also*, *Burrows v Redbud Community Hosp. Dist.* (1998, ND Cal) 187 FRD 606 (Act creates private right of action under federal law against offending hospitals, and incorporates state law only in determination of damages)

Discovery of **Other** Patients' Charts

- Hospital's objection to production of hospital records of patients other than decedent was **overruled** because, under EMTALA, l395dd(b), whether hospital provided "appropriate" medical screening was measured by comparison to other patients and their symptoms
  - *Southard v United Reg'l Health Care Sys.*, 245 FRD 257 (N.D. Tex. 2007), *motion to strike den* (N.D. Tex 2008) 2008 U.S. Dist. LEXIS 87599

Discovery of Personnel Files

- Because physician's qualifications and/or disciplinary history was wholly irrelevant to plaintiffs' § l395dd(b) [STABILIZING] action, plaintiffs' discovery request for physician's credentialing files was denied
  - *Southard v United Reg'l Health Care Sys*. (N.D. Tex. 2007) 245 FRD 257, *motion to strike den* (N.D. Tex. 2008) 2008 US Dist LEXIS 87599

This presentation is intended solely to provide general information and does not constitute legal advice. Attendance at the presentation or later review of these printed materials does not create an attorney-client relationship with the presenter(s). You should not take any action based upon any information in this presentation without first consulting legal counsel familiar with your particular circumstances.

Thank You for Attending!

Questions? Comments?

Joseph P. McMenamin, M.D., J.D.
McMenamin Law Offices, PLLC
804.921.4856
joe.mcmenamin@venebio.com