AHC Media

November 2, 2015

EMTALA from A to Z

Part 3

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.

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.

Objectives

- Describe what responsibilities a hospital with a dedicated emergency department has.
- Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.
- Evaluate compliance requirements and penalties.

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

Part 3, 11/2/15

- 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

Public Health Emergencies

- No exception to MD's EMTALA duties where patient's condition poses a risk to physician's health
  - Ariel R. Schwartz, Note, "Doubtful Duty: Physicians' Legal Obligation to Treat During an Epidemic," 60 *Stan. L. Rev*. 657, 679 (2007)
- Under EMTALA and related state laws, MDs in hospital EDs might be obliged to provide care to patients despite risk to themselves
  - Risk would be augmented and far more prevalent during a public health emergency or other disaster

Public Health Emergencies, 2

- Flu epidemic, e.g., sends many, including worried well, to EDs
  - Many arrivees may satisfy EMTALA's definition of "EMC"
  - Remainder would at minimum have to get MSE, requiring direct contact between patient and clinician
- Declared and activated emergency: hospitals "with DEDs in the emergency area will **not**, during the emergency period, be subject to EMTALA **sanctions** for … redirecting individuals seeking [a MSE] … or [for] inappropriate transfers arising out of the circumstances of the emergency."
  - Thomas E. Hamilton, CMS, "Waiver of EMTALA Sanctions in Hospitals Located in Areas Covered by a Public Health Emergency Declaration" (2007), http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter08-05.pdf (citing 42 C.F.R. § 489.24(a)(2) (2006))

Public Health Emergencies Waiver Under Section 1135

- (i) Sanctions for **transfer** or for direction or relocation of an individual for MSE to an alternate location **N/A** hospital with DED if:
  - (A) During the emergency, **circumstances necessitate** transfer
  - (B) The direction or relocation is pursuant to **State emergency preparedness plan** or State pandemic preparedness plan
  - (C) Hospital **does not discriminate** on basis of source of payment or ability to pay
  - (D) Hospital is **located in emergency area during emergency period**
  - (E) **Determination: waiver of sanctions is necessary**
- (ii) Waiver limited to 72-hours from implementation of hospital disaster protocol
  - Pandemic: waiver continues until the termination of declaration
    - §489.24(a)(2)

Public Health Emergencies Waiver Under Section 1135, 2

- **MSE still required**, if not in ED, then at alternate care site pts are redirected or relocated to
- **No waiver** of recipient hospital's duty to accept **transfer**
- For waiver to apply:
  - Hospital must activate its disaster protocol; and
  - State must have activated an emergency or pandemic preparedness plan in the emergency area, and any redirection of individuals for an MSE must be consistent with the plan
    - **State need not activate its plan statewide**
    - **State plan need not identify the location of alternate screening sites**
      - Interpretive Guidelines: §489.24(a)(2)

EMTALA and Ebola

- Must screen individuals suspected of having been exposed
  - Ambulance or walk-ins
- Every ED is expected to be able to
  - Apply appropriate Ebola screening criteria
  - Immediately isolate those meeting criteria
  - Contact state or local public health officials to see if Ebola testing needed
  - When a decision to test is made, to provide treatment, with isolation, until a determination is made whether the individual has Ebola
    - S&C: 15-10-Hospitals (11.21.14)

EMTALA and Ebola, 2

- EMTALA **violation** for hospitals and CAHs with EDs to use **signage** that presents barriers to individuals who may have been exposed from coming to ED, or to otherwise refuse to provide appropriate MSE to anyone who has come to ED for examination or treatment of a medical condition
- Complaints alleging inappropriate transfers or refusal to accept appropriate transfers: CMS will consider the public health guidance in effect at the time
- CMS urges State Survey Agencies (SAs), hospitals and CAHs to monitor CDC's and State public health websites
  - S&C: 15-10-Hospitals (11.21.14)

Part 3

- 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

No Delay in Exam or Treatment (h)

- A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) of this section in order to inquire about the individual's method of payment or insurance status.
  - 42 USC 1395dd (h)

No Delay, 2

- Hospital may seek other info, such as medical hx (not payment), from individual's health plan
  - Hospital may not predicate screening upon completion of a registration form
    - *Baugher v. Kadlec Health Sys*., 2015 U.S. Dist. LEXIS 120075 (E.D. Wash. Sept. 3, 2015)
- EMC: once the hospital has conducted the MSE and has initiated stabilizing treatment, it may **seek authorization** for all services from the plan, so long as doing so does not **delay** the implementation of the required MSE and stabilizing treatment
  - Interpretive Guidelines §489.24(a)(1)(i)

No Delay, 3

- "P asserts that his status was **known to Ds almost immediately** after he arrived at the ER…As a result, the [complaint] does not state a plausible claim for violation of § 1395dd(h)."
  - *Leimbach v. Haw. Pac. Health*, 2015 U.S. Dist. LEXIS 95397 (D. Haw. 2015)
- Hospital may ask the individual for **insurance card**, so long as doing so does not delay MSE
  - Requiring an individual to sign a standard intake form does not violate EMTALA
    - *Quinn v. Bjc Health Sys*., 364 F. Supp. 2d 1046 (E.D. Mo. 2005)
  - Allegations that, before providing MSE or treatment, providers first **determined patients' ability to pay** and **required them to sign form contracts agreeing to pay** in full for care: insufficient to state a claim
    - *Amato v. UPMC*, 371 F. Supp. 2d 752 (W.D. Pa. 2004)

Asking About Ability to Pay

- Hospital may ask whether individual is insured and, if so, what that insurance is, as long as inquiry does not **delay** screening or treatment; processes may not unduly discourage pts from remaining for further evaluation
  - EMTALA, §1867(h); 42 CFR §§489.24(c)(3); (d)(4)(iv)
  - *Burton v. William Beaumont Hosp*., 373 F.Supp.2d 707 (E.D. Mich. 2005)
- Ps failed to state claim because they had not alleged that hospitals' **inquiry** into patients' ability to pay had **delayed** or **discouraged** patients from receiving medical treatment
  - *Hutt v. Albert Einstein Med. Ctr*., 2005 US Dist LEXIS 21548, (E.D. Pa. 2005) *dismd, in part*, 96 AFTR 2d 6413 (E.D. Pa.2005)
- Patient stated claim by alleging that medical center did not perform screening exams equitably, allegedly because of his uninsured status, and that, despite knowing his condition, center failed to stabilize before discharge
  - *Stowe v Russell,* 564 F. Supp. 2d 666 (E.D. Tex. 2008)

Prior Authorization

- Hospital **may not seek authorization** from individual's insurance company for screening services or services required to stabilize EMC **until** after the hospital has provided the appropriate MSE and has initiated any further medical examination and treatment that may be required to stabilize the EMC
- Hospital policy should strike a reasonable **balance** between need to **avoid delays** in screening or stabilization and the equally important need to **protect the individual from avoidable liability for the costs** of emergency health care services
  - Clarifying Policies

Collections Actions

- Court dismissed uninsured, indigent patient's suit against non-profit hospital and hospital system based on its actions to collect medical fees for services rendered to her on two occasions because hospitals did not delay or discourage her from receiving treatment
  - *Feliciano v. Thomas Jefferson Univ. Hosp*., 96 AFTR 2d 6403 (E.D. Pa. 2005)

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

Part 3

- 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

Enforcement (d): Hospitals

- Civil monetary penalties (OIG). Penalties usually < caps:
  - <100 beds: ≤$25,000
  - ≥100 beds$ ≤50,000
  - PRO review before HHS may impose CMP
    - PRO report provides expert opinion re: whether individual had an EMC, whether EMC was stabilized, whether individual was transferred appropriately, and whether there were any medical utilization or quality of care problems
      - 42 C.F.R. § 489.24(g)(2)(v); *St. Anthony Hosp. v. United States HHS*, 309 F.3d 680 (10th Cir. 2002)
- Termination of Medicare participation (CMS)
  - Rare unless hospital fails to take corrective action
    - To 2008, after 22 years, only 13 hospitals
      - Guza, et al. (2008)
    - Many terminated hospitals were later recertified. GAO

Enforcement: EMTALA(d) Hospitals, 2

- Liability under a private cause of action
  - Hospitals only (see below)
    - § 1395dd(d)(2)
  - Not hospital supervisors
    - *Lopes v. Kapiolani Med. Ctr*., 410 F. Supp. 2d 939 (D. Haw. 2005)
  - Damages
  - Injunction
- Another hospital suffering financial loss as a result of 1st hospital's violation can maintain a civil cause of action [text: next slide]
  - To report in <72h; failure sanctionable
  - Damages or injunction
  - Reporting rare

Private Right of Action 42 USCS § 1395dd(d)(2)(A)

- "Any **individual** who suffers **personal harm** as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating **hospital**, obtain those **damages available for personal injury under the law of the State** in which the hospital is located, and such equitable relief as is appropriate."
- May be initiated in either **state or federal** court
  - *Huffine v. Tomball Hosp. Auth*., 979 S.W.2d 795 (Tex. App. 1998); *Trivette v. North Carolina Baptist Hosp., Inc.*, 507 S.E.2d 48 (N.C. Ct. App. 1998); *Lear v. Genesee Mem'l Hosp.*, 678 N.Y.S.2d 228 (N.Y. App. Div. 1998)

Claims Lie Against Hospitals Only

- "Any individual who suffers personal harm as a direct result of a participating **hospital's** violation…" (d)(2)(A)
- No private right of action against **MDs or private companies**
  - *Alvarez-Torres v Ryder Mem. Hosp., Inc*., 576 F. Supp. 2d 278 (D.P.R. 2008), *aff'd* 582 F.3d 47 (1st Cir. 2009); *King v. Ahrens,* 16 F.3d 265, *reh den* (8th Cir. 1994)
    - **Except** where MD is under contract to hospital
      - *Battle v. Memorial Hosp*., 228 F.3d 544 (5th Cir 2000), *reh den, reh en banc den* 237 F3d 633 (5th Cir 2000)
  - No private right of action against private corporation that provides medical professional services **under contract with municipality** even though **indigent patients** were likely seen at treatment center and **Medicare paid** municipality for treatment
    - *Medero Diaz v. Grupo de Empresas de Salud,* 112 F. Supp. 2d 222 (D. P. R. 2000)

Can Relatives Sue the Hospital?

- **Yes**: *Correa*, 69 F.3d at 1196; *Jackson v. East Bay Hosp*., 980 F. Supp. 1341 (N.D. Cal. 1997)
  - Court to make available those damages that flow from breach of legal duty [(d)(2)], so deceased patient's wife cannot be deprived from bringing such action by limiting statute's construction of word "individual" to include patient exclusively
    - *Marrero v. Hosp. Hermanos Melendez,* 253 F. Supp. 2d 179 (D. P.. R. 2003)
- **No**: *Ziegler v. Elmore County Health Care Auth*., 56 F. Supp.2d 1324 (M.D. Ala. 1999)

More than Economic Injury Needed

- Alleged: hospital
  - Required Ps to sign forms that guaranteed payment
  - Billed them at inflated rates
  - Aggressively pursued collection
- Held: No EMTALA violation because Ps did not allege **personal harm**
  - *Burton v. William Beaumont Hosp*., 373 F. Supp. 2d 707 (E.D. Mich. 2005)(uninsured patients alleged that hospital conditioned its treatment on their ability to pay)

More than Economic Injury Needed, 2

- Requiring Ps to sign **payment guarantees before receiving medical treatment** fails to state a claim because Ps did not allege that they were denied proper emergency screening or medical treatment, that their screening or treatment was delayed, that they received inadequate treatment, or that they suffered physical injury as result of policy
  - *Kabeller v. Orlando Reg'l Healthcare Sys.,* 18 FLW Fed D 986 (M.D. Fla. 2005); accord, *Valencia v. Miss. Baptist Med. Ctr., Inc*. 363 F. Supp. 2d 867 (S.D. Miss. 2005)
  -

Damages: Pain and Suffering

- To trigger EMTALA liability, violation must result in actual "personal harm" or "financial loss."
  - 42 U.S.C. § 1395dd(d)(2)(A)-(B)
- Although some damage is required, "EMTALA contains no *de minimus* exception" and therefore even slight or **emotional harm** might trigger liability
  - *Ziegler v. Elmore County Health Care Authority,* 56 F. Supp.2d 1324, 1327 (M.D. Ala. 1999)(mother alleged hospital refused to treat dehydrated infant until mother paid a portion of past-due bills; mother was not patient and so cannot recover, but because treatment was delayed infant can)

Damages: Loss of Consortium

- EMTALA does not preclude the recovery of damages for loss of familial support and the like
  - *Correa*, 69 F.3d at 1196 (construing (d)(2))
- Because record did not support jury's determination of past and future costs of raising child, now stillborn, remittitur was issued that would reduce total award from $1,710,000 to $1,550,000
  - *Heimlicher v Steele,* 615 F. Supp. 2d 884 (N.D. Iowa 2009).

Damages: Wrongful Death

- Survivor actions are permissible under the Act to the extent that state law allows them
  - *Correa*; *Jackson v. East Bay Hosp*., 980 F. Supp. 1341, 1354 (N.D. Cal. 1997); *Lane v. Calhoun-Liberty County Hosp. Ass'n, Inc*., 846 F. Supp. 1543 (N.D. Fla. 1994); *Griffith v. Mt. Carmel Medical Center*, 826 F. Supp. 382, 383-84 (D.Kan.1993)
- Patient's widow could maintain claims under both state Wrongful Death Act and EMTALA as alternative bases for holding hospital and physicians liable for death, but damages would be limited to those recoverable under wrongful death statute
  - *Feighery v. York Hosp*., 38 F. Supp. 2d 142 (1999, D. Me.)

Damages Caps Apply

- P is entitled to only those damages available for **personal injury** under law of state in which violating hospital is located
  - *Lewellen v. Schneck Med. Ctr*., 2007 U.S. Dist. LEXIS 60358 (S.D. Ind. 2007); *Fotia v. Palmetto Behavioral Health*, 317 F. Supp. 2d 638 (D.S.C. 2004)
- Statutory damages cap in **med mal** applies to action under (d)(3)
  - *Reid v. Indianapolis Osteopathic Medical Hospital, Inc.,* 709 F. Supp. 853 (S.D. Ind. 1989)
  - *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 861 (4th Cir. 1994)
  - *Jackson v. East Bay Hosp*., 980 F. Supp. 1341, 1348 (N.D. Cal. 1997); *Burrows v Redbud Community Hosp. Dist*. 188 FRD 356 (N.D. Cal. 1997), *judgment entered* 187 FRD 606 (N.D. Cal. 1998)(death of 11 m.o. infant after transfer); *Barris v. County of Los Angeles*, 972 P.2d 966 (Cal. 1999)
  - *Lane v. Calhoun-Liberty County Hosp. Ass'n, Inc*., 846 F. Supp. 1552-53 (N.D. Fla. 1994)

Med Mal Caps Do Not Apply

- State damages caps for medical malpractice claims do not apply to EMTALA, but state law limits on personal injury claims do
  - *Cooper v. Gulf Breeze Hosp., Inc*., 839 F. Supp. 1538, 1542 (N.D. Fla. 1993)

Punitives

- Plaintiff cannot obtain punitive damages since under controlling Illinois law, punitive damages are forbidden in **medical malpractice** cases
  - *Maziarka v St. Elizabeth Hospital,* 1989 US Dist LEXIS 1536 (N.D. Ill. 1989)
  - Accord, *Taylor v Dallas County Hosp. Dist*., 976 F Supp 437 (N.D. Tex. 1996)

Equitable Relief

- The Act's "individual" and "personal harm" caveats also limit the courts' ability to grant equitable relief
  - 42 U.S.C. 1395dd(d)(2)(A) (1999)
- So, an injunction can require a hospital to treat only the particular plaintiffs seeking the injunction
  - *Hart v. Riverside Hosp., Inc*., 899 F. Supp. 264, 268 (E.D. Va. 1995)
- Plaintiff **need not prove irreparable harm** to obtain injunction barring future violations by hospital
  - *Maziarka v. St. Elizabeth Hospital*, 1989 US Dist LEXIS 1536 (N.D. Ill. 1989)

Enforcement: Physicians

- CMPs: Physicians, or entity providing management services to D hospital
  - *Ziegler*, 56 F. Supp.2d at 1336
  - Negligent violation: ≤$50,000 per violation
    - 42 U.S.C. § 1395dd(d)(1)
  - Gross, flagrant, or repeated violations: exclusion
    - Rarely enforced
      - Schaffner, 2005 *U. Ill. L. Rev*. 1021, 1025 (2005)

Physicians: CMPs

- MD fined $20,000 for refusing to treat hypertensive woman in labor. MD told nurses that he "didn't want to take care of this lady," and ordered her taken to a hospital 170 miles away. **Neither mother nor child harmed**
  - *Burditt*, 934 F.2d 1366.
- Sixth Circuit refused to enforce a $100,000 fine against MD who transferred two patients to a hospital better-equipped to deal with severe head injuries. Found: ALJ misinterpreted "stabilize;" there was not substantial evidence that patients were not stabilized before transfer. Held: MD could not be liable for failing to perform surgery that might have stabilized patient when an **anesthesiologist refused to provide anesthesia**, despite ALJ's finding that physician should have forced anesthesiologist to assist
  - *Cherukuri v. Shalala*, 175 F.3d 446 (6th Cir. 1999)

Enforcement **Procedure**: Hospitals

- Exclusion:
  - Complaint to CMS; OIG or state agency required to transmit to CMS
    - 42 C.F.R. 488.18(d)
  - If CMS finds a violation, it informs hospital
    - "**Serious**": "fast track" (23d) termination of Medicare participation
      - 42 C.F.R. 489.53(c)(2)
    - Otherwise: 90d
    - Hospital can prevent by complying
      - *See, St. Anthony Hosp. v. HHS*, 309 F.3d 680, 693 (10th Cir. 2002)

Enforcement **Procedure**: Hospitals, 2

- CMP: If OIG and hospital cannot reach settlement, OIG must prove violation to an ALJ by a preponderance of the evidence
  - ALJ's favor OIG; make credibility determinations accordingly
    - *Inspector General v. Cherukuri*, No. C-96-020 (HHS May 23, 1997), *not enforced*, 175 F.3d 446 (6th Cir. 1999).
  - ALJ's decision is appealable to an administrative appeals board
    - *Cherukuri*, 175 F.3d at 448-49
  - Administrative board review is sometimes cursory

Supplemental Jurisdiction

- Once federal question jurisdiction exists, trial court has discretion to exercise supplemental jurisdiction over those **state law claims** that derive from "a common nucleus of operative facts."

- Reasons to **decline jurisdiction**:
  - (1) Claim raises a novel or complex issue of State law
  - (2) Claim substantially predominates over the claim(s) over which the district court has original jurisdiction
  - (3) District court has dismissed all claims over which it has original jurisdiction or
  - (4) In exceptional circumstances, there are other compelling reasons for declining jurisdiction

Jurisdiction Exercised

- "The doctor Ds argue that the 2 state law claims, med mal and wrongful death, heavily predominate the lone federal claim and thus the Court should decline…supplemental jurisdiction. P's federal EMTALA claim, however, remains a **valid claim**…Thus, although there are two state law claims, the Court disagrees that the two state law claims substantially predominate over the federal claim."
  - *Hawkins v. Mercy Kan. Cmtys., Inc.,* 2015 U.S. Dist. LEXIS 78799 (D. Kan. 2015)(two state law claims derive from a common nucleus of facts)
- Accord, *Sorrells v. Babcock*, 1992 US Dist LEXIS 17148 (N.D. Ill. 1992)(common nucleus of facts); *Alvarez Torres v. Hosp. Ryder Mem., Inc*. (D.P.R. 2004) 308 F. Supp. 2d 38, *summary judgment gr, claim dismissed, judgment entered,* 576 F. Supp. 2d 278 (D.P.R. 2008), *affd,* 582 F.3d 47 (1st Cir. 2009)
- Court can retain jurisdiction when in the interest of judicial economy
  - *Lopez v. Contra Costa Reg'l Med. Ctr*., 2014 U.S. Dist. LEXIS 27663 (N.D. Cal. Feb. 28, 2014).

Jurisdiction Declined

- "The balancing of these factors under the circumstances of this case [med mal suit in which all discovery had been completed, so Ps could move the court to set trial as soon as practicable, and the non-diverse Ps' claims would outweigh the diverse Ps' claims if tried in federal court], dictates that in the absence of a viable federal claim, non-diverse parties' state claims should be decided by state court."
  - *Mattarodríguez v. Ashford Presbysterian Cmty. Hosp.*, 2015 U.S. Dist. LEXIS 63983 (D.P.R. 2015)

Appeals

- Appeals lie to the United States Courts of Appeals
  - Broad power to review ALJ's interpretations of statute
  - May perform only a limited review of ALJ's factual findings under the substantial evidence standard
    - 42 U.S.C. 1320a-7a(e)
- "Substantial evidence": such relevant evidence as a reasonable mind might accept as adequate to support a conclusion
    - *Richardson v. Perales*, 402 U.S. 389, 401 (1971)
  - Court reviews entire record; however, it does not substitute its judgment for that of lower tribunal by reconsidering facts, re-weighing evidence, resolving conflicts in evidence, or deciding questions of credibility
    - *Estok v. Apfel*, 152 F.3d 636, 638 (7th Cir. 1998)

Enforcement **Procedure**: Physicians

- Secretary requests report from appropriate peer review organizations re: whether violation occurred
  - 42 C.F.R. 489.24(g)

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

Part 3

- 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

Summary Judgment for D: Deference to HCP's Judgment

- District court properly granted summary judgment for D despite competing affidavits (doctor for D, LPN for P) re: uniformity of the screening used with a 15 yo whose stroke was taken for a URI
  - *Marshall v. East Carroll Parish Hospital Service District*, 134 F.3d 319 (5th Cir. 1998)
- D properly granted MSJ in a claim that doc missed fx T7, sternum, and 7th rib
  - *Summers v. Baptist Medical Center Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996) (*en banc*)
- Summary judgment proper for D hospital on P's screening claim: "the facts…are similar to those in *Summers*." Ct relied on **deference to MD's perceived diagnosis**: Thinking waiting unnecessary, doctor discharged patient before reading results of white count differential
  - *Guzman v. Memorial Hermann Hospital System*, 637 F. Supp. 2d 464 (S.D. Tex. 2009), *aff'd*, 409 F. App'x 769 (5th Cir. 2011)

Deference, 2

- Court granted MSJ on P's disparate screening claim despite hospital records that allegedly showed instances of **4 other patients** with similar symptoms receiving **more extensive screenings**. Ps also tried to show non-uniformity by arguing that patient's "condition was labeled as 'Non-urgent' with a diagnosis of 'swelling,' while other patients presenting to the ED … with a diagnosis of 'swelling' were labeled as 'Urgent.' They claimed that from 2000 to 2001 there were **25 such cases** and therefore, this is a disparity in treatment. Persuaded by affidavits submitted by the hospital, its VP of nursing. and MD who performed the screening, court held: **insufficient evidence** to show disparate screening
  - *Magruder v. Jasper County Hospital*, 243 F. Supp. 2d 886 (N.D. Ind. 2003)

Deference, 3

- Treating MD admitted that, for the symptoms presented, he would normally have examined the patient's abdomen; P denied abdominal exam. Hospital affidavits: appropriate screening was performed

- Held: **One MD's routine was not representative** of a general screening policy: "[I]t is the **hospital's standard practices**, rather than the **individual practices of the physicians** employed there, that are relevant in determining EMTALA liability." Hence, "showing that an individual physician either chose not to or forgot to conduct a physical exam of a specific area, which he or she normally performs, is not enough to establish the hospital's liability under the EMTALA."
  - *Bryant v. John D. Archbold Memorial Hospital*, 202 F. App'x 410 (11th Cir. 2006)

Deference, 4

- Court initially denied motion, because treating physician had failed to conduct tests and exams hospital's own explicit protocol for 3d trimester bleeding demanded. A month later, court vacated prior opinion and instead granted the motion. Court excused treating physician's failure to perform tests "required" by the hospital's protocol because the doctor "**made a medical judgment** not to perform [the] additional tests."
  - *Cruz-Vazquez v. Mennonite General Hospital*, No. 08-1236 (JP), 2011 WL 3607669 (D.P.R. 2011); *Cruz-Vazquez v. Mennonite Gen. Hosp., Inc*., No. 08-1236 (JAF/JP), 2011 WL 4381888 (D.P.R. 2011)

Sovereign Immunity: Federal, State, but Not Local

- Congress did not abrogate US sovereign immunity; therefore US-owned hospitals are immune from civil actions under EMTALA
  - *Cheromiah v. US*, 55 F. Supp.2d 1295, 1300-1301 (D. N.M. 1999)
- EMTALA does not abrogate a state's 11th Amendment immunity; ∴ Amendment precludes suits against hospitals that qualify as state agents so long as the state has not waived its immunity
  - *Ward v. Presbyterian Healthcare Serv*., 72 F. Supp.2d 1285 (D.N.M. 1999); *Lebron v. Ashford Presbyterian Comm. Hosp*., 975 F. Supp. 407 (D.P.R. 1997)
- Eleventh Amendment immunity is construed narrowly, and generally **N/A to municipalities or state political subdivisions**, including county hospitals or hospital districts
  - *Draper v. Chiapuzio*, 9 F.3d 1391 (9th Cir. 1993); *Root v. New Liberty Hosp. Dist*., 209 F. 3d 1068 (8th Cir. 2000)

Sovereign Immunity Upheld

- EMTALA does not mention US government or any US owned or maintained-hospital; ∴ EMTALA **lacks unequivocally expressed waiver** of immunity
  - *Hoffman v. United States,* 593 F. Supp. 2d 873 (2009, E.D. Va.)
- State sovereign immunity precluded parent from suing state university's board in state court for daughter's suicide in university hospital, though she could sue under Tort Claims Act in state court
  - *Ward v. Presbyterian Healthcare Servs*.
- Where patient died after being allowed to leave, action v. state hospital dismissed; EMTALA contains no language abrogating sovereign immunity and evidence insufficient for civil rights claims
  - *Drew v. University of Tenn. Reg'l Med. Ctr. Hosp*., 2000 US App LEXIS 8936(6th Cir. 2000)
  - Accord, *Isidra v. Perez-Bourdon v. Commonwealth of Puerto Rico*, 951 F. Supp. 22, 24 (D.P.R. 1997)

Sovereign Immunity Held Inapplicable

- EMTALA preempts Missouri statute "which provides sovereign immunity to public entities to the extent they have no insurance coverage"
  - *Helton v. Phelps County Reg'l Med. Ctr*., 817 F. Supp. 789, 791 (E.D. Mo. 1993)
  - *Accord, Johnson v. Bishof*, 2015 Ill. App. (1st) 131122, 33 N.E.3d 624, (Ill. App. Ct. 1st Dist. 2015), *Williams v. County of Cook*, No. 97- C-1069, 1997 WL 428534, at *5 (N.D. **Ill**. 1997) (EMTALA preempts Illinois Tort Immunity Act); *Etter v. Board of Trustees of N. Kansas City Hosp*., No. 95-0624- CV-W-6, 1995 WL 634472, at *2 (W.D. Mo. 1995); *Root v. New Liberty Hosp. Dist*. (**8th** Cir. 2000) 209 F3d 1068, *reh, en banc, den* (8th Cir. 2000) 2000 US App LEXIS 11719

Charitable Immunity Upheld

- *Tep v. Southcoast Hosps. Group, Inc*., 2014 U.S. Dist. LEXIS 132678 (D. Mass. 2014)(death of primary pulmonary hypertension patient in ambulance during transfer to Tufts)

Pre-Emption

- EMTALA incorporates state's personal injury law and "does not preempt any State or local law requirement, except to the extent that the requirement **directly conflicts** with a requirement" within EMTALA
  - 42 U.S.C. § 1395dd(f)
- State statute directly conflicts with federal law in either of two cases:
  - If "compliance with both federal and state regulations is a **physical impossibility**," or
  - State law "is an **obstacle** to the accomplishment and execution of the full purposes and objectives of Congress."
    - *Draper v. Chiapuzio*, 9 F.3d 1391, 1393 (9th Cir. 1993) (*per curiam*)

Pre-Emption, 2

- Federalism compels a narrow scope for the Act
  - *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996)
- Iowa negligence law does not conflict with EMTALA and both its legislative history, and its language at (f), demonstrate that Congress never intended EMTALA to displace state malpractice law
  - *Heimlicher v. Steele,* 615 F. Supp. 2d 884 (N.D. Iowa 2009)(transfer of expectant mother who needed emergency delivery)
- Where a hospital is not licensed to perform angioplasty, but patient cannot be stabilized and may die without it, and where no physician is willing to certify that the benefits of transport outweigh the risks, EMTALA may need to preempt state licensing law. Where **record is insufficient** to determine whether transfer risks were substantially created by hospital's own action and inactions and, if so, whether such **self-created risks** negate hospital's asserted justifications for performing the angioplasties, case is reversed and remanded to develop that record. *Warren Hosp. v. New Jersey Dep't of Health*, 2013 N.J. Super. Unpub. LEXIS 1678 (App.Div. 2013)

Statute of Limitations

- 2y from the date of alleged violation. (d)(2)(C)
  - Jurisdictional. *Vogel v. Linde*, 23 F.3d 78, 80 (4th Cir. 1994)
- Provision strictly construed; not tolled for incompetency, infancy, disability, or state procedural grounds
  - *Burrows v. Turner Mem'l Hosp., Inc.,* 762 F. Supp. 840, 843 (W.D. Ark. 1991) (state law that tolls the statute for 1y upon voluntary dismissal of suit does not toll EMTALA's 2y statute)
- No discovery rule
  - *Merce v. Greenwood,* 348 F Supp. 2d 1271 (D. Utah 2004)

Tolling

- Its 2y statute bars EMTALA claim: equitable tolling on basis of inability to discover information essential to suit was not available where claimant **accompanied her mother** throughout her stay in ER and thus was **privy to what occurred**, and where delay in receipt of expert report was not sufficient to toll time period
  - *Monrouzeau v. Asociacion del Maestro,* 354 F. Supp. 2d 115 (D.P.R. 2005), *affd,* 153 Fed. Appx. 7 (1st Cir. 2005)
  - *See also Saltares v. Hosp. San Pablo, Inc*., 371 F. Supp. 2d 28 (D.P.R. 2005)

Limitations: Preemption

- 2y EMTALA statute **does not toll** state 1y limitation period for filing notice of tort claim; EMTALA preempts state law only where there is **direct conflict** and compliance with both would be physical impossibility; here, plaintiff need only **file notice under state statute within 1y**, and file suit under EMTALA within 2
  - *Draper v. Chiapuzio,* 9 F.3d 1391 (9th Cir. 1993)
- Because potential direct conflict exists between Utah's pre-litigation claim screening requirements and EMTALA's statute of limitations, EMTALA preempts state law; so, **Utah's screening requirements and delayed-discovery provisions are not "incorporated"** into EMTALA and do not toll EMTALA's two-year limitations period
  - *Merce v. Greenwood,* 348 F. Supp. 2d 1271 (D.C. Utah 2004)

Comparative Fault

- State's comparative fault statute **N/A EMTALA** actions because EMTALA is not a negligence-based cause of action
  - *Griffith v. Mt. Carmel Med. Center*, 842 F. Supp. 1359 (D. Kan. 1994)

Tort Reform and State Procedural Requirements +

- Filing of pre-suit **notice**, mandatory **screening panel**, mandatory **arbitration**: apply in EMTALA cases?
- NY statute requiring individual to file **notice of claim** as condition precedent to commencing personal injury action against municipal corporation applies to EMTALA action against municipal hospital and is not preempted
  - *Hardy v. New York City Health & Hosps. Corp*., 164 F.3d 789 (2d Cir. 1999); *accord, Cox v. Cabell Huntington Hosp., Inc*., 863 F. Supp. 2d 568 (S.D. W. Va. 2012)
- Circuits **9, 2**: EMTALA plaintiff must submit a **notice of claim** pursuant to the state tort claims act before suing state entity
  - *Draper*, 9 F.3d at 1393; *accord Hardy v. New York City Health & Hosp. Corp*., 164 F.3d 789 (2d Cir. 1999)

Tort Reform and State Procedural Requirements -

- State procedural requirement that malpractice P first seek **medical review panel** opinion N/A federal court EMTALA action
  - *Reid v. Indianapolis Osteopathic Medical Hospital, Inc.,* 709 F. Supp. 853 (S.D. Ind. 1989); *Cox v. Cabell Huntington Hosp., Inc*., 863 F. Supp. 2d 568 (S.D. W. Va. 2012)
- State statute requiring prelitigation **notice and scr**eening of med mal claims did not apply to EMTALA action
  - *Hewett v. Inland Hosp*., 39 F. Supp. 2d 84 (D. Me. 1999)
- Turned away from county-owned hospital, mother of deceased child may proceed even though she failed to comply with state governmental immunity act **notice requirements;** federal statute **preempts state notice of claim statute** since state procedural requirement stands as obstacle to Congress's objectives
  - *Bird v. Pioneers Hosp*., 121 F Supp 2d 1321 (D. Col. 2000)

Tort Reform and State Procedural Requirements -

- Florida's med mal statute provided that a potential P or D may offer to **arbitrate** the damages rather than try the issue. If potential **P refuses** to arbitrate, then her recovery for non-economic damages is **capped** at $ 350,000 per incident
  - Fla. Stat. Ann. § 766.206
  - Held: **N/A**. **Strict liability, not negligence**.
    - *Cooper v. Gulf Breeze Hospital, Inc*., 839 F. Supp. 1538, 1540 (N.D. Fla. 1993)
- EMTALA incorporated state caps on PI claims but not caps specific to med mal: "EMTALA…incorporates state law in the determination of damages," but the issue is the extent or scope of incorporation. Because MICRA does not extend to **all** tort claims but rather **only** to those actions "based on **professional negligence**," damage cap N/A EMTALA
  - *Jackson v. East Bay Hospital*, 980 F. Supp. 1341, 1344, 1346 (N.D. Cal. 1997)

Tort Reform and State Procedural Requirements -

- Other courts: pre-suit procedure N/A for two reasons:
  - Such statutes are often limited to **malpractice** claims; EMTALA claims are not malpractice claims
    - *Brooks*, 996 F.2d at 713 (state law requiring arbitration before a malpractice complaint could be filed did not apply to EMTALA)
  - State procedural statutes directly **conflict**, so are preempted
    - *Power*, 42 F.3d at 866 (EMTALA preempted state law that **required** [?] malpractice claims be submitted to a screening panel); *Hewett v. Inland Hosp*., 39 F. Supp.2d 84, 86 (D. Maine 1999) (same); *Reid*, 709 F. Supp. 853 (same); *Spradlin v. Acadia-St. Landry Med. Foundation*, 2000 WL 225877 at *6 (La. 2000) (same)

Regulatory Taking?

- "…nor shall private property be taken for public use, without just compensation."
  - United States Constitution, Amendment V

Costs

- EMTALA is an unfunded mandate
  - Medicare, Medicaid do pay hospitals small sums for losses incurred for treating indigent illegal immigrants
    - Partial, indirect
    - Goes only to hospitals, not physicians or other individuals
- Pt in MVA had been in-patient for **six weeks** and required considerable further care
  - *Roberts v. Galen of Va., Inc*., 525 U.S. 249, 251 (1999)
- **Anencephalic** infant lacking major portions of brain except brain stem to be readmitted, for intensive care if necessary, any time that respiratory distress or other emergent condition required it
  - *In re Baby K*, 16 F.3d 590, 592, 598 (4th Cir. 1994)

Consequences of Unreimbursed Costs

- 27% of hospitals have shuttered EDs (visits↑35%)
  - Hsia, et al., 305 *JAMA* 1978, 1980 (2011)
- During 1991-2011, EDs closed at greater rates than hospitals
  - AHA, "Trendwatch Chartbook 2013: Trends Affecting Hospitals and Health Systems," at A-28 (2013)(12.7% v. 7%)
- Medical repatriations
  - *Montejo v. Martin Memorial Medical Center Inc*., 874 So.2d 654 (Dist. Ct. App. Fla. 2004)(hospital failed to comply with EMTALA when it did not show that the Guatemalan public hospital where pt was transferred could serve his medical needs, but court lacked authority to order his return)

Takings Clause Analysis

- [1] Is there a property interest?
- [2] Is there a taking of property?
- [3] If there is a taking, is it for public use? and
- [4] If there is a taking of property for public use, is there just compensation?
  - *Ruckelshaus v. Monsanto Co.*, 467 U.S. 986 (1984)

Voluntariness Argument

- Hospitals are not forced to accept Medicare
  - "Congress may attach appropriate conditions to federal taxing and spending programs to preserve its control over the use of federal funds."
    - *Nat'l Fed'n of Indep. Bus. v. Sebelius* (*NFIB*), 132 S. Ct. 2566, 2603 (2012); *Baker County Med. Servs. v. US AG,* 763 F.3d 1274 (11th Cir. 2014)(voluntary participation in regulated program such as Medicare defeated Takings Clause challenge)
- But financial inducement that becomes coercive is an unconstitutional overreaching of federal powers
  - *NFIB*, 132 S. Ct. at 2604 (referring to ACA's then-requirement that states broaden their Medicaid programs significantly or lose all federal Medicaid funding)
    - See, E.H. Morreim, "Dumping the 'Anti-Dumping' Law: Why EMTALA Is (Largely) Unconstitutional and Why It Matters," 15 *Minn. J.L. Sci. & Tech*. 211 (2014)
- *But see, Baker County Med. Servs. v. United States AG*, 763 F.3d 1274, 2014 U.S. App. LEXIS 15568 (11th Cir. 2014) (voluntary participation in Medicare defeats takings claim).

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

Part 3

- 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

Anti-Retaliation: 42 USC § 1395dd(i)

- "A participating hospital may not penalize or take adverse action
  - [1] against a QMP . . . or [MD] because [either] **refuses to authorize** the **transfer** of an individual with an EMC that has not been stabilized or
  - [2] against any hospital employee because [she] **reports a violation**..."
- Social worker alleging he was fired in retaliation for reporting employer's EMTALA violation could bring private right of action against former employer; worker had sufficiently asserted claim for damages because firing constituted personal injury
  - *Fotia v. Palmetto Behavioral Health,* 317 F. Supp. 2d 638 (DSC 2004)

Proving Retaliation Claim

- Plaintiff must prove
  - (1) that he engaged in activity protected by EMTALA
  - (2) that he suffered an adverse employment action at the hand of his employer; and
  - (3) that a causal connection exists between the protected activity and the employer's decision to impose the adverse employment action
    - *Kaplan v. Blue Hill Mem. Hosp*., 2014 U.S. Dist. LEXIS 167384 (D. Me. 2014) citing *Elkharwily v. Mayo Holding Co*., 955 F. Supp. 2d 988 (D. Minn. 2013) (borrowing the standard applicable to Title VII retaliation claims)

Anti-Retaliation

- MD's suit v. medical center, its parent, and various officials related to those entities asserted retaliation in violation of EMTALA and other tort claims. Ds not entitled to summary judgment since, in part, **genuine issues of material fact** existed whether MD's clinical privileges were suspended for his **refusal to transfer** pregnant patient where there was ample evidence that he believed patient had **EMC requiring stabilization**
  - *Ritten v. Lapeer Reg'l Med. Ctr.*, 611 F. Supp. 2d 696 (E.D. Mich. 2009).

Anti-Retaliation

- Court properly dismissed MD's suit alleging that he was terminated in violation of EMTALA because he was terminated after complaining about the hospital **taking too many ER patients**, which did not state an EMTALA violation or show that he was terminated in retaliation for reporting an EMTALA violation…The second clause of the whistleblower protection provision permits suit only by those reporting "a violation of a requirement of EMTALA." Id. § 1395dd(i) (emphasis added). Neither contemplates a cause of action for an EMTALA violation that is yet to be.
  - *Genova v. Banner Health*, 734 F.3d 1095, 2013 U.S. App. LEXIS 17372, 36 I.E.R. Cas. (BNA) 636, 2013 WL 4419326 (10th Cir. 2013)

Who is a "Reporter"?

- A risk management nurse who received report of improper transfer of a mother of twins in premature labor from another hospital, brought complaint to senior management's attention, and prepared a self-report to CMS, is a "reporter
  - *O'Connor v. Jordan Hosp*., 2013 U.S. Dist. LEXIS 84655 (D. Mass. 2013)
- Given the purpose of the statute, EMTALA's whistleblower protections extend to non-employed physicians with privileges at the hospital
  - *Muzaffar v. Aurora Health Care S. Lakes, Inc*., 985 F. Supp. 2d 875 (E.D. Wis. 2013)

Anti-Retaliation and Peer Review

- Where Defendant maintains that P's [EP] employment was terminated for quality of care concerns, Ps must have access to peer review records of other physicians documenting performance issues
  - *Kaplan v. Blue Hill Mem. Hosp*., 2014 U.S. Dist. LEXIS 167384 (D. Me. 2014)

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

Part 3

- 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

What the Investigator Will Request

- Dedicated ED logs for the past 6-12 months
- Dedicated ED P&P manual
- Consent forms for transfers of unstable individuals
- Dedicated ED committee meeting minutes x12m
- Dedicated ED staff schedule (MDs x3m; nurses x4 w) or as appropriate;
- Bylaws/rules and regulations of the medical staff
- Minutes from medical staff meetings x 6-12 m
  - State Operations Manual, Appendix V – Interpretive Guidelines

What the Investigator Will Request, 2

- Current medical staff roster
- Physician on-call lists x 6m
- Credential files for ED Director and MDs
  - Review optional, but will scrutinize for turnover; problem in a particular MD's screening or treatment
- QAPI Plan (f/k/a QA)
- QAPI minutes (EMTALA-relevant portion). If problem identified that would require a more thorough review, may request more
- If potential violation noted and the use of contracted services is questioned, list of contracted services
  - State Operations Manual, Appendix V – Interpretive Guidelines

What the Investigator Will Request, 3

- Dedicated ED personnel records (optional)
- In-service training program records, schedules, reports, etc. (optional review if questions arise through interview and record review regarding the staff's knowledge of 42 CFR §489.24) [the EMTALA regs]
- Ambulance trip reports and memoranda of transfer, if available (investigator selects if the cases under review concern transfers)
- Ambulance ownership information and applicable State/regional/community EMS protocols
  - State Operations Manual, Appendix V – Interpretive Guidelines

Case Selection Methodology

- Investigator chooses **20-50** charts for in-depth review
  - Sample not intended to be statistically valid
  - Focus selection on potential problem areas
  - Expand sample size should be expanded as necessary
- Will use **log** to identify:
  - Patients transferred to other facilities
  - Gaps, return cases, or nonsequential entries in the log
  - Refusals of examination, treatment, or transfer
  - Patients leaving AMA or without being seen (LWBS)
  - Patients returning to ED within 48 hours
    - State Operations Manual, Appendix V – Interpretive Guidelines

Interviews

- Targets:
  - Admitting clerk
  - Nurses on shift at the time the individual sought treatment
  - Hospital's Director of Quality Improvement
  - Witnesses, the patient, and/or the patient's family
  - Physician(s) involved
  - Transfer: personnel at receiving hospital
- Details recorded:
  - Individual's job title and assignment at the time
  - Relationship to the patient and/or reason for the interview
  - Summary of the information obtained
    - State Operations Manual, Appendix V – Interpretive Guidelines

If a Violation is Found:

- Investigator will search for patterns:
  - Diagnosis (e.g., labor, AIDS, psych)
  - Race
  - Color
  - Type of insurance (Medicaid, uninsured, under-insured, managed care)
  - Nationality
  - Disability
    - State Operations Manual, Appendix V – Interpretive Guidelines

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

Part 3

- 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

What a Hospital with a DED Must Do

- Adopt and enforce P&P to comply with 42 CFR §489.24
- Post signs in DED re rights of individuals with EMCs and women in labor who come to DED for health care services; whether hospital participates in Medicaid
- Maintain medical and other records re: individuals transferred to and from hospital x5y from transfer date
- Maintain list of MDs on-call to provide further evaluation and or treatment necessary to stabilize EMCs
  - State Operations Manual, Appendix V – Interpretive Guidelines

What a Hospital with a DED Must Do, 2

- Maintain log of individuals who come to DED seeking treatment and indicate whether these individuals:
  - Refused treatment
  - Were denied treatment
  - Were treated, admitted, stabilized, and/or transferred or were discharged
    - 489.20(r)(3)
- Provide for an appropriate MSE
- Provide necessary stabilizing treatment for EMCs and labor within the hospital's capability
  - State Operations Manual, Appendix V – Interpretive Guidelines

What a Hospital with a DED Must Do, 3

- Provide appropriate transfer of an unstabilized individual to another medical facility if:
  - Individual (or one acting on her behalf) after being informed of risks and hospital's obligations so **requests**
  - MD has signed **certification** that benefits of transfer outweigh risks or
  - **QMP** has signed certification after MD, not in ED at time, in consultation with QMP, has determined that benefits of transfer outweigh risks and MD timely countersigns
  - Provide treatment to **minimize risks** of transfer
  - Send all pertinent **records** to receiving hospital
  - Obtain receiving **hospital's consent** to transfer
  - Transfer unstabilized individual through **qualified personnel** and transportation **equipment**, including medically appropriate life support measures
    - State Operations Manual, Appendix V – Interpretive Guidelines

What a Hospital With a DED Must Do, 4

- Do not delay medical screening examination and/or stabilizing treatment to inquire about payment status
- Accept appropriate transfer of individuals with EMCs if the hospital has specialized capabilities or facilities and has the capacity to treat those individuals
- Do not penalize or take adverse action against MD or a QMP because either refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee who reports a violation
  - State Operations Manual, Appendix V – Interpretive Guidelines

Hospital with No 42 CFR 489.24(b) DED

- Apply 42 CFR §482.12(f):
- Hospital's governing body must assure that the medical staff has written P&P for appraisal of emergencies and the provision of initial treatment and referral
  - State Operations Manual, Appendix V – Interpretive Guidelines; Form CMS-1537, "Medicare/Medicaid Hospital Survey Report"

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