AHC Media

January 7, 2016

EMTALA & the On-Call Physician

Speaker

- Sue Dill Calloway RN Esq CPHRM, CCMSCP
- AD, BA, BSN, MSN, JD
- President Patient Safety and Healthcare Consulting
- 5447 Fawnbrook Lane
- Dublin, Ohio 43017
- 614 791-1468 (Call with questions, No emails)
- sdill1@columbus.rr.com

Objectives

- Identify the education responsibilities of on call physicians as set forth by EMTALA.
- Explain why a list of physicians who are on call must be maintained.
- Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.
- Evaluate compliance requirements and penalties.

Proposed Changes by the OIG

- The OIG has proposed changes to the EMTALA law
- This was posted in the FR on May 12, 2014
- There was a 60 comment period
- Discusses and clarifies many existing sections
- Does make a couple of important proposed changes
- Hospitals should be familiar with this document and watch for the final changes when they become available

Proposed Changes in Summary

- Clarify that on-call physicians at any participating hospital subject to EMTALA, including the hospital a patient initially presents to and the hospital with specialized capabilities or that has received a request to accept a transfer, face potential CMP and exclusion liability under EMTALA; and
- Revise the factors to clarify that aggravating circumstances include: a request for proof of insurance or payment prior to screening or treatment, patient harm, unnecessary risk of patient harm, premature discharge, or a need for additional services or subsequent hospital admission that resulted or could have resulted from the incident, and whether the individual presented with a medical condition that was an emergency medical condition.

Proposed EMTALA Changes

- https://oig.hhs.gov/authorities/docs/2014/fr-79-91.pdf

FEDERAL REGISTER

Vol. 79 Monday,
No. 91 May 12, 2014

Part III

Department of Health and Human Services

Office of Inspector General

42 CFR Parts 1003 and 1005

Medicare and State Health Care Programs: Fraud and Abuse; Revisions to the Office of Inspector General's Civil Monetary Penalty Rules; Proposed Rule

addition, we include the statutory language stating that the calculation of the total remuneration for purposes of an assessment does not consider whether any portion of the remuneration had a lawful purpose.

Subpart D—CMPs and Assessments for Misconduct by a Managed Care Organization

Subpart D contains the proposed provisions for penalties and assessments against managed care organizations. We propose several stylistic changes to the regulations currently listed at § 1003.103(f). We changed the verbs in this subpart from past tense to present tense to conform to the statutory authorities and many other regulations in this part. The proposed regulation also removes superfluous phrases, such as "in addition to or in lieu of other remedies available under law." The proposed regulation replaces references to "an individual or entity" with "a person" because "person" is defined in the general section as an individual or entity. The proposed regulation also removes the phrase "for each determination by CMS." OIG may impose CMPs in addition to or in place of sanctions imposed by CMS under its authorities.

We also added to the regulations OIG's authority to impose CMPs against Medicare Advantage contracting organizations pursuant to section 1857(g)(1) of the Act and against Part D contracting organizations pursuant to section 1860D–12(b)(3) of the Act.

As discussed above, ACA amended several provisions of the Act that apply to misconduct by Medicare Advantage or Part D contracting organizations. We have included these provisions in the proposed regulations. We added the change in section 6408(b)(2)(C) of ACA regarding assessing penalties against a Medicare Advantage or Part D contracting organization when its employees or agents, or any provider or supplier that contracts with it, violates section 1857. We propose to add the five new violations created in ACA, and their corresponding penalties, at § 1003.400(c). We also propose to include the new assessments, which are available for two of the five new violations, at § 1003.410(c). The proposed regulatory text closely mirrors that of the statute.

The violations in this subpart are grouped according to the contracting

1857, 1860D–12, or 1876. Section 1003.400(c) violations apply to Medicare Advantage and Part D contracting organizations, *i.e.*, those with contracts under sections 1857 or 1860D–12 of the Act. Section 1003.400(d) violations apply to Medicare Advantage contracting organizations, *i.e.*, those with contracts under section 1857 of the Act. Section 1003.400(e) violations apply to Medicaid contracting organizations, *i.e.*, those with contracts under section 1903(m) of the Act.

We also propose to remove the definition of "violation," which is currently found at § 1003.103(f)(6), because throughout this part, violation means each incident or act that violates the applicable CMP authority. We also propose including aggravating circumstances to be used as guidelines for taking into account the factors listed in proposed § 1003.140. These aggravating circumstances are adapted from those listed in the current regulations at §§ 1003.106(a)(5) and 1003.106(b)(1) and those published in the **Federal Register** in July 1994. 59 FR 36072 (July 15, 1994).

Subpart E—CMPs and Exclusions for EMTALA Violations

Subpart E contains the penalty and exclusion provisions for violations of EMTALA, section 1867 of the Act (42 U.S.C. 1395dd). EMTALA, also known as the patient antidumping statute, was passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law 99–272. Section 1867 of the Act sets forth the obligations of a Medicare-participating hospital to provide medical screening examinations to individuals who come to the hospital's emergency department and request examination or treatment for a medical condition. EMTALA further provides that if the individual has an emergency medical condition, the hospital is obligated to stabilize that condition or to arrange for an appropriate transfer to another medical facility where stabilizing treatment can be provided. EMTALA also requires hospitals with specialized capabilities or facilities to accept appropriate transfers of individuals from other hospitals. Finally, EMTALA creates obligations for physicians responsible for the examination, treatment, or

Under section 1867(d) of the Act, participating hospitals and responsible physicians may be liable for CMPs of up to $50,000 ($25,000 for hospitals with fewer than 100 State-licensed and Medicare-certified beds) for each negligent violation of their respective EMTALA obligations. Responsible physicians are also subject to exclusion for committing a gross and flagrant or repeated violation of their EMTALA obligations. OIG's regulations concerning the EMTALA CMPs and exclusion are currently at 42 CFR 1003.102(c), 103(e) and 106(a)(4) and (d).

We propose several clarifications to the EMTALA CMP regulations. First, as part of our proposed general reorganization, we have included the EMTALA authorities within a separate subpart. Further, the proposed revision removes outdated references to the pre-1991 "knowing" scienter requirement. We also propose minor revisions to clarify that the CMP may be assessed for each violation of EMTALA and that all participating hospitals subject to EMTALA, including those with emergency departments and those with specialized capabilities or facilities, are subject to penalties.

As discussed above, we propose revising the "responsible physician" definition to clarify that on-call physicians at any participating hospital subject to EMTALA, including the hospital the individual initially presented to and the hospital with specialized capabilities or facilities that has received a request to accept an appropriate transfer, face potential CMP and exclusion liability under EMTALA.

Section 1867(d) of the Act provides that any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including any physician on-call for the care of such an individual, and who negligently violates section 1867 may be penalized under section 1867(d)(1)(B). The current definition of "responsible physician" also provides for on-call physician liability. We propose to revise the definition to clarify the circumstances when an on-call physician has EMTALA liability. An on-call physician that fails or refuses to appear within a reasonable time after such physician is requested to come to the hospital for examination, treatment, or transfer purposes is subject to EMTALA liability. This includes on-

Proposed EMTALA Changes

- Put the EMTALA authorities all in one section
- Removed outdated references to the pre-1991 knowing requirement
- Clarify the CMP may be assessed for each violation
- Clarified that all participation hospitals are subject to EMTALA
  - Including those hospitals with specialized capabilities

Proposed EMTALA Changes

- Proposed to revise responsible physician to clarify that the on-call physician at any participating hospital is subject to EMTALA
- Clarifies that this includes taking care of a patient when the hospital has received a request to accept an appropriate transfer
- Otherwise the physician can be excluded and face a fine
- Any physician, including on-call physician, who fails to exam, treat, or transfer a patient appropriately can be penalized

Proposed EMTALA Changes

- On-call physician who fails to appears within a reasonable amount of time or refuses to show up is subject to EMTALA liability
- This includes on-call physicians at the hospital where the patient appears and the other hospital that has specialized capabilities
  - Ie refusing to accept an appropriate transfer
- CMS is modifying the definition of responsible physician to make it clear between the on-call physician at the hospital the patient presents and where they would send the patient

Proposed EMTALA Changes

- Wanted to clarify the OIG's enforcement policy
- Lists factors that will be considered in making both CMP (civil monetary penalties) and exclusion criteria
  - Removed mitigating factors
  - See list of aggravating factors
  - OIG will consider if physician failed to follow EMTALA in the past
  - Violations involve a case by case inquiry
  - This would include if the hospital failed to screen the patient in a timely manner and they left

Access to Hospital Complaint Data

- CMS issued Survey and Certification memo on March 22, 2013 regarding access to hospital complaint data
- Includes acute care and CAH hospitals
  - Does not include the plan of correction but can request
  - Questions to bettercare@cms.hhs.com
- This is the CMS 2567 deficiency data and lists the tag numbers
- Updated quarterly
  - Available under downloads on the hospital website at www.cms.gov

Access to Hospital Complaint Data

- There is a list that includes the hospital's name and the different tag numbers that were found to be out of compliance
  - Many on restraints and seclusion, EMTALA, infection control, patient rights including consent, advance directives and grievances
  - Shows one of the most common deficiencies against hospitals is in the area of EMTALA with **2,303** November 10, 2015
- Will you be prepared if a surveyor shows up tomorrow with an EMTALA complaint??

Access to Hospital Complaint Data

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 13-21- ALL

DATE: **March 22, 2013**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Access to Statements of Deficiencies (CMS-2567) on the Web for Skilled Nursing Facilities, Nursing Facilities, Hospitals, & Critical Access Hospitals

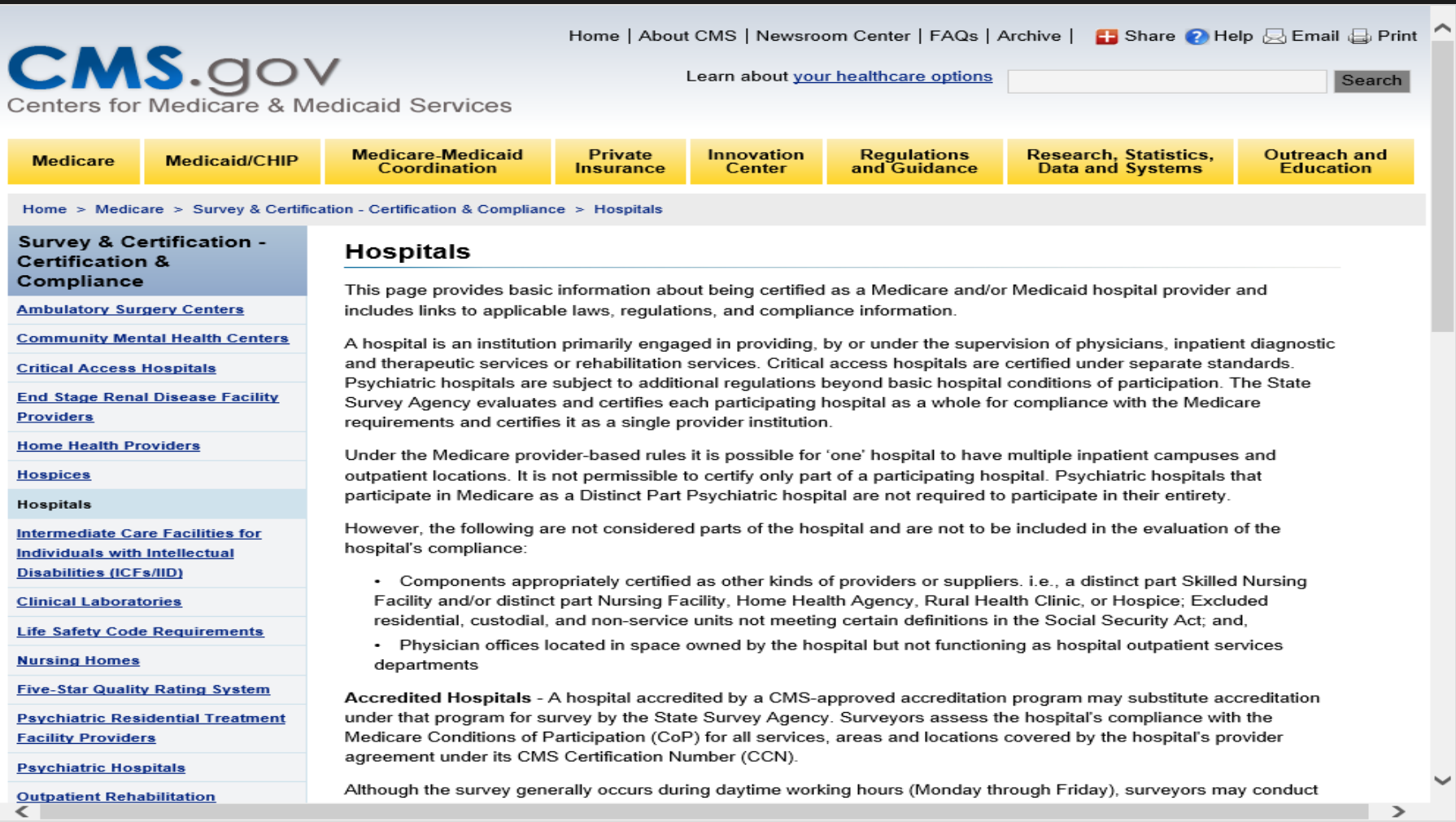
Memorandum Summary

- ***Survey Findings Posted on*** *http://www.cms.gov:* In July 2012, the Centers for Medicare & Medicaid Services (CMS) began posting redacted Statements of Deficiencies (CMS-2567s) for skilled nursing facilities and nursing facilities on *Nursing Home Compare*. In March 2013, CMS began posting CMS-2567s for short-term acute care hospitals and critical access hospitals (CAHs) for surveys based on complaint investigations. This memorandum describes the contents and location of these files.
- ***Other Web-based Tools Based on These Data:*** At least two additional websites, provided by private parties (*ProPublica* and the Association for Health Care Journalists), publish information based on the CMS-2567 data. These websites are independent of CMS. CMS does not endorse or sponsor any particular private party application.
- ***Plans of Correction (POC):*** The posted CMS data do not contain any POC information. State Survey Agencies (SAs) and CMS Regional Offices (RO) may see an increase in requests for both the CMS-2567 and any associated POCs.
- ***Question & Answers:*** We plan to issue an update to this memorandum that will include an attachment of frequently asked questions in order to provide answers to other queries that may arise.

Background – Nursing Home Survey Findings

In July 2012, CMS began posting nursing home statements of deficiencies, derived from the Form

Updated Deficiency Data Reports



- www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals.html

EMTALA Deficiencies

	A	B	C	D	E	F	G	H	I	J	
289	ABBOTT NORTHWESTERN HOSPITAL	24(	800	MN	55407	Short Term	A	2400		10/30/2012	Based on a review of twenty-two emergency department records, patient #1's 9/29/12 inpatient obstetrical record, a revie
290	ADVANCED HEALTHCARE MEDICAL CENTER	261	ROL	MO	63638	Critical Access H	C	2400		3/6/2012	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews
291	ADVOCATE ILLINOIS MASONIC MEDICAL CEN	14(	836	IL	60657	Short Term	A	2400		4/4/2011	A. Based on review of the Transfer Reports log, staff interview and clinical record review, it was determined that for 1 of 1
292	ALEGENT CREIGHTON HEALTH CREIGHTON UI	28(	601	NE	68131	Short Term	A	2400		12/23/2011	Based on record review and interview, the hospital failed to follow their policy and did not provide an adequate medical s
293	ALEGENT HEALTH MEMORIAL HOSPITAL	281	104	NE	68661	Critical Access H	C	2400		7/5/2012	Based on record review, staff interviews and review of facility policies and procedures the facility failed to ensure staff fol
294	ALTRU HOSPITAL	35(	120(	ND	58201	Short Term	A	2400		5/3/2012	Based on record review, review of policies/procedures, and staff interview, the facility failed to enforce policies and proce
295	ATCHISON HOSPITAL	171	800	KS	66002	Critical Access H	C	2400		8/4/2011	Based on record review and interview, the hospital failed to follow their policy and did not provide one patient (patient #1
296	ATCHISON HOSPITAL	171	800	KS	66002	Critical Access H	C	2400		7/20/2011	Based on record review and interview, the hospital failed to follow their policy and did not provide one patient (patient #1
297	ATRIUM MEDICAL CENTER	36(	ONE	OH	45005	Short Term	A	2400		5/12/2011	Based on review of medical records, review of the hospital's policies and procedures and staff interviews, it was determin
298	AURORA MED CTR KENOSHA	52(	104(	WI	53142	Short Term	A	2400		2/8/2012	Based on hospital record review, patient interview and Hospital A and Hospital B staff interviews, review of Hospital A's EM
299	BAPTIST MEDICAL CENTER	10(	800	FL	32207	Short Term	A	2400		4/3/2012	Based on reviews of medical records, Policies and Procedures, and staff interview, the facility failed to provide a medical
300	BAPTIST MEMORIAL HOSPITAL	44(	601	TN	38120	Short Term	A	2400		4/6/2011	Intakes: TN 624Based on interview, the facility failed to ensure documentation of an Emergency Medical Treatment And La
301	BELTON REGIONAL MEDICAL CENTER	26(	170(	MO	64012	Short Term	A	2400		10/3/2012	Based on review of hospital policies, interviews and closed patient medical records, the hospital failed to provide an appr
302	BILLINGS CLINIC HOSPITAL	27(	280(	MT	59101	Short Term	A	2400		3/24/2011	On March 24, 2011, an unannounced on-site EMTALA (Emergency Medical Treatment and Labor Act) complaint investigatior
303	BORGESS MEDICAL CENTER	23(	152:	MI	49048	Short Term	A	2400		11/19/2012	Based on record review and interview, it was determined that the facility failed to comply with the requirements of 42 CFI
304	BRANDON REGIONAL HOSPITAL	10(	119	FL	33511	Short Term	A	2400		11/2/2011	Based on staff interview it was determined the facility failed to comply with 42 CFR 489.24 related to failure to provide a M
305	BRANDON REGIONAL HOSPITAL	10(	119	FL	33511	Short Term	A	2400		8/9/2012	Based on record review, document review, staff interview and policy review, it was determined the facility failed to comp
306	BRIGHAM CITY COMMUNITY HOSPITAL	46(	950	UT	84302	Short Term	A	2400		2/6/2012	Based on review of a 20 patient sample of emergency department medical records, interview with facility staff members a
307	CAMDEN CLARK MEDICAL CENTER	51(	800	WV	26101	Short Term	A	2400		6/14/2012	The hospital failed to comply with the Special Responsibilities of Medicare Hospitals in Emergency Cases (42 CFR 489.24) b
308	CAPE CANAVERAL HOSPITAL	10(	701	FL	32932	Short Term	A	2400		6/15/2011	Based on record review and interview, the facility failed to ensure the medical staff or governing body designated the qua
309	CAPE FEAR VALLEY MEDICAL CENTER	34(	163	NC	28302	Short Term	A	2400		2/22/2012	Based on hospital policy review, closed medical record review, physician interview, Medical Staff Rules and Regulations re
310	CAPE FEAR VALLEY MEDICAL CENTER	34(	163	NC	28302	Short Term	A	2400		11/17/2011	Based on hospital policy review, closed medical record review, security log review, staff and physician interviews, and Con
311	CAPE FEAR VALLEY MEDICAL CENTER	34(	163	NC	28302	Short Term	A	2400		3/4/2011	Based on policy review, closed medical record review, staff and physician interviews, and Transfer Center call log review, t
312	CAROLINAS MED CENTER-MERCY	34(	200:	NC	28207	Short Term	A	2400		5/16/2012	Based on policy and procedure review, closed medical record reviews and staff interviews the facility failed to ensure con
313	CAROLINAS MEDICAL CENTER-LINCOLN	34(	433	NC	28092	Short Term	A	2400		2/18/2011	Based on facility policy review, medical record review, medical staff bylaws review, physician interview, staff interview, in
314	CARONDELET ST MARYS HOSPITAL	03(	160:	AZ	85745	Short Term	A	2400		8/4/2011	Based on review of clinical records, review of policies and procedures/documentation and staff interviews, it was determi
315	CARRINGTON HEALTH CENTER	351	PO I	ND	58421	Critical Access H	C	2400		9/19/2011	Based on record review, review of policies/procedures, and staff interview, the Critical Access Hospital (CAH) failed to enf
316	CASS COUNTY MEMORIAL HOSPITAL	161	150:	IA	50022	Critical Access H	C	2400		3/21/2012	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and staff int
317	CATAWBA VALLEY MEDICAL CENTER	34(	810	NC	28602	Short Term	A	2400		6/23/2011	An unannounced EMTALA complaint survey was conducted to investigate complaint numbers NC 360 and NC 617.Based on
318	CENTRAL FLORIDA REGIONAL HOSPITAL	10(	140:	FL	32771	Short Term	A	2400		7/12/2012	Based on review of medical records, policies and procedures, Medical Staff Bylaws, on-call lists and staff interviews the fa

Sheet1

Deficiencies	Nov 10, 2015
Tag 2400 Compliance with EMTALA 489.24	**660**
Tag 2401 Receiving Inappropriate Transfer	8
Tag 2402 Posting Signs	125
Tag 2403 Maintain MR	24
Tag 2404 On call physician	110

Deficiencies Nov 10, 2015

Tag 2405	ED Log		219	
2406	MSE		505	
2407	Stabilization Treatment		217	
2408	Delay in Exam		54	
2409	Appropriate Transfer		272	
2410	Sp Capability & Lateral Transfers		0	
2411	Recipient Hospital Responsibility		95	**Total 2,303**

CMS Region 4 and 5

- Posting signs regarding guidelines regarding narcotic policy might be considered to be coercive or intimidating to patients who present to the ED with painful medical conditions
- Therefore violating both the language and intent of the EMTALA statute and regulation
- Some patients with legitimate need for pain control might be unduly coerced to leave the ED before receiving an appropriate medical screening exam
  - Consider removing the ED guidelines that may be posted in your ED although no prohibition against following SOC

Posters Regarding Prescribing Pain Medication

ACEP Now
The Official Voice of Emergency Medicine

NAVIGATION

- www.acepnow.com/article/ed-waiting-room-posters-prescribing-pain-medications-may-violate-emtala/

ED Waiting Room Posters on Prescribing Pain Medications May Violate EMTALA

By Richard E. Wild, MD, JD, MBA, FACEP | on January 8, 2014 | 0 Comment

Uncategorized

Statement from CMS region 4 office could have far-reaching implications for EDs nationwide

Ohio Emergency and Acute Care Facility
Opioids and Other Controlled Substances (OOCS) Prescribing Guidelines

These guidelines are to provide a general approach in the prescribing of OOCS. They are not intended to take the place of clinical judgment, which should always be utilized to provide the most appropriate care to meet the unique needs of each patient.

1. OOCS for acute pain, chronic pain and acute exacerbations of chronic pain will be prescribed in emergency/acute care facilities only when appropriate based on the patient's presenting symptoms, overall condition, clinical examination and risk for addiction.
    a. Doses of OOCS for routine chronic pain or acute exacerbations of chronic pain will typically NOT be given in injection (IM or IV) form.
    b. Prescriptions for chronic pain will typically NOT be provided if the patient has either previously presented with the same problem or received an OOCS prescription from another provider within the last month.
    c. IV Demerol (Meperidine) for acute or chronic pain is discouraged.

2. Emergency medical clinicians will not routinely provide:
    a. Replacement prescriptions for OOCS that were lost, destroyed or stolen.
    b. Replacement doses of Suboxone, Subutex or Methadone for patients in a treatment program.
    c. Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, and methadone).

3. Prior to making a final determination regarding whether a patient will be provided a prescription for OOCS, the emergency clinician or facility:
    a. Should search the Ohio Automated Rx Reporting System (OARRS) database (https://www.ohiopmp.gov/portal/Default.aspx) or other prescription monitoring programs, per state rules.
    b. Reserves the right to request a photo ID to confirm the identity of the patient. If no photo ID is available, the emergency or other acute care

5. Prior to making a final determination regarding whether a patient will be provided a prescription for an OOCS, the emergency clinician should consider the following options:
    a. Contact the patient's routine provider who usually prescribes their OOCS.
    b. Request a consultation from their hospital's palliative or pain service (if available), or an appropriate sub-specialty service.
    c. Perform case review or case management for patients who frequently visit the emergency/ acute care facilities with pain-related complaints.
    d. Request medical and prescription records from other hospitals, provider's offices, etc.
    e. Request that the patient sign a pain agreement that outlines the expectations of the emergency clinician with regard to appropriate use of prescriptions for OOCS.

6. Emergency/acute care facilities should use available electronic medical resources to coordinate the care of patients who frequently visit the facility, allowing information exchange between emergency/acute care facilities and other community-care providers.

7. Except in rare circumstances, prescriptions for OOCS should be limited to a three-day supply. Most conditions seen in the emergency/acute care facility should resolve or improve within a few days. Continued pain needs referral to the primary care physician or appropriate specialist for re-evaluation.

8. Each patient leaving the emergency/acute care facility with a prescription for OOCS should be provided with detailed information about the addictive nature of these medications, the potential dangers of misuse and the

The Basic Concept of EMTALA

- Hospitals that participate in the Medicare program must provide a medical screening exam to determine if the patient is in an emergency medical condition (EMC) and if so must be provided stabilizing treatment or transfer
- Provided to any person who comes to the ED requesting emergency services
- Passed to prohibit hospitals from denying care to women in labor

Original Case

- Case ignited blitz of national coverage
- Eugene Barnes, 32 YO male brought on 1-28-85 to Brookside Hospital ED
- Had penetrating stab wound to scalp and the neurosurgeon refused to come
- Called 3 other hospitals and refused to take
- Finally sent to San Francisco General four hours after arrival but patient died

Who Are the Players?

- CMS or the Center for Medicare and Medicaid Services
- OIG is the Office of Inspector General
- QIO (Quality Improvement Organization)
- State survey agencies (abbreviated SA and an example is the Department of Health)

CMS EMTALA Website

- CMS has a website that lists resources on this issue
- It includes CMS guidance to state survey agency directors and CMS regional offices
- Includes information about the Technical Advisory Group (TAG)
- Available at www.cms.hhs.gov/EMTALA/
  - New website where all manuals are located at www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf

CMS EMTALA Website

- Exam and treatment of women in labor
- Payment for EMTALA
- Final rule on EMTALA
- Interpretive Guidelines May 29, 2009 and amended July 16, 2010
- Provider agreement under SSA

CMS EMTALA Website

- www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html

CMS EMTALA Website

- www.cms.gov/EMTALA/

EMTALA

- Overview
- CMS Guidance to State Survey Agency Directors
- Emergency Medical Treatment and Labor Act Technical Advisory Group (EMTALA TAG)

CMS Guidance to State Survey Agency Directors

CMS guidance to state survey agency directors and CMS regional offices.

The purpose of these memorandum is to release the revised EMTALA interpretive guidelines to the regional offices (ROs) and State Survey Agencies (SAs).

Downloads

There are no Downloads

Related Links Inside CMS

EMTALA Survey & Certification Letters

Related Links Outside CMS

There are no Related Links Outside CMS

EMTALA Policy Memos

Title	Memo #	Posting Date	Fiscal Year
EMTALA Regulation Changes and H1N1 Pandemic Flu and EMTALA Waivers	10-05-EMTALA	10/06/2009	2010
EMTALA Requirements and Options for Hospitals in a Disaster	09-52	08/14/2009	2009
Inpatient Prospective Payment System (IPPS) 2009 Final Rule Revisions to EMTALA Regulations	09-26	03/06/2009	2009
Waiver of EMTALA Sanctions in Hospitals Located in Areas Covered by a Public Health Emergency	08-05 (revised)	12/07/2007	2008
Revised State Operations Manual Appendix V - EMTALA	08-15	03/21/2008	2008
EMTALA Issues Related to Emergency Transport Services	07-20	04/27/2007	2007
EMTALA On-Call Requirements and Remote Consultation Utilizing Telecommunications Media	07-23	06/22/2007	2007
Revisions to Special Responsibilities of Hospitals under EMTALA	06-21	07/13/2006	2006
Revisions to Special Responsibilities of Hospitals under EMTALA	06-32	09/29/2006	2006

CMS Memo Dec 13, 2013

- CMS issues 7 page memo dated Dec 13, 2013 regarding payor requirements and collection practices
- Every hospital should be familiar with this memo
- EMTALA is a federal law and pre-empts any inconsistent state law
- Some proposed or existing payment policies of third party payors of hospital services are in violation of the federal EMTALA law

CMS Memo Dec 13, 2013

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality /Survey & Certification Group

Ref: S&C: 14-06-Hospitals /CAHs

DATE: **December 13, 2013**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Emergency Medical Treatment and Labor Act (EMTALA) Requirements & Conflicting Payor Requirements or Collection Practices

Memorandum Summary

- ***EMTALA & Payor Requirements:*** Some proposed or existing payment policies of third party payors of hospital services have generated confusion among providers about their EMTALA obligations. The Centers for Medicare & Medicaid Services (CMS) is clarifying for Medicare-participating hospitals and critical access hospitals (CAH) that they are required to comply with EMTALA, regardless of any conflicting requirements of third-party payors, including when those payors are State Medicaid programs.

- ***Certain Hospital Collection Practices May Also Conflict with EMTALA:*** It is not acceptable for a hospital or CAH to request immediate payment, by cash or other methods, for services provided to an individual who is protected under EMTALA prior to the receipt of such services. A hospital may only request on-the-spot payment after it has conducted an appropriate medical screening examination (MSE) and, if applicable, stabilized an individual's emergency medical condition (EMC) or admitted the individual. Hospital patients are further protected under the patient's rights Condition of Participation at 42 CFR 482.13(c)(3), which protects patients from abuse or harassment.

CMS Memo Dec 13, 2013

- Hospital cannot request payment or co-pays until **after** an appropriate medical screening exam (MSE) is done and the emergency medical condition (EMC) is stabilized
- The ACA provided several provisions requiring certain insurers to cover emergency services, including stabilization, with preauthorization
- Some have asked CMS to intervene if they believe a state Medicaid policy conflicts with EMTALA
- CMS will only approve ones that do not conflict with EMTALA

EMTALA, CAH & Telemedicine

- CMS welcomes the use of telemedicine by CAH
- CAH not required to have a doctor to appear when patient comes to the ED
- PA, NP, CNS, or physician with emergency care experience must show up within 30 minutes
- If MD/DO does not show up must be immediately available by phone or radio contact 24 hours a day
- This can be met by use of telemedicine physician or the physician on site

CMS S&C Memo EMTALA & CAH

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 13-38-CAH/EMTALA

DATE: **June 7, 2013**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Critical Access Hospital (CAH) Emergency Services and Telemedicine: Implications for Emergency Services Condition of Participation (CoPs) and Emergency Medical Treatment and Labor Act (EMTALA) On-Call Compliance

Memorandum Summary

- ***The Center for Medicare & Medicaid Services (CMS) Welcomes use of Telemedicine by CAHs:*** Telemedicine has great potential to expand availability of specialty care services, including emergency medicine services, to rural populations. However, misconceptions about CAH CoP and EMTALA requirements may cause unnecessary concerns about, or create barriers to, using telemedicine.

- ***The CAH Emergency Services CoP does not Require a Physician to Appear On-site Whenever an Individual Comes to the Emergency Department (ED):***
  - Under 42 CFR 485.618(d), a doctor of medicine (MD), a doctor of osteopathy (DO), a physician assistant (PA), a nurse practitioner (NP), or a clinical nurse specialist (CNS), with training or experience in emergency care, must be immediately available by telephone or radio, and available on-site within 30 minutes (60 minutes for CAHs in frontier areas that meet certain conditions). Under the CAH CoPs an MD or DO is *not* required to be available *in addition* to a non-physician practitioner.
  - Under the CoP at §485.618(e), an MD or DO must be immediately available by telephone or radio contact on a 24-hours a day basis to receive emergency calls, provide information on treatment of emergency patients, and refer patients. This requirement can be met by the use of a telemedicine MD/DO as well as by an MD/DO who practices on-site at the CAH.

- ***EMTALA is Not a Barrier to Using Telemedicine to Extend CAH Emergency Services:***
  - If using telemedicine for emergency and other services, a CAH is not required to include the telemedicine physicians on its physician on-call list mandated under the

EMTALA and Ebola

- CMS issues 4 page survey memo on November 21, 2014 and questions at hospitalSCG@cms.hhs.gov
- Every hospital, including CAHs, with a DED, must conduct an appropriate MSE on all patients coming to the ED
- This includes patients suspected of having been exposed to Ebola
- All EDs are expected to be able to apply appropriate Ebola screening
- And if necessary to isolate and notify state agency

EMTALA and Ebola

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey and Certification Group

Ref: S&C: 15-10-Hospitals

DATE: **November 21, 2014**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implications Related to Ebola Virus Disease (Ebola)

Memorandum Summary

- ***Ebola and EMTALA requirements:*** This Memorandum conveys information useful in responding to inquiries from hospitals concerning implications of Ebola for their compliance with EMTALA.
- ***EMTALA Screening Obligation:*** Every hospital or critical access hospital (CAH) with a dedicated emergency department (ED) is required to conduct an appropriate medical screening examination (MSE) of all individuals who come to the ED, including individuals who are suspected of having been exposed to Ebola, and regardless of whether they arrive by ambulance or are walk-ins. Every ED is expected to have the capability to apply appropriate Ebola screening criteria when applicable, to immediately isolate individuals who meet the screening criteria to be a potential Ebola case, to contact their state or local public health officials to determine if Ebola testing is needed, and, when a decision to test is made, to provide treatment to the individual, using appropriate isolation precautions, until a determination is made whether the individual has Ebola.
- ***EMTALA Stabilization, Transfer & Recipient Hospital Obligations:*** In the case of individuals who have Ebola, hospitals and CAHs are expected to consider current guidance of public health officials in determining whether they have the capability to provide appropriate isolation required for

EMTALA and Ebola

- If patient has Ebola then must follow current guidelines
- If any complaints, CMS will take into consideration the public health guidance in effect at the time
- Hospitals are encouraged to monitor the CDC's website for the current guidance and information
- CMS has received a number of inquiries from hospitals regarding their EMTALA obligations
- EMS or public health protocols may develop community wide protocols for bringing patients only to specified hospitals if suspected of having Ebola

CMS Memo Q&A Ebola

- CMS Issues 13 page FAQ memo on Feb 13, 2015
- CMS issued after receiving many questions on this topic
- Hospitals with specialized capabilities should accept appropriate transfers if they have capacity to provide care including those with Ebola
- The states are formally identifying hospitals that are qualified as a EVD treatment facility
- CDC's 3 tiered system does not violate EMTALA: frontline healthcare facility, Ebola assessment hospital and Ebola treatment hospital
- Questions can be addressed to hospitalscg@cms.hhs.gov

CMS Memo Feb 13, 2015 Q&A Ebola

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 15-24-Hospitals

DATE: **February 13, 2015**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Emergency Medical Treatment and Labor Act (EMTALA) and Ebola Virus Disease (EVD) – Questions and Answers (Q+A)

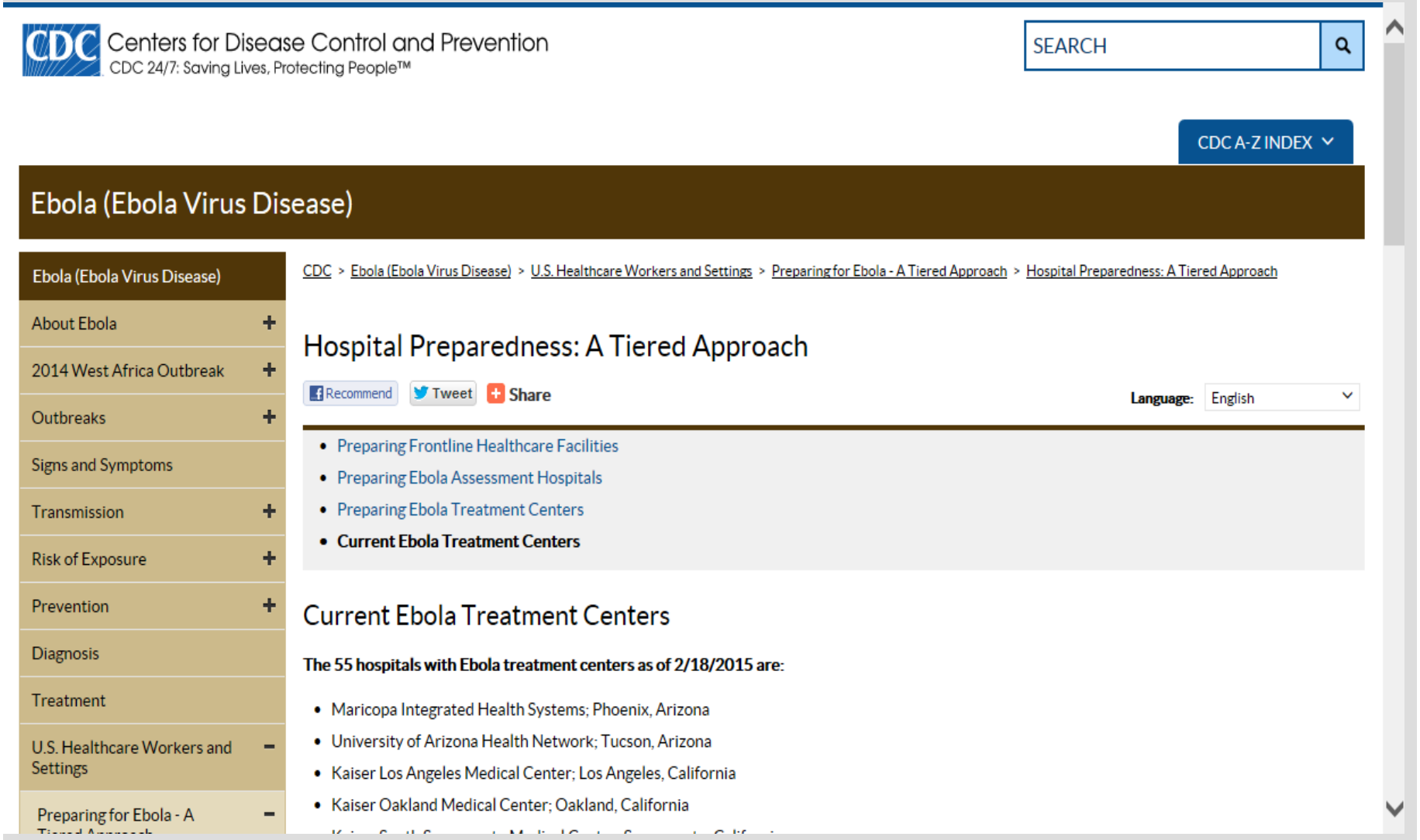
Memorandum Summary

***EMTALA & Ebola Requirements*:**

- On November 21, 2014 the Centers for Medicare & Medicaid Services (CMS) Survey & Certification Group released SC 15-10-Hospitals concerning EMTALA Requirements and Implications Related to the EVD.
- The CMS has received follow-up questions regarding EMTALA and Ebola and has produced a Q+A document in response.

The CMS released S&C 15-10 on November 21, 2014 to provide guidance to hospitals and critical access hospitals (CAHs) regarding meeting EMTALA requirements in the case of individuals potentially exposed to Ebola. The memo is available via the following link:

CDC Updates List of Treatment Centers



ENA and Ebola

- ENA has many resources available
- Discusses how we triage patients
  - Determine if the patient has a fever
  - Ask patients about travel to Ebola effected area in the last 21 days
  - If yes isolate until further screening is done
- Discusses how to don and doff PPE
  - Use a buddy system to make sure equipment is put on and taken off correctly
- Guidelines on how to transport patients

ENA Website on Ebola Resources

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Home » About ENA » Media » Ebola News and Resources

Ebola News and Resources

As the Ebola story continues to evolve, ENA would like to keep you informed with current and accurate information of the management of this health issue in the US. The current CDC guidelines on restricted movement, current as of October 29th, 2014 has been posted to the ENA Ebola resource website under Preparedness. The supportive evidence to assist you to write guidance and corresponding protocols is being developed on a daily basis. ENA recommends that emergency nurses remain informed, review information from recognized sources, and to assure appropriate communication and reassurances in your various clinical settings on how to meet this health emergency. Emergency nurses are masters of FACT not FEAR. We salute you and everything you do every day.

Get Started with our FAQs

News

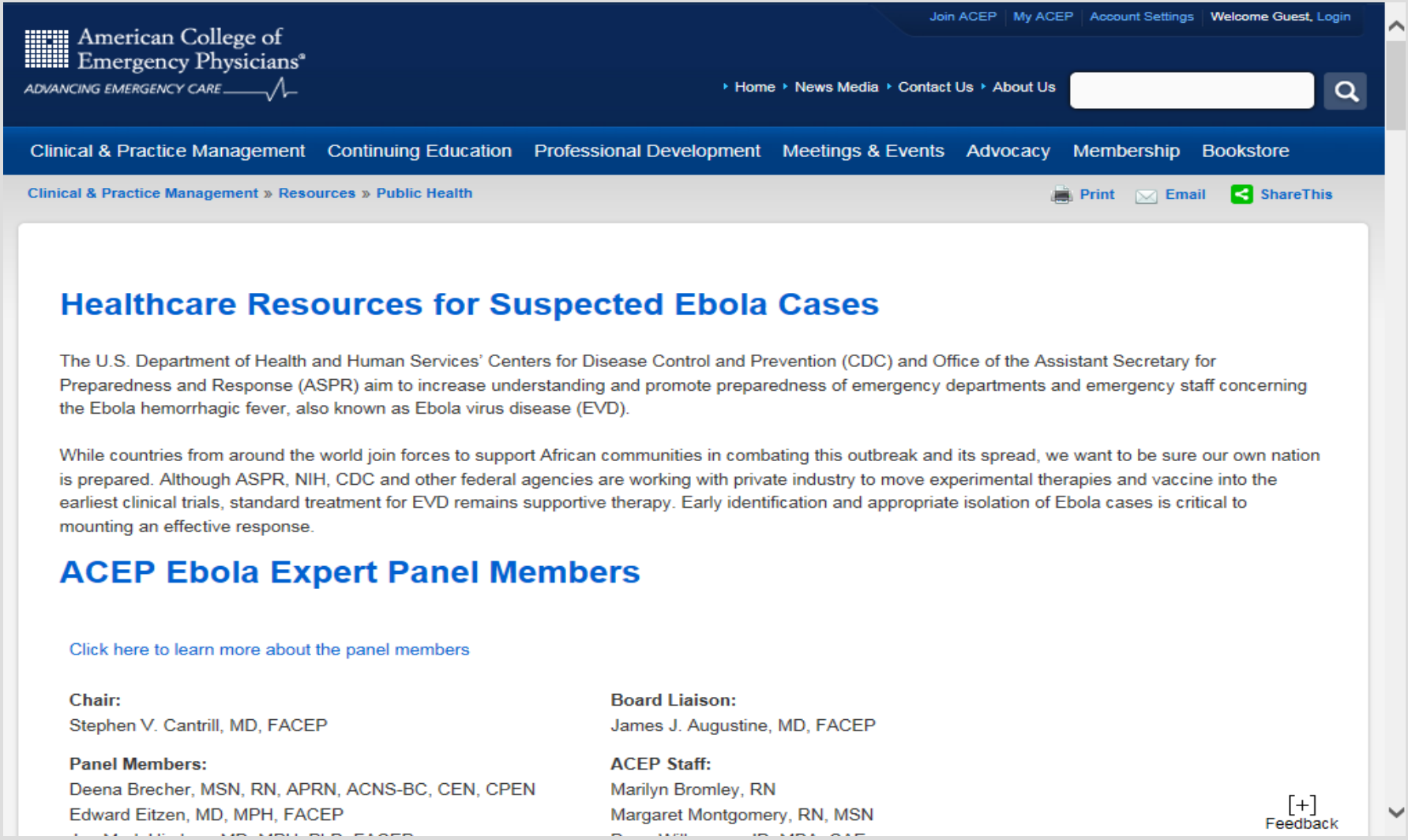
- www.ena.org/about/media/ebola/Pages/default.aspx?utm_source=iContact&utm_medium=email&utm_campaign=Emergency%20Nurses%20Association&utm_content=10-16-14+Ebola

Press Releases
Breaking News
ENA News Updates
CDC Health Advisory
Ebola News and

For additional information visit the ENA President's Blog

Table of Contents
News
General Information and Disease Transmission

ACEP Resources on Ebola



Identify, Isolate, Inform

News & Updates

- Key Messages: Ebola Virus Disease - Nov. 19, 2014
- ACEP at the White House - Nov. 13, 2014
  Video of ACEP President Dr. Mike Gerardi's visit to discuss Ebola preparedness
- Ten Key "Facts" About Ebola: True or False? - Nov. 7, 2014
  From *NEJM Journal Watch*
- ACEP Ebola Expert Panel Consensus Statement on Restrictive Movement, Including Quarantine of Health Care Workers - Nov. 13, 2014
- CDC Ebola Expert Tim Uyeki, MD, MPH, Offers Ebola Management and Safety Information - Nov. 13, 2014
  From *ACEP Now*

Ebola Background & Diagnosis

- Case Definition for Ebola Virus Disease (EVD) - updated Nov. 16, 2014
- Ebola (Ebola Virus Disease) Signs and Symptoms - updated Nov. 14, 2014
- Safe Management of Patients with Ebola Virus Disease (EVD) in U.S. Hospitals - updated Nov. 16, 2104

ED Triage

- Identify, Isolate, Inform: Emergency Department Evaluation and Management for Patients Who Present with Possible

[+] Feedback

Major Revisions May 29, 2009 Amended July 2010

Part II - Interpretive Guidelines - Responsibilities of Medicare Participating Hospitals in Emergency Cases

The Interpretive Guidelines is a tool for surveyors where the regulation is broken into regulatory citations (tag numbers), followed by the regulation language and provides detailed interpretation of the regulation(s) to surveyors.

Basic Section 1866 Commitments Relevant to Section 1867 Responsibilities – *Tags A-2400/C2400 – A2405/C2405*

(Rev.46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

Tag A-2400/C-2400

(Rev.46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

§489.20(l)

[The provider agrees to the following:]

(l) In the case of a hospital as defined in §489.24 (b) *to comply with §489.24* .

Current CMS EMTALA Manual

State Operations Manual

Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases

(Rev. 60, 07-16-10)

Transmittals for Appendix V

Part I- Investigative Procedures

- http://www.cms.gov/EMTALA/

Part II - Interpretive Guidelines - Responsibilities of Medicare

Medicare State Operations Manual

Appendix

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the 'Download' column to see any available file in PDF.
- To return to this page after opening a PDF file on your desktop. use the browser "back" button. This is because closing the file usually will also close most browsers

- New at www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf

App. No.	Description	PDF File
A	Hospitals	2,185 KB
AA	Psychiatric Hospitals	606 KB

CMS Complaint Manual

- CMS has a manual which assists surveyors in reviewing complaints
- It is SOM Manual, Chapter 5, Complaint Procedures
- It has a section for surveyors on how to review an EMTALA complaint
- Hospitals should be aware of the information contained in the complaint manual
  - Will ask for list of on call physicians

CMS Complaint Manual

- www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c05.pdf

State Operations Manual
Chapter 5 - Complaint Procedures

Table of Contents
(Rev. 88, 08-27-13)

Transmittals for Chapter 5

Sections 5000 to 5080.1 relate to all Medicare/Medicaid-certified provider/supplier types.

Sections 5400 to 5480.2 relate to alleged EMTALA violations

5400 - Investigations Involving Alleged EMTALA Violations

5410 - EMTALA and Born-Alive Infants Protection Act of 2002

- 5410.1 - Interaction of the Born-Alive Infant Protection Act and EMTALA
- 5410.3 - Conduct of Investigations

5420 - Basis for Investigation

5430 - RO Direction of Investigation

- 5430.1 - Evaluation of Allegation
- 5430.2 - Request for Investigation of Allegations

5440 - Conducting an Investigation

- 5440.1 - Selecting the Team
- 5440.2 - Scheduling the Investigation
- 5440.3 - Guidelines for Surveyors Conducting Investigations
- 5440.4 - Conducting the Investigation
- 5440.5 - Exit Conference

5450 - Forwarding Report of Investigation to the RO

5460 - RO Review of Investigation

- 5460.1 - Hospital Is In Compliance - No Past Violation
- 5460.2 - Hospital Is In Compliance - Past Violation, No Termination
- 5460.3 - Hospital Is Not in Compliance - Immediate Jeopardy to Patient Health and Safety
- 5460.4 - Hospital Is Not in Compliance - Situation Does Not Pose an Immediate Jeopardy to Patient Health and Safety

Investigating EMTALA Complaints

5400 - Investigations Involving Alleged Emergency Medical Treatment and Labor Act (EMTALA) Violations
(Rev. 18, Issued: 03-17-06; Effective/Implementation Dates: 03-17-06)

Section 1866 of the Act, Agreements with Providers of Services, specifies that for a hospital, or any provider of services, to qualify for participation in the Medicare program, it must enter into an agreement with the Secretary of HHS. Effective August 1, 1986, participating hospitals with emergency departments must comply with the requirements of §1867 of the Act as a condition of their provider agreement.

The following Medicare provider agreement requirements, which closely parallel provisions contained in §1866of the Act, must be met by Medicare participating hospitals with emergency departments:

- 42 CFR 489.20(l) requires a hospital to comply with the requirements of 42 CFR 489.24. Section **1866(a)(1)(I)** of the Act requires a hospital to have and enforce policies to ensure compliance with the requirements of §1867;

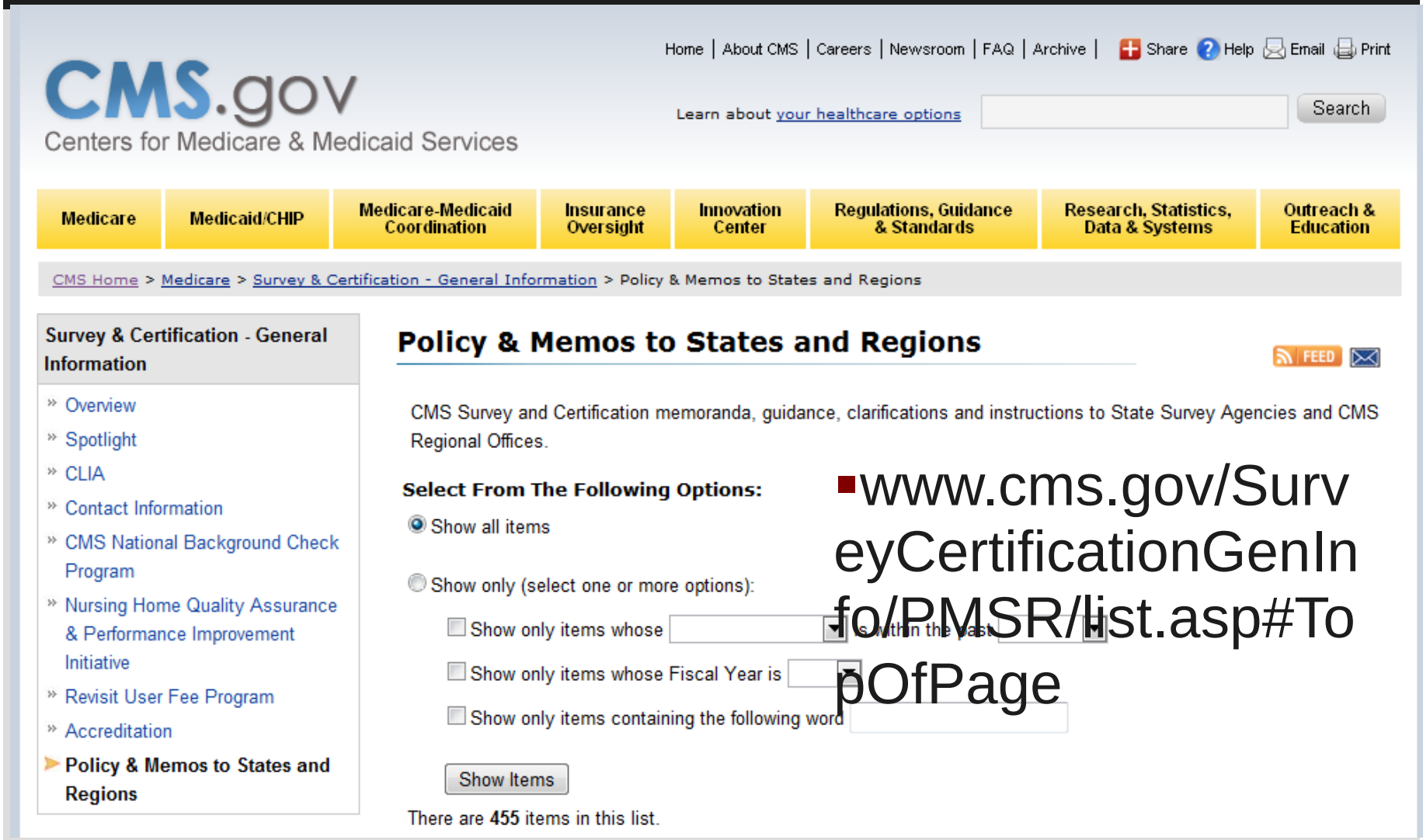
- 42 CFR 489.20(m) requires a hospital to report to CMS or the SA any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition (EMC) from another hospital in violation of the requirements of 42 CFR 489.24(e);

- 42 CFR 489.20(q) requires a hospital to post conspicuously a sign(s) specifying the rights of individuals, under **§1867** of the Act, with respect to examination and treatment for emergency medical conditions and women in labor and to indicate whether or not the hospital participates in the Medicaid program. The letters within the signs must be clearly readable at a distance of at least 20 feet or the expected vantage point of the emergency department clients. The wording of the sign(s) must be clear and in simple terms and language(s) that are understandable by the population served by the hospital;

Policy & Memos to States and Regions

- This is a very important website
- Hospitals may want to have one person periodically check this, at least once a month
- This is where new interpretive guidelines are published
- This is where new EMTALA memos are posted
- www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

CMS Survey and Certification Website



- www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

OIG Compliance Program Guidance for Hospitals

- Department of HHS, OIG, issued "Supplemental Compliance Program Guidance (CPG) for Hospitals issued January 2005
  - Available at http://oig.hhs.gov/fraud/complianceguidance.asp
- OIG promotes voluntary compliance programs for hospitals
- This document contained a section on EMTALA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

OIG Supplemental Compliance Program Guidance for Hospitals

AGENCY: Office of Inspector General (OIG), HHS.

ACTION: Notice.

SUMMARY: This **Federal Register** notice sets forth the Supplemental Compliance Program Guidance (CPG) for Hospitals developed by the Office of Inspector General (OIG). Through this notice, the OIG is supplementing its prior compliance program guidance for hospitals issued in 1998. The supplemental CPG contains new compliance recommendations and an expanded discussion of risk areas, taking into account recent changes to hospital payment systems and

relevant risk areas. Copies of these CPGs can be found on the OIG Web page at *http://oig.hhs.gov.*

Supplementing the Compliance Program Guidance for Hospitals

The OIG originally published a CPG for the hospital industry on February 23, 1998. (*See* 63 FR 8987 (February 23, 1998), available on our Web page at *http://oig.hhs.gov/authorities/docs/cpghosp.pdf.*) Since that time, there have been significant changes in the way hospitals deliver, and are reimbursed for, health care services. In response to these developments, on June 18, 2002, the OIG published a notice in the **Federal Register,** soliciting public suggestions for revising the hospital CPG. (*See* 67 FR 41433 (June 18, 2002), available on our Web page at *http://oig.hhs.gov/authorities/docs/cpghospitalsolicitationnotice.pdf.*) After consideration of the public comments and the issues raised, the OIG published

Services (the Department) publishes this Supplemental Compliance Program Guidance (CPG) for Hospitals.[1] This document supplements, rather than replaces, the OIG's 1998 CPG for the hospital industry (63 FR 8987; February 23, 1998), which addressed the fundamentals of establishing an effective compliance program.[2] Neither this supplemental CPG, nor the original 1998 CPG, is a model compliance program. Rather, collectively the two documents offer a set of guidelines that hospitals should consider when developing and implementing a new compliance program or evaluating an existing one.

We are mindful that many hospitals have already devoted substantial time and resources to compliance efforts. We believe that those efforts demonstrate the industry's good faith commitment to ensuring and promoting integrity. For those hospitals with existing

EMTALA OIG CPG for Hospitals

- Hospitals should review their obligations under this federal law
- Know when to do a medical screening exam
- Know when patient has an emergency medical condition
- Know screening can not be delayed to inquire about method of payment or insurance

EMTALA OIG CPG for Hospitals

- If on diversion and patient shows up- they are yours
- Do not transfer a patient unless there is a transfer agreement for unstable patients with benefits and risks
- Provide stabilizing treatment to minimize the risks of transfer
- Medical records must accompany the patient
- Understand specialized capability provision

EMTALA OIG

- Must provide screening and treatment within full capability of hospital including staff and facilities
  - Includes on call specialist
- On call physicians need to be educated on their responsibilities including responsibility to accept transferred individuals from other facilities
- Must have policies and procedures
- Persons working in the ED should be periodically trained and reminded of EMTALA obligations and hospital's P&P

EMTALA OIG

- On call physicians need to be educated on their responsibilities including responsibility to accept transferred individuals from other facilities
- Must have policies and procedures
- Persons working in the ED should be periodically trained and reminded of EMTALA obligations and hospital's P&P

Introduction to EMTALA

- EMTALA is a COP (Condition of Participation) in the Medicare program for hospitals (PPS) and critical access hospitals (CAH)
- Hospitals agree to comply with the provisions by accepting Medicare payments
- Hospitals should maintain a **copy** of these interpretative guidelines (the most important resource)
- Recommend hospitals have a resource book on EMTALA in ED, OB, and behavioral health units

CMS EMTALA Interpretive Guideline

- Revised EMTALA guidelines published May 29, 2009, amended July 16, 2010, and continues
  - copy at http://cms.hhs.gov/manuals/Downloads/som107ap_v_emerg.pdf
    - Amended Tag 2406 on waivers
- First, the regulation is published in the federal register
- Next, CMS take and adds interpretive guidelines and survey procedure
- Not all sections have a survey procedure

Current CMS EMTALA Manual

State Operations Manual

Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases

(Rev. 60, 07-16-10)

Transmittals for Appendix V

Part I- Investigative Procedures

cms.hhs.gov/manuals/Downloads/som107ap_v_emerg.pdf

Part II - Interpretive Guidelines - Responsibilities of Medicare

CMS Interpretive Guidelines

- Each section has a tag number
- To read more about any section go to the tag number such as A-2403/C-2403
- A indicates a hospital standard and C is for Critical Access Hospitals
- 68 pages long and starts with Tag 2400 and goes to Tag to 2411
- First part is the investigative procedures and includes entrance, record review, exit conference etc.

CMS Interpretive Guidelines

- Part II is the section on responsibilities of Medicare Participating Hospitals in Emergency Cases
- Includes on-call physician requirements
- Includes use of dedicated emergency departments (DEDs)
- Includes stabilization and transfer requirements

Sample Page

Tag *A-2403/C-2403*

(Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

§489.20(r)

[The provider agrees to the following:]

In the case of a hospital as defined in §489.24(b) (including both the transferring and receiving hospitals), to maintain—

(1) Medical and other records related to individuals transferred to or from the hospital for a period of 5 years from the date of transfer;

Interpretive Guidelines: §489.20(r)(1)

The medical records of individuals transferred to or from the hospital must be retained in their original or legally reproduced form in hard copy, microfilm, microfiche, optical disks, computer disks, or computer memory for a period of 5 years from the date of transfer.

On Call Physician Issues

On Call Physicians

- January 17, 2008 study found 75% of hospital EDs do not have enough specialists to treat patients, especially cardiac and neurological problems
- Strategies include: enforcing hospital medical staff bylaws that require physicians to take call
- Contracting with physicians to provide coverage
- Paying physicians stipends and employing physicians
- Study “Hospital emergency on-call coverage: Is there a doctor in the house?” Center for Studying Health System Change, http://www.hschange.com/CONTENT/956/

On Call Physicians

- 21% of deaths and permanent injuries related to ED delays due to lack of physician specialists
- National survey that 36% of hospitals pay at least one specialist to be on call, most often a surgeon
- Little Rock hospital pays trauma surgeon $1,000 a night to be on call
- Miami hospital reports paying $10 million a year for on call emergency coverage
- ACEP report cited the 2008 report
  - ACEP has practice position on EMTALA also at www.acep.org

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- EMS & Disaster Preparedness
- Find a Physician Group
- Residency Programs

EMTALA and On-call Responsibility for Emergency Department Patients

Revised and approved by ACEP Board of Directors April 2006
Replaces policy statement entitled "Hospital, Medical Staff, and Payer Responsibility for Emergency Department Patients" approved September 1999; revised and replaced "Medical Staff Responsibility for Emergency Department Patients" approved by the ACEP Board of Directors September 1997 and "Medical Staff Call Schedule" approved as a Board Motion 1987

The American College of Emergency Physicians (ACEP) believes that:

- Hospitals, medical staff, and payers share an ethical responsibility for the provision of emergency care.
- Hospital emergency departments (EDs) require a reliable on-call system that

Related Links

Policy statements

- www.acep.org

ACEP On-Call Physicians

ACEP endorses the following principles:

- Hospitals and their medical staffs must be familiar with and comply with the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA).[1]
- All patients who come to an ED requesting care must receive a medical screening examination and the necessary treatment to stabilize an emergency medical condition without unnecessary delay and without regard to the patient's ability to pay.[1,2] Under most circumstances, these services are best provided by an emergency physician.
- A medical screening examination and any necessary stabilizing treatment may require the use of ancillary, consultative, or inpatient services within the capability of the hospital and its medical staff.[1]
- All hospitals that provide emergency services must maintain a schedule of medical and surgical specialists on-call for the ED in a manner that best meets the needs of the hospital's patients who are receiving services.[1]
- To ensure institutional compliance with the provisions of EMTALA, hospital medical staff bylaws and/or rules, and regulations must delineate the responsibilities of the on-call physician and should specify methods for monitoring and ensuring compliance.
- On-call physician services must be available within a reasonable time to provide necessary stabilizing treatment1 and without regard to the patient's ability to pay.
- If a hospital lacks the medical staff resources to provide on-call coverage for a given specialty, the hospital must have a plan that specifies how such referrals should be managed.[1]
- Follow-up care should be arranged for all patients who require such care.
- Physicians who choose to assume direct on-site emergency care responsibility for their patients must be physically present in the ED and must be members of the medical staff, privileged to provide such care.
- Requests for consultative services should be made in accordance with the patient's preferences and/or health plan when feasible.
- Physician services (including medically necessary post-stabilization care), when provided in response to the request for emergency care, should be recognized as emergency services for reimbursement purposes and should be compensated in

Appropriate Interhospital Patient Transfer

Revised and approved by the ACEP Board of Directors September 1992 titled, "Appropriate Interhospital Patient Transfer; June 1997; February 2002; and February 2009
Originally approved by the ACEP Board of Directors September 1989 as a position statement titled, "Principles of Appropriate Patient Transfer"

The American College of Emergency Physicians (ACEP) believes that quality emergency care should be universally available and accessible to the public. For patients evaluated or treated in the emergency department (ED) who require transfer from the ED to another facility, ACEP endorses the following principles regarding patient transfer.

- The optimal health and well-being of the patient should be the principal goal of patient transfer.
- Emergency physicians and hospital personnel should abide by applicable laws regarding patient transfer. All patients should be provided a medical screening examination (MSE) and stabilizing treatment within the capacity of the facility before transfer. If a competent patient requests transfer before the completion of the MSE and stabilizing treatment, these should be offered to the patient and documented. Hospital policies and procedures should articulate these obligations and ensure safe and efficient transfer.
- The transferring physician should inform the patient or responsible party of the risks and the benefits of transfer and document these. Before transfer, patient consent should be obtained and documented whenever possible.
- The hospital policies and procedures and/or medical staff bylaws should identify the individuals responsible for and qualified to perform MSEs. The policies and procedures or bylaws must define who is responsible for accepting and transferring patients on behalf of the hospital. The examining physician at the transferring hospital will use his or her best judgment regarding the condition of

OIG CPG for Hospitals

- Remember the Department of HHS, OIG, issued “Supplemental Compliance Program Guidance (CPG) for Hospitals, January 2005 report discussed earlier
- On call physicians need to be educated on their responsibilities including responsibility to accept transferred individuals from other facilities

On Call Physician Issues

- So what do you do to educate your on call physicians?
- Is education mandatory as a condition for being credentialed and privileged?
  - Mandatory for new staff and periodically
- Hospitals can make it simple
- Hospitals can have supplemental materials such as videotape, self assessment learning guide, or educational CD
- Sample education memo at end

On Call Physician Issues

- Some on call physicians should receive orientation to the hospital's P&P on EMTALA
- For example, emergency department physicians need to be well versed on the federal EMTALA law (also OB and psychiatrists)
- Remember, the OIG can assess money damages or exclude physicians from the Medicare program if they violate EMTALA

On-Call Physicians 2404

- There were many changes to the EMTALA regulations in 2009 IPPS that significantly impact EMTALA's on-call obligations
- Referred to as the shared/community call
- Page 222 of 651 page FR PDF format (73 FR 48434) ,CMS issues memo on same March, 2009 and now Tag number 2404 in May 2009 edition
- Implemented some of the 55 recommendations from the EMTALA Technical Advisory Group that concluded its work in 2007
- http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter09-26.pdf

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Service
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-09-26

DATE: **March 6, 2009**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: **Inpatient Prospective Payment System (IPPS) 2009 Final Rule Revisions to Emergency Medical Treatment and Labor Act (EMTALA) Regulations**

Memorandum Summary

- **EMTALA Regulations Revised**: The Fiscal Year (FY) 2009 IPPS final rule included EMTALA revisions, effective October 1, 2008.
- **On-Call Obligations**: The regulatory provisions have been revised and reorganized. Key changes include introduction of a shared community call (CCP) plan option and elimination of ambiguous language concerning on-call list criteria.

Final Rule Changes

- Moved the physician on call requirements from the EMTALA regulation section (§ 489.24(j)(1)) to the provider agreement regulations (§ 489.20(r)(2)
- CMS backed off a plan to expand EMTALA to hospitals that receive transferred patients
- CMS said a hospital with specialized capabilities is not required under EMTALA to accept the transfer of a hospital **inpatient**
- Would still have to accept an unstable patient in the ED if the hospital has specialized capabilities

Provider Agreement Basic Commit 489.20

individuals waiting for examination and treatment in areas other than traditional emergency departments (that is, entrance, admitting area, waiting room, treatment area), a sign (in a form specified by the Secretary) specifying rights of individuals under Section 1867 of the Act with respect to examination and treatment for emergency medical conditions and women in labor; and

(2) To post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital or rural primary care hospital participates in the Medicaid program under a State plan approved under title XIX.

(r) In the case of a hospital as defined in §489.24(b) (including both the transferring and receiving hospitals), to maintain—

(1) Medical and other records related to individuals transferred to or from the hospital for a period of 5 years from the date of the transfer;

(2) A list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition; and

(3) A central log on each individual who comes to the emergency department, as defined in §489.24(b), seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged.

(s) In the case of an SNF, either to furnish directly or make arrangements (as defined in

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

top

Link to an amendment published at 71 FR 48143, Aug. 18, 2006.

(a) *Applicability of provisions of this section.* (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must—

(i) Provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction; and

(ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.

Final Rule Revision

- Revised the EMTALA regulations, section on on-call obligations, emergency waivers, and recipient hospital responsibilities
- "Community Call" program that would allow hospitals to work together to satisfy their EMTALA obligations
- The Community Call requirements include a written agreement that addresses key critical points
- Requires a written P&P

On-Call List 2404

- The new language reads as follows;

  An on-call list of physicians on its medical staff, who are on staff and have privileges

  At the hospital or another hospital in a formal community call plan

  Are available to provide treatment necessary after the initial examination to stabilize individuals with EMCs

  Who are receiving services required in accordance with the resources available to the hospital

Shared/Community Call

- The hospitals work out a plan and put it in writing such as one doctor could be on call for both hospitals
- Or EMS takes OB patients to Hospital A for first 15 days of the month and to Hospital B for the second 15 days of the month
- Hospital A is designated as the stroke hospital and all patients go there or on call for neurosurgery cases

Shared/Community Call

- Need to make sure that EMS is aware of the protocol as part of annual plan
- EMS needs to know so they know where to take the patient
- Must include statement in your plan that if patient shows up at hospital not designated today that hospital must still meet EMTALA obligations,
- Annual assessment of community call plan must be done
- Questions should be addressed to Tzvi Hefner at 410 786-4487 or tzvi.hefner@cms.hhs.gov,

Shared/Community Call

- Hospital needs back up plan when on call physician is not available due to community call (calling in another physician, back up call, use of telemedicine, transfer agreement and send patient to another hospital)
- CMS has **removed** the italicized part of the sentence below since this phase has caused confusion.
- There was a statement that hospitals needed to manage a list of their on-call physicians *in a manner that best meets the needs* of the hospital's patients

Shared/Community Call

- If on call physician refuses or fails to show up, both the physician and hospital are still responsible
- Physicians can do elective surgery while on call or be simultaneously on call if permitted by the hospital
- Plan needs to specify what geographic area it covers like the city of Columbus or Franklin County,
- Person from each hospital has to sign the written plan

Shared/Community Call

- Has to be a formal plan and in writing
- Does not have to be submitted to CMS but CMS may come in and look at the plan
- If paramedics bring patient to your hospital, you still have to see them and do MSE to determine if the patient is in an emergency medical condition
- Still have to keep written copy of list of which doctors are on call and include physicians on call at the other facility

On-Call Requirements 2404

- Hospital must maintain a list of physicians who are on-call
- The hospital has to keep the list of physicians who are on-call to provide necessary treatment to stabilize a patient in an EMC
- This is in the general provider agreement previously discussed
- This on-call requirement applies to hospitals without an ED if they have specialized capabilities

On-Call Requirements 2404

- Staff must be aware of who is on-call including specialists and sub-specialists
- The on-call list must be composed of physicians who are members of the MS and who have hospital privileges
- If hospital participated in community call must include the names of the physicians pursuant to this plan
- Hospitals need to provide sufficient on-call physicians to meet the needs of the community

On-Call Requirements 2404

- The plan for community call must clearly articulate which on-call services will be provided and when
- CCP does not always mean that the physician must come to the other hospital as the patient can be transferred (example stroke center)
- Consider which is best approach for the patient if physician has privileges at both hospitals
- Sending hospital must still conduct MSE and stabilize within its capability and capacity if the patient an EMC

On-Call Requirements 2404

- Hospitals participating in CCP must still accept appropriate transfers from hospitals not participating in the plan
- All Medicare participating hospitals must fulfill their EMTALA obligation whether participating in a CCP or not
- EMTALA does not apply to pre-hospital setting or paramedics in the field but good to educate them on this
- Updates to the CCP plan must be communicated to EMS providers so they include the information in their protocols

Simultaneous Call 2404

- Hospitals can permit physicians if they want to be on call at two or more facilities
- Hospitals have to be aware and agree to this
- Hospitals must have a P&P on this
- Staff will follow the written P&P if on-call is not available when called to another hospital
- Back up plan might be to transfer the patient to the next appropriate hospital

Scheduled Elective Surgery 2404

- Hospital can decide if they will allow on-call physician to do elective surgery or elective procedures
- Hospitals need to have P&P on this
- CAH that reimburse physicians for being on call may not want to do this since Medicare payment policy regulations
- Hospital must have back up plan in case on-call physician is not available

Medical Staff Exemptions

- No requirement that all the physicians on the MS must take call
- For example, a hospital may exempt a senior physician (over 60) or physicians who have been on the staff for over 20 years
- However, can not permit physicians to selectively take call
- Hospital needs to ensure adequate call schedule

On-Call Requirements 2404

- Hospital must have an on-call policy
- EMTALA is the hospital's on-call policy
- P&P must clearly delineate the responsibilities of the on-call physician to respond, exam, and treat
- P&P must address steps to follow if on-call physician can not respond due to circumstances beyond their control
  - blizzard, flood, personal illness, transportation problems

On-Call Requirements 2404

- CMS does not have a specific requirement regarding how frequent physicians have to be on call
- CMS recognizes for safe and effective care hospital needs to have one physician on call every day
- There is no predetermined ratio CMS uses
- Use to use unwritten rule of 3
- If 3 specialists on the staff then need 24 hour coverage
  - Which CMS suggested never existed

On-Call Requirements 2404

- CMS will consider all relevant factors in determining if appropriate
  - Called the relevant factor test
- This would include number of physicians on the medical staff, other demands of physicians, number of times requiring stabilizing services of the on-call physician, vacations, and conferences
- Hospital does a significant number of cardiac catheterization and holds itself out as a center of excellence so CMS would expect 24 hour coverage

On Call Physician Issues

- So what can hospitals do?
- If 1 or 2 specialists then have reasonable call schedule which includes some weekends and off hours
- Maybe on call 7-10 days per month
- If services needed then permissible to transfer to a facility with these services in “no coverage” periods
- P&P covers what to do such as transfer to another hospital as part of the plan

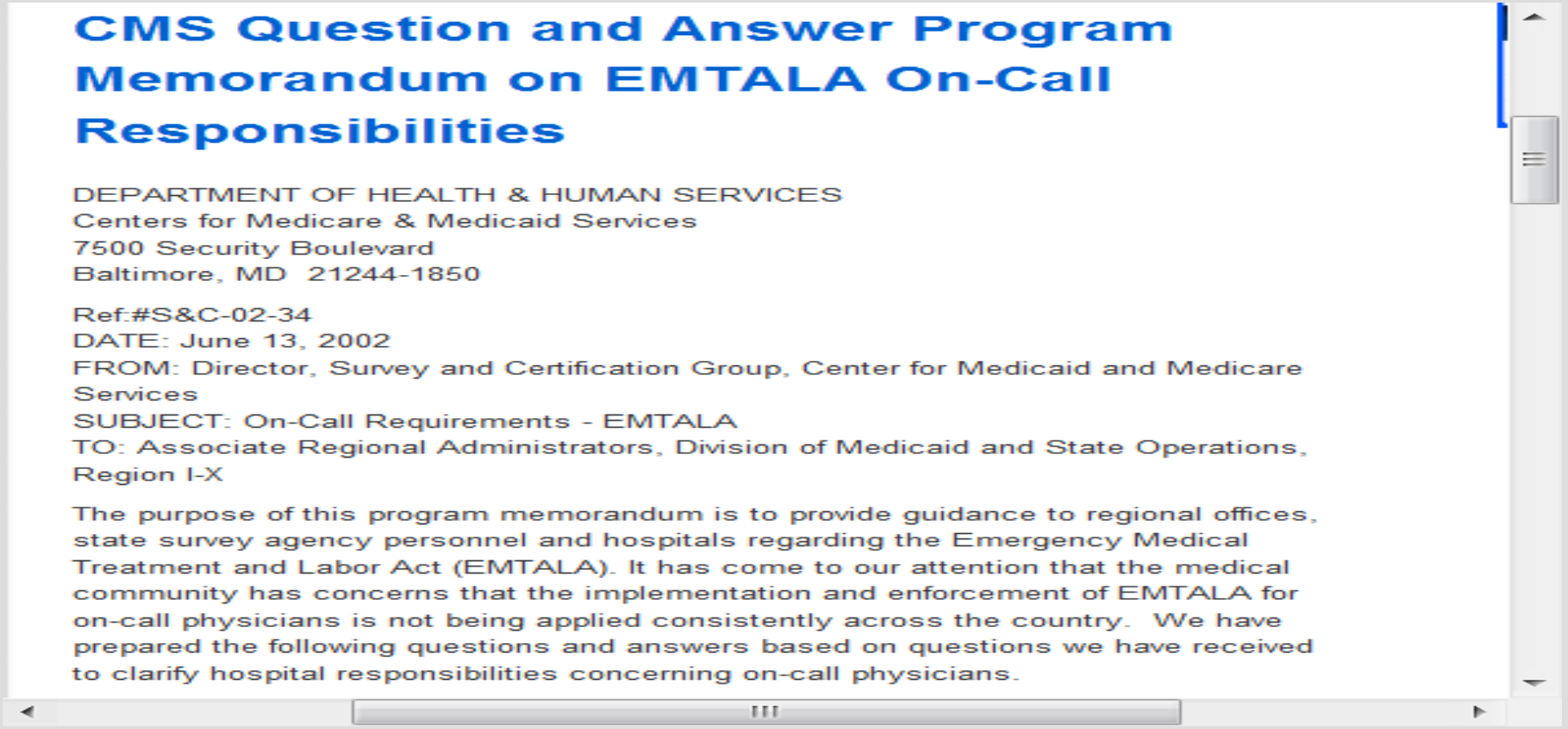
CMS FAQ on How Frequent to be On-Call

medical benefits of transfer outweigh the risks.

2.Q: How frequently is a hospital's medical staff of on-call physicians expected to provide on-call coverage?

2.A: Medicare does not set requirements on how frequently a hospital's medical staff of on-call physicians is expected to provide on-call coverage. Hospitals are expected to provide services based upon the availability of physicians required to be on-call. We are aware that practice demands in treating other patients, conferences, vacations, and days off must be incorporated into the availability of staff. We are also aware that there are some hospitals that have limited financial means to maintain on-call coverage all of the time. CMS allows hospitals flexibility to comply with EMTALA obligations by maintaining a level of on-call coverage that is within their capability.

CMS FAQ on On-Call Responsibilities



CMS Question and Answer Program Memorandum on EMTALA On-Call Responsibilities

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Ref:#S&C-02-34
DATE: June 13, 2002
FROM: Director, Survey and Certification Group, Center for Medicaid and Medicare Services
SUBJECT: On-Call Requirements - EMTALA
TO: Associate Regional Administrators, Division of Medicaid and State Operations, Region I-X

The purpose of this program memorandum is to provide guidance to regional offices, state survey agency personnel and hospitals regarding the Emergency Medical Treatment and Labor Act (EMTALA). It has come to our attention that the medical community has concerns that the implementation and enforcement of EMTALA for on-call physicians is not being applied consistently across the country. We have prepared the following questions and answers based on questions we have received to clarify hospital responsibilities concerning on-call physicians.

www.acep.org/content.aspx?id=30120&terms=emtala%20on%20caLL

On-Call Requirements 2404

- Remember that if on-call physician is requested to come to the ED and refuses, it is a violation against both the physician and the hospital
- Also a violation if the physician refused to come within a reasonable time
  - Failure of hospital to discipline physicians who violate EMTALA is a violation of law and may result in CMS terminating the provider agreement which is why some hospital will terminate physician's privileges or fine them
- CMS says hospitals are well advised to make physicians who are on call aware of their on-call P&P and the physician's obligation

On-Call Requirements 2404

- If hospital A with an EMC need the specialty services of hospital B, pursuant to the CCP, then the physician is required to report to hospital B to provide the stabilization treatment
- ED physician can call the on-call physician for consultation and on-call physician does not have to show up if not requested
- The decision to have the physician show up is made by the ED physician who has examined the patient

On-Call Requirements Introduction

- MS and hospital must decide which physicians take call and how often
- The on-call list must be provided to the ED so staff know if particular specialty is available for emergencies
  - Important for notifying EMS
  - Important in accepting or rejecting transfers in from other hospitals
- Everyone needs to be clear in advance to avoid the EMTALA nightmare

On-Call Requirements Introduction

- Board is responsible for the on-call system but often look to MS to monitor it
- The hospital has direct liability (not vicarious liability) if harm comes to a patient due to a failure of the on-call system to work
- MS need to include in their bylaws or R/R the responsibility to provide on-call services
- Hospital and MS should be familiar with the on-call provisions under the CMS EMTALA interpretive guidelines

On-Call Requirements 2404

- Remember to include in P&P and education the following
- Physicians who are on call are not representing their office practice when they are on call
- They are representing the hospital
- When they are on call they must show up within a reasonable time if requested to come to the ED

On-Call Requirements 2404

- Physician having an office full of patients is no excuse to not showing up when on-call and requested by the ED doctor to see the patient
- Also inappropriate if surgeon on call can not respond because he had 8 hours of elective surgeries scheduled
- It is generally not acceptable to send ED patients to their offices for exam and treatment of an EMC
- Exception is made when medically indicated and patient need specialized service like special equipment the hospital does not have

On-Call Requirements 2404

- However, physician's office must be part of hospital's provider based system with same CMS certification number as the hospital
- It must be clear that the transport is not done for the convenience of the physician
- Must be genuine medical issue and all individuals with same medical condition are treated the same way
- Appropriate medical personnel must accompany the patient to the physician's office

On-Call Requirements 2404

- Decision as to whether the on-call physician must respond personally or whether a non- physician can respond (PA, NP, or orthopedic tech) can be made by on-call physician
- It must also be permitted by the hospital's P&P
- Actually the ED physician makes the decision based on the patient's need
- Also, must be within scope of practice for the representative such as the PA or NP

On-Call Requirements 2404

- Determination is also based on capabilities of the hospital as to whether on-call physician can send a representative
- Determination is based on MS by-laws and Rules and Regulations (R&R)
- On-call physician is still responsible for making sure the necessary services are provided to the patient
- Monitor on-call response time as part of QI program

On-Call Requirements 2404

- There is no prohibition against the treating physician consulting on a case with another physician
- This physician may or may not be on the on-call list
- May consult by telephone, video conferencing, transmission of test results, or any other means of communication
- Example, patient bitten by poisonous pet snake and physician consults with expert in this area

On-Call Requirements

- CMS recognized that some hospitals use telecommunication to exchange x-rays or test results with consulting doctors not on the premises
- However, if the physician specialist is on-call and is requested by the treating physician to come to the hospital this must occur
- Reimbursement issues are outside the scope of EMTALA enforcement but be aware of telemedicine reimbursement policy

On-Call Requirements 2404

- Telehealth or telemedicine policy is located in the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 18, Section 270
  - http://www.cms.hhs.gov/Manuals/IOM/list.asp
  - CMS has telehealth standards in FR May 5, 2011 and IG is now in the hospital CoP manual
- Also remember that EMTALA is a requirement to treat and not a requirement to pay
- On-call physician must see patient even if physician does not accept that insurance plan or patient does not have insurance

May 5, 2011 TeleMedicine Standards

have concluded this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This rule is categorically excluded, under figure 2–1, paragraph (34)(g), of the Instruction. The rule involves establishing a safety zone. An environmental analysis checklist and a categorical exclusion determination are available in the docket where indicated under **ADDRESSES**.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, and Waterways.

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

Authority: 33 U.S.C. 1226, 1231; 46 U.S.C. Chapter 701; 50 U.S.C. 191, 195; 33 CFR 1.05–1(g), 6.04–1, 6.04–6, and 160.5; Pub. L. 107–295, 116 Stat. 2064; Department of Homeland Security Delegation No. 0170.1.

■ 2. Add § 165.1184 to read as follows:

§ 165–1184 Safety Zone; Coast Guard Use of Force Training Exercises, San Pablo Bay, CA

(a) *Location.* This safety zone will apply to the navigable waters in the San Pablo Bay, and will encompass an area beginning at position 38°01′44″ N, 122°27′06″ W; 38°04′36″ N, 122°22′06″ W; 38°00′35″ N, 122°26′07″ W; 38°03′00″ N, 122°20′20″ W (NAD 83) and back to the starting point.

(b) *Enforcement.* The Coast Guard will notify the public via a Broadcast Notice to Mariners prior to the activation of this safety zone. The safety zone will be activated on average two times per month, but could be activated up to six times per month. It will be in effect for Federal, State, and local officer designated by or assisting the Captain of the Port San Francisco (COTP) in the enforcement of the safety zone.

(d) *Regulations.* (1) Under the general regulations in § 165.23, entry into, transiting, or anchoring within the safety zone is prohibited unless authorized by the COTP or the COTP's designated representative.

(2) The safety zone is closed to all vessel traffic, except as may be permitted by the COTP or the COTP's designated representative.

(3) Vessel operators desiring to enter or operate within the safety zone must contact the COTP or the COTP's representative to obtain permission to do so. Vessel operators given permission to enter or operate in the safety zone must comply with all directions given to them by the COTP or the COTP's designated representative. Persons and vessels may request permission to enter the safety zone on VHF–16 or the 24-hour Command Center via telephone at (415) 399–3547.

Dated: March 31, 2011.

Cynthia L. Stowe,

Captain, U.S. Coast Guard, Captain of the Port San Francisco.

[FR Doc. 2011–10930 Filed 5–4–11; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 482 and 485

[CMS–3227–F]

RIN 0938–AQ05

Medicare and Medicaid Programs: Changes Affecting Hospital and Critical Access Hospital Conditions of Participation: Telemedicine Credentialing and Privileging

This final rule will remove this undue hardship and financial burden.

DATES: *Effective Date:* These regulations are effective on July 5, 2011.

FOR FURTHER INFORMATION CONTACT: CDR Scott Cooper, USPHS, (410) 786–9465. Jeannie Miller, (410) 786–3164.

SUPPLEMENTARY INFORMATION:

I. Background

This final rule reflects the Centers for Medicare and Medicaid Services' commitment to the general principles of the President's Executive Order released January 18, 2011, entitled "Improving Regulation and Regulatory Review." The rule revises the conditions of participation (CoPs) for both hospitals and critical access hospitals (CAHs) to: (1) Make current Federal requirements more flexible for rural and/or small hospitals and for CAHs; and (2) encourage innovative approaches to patient-service delivery.

CMS regulations currently require a hospital to have a credentialing and privileging process for all physicians and practitioners providing services to its patients. The regulations require a hospital's governing body to appoint all practitioners to its hospital medical staff and to grant privileges using the recommendations of its medical staff. In turn, the hospital medical staff must use a credentialing and privileging process, provided for in CMS regulations, to make its recommendations. CMS requirements do not take into account those practitioners providing only telemedicine services to patients. Consequently, hospitals apply the credentialing and privileging requirements as if all practitioners were onsite. This traditional and limited approach fails to embrace new methods and technologies for service delivery that may improve patient access to high quality care.

This final rule will permit hospitals and CAHs to implement a new

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7000 Security Boulevard, Mail Stop 02-02-38
Baltimore, Maryland 21244-1850

Center for Medicaid, CHIP, and Survey & Certification/Survey & Certification Group

Ref: S&C: 11-32- Hospital/CAH

DATE: **July 15, 2011**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Telemedicine Services in Hospitals and Critical Access Hospitals (CAHs)

- www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPag

Memorandum Summary

- ***Telemedicine Rules Adopted for Hospitals/CAHs:*** New and amended rules effective July 5, 2011 permit hospitals and CAHs to provide telemedicine services to their patients through written agreements with a distant-site hospital or a distant-site telemedicine entity
- ***Streamlined Credentialing & Privileging for Telemedicine Physicians & Practitioners.*** Hospitals and CAHs may rely, when granting telemedicine privileges, upon the privileging decisions of a distant-site hospital or telemedicine entity with which they have a written agreement that meets Medicare requirements.

On May 5, 2011, the Centers for Medicare & Medicaid Services (CMS) published a final rule (76 FR 25550), effective July 5, 2011, governing the agreements under which a hospital or CAH may provide telemedicine services to its patients. "Telemedicine," as the term is used in this rule, means the provision of clinical services to patients by physicians and practitioners from a distance via electronic communications. The distant-site telemedicine physician or practitioner provides clinical services to the hospital or CAH patient either simultaneously, for example, as in teleICU services, or non-simultaneously, as is the case with many teleradiology services.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-23

DATE: **June 22, 2007**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Emergency Medical Treatment and Labor Act (EMTALA) On-Call Requirements and Remote Consultation Utilizing Telecommunications Media

Memorandum Summary

- The treating physician in a hospital's or critical access hospital's (CAH) dedicated emergency department (DED) who is conducting the medical screening examination and/or providing stabilizing treatment of an individual required by the EMTALA regulations at 42 CFR 489.24 may, without violating EMTALA, consult on the individual's case with a physician who is not present in the DED by means of any telecommunications medium that the physicians choose to use.
- This does not change the obligation under EMTALA of a physician who is on-call to make an in-person appearance in the DED **when requested to do so by the treating physician.**

www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter07-23.pdf.

On-Call Requirements 2404

- If physician who is on-call typically directs the individual to be transferred to another hospital when on-call, instead of making an appearance when requested
- Then the physician as well as the hospital may be found in violation of EMTALA unless higher level of care is needed
- CMS reminds that while enforcement is against the hospital the OIG can fine the physician for a violation (remember the OIG slide previously where physicians were fined)

On-Call Requirements 2404

- What is a reasonable time to respond?
- CMS previously required hospitals to delineate expected response time in minutes
  - Dropped this mandate in May of 2009 and reverted to prior requirement
- Now says hospital is well-advised to establish in its P&P the maximum number of minutes what constitutes a reasonable response time
- Generally response time for true emergencies is expected in the range of 30-45 minutes
  - Some states like Missouri and NJ require 30 minute response time

On-Call Requirements 2404

- Differentiate between response times on phone and physical presence
  - Example, on-call doc returns page from ED within 15 minutes
- Include what to do if they don't show such as contact department chair or VP of MS (CMO)
- If on-call physician doesn't show up timely, take this seriously (physician is in violation of EMTALA)
- Try to get partner or another physician to come in and if hospital does this then CMS now says the hospital is not in violation of EMTALA

On-Call Requirements 2404

- Have a process to follow if on-call doc is unable or unwilling to respond
  - What chain of command to follow such as notify chief of dept, chief of staff, CMO
- However, if on-call physician does not show up and patient has to be transferred to another hospital
- The hospital is in violation of EMTALA
- Need to maintain list of on-call physicians
- Need to have the name of the physician and not group practice name like OB-GYNs Incorporated

On-Call Requirements 2404

- Remember if on-call physician refuses to show up when requested by the ED doctor hospital is required to put on the transfer form the name and address of the physician who failed to show up
  - Failure to do this is in itself is a violation of the law and the sending hospital can be fined or kicked out of the Medicare program at 42 USC 1395dd(1)(C)
- Remember if service generally available to the public, they is available to ED patients like ultrasound

On-Call Requirements 2404

- The on-call physician must immediately be required to notify the ED or hospital promptly if he or she becomes unable to respond when on call
- Sometime circumstances can arise beyond the control of the physician
- Remember that the on-call physician must carry out their responsibilities when on call and cannot refuse a patient because they don't have insurance or don't accept that insurance
  - "Hospitals with specialized capabilities or facilities shall not refuse to accept appropriate transfers of individuals who require such specialized capabilities or facilities if the hospital has the capacity to treat the individual." [1395dd(g).]

Follow Up Care and EMTALA

- Obtaining follow up for patients is a significant issue especially if patient has no insurance or is on Medicaid
- EMTALA is over at that point in time so no legal duty under EMTALA
- Medical staff bylaws or P&P must define the responsibility of the on call physician for certain things
  - Example, hospital expects on-call physician to see patient for issue in which patient presented to the ED
  - This would include responsibility to respond, examine, and treat patients with emergency medical condition in the ED

Follow Up Care

- Designate in policy physician is responsible for the care of the patient when on call through the episode created by the EMC
- Physician does not have to take patient for subsequent problems unless the physician on call at the time again
- On call physician can not require co-pay or insurance information before assuming responsibility for the care of the patient
- But advise patients to return to the ED if their condition deteriorated before seeing referral doc

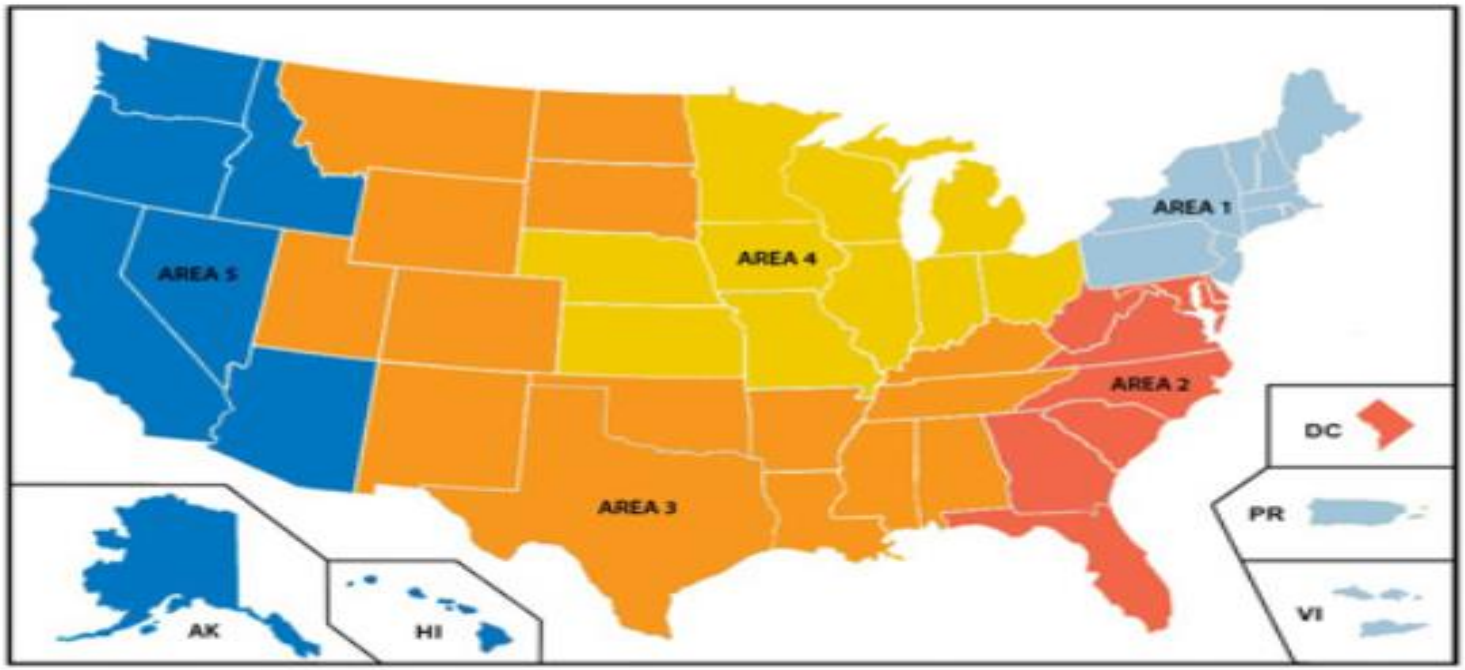
Beneficiary & Family Centered Care QIOs

- Beneficiary and Family Centered Care (BFCC)-QIOs will manage:
  - All beneficiary complaints,
  - Quality of care reviews,
  - **EMTALA**
  - And other types of case reviews
  - To ensure consistency in the review process while taking into consideration local factors important to beneficiaries and their families

KEPRO and Livanta QIOs

Beneficiary and Family Centered Care - Quality Improvement Organizations (BFCC-QIOs)

- www.qionews.org/articles/july-2014-special-focus/beneficiary-and-family-centered-care-quality-improvement-orga



Beneficiary & Family Centered Care QIOs

- **Area 1 – Livanta**
  9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701
  Toll-free: 866-815 5440
  www.BFCCQIOAREA1.com
- Miayan/Dr Brian Murphy EMTALA
- **Area 2 – KEPRO**
  5201 W. Kennedy Blvd., Suite 900
  Tampa, FL 33609
  Toll-free: 844-455-8708 X7330
- Chuck Hester/Dr Ferdinand Richards
  www.keproqio.com
- **Area 3 – KEPRO**
  5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131
  Toll-free: 844-430-9504
  www.keproqio.com
- **Area 4 – KEPRO**
  5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609
  Toll-free: 855-408-8557
  www.keproqio.com
- **Area 5 – Livanta**
  9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701
  Toll-free: 877-588-1123
  www.BFCCQIOAREA5.com

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Quality Improvement Organizations
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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INTELLIGENT VALUE

A A A Search the Site:

EMTALA

We are the Medicare Quality Improvement Organization, working to improve the quality of care for Medicare beneficiaries. Our site offers beneficiary and family-centered care information for providers, patients, and families. Welcome!

KEPRO conducts a five-day medical advisory review upon request from the appropriate Centers for Medicare & Medicaid Services (CMS) regional office. KEPRO's physician conducts a medical assessment of a potential Emergency Medical Treatment and Labor Act (EMTALA) violation case as specified in Part 9 of the QIO Manual (Attachment J-4). The five-day review is not mandated by the federal statute and regulations. However, the regional office may use this review as a resource in making a compliance determination, rather than simply determining the merits of the complaint.

Under sections 1867(d)(3) of the Act and 42 CFR §489.24(g), KEPRO is required to conduct a 60-day review upon receipt of a completed EMTALA case sent to the Office of the Inspector General for possible civil monetary penalty or exclusion sanction as outlined in Part 9 of the QIO Manual.

QIO Manual 68 Pages Anti-Dumping

Quality Improvement Organization Manual

Chapter 9 - Sanction and Abuse Issues

TABLE OF CONTENTS

(Rev. 12, 10-03-03)

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c09.pdf

9100 - Statutory Background

(Rev.12, 10-03-03)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), PL 99-272, revised §1866, "Agreements with Providers of Services," of the Social Security Act (the Act), and added §1867, "Examination and Treatment for Emergency Medical Conditions and Women in Active Labor." This section prohibited hospitals with emergency departments from turning away or transferring patients without screening for emergency medical conditions, and stabilizing such conditions or determining that transfer is in the best interest of the patient. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89), PL 101-239, further refined the requirements of §1154, "Functions of Peer Review Organizations," §§1866 and 1867 of the Act, and deleted the word "Active" from the title of §1867.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90), PL 101-508, added §1867(d)(3). This section, titled "Consultation with Peer Review Organizations," is implemented by 42 CFR 489.24(g). These regulations require that, unless the delay would jeopardize the health or safety of individuals, or when there was no screening examination, CMS will request Quality Improvement Organizations (QIOs) to review cases where a medical opinion is necessary to determine a physician's or hospital's liability under §1867(d)(1) of the Act. The QIO will provide a report on their findings before the OIG may impose a Civil Monetary Penalty (CMP) against a physician or hospital or an exclusion sanction against a physician. The QIO must also offer the involved physician(s) and hospital(s) an opportunity to discuss the case and an opportunity to submit additional information before OIG may impose sanctions (except in cases where the delay would jeopardize the health or safety of individuals or when there was no screening examination).

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about the individual's method of payment or insurance status.

Hospitals that fail to meet the requirements of §1867 may have their provider agreements terminated. In addition, a hospital with fewer than 100 beds is subject to a Civil Monetary Penalty (CMP) of up to $25,000 for each negligent violation, while a hospital with 100 or more beds is subject to fines of not more than $50,000 per violation. A physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement, is subject to a CMP of not more than $50,000 for each such violation, and if the violation is gross and flagrant, or repeated, to exclusion from participation in Medicare and State health care programs. A participating hospital may not penalize or take adverse action against a physician because the physician refuses to authorize the transfer of an individual with an emergency condition that has not been stabilized. Additionally, individuals suffering personal harm as a direct result of a violation may bring civil action against the hospital for damages for personal injury under the law of the State in which the hospital is located. Medical facilities suffering financial loss as a direct result of a participating hospital's violation may bring a civil action against the hospital for financial loss under the law of the State in which the hospital is located. Filing a civil action is limited to a period of 2 years after the date of the alleged violation.

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SECTION II

(Completed by reviewing physician.)

MEDICAL SCREENING EXAMINATION

1. Did the hospital provide, within its capability, including ancillary services routinely available and on-call physicians, for a medical screening examination that was:

1.a. Appropriate to the individual's medical complaint, and

YES_____ NO _____

Remarks/Rationale:

1.b. Within reasonable clinical confidence, sufficient to determine whether or not an EMERGENCY MEDICAL CONDITION (as defined below) existed?

EMTALA

- Are you up to the challenge?
- Sample educational memo for physician follows this slide
- List of regional offices follows this

Additional Information

- 2 OIG opinions regarding the payment of on call physicians
- Information from memo for physicians to sign every two year to remind them of their EMTALA on call responsibilities
- Detailed information from article on 20 Common Practices that will Get the On call physician cited
- Information if physicians who try to resign privileges to avoid on call responsibilities
- List of regional officers

The End! Questions?

- Sue Dill Calloway RN Esq CPHRM, CCMSCP
- AD, BA, BSN, MSN, JD
- President Patient Safety and Healthcare Consulting
- 5447 Fawnbrook Lane
  Dublin, Ohio 43017
  614 791-1468
- sdill1@columbus.rr.com

OIG Advisory Opinion

- There is also an important Office of Inspector General Advisory Opinion related to EMTALA
- Issued September 20, 2007, No. 07-10 (also issued second one, No. 09-05 on May 21, 2009)
- OIG agrees not to prosecute a hospital for paying for certain on call services for on call physicians
- Physicians agree to take call rotation on even basis
- http://www.oig.hhs.gov/fraud/docs/advisoryopinions/2007/AdvOpn07-10A.pdf

OIG Advisory Opinion

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

[*We redact certain identifying information and certain potentially privileged, confidential, or proprietary information associated with the individual or entity, unless otherwise approved by the requestor.*]

Issued: September 20, 2007

Posted: September 27, 2007

[Name and address redacted]

Re: OIG Advisory Opinion No. 07-10

Dear [name redacted]:

OIG Advisory Opinion

- Physicians are paid a rate for each day on call
- 18 days a year are gratis
- Rate based on specialty and whether coverage is weekday or weekend, like hood to be called, severity of illness, degree of inpatient care required
- Rates provided at fair market value
- Program open to all

OIG Opinion 2009 No 09-05

- 400 bed non profit general hospital and only provider in that county area for acute care services
- Had many times where no one on call and had to transfer patients out
- Proposed to allow on-call doctors to submit claims for services rendered to indigent and uninsured patients presenting to the ED
- Signed an agreement that this was payment in full and would show up in 30 minutes

OIG Opinion 2009 No 09-05

- Got $100 for ED consultation, $300 per admission, $350 for primary surgeon and for physician doing an endoscopic procedure
- OIG allowed finding it did not include any of the four problematic compensation structures and presented a low risk of fraud and abuse
- Payments were fair market value and without regard to referrals or other business generated by the parties

Paying for On-Call Physicians

- Arrangement does not take into account and the value or volume of past or future referrals
- Each and every arrangement has to be based on the totality of its facts and circumstances
- Safe harbor for personal services used (contract, over one year) but does not fit squarely since aggregate amount can not be set in advance
- Arrangement in this case presents low risk of fraud and abuse

Paying for On-call Services

- Bottom line is that hospitals should be aware of the OIG advisory opinions
- Hospitals should have a process to support the rationale for paying physicians for on-call services
- Hospitals should be able to justify the reasonableness of the amount of the payments
- Try and get the on-call payment arrangements to fit within the fraud and abuse laws to satisfy the OIG

On Call MGMA Survey 4-26-2011

- MGMA or Medical Group Management Association did a report called Medical Directorship and On-Call Compensation Survey: 2011
- 35% of providers report receiving on call compensation for days on call
- 21% report annual payment for on call pay
- Invasive cardiologist had the highest median daily rate of on call compensation at $1,600 per day
- General surgeons earned median of $1,150 per day and urologists $520

On Call MGMA Survey

- Practice size also influenced compensation for on call coverage with larger practices earning more money
- Anesthesiologists made $450 a day in groups less than 25 compared with $660 per day in groups with 26-75 FTEs
- General surgeons made $1,000 in groups less than 25 and $1,475 in bigger groups
- More physicians are being compensated for their on call coverage than in the past

On Call MGMA Survey

- Holiday and weekend on-call rates also varied by specialty
- Most specialties reported receiving higher rates on holidays than weekend rates
- Radiologists received $700 more for holiday rate than on the weekend
- Orthopedists earned a median of $1,025 for holidays
- OB GYN reported median holiday rate of $125.

Physician Education

- The following lists important elements that a hospital could use to provide a memo to physician to educate them on EMTALA
- Also make sure they know how to complete an EMTALA transfer form
- Include a sample of a completed one for reference

Physician Education

- On Call Memo for your physicians on EMTALA might include the following points
- The hospital has a legal duty to provide on-call physicians for emergency patients under the federal EMTALA law
- Whenever you are on-call, you are representing the hospital and not your office practice

Physician Education

- It is the treating Emergency Department physician who makes the final decision regarding which on-call individual to contact and whether or not that physician must come to the hospital
- The ED physician can do a phone consult or may require the physician to come to the Department to actually see the patient

Physician Education

- The ED physician may agree, if it is appropriate for the physician's PA, NP, or orthopedic tech to come and see the patient or whether the physicians needs to come
- Under the federal EMTALA law, if you are on-call you must show up within a reasonable time when called and requested to show up

Physician Education

- The rule of thumb that has been used by CMS surveyors for a patient covered by EMTALA is 30-60 minutes, absent extenuating circumstances (e.g. in surgery, weather, etc.)
- Federal law requires the hospitals to have a time specified in our policy which for a true emergencies is __ minutes

Physician Education

If the hospital has to transfer a patient because the on-call MD did not show up, the sending hospital must provide the name and address of that physician to the receiving hospital

The receiving hospital must report the violation to CMS

This means both the hospital and physician could be surveyed and scrutinized to determine if a violation of EMTALA,

Physician Education

- Physicians, as well as hospitals, may be subject to penalties for violating EMTALA's on-call provisions
- Physician risks include civil monetary penalties, lose of license, termination from Medicare and other federal health programs, criminal prosecution or civil lawsuits , and medical staff suspension and can be reported to the State Medical Board by OIG

Physician Education

- Per CMS, having an office full of patients is not an allowable excuse for not coming in timely when on call and requested by the ED physician to come to the hospital
- EMTALA requires the name of individual physician & not the name of the physician's group practice to be included on the on-call list

Physician Education

EMTALA is a requirement to treat; it is not a requirement to pay

The on-call physician must respond whether or not the patient belongs to a Managed Care Organization in which that physician participates, is a Medicaid or Medicare patient, or whether the patient has no insurance

20 Common Practices Article

- Article by Stephen Frew JD
- When asked to come to the ED physician responds to admit and will see the patient later. EMTALA requires a reasonable response time
- When asked to come to the ED to see patient physician debates the necessity of coming in. Response is not negotiable or debatable
- When asked to come in refuses and orders patient sent to another facility
  - http://www.medlaw.com/healthlaw/EMTALA/education/20-common-practices-that-.shtml

20 Common Practices Article

- When asked to come to the ED physician declines saying patient needs exceeds their scope of practice. Physician must render care within their privileges and not their usual scope of practice.
  - Physician must come in and justify any transfers
- When covering more than one hospital and physician asks patient be sent where physician is currently seeing patients instead of the patient's location
  - Unless an emergency and it is done to meet the needs of the patient

20 Common Practices Article

- When asked to come to the ED physician responds patient was previously discharged from their practice for non compliance or non payment
- When asked to come to the ED the on-call physician responds not interested because patient is aligned with another physician who is unavailable or declined to come in
- Declining a requested transfer from a hospital without the capability to deal with the patient's needs and regardless of the ability to pay

20 Common Practices Article

- On-call physician refuses to accept a patient because a specialist at the first hospital was not available
- Refusing to participate in the call list which then leads gaps in the list but expecting to be called for your patients and patient for whom you are covering
- Listing your PA or NP on the call rooster instead of the on-call physician
- Not signing the transfer form prior to the transfer

Resignation of Privileges

- May want to have a section in your on call policy on this
- One way physicians have tried to limit their on call responsibility is to limit or resign a portion of their privileges
- MS leaders may want to respond to this because if could affect the rest of the physicians in that specialty
- Privileges within the core are related enough that competency in one supports competency in other privileges within the core

Resignation of Privileges

- As a general rule, physicians will not be permitted to resign privileges that are included in the core for their specialty and may be required to participate in general on call schedule even if they have limited their private practice
- Physicians expected to maintain sufficient competencies within their core
- If physician does not feel clinically competent, it is their responsibility to arrange for coverage

Resignation of Privileges

- If physician responds to call and requires additional expertise, physician should attempt to stabilize and request appropriate consult
- Members of MS will not permitted to relinquish specific clinical privileges for the purpose of avoiding on-call responsibility

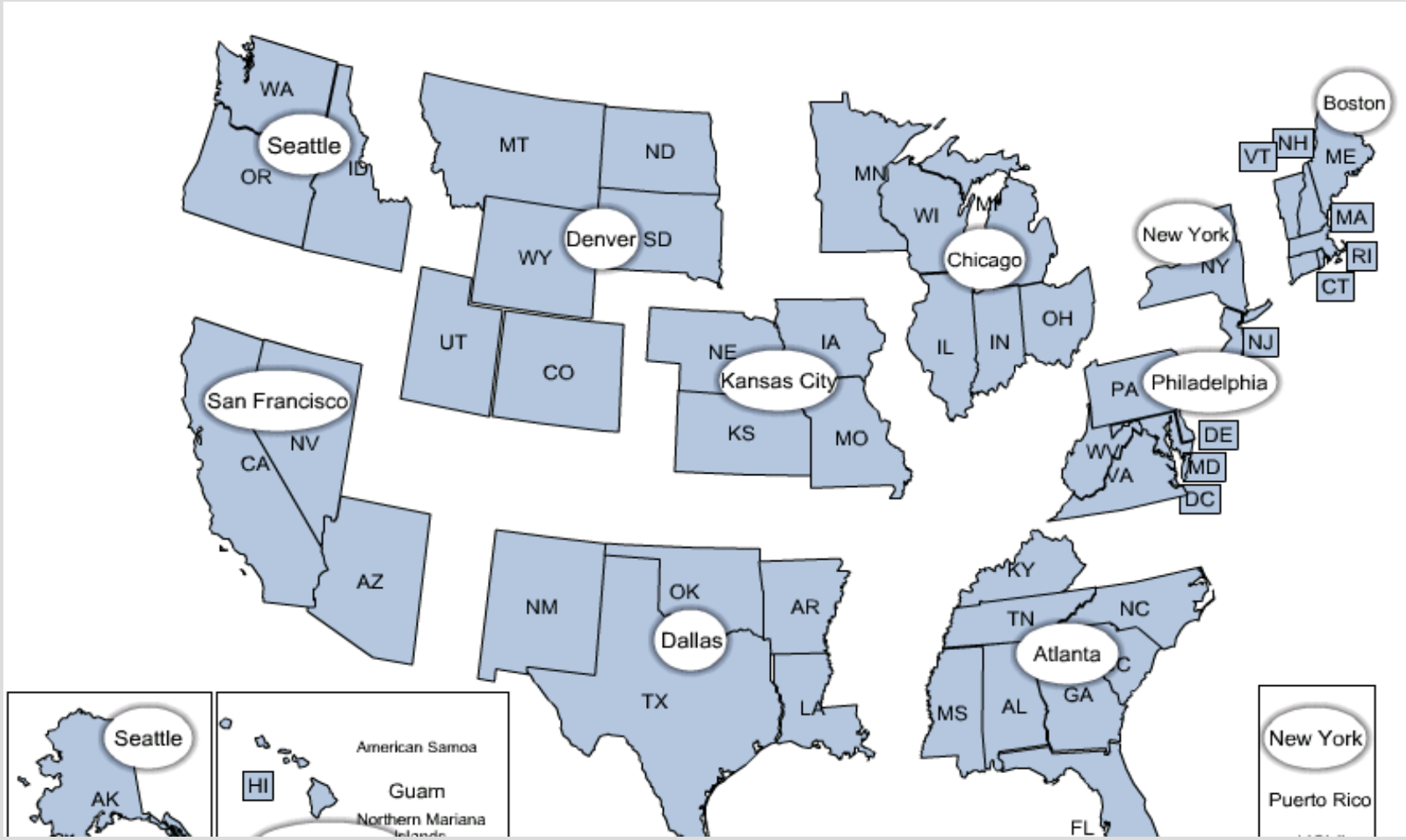
Resources

- 20 Common Practices that will Get On-Call Physicians Cited at http://medlaw.com/healthlaw/EMTALA/education/20-common-practices-that-.shtml,
- The EMTALA Answer Book 2009 by Mark Moy, Aspen Publication,
- Bitterman, Robert A, MD, JD. Providing Emergency Care Under Federal Law-EMTALA, American College of Emergency Physicians. 2001. Supplement 2004.

Resources

- On Call Specialist Coverage in ED, ACEP Survey of ED Directors, Sept 2004, and 2006 ACEP Survey
- Surgeons Violate Sherman Act by Refusing On Call Emergency Care Duty, Hospital Says, Health Law Reporter, Vol 15, Number 2, January 12, 2006

CMS Regional Offices



Regional Offices

- Region 1: Boston Regional Office
  States served: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
- Health Standards & Quality
  Center for Medicare Services
  JFK Federal Building, Room 2325
  Boston, MA 02203
  617-565-1298
  fax 617-565-4835

Regional Offices

- Region II: New York Regional Office
  States and territories served: New Jersey, New York, Puerto Rico, Virgin Islands
- State Operations Branch (NY)
  Center for Medicare Services
  26 Federal Plaza, Room 3811
  New York, NY 10278-0063
  212-264-3124; fax 212-861-4240
- State Operations Branch (NJ, PR & VI)
  Center for Medicare Services
  26 Federal Plaza, Room 3811
  New York, NY 10278-0063
  212-264-2583; fax 212-861-4240

Regional Offices

- Region III: Philadelphia Regional Office
- States and territories served: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia
- Division of Medicaid and State Operations
  Center for Medicare Services
  Suite 216, The Public Ledger Bldg.
  150 S. Independence Mall West
  Philadelphia, PA 19106
  215-861-4263
  fax 215-861-4240

Regional Offices

- Region IV: Atlanta Regional Office
  States served: Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi, Tennessee
- Health Standards & Quality
  Center for Medicare Services
  61 Forsythe Street, SW, #4T20
  Atlanta, GA 30301-8909
  404-562-7458
  fax 404-562-7477 or 7478

Regional Offices

- Region V: Chicago Regional Office
  States served: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
- Health Standards & Quality
  Center for Medicare Services
  233 N. Michigan Ave, Suite 600
  Chicago, IL 60601
  312-353-8862
  fax 312-353-3419

Regional Offices

- Region VI: Dallas Regional Office

  States served: Arkansas, Louisiana, New Mexico, Oklahoma, Texas

  State Operations Branch (TX)
  Center for Medicare Services
  1301 Young St., 8th Floor
  Dallas, TX 75202
  214-767-6179
  fax 214-767-0270

Regional Offices

- State Operations Branch (OK, NM)
  Center for Medicare Services
  1301 Young St., 8th Floor
  Dallas, TX 75202
  214-767-3570
  fax 214-767-0270
- State Operations Branch (AR, LA)
  Center for Medicare Services
  1301 Young St., 8th Floor
  Dallas, TX 75202
  214-767-6346
  fax 214-767-0270

Regional Offices

- Region VII: Kansas City Regional Office
  States served: Iowa, Kansas, Missouri, Nebraska
- Center for Medicare Services
  Richard Bolling Federal Building
  601 E. 12th St., Room 235
  Kansas City, MO 64106-2808
  816-426-2408
  fax 816-426-6769

Regional Offices

- Region VIII: Denver Regional Office
  States served: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
- Health Standards & Quality
  Center for Medicare Services
  1600 Broadway, Suite 700
  Denver, CO 80202
  303-844-2111
  fax 303-844-3753

Regional Offices

- Region IX: San Francisco Regional Office
  States and territories served: American Samoa, Arizona, California, Commonwealth of Northern Marianas Islands, Guam, Hawaii, Nevada
- Health Standards & Quality
  Center for Medicare Services
  75 Hawthorne Street, 4th Floor
  San Francisco, CA 94105-3903
  415-744-3753
  fax 415-744-2692

Regional Offices

- Region X:
- Seattle Regional Office
  States served: Alaska, Idaho, Oregon, Washington
- Health Standards & Quality
  Center for Medicare Services
  2201 Sixth Ave.
  Mail Stop RX40
  Seattle, WA 98121-2500
  206-615-2410
  fax 206-625-2435

EMTALA

- Are you up to the challenge?

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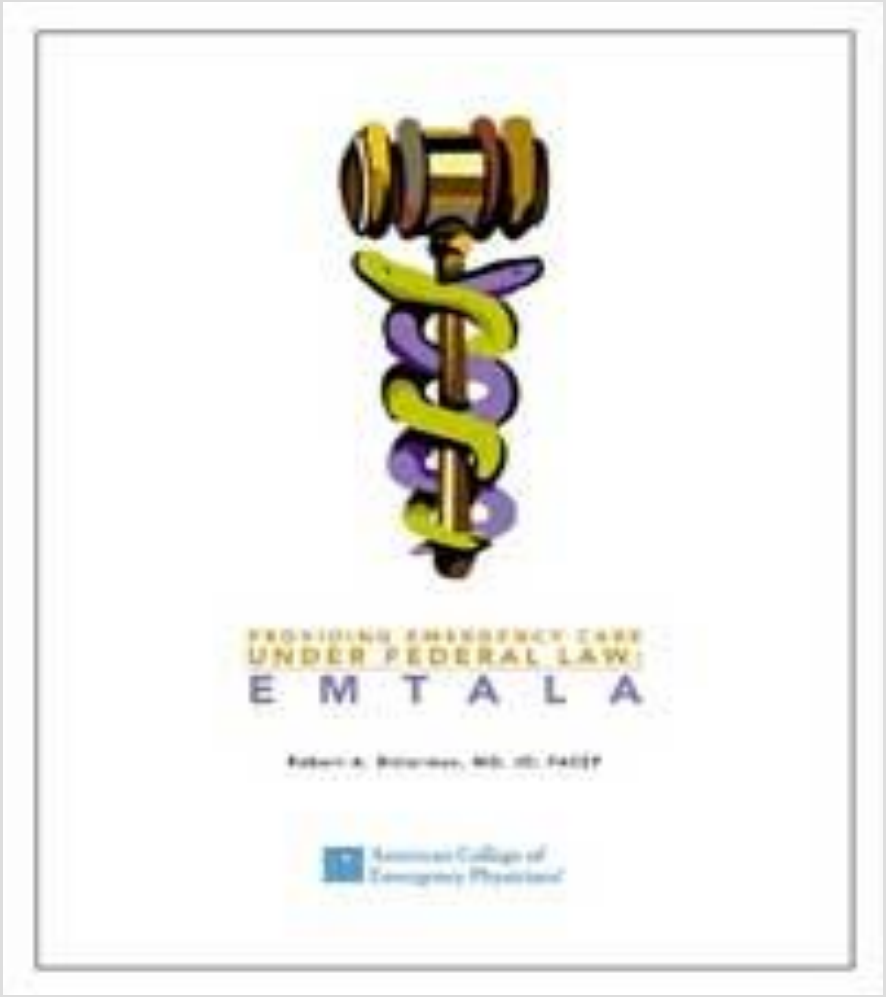
Thanks for Attending!



- Sue Dill Calloway RN Esq CPHRM, CCMSCP
- AD, BA, BSN, MSN, JD
- President Patient Safety and Healthcare Consulting
- 5447 Fawnbrook Lane
Dublin, Ohio 43017
614 791-1468
- sdill1@columbus.rr.com