Selected Topics: EMTALA Law

Dann W. Brown, RN, JD, CPPS, CPHRM, FASHRM
Senior Healthcare Risk Management Consultant
The Zurich Services Corporation
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Oregon Society for Healthcare Risk Management
Objectives

Participants will:
1. Explain the federal circuit court split on application of EMTALA to the stabilization of inpatients
2. Understand the circuit court split on whether a suit for failure to stabilize is dependent upon receiving a medical screening exam
3. Identify three nuances of EMTALA case decisions that can impact their facilities/customers
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More Disclaimers

- A basic understanding of the following elements of EMTALA is assumed
  - *Coming to the Emergency Department*
  - *Dedicated Emergency Department*
  - *Hospital Property*
  - *Emergency Medical Condition*
  - *Medical Screening Exam*
  - *Triage*
  - *Stabilize*
  - *Capacity*
  - *Capability*
  - *Transfer*

- I cannot tell you what is and is not an EMTALA violation. Only a government surveyor or court of law can do that.

- I do not have all the answers.
Agenda

- Federal Circuit Splits
  - Medical Screening Examinations
  - Medical Stabilization
  - Conjunctive vs. Disjunctive Causes of Action
- Other Issues
  - Rejection of Negligence as an Element
  - Bad Faith Admissions
  - Boarded ED Patients
  - Medical Futility
  - Behavioral Health
- Third Party Standing to Sue
- Malpractice Caps
- Physicians in Triage
- Submitted Scenarios
Where do issues arise?

- Transfers
- Patients returning to ED
- Said something to drive them away
FEDERAL CIRCUIT SPLITS
Medical Screening Requirements
Fulfilling the Duty

Objectively Reasonable Standard
- 1st and 9th Circuits
- Duty fulfilled when hospital provides that level of screening uniformly to all those who present substantially similar complaints

Subjective, Nondisparate Treatment Standard
- 6th, 8th, 10th and 11th circuits
- Requires a hospital to screen, examine and treat its patients in a nondisparate manner within its capabilities.
- Care given to other, similarly situated patients, and
- Not known by the providers to be insufficient or below their own standards
Medical Stabilization Requirement

Inpatients

Must Stabilize Regardless

- 6th Circuit

- Moses v. Providence Hospital and Medical Centers, Inc., (6th Cir. April 2009).

- Liles v. TH Healthcare LTD (East. Dist. TX, Sept 2012)

Admission Ends Requirements

- 4th & 9th Circuit

- CMS Regulations and reaffirmation after Moses


- Lopez-Soto v Hawayek (Dist. Ct Puerto Rico 1997)

- Bryan v. Rectors & Visitors of the University of Virginia Medical Center (4th Cir. 1996)
Tug of War Timeline

- 2003 CMS regulations, inpatient status defeats EMTALA
- Apr 2009 *Moses v. Providence Hospital and Medical Centers, Inc.*, (6th Cir.)
- Jun 2010 SCOTUS refuses certiorari.
- Feb 2012 CMS reiterates its position that inpatient status defeats EMTALA
- Sept 2012 *Liles v. TH Healthcare, Ltd* (E Dist. TX 2012) Motion to Dismiss
Conjunctive vs. Disjunctive Causes of Action

Conjunctive
- 4th, & 9th circuits
- Elements of the statute are treated as interdependent and sequential requirements
- CASES
  - Bryan v. Rectors (4th Cir. 1996)
  - James v. Sunrise Hospital (9th Cir., 1996)

Disjunctive
- 1st, 6th, & 10th Circuits
- Elements are treated as independent of each other
- CASES
  - Lopez-Soto v Hawayek (Dist. Ct Puerto Rico, 1997)
  - Thornton v. Southwest Detroit Hospital (6th Cir., 1990)
  - Urban v. King (10th Cir. 1994)
Selected Issues
Rejection of a Negligence as an Element

- *Summers v. Baptist Medical Center* (8th Cir., 1996)
  - Motion for summary judgment
Bad Faith Admissions

- “If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual”
Bad Faith Admissions

- The U.S. District Court for the Northern District of California
  - Motion to Dismiss
- Whether or not the admission was in good faith is a question of fact for the jury.
Boarded ED Patients

- Stabilization Requirement

- §489.24(d) Necessary Stabilizing Treatment for Emergency Medical Conditions

  (1) General. Subject to the provisions of paragraph (d)(2) of this section, if any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

  (i) Within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition.

  (ii) (transfer section)
Boarded ED Patients

- Within the capabilities of the staff and facilities of the hospital
- Did the hospital meet this criteria?
Medical Futility

- EMTALA required the stabilization of an anencephalic infant's respiratory distress because that was an emergency medical condition.
- The court held that EMTALA's obligations are categorical and unaffected by medical standards of care.
- *Baby K* has never been overruled.
Behavioral Health

• Does a Behavioral Health Facility have a Dedicated Emergency Department?
  – 33% of treatments are unscheduled

• Mental issues secondary to traumatic brain injury
Discharging Behavioral Health Patients

- *Goodvine v. Pasha* (E Dist Wis, 2014)
Behavioral Health Risk By the Numbers
Case Law Review

- 33 Cases

- Reasons for litigation
  - Suicide 19
  - Suicide attempt 5
  - Other 9

- Characteristics of Evaluation
  - ED phys only 18
  - Psychiatrist 11
  - Non-phys provider 4

- Characteristics of Disposition
  - Discharge 20
  - Transferred/Admitted 10
  - LWBS 2
  - Admitted to Observation 1
Third Party Standing to Sue

Allowed

• Moses v. Providence Hospital and Medical Centers, Inc., (6th Cir. April 2009) allowed a third party action to go forward

Barred

• Pauly v Stanford Hospital (N Dist. CA 2011) granted motion to dismiss a parent’s EMTALA claim due to lack of standing. It did not rule out bringing a claim on behalf of her daughter.
Malpractice Caps

Caps Not Allowed

- **Romar v. Fresno Community Hospital & Medical Center** (E Dist CA 2008)
- Plaintiff’s EMTALA disparate screening claim is not subject to the Medical Injury Compensation Reform Act (MICRA)
  - **Jackson v East Bay Hosp** (N Dist CA 1997)
  - **Burrows v Redbud Community Hosp Dist** (N Dist CA 1997)
- **Brooks v Maryland General Hospital** (4th Cir. 1993)

Caps Not Affected

- **Smith v. Botsford General Hospital** (6th Cir., 2005)
  - Sued under EMTALA specifically to avoid Michigan’s malpractice caps

 ISSUE: if a malpractice claim can incorporate an EMTALA issue the case can be moved to federal court where state caps may be removed
Physicians/Mid-Levels in Triage

• ED Visits
  – 1995 96.5 million
  – 2005 115.3 million
  – 2013 136.3 million

• Hospital screening exam must be performed “within the capability of the hospital’s emergency department.”

• Question: Does a screening exam in triage meet this requirement?
  • Initiates the MSE but does not necessarily satisfy it
  • Within the Capabilities vs. Cursory Exam

• Side Note: This initiates the doctor-patient relationship earlier which is one element of a negligence claim.

ED Visit data from CDC.gov
Scenario Analysis
Going Through the Statute

ARRIVES
1. Is the entity a “Dedicated Emergency Department?”
2. Did the patient “come to the hospital?”
3. Did the patient or someone else request treatment?
4. Would a layperson recognize the person’s condition as emergent?
5. Was a medical screening exam performed?
6. Was it done by an qualified provider?
7. Was the patient stabilized?

TRANSFER
1. Is the patient stable?
2. If not, do the rewards outweigh the risks?
3. Is it a transfer to a higher level of care?
4. Do they have the capability?
5. Do they have the capacity?
Dedicated Emergency Department

Qualifications

- CMS MEMO: Requirements for Provider-based Off-campus Emergency Departments and Hospitals that Specialize in the Provision of Emergency Services (11 JAN 2008)

- 42 CFR 489.20 and 489.24

“Dedicated emergency department means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

1. It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;

2. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

3. During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.”
Scenario: Fetal Demise
Meeting the Standard of Care as a Defense

- Female 16 weeks pregnant develops mild contractions and drives 90 minutes to the nearest ED after speaking with the OB on call for her physician
- Ultrasound cannot detect fetal movement or a heartbeat
- The on-call OB comes in and confirms the diagnosis of fetal demise
- He instructs the ED physician to discharge the patient, despite objections from her and her boyfriend
- Reason: a dilation and evacuation would be too risky with the cervix not dilated or effaced
- Later that evening at home she delivers a non-viable fetus.
- She goes to her doctor the next day due to excessive bleeding and he performs a D&E
- She makes an EMTALA claim for failure to stabilize an emergency medical condition
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 and Certification Group

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 as 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.
Submitted Scenario
Outpatient Clinics

• An outpatient rehab facility is a separate building but on a main hospital campus. The facility will not have RNs or physicians on site. The plan is to call 911 for a patient coding while in the facility. Any EMTALA concerns with this plan?

• We have provider-based clinics on and off our 250 yard radius campus. There is a lack of agreement regarding what our policy should be if a patient has potential medical emergency and is; under the prudent person would think they required emergency care interpretation.
Submitted Question
Transfer Within the Same System

• If a patient is going to another hospital for higher level services is there any obligation under EMTALA to stabilize and transfer by appropriate transportation or does EMTALA not apply at all because the patient is moving between hospitals or ED`s within the same system?
Scenario

- Insurance company directs you to a behavioral health facility who cannot immediately accept the patient.
- There is a second facility to which the patient refuses to go
- You admit the patient to your facility for the purpose of waiting for the behavioral health facility to have a space become available.
- You transfer the patient two days later; or
- You discharge the patient after 4 days when your physician determines he is no longer suicidal
Scenario

- A specialty physician is on call but refuses to answer the page and come in. The hospital finds another physician in the same specialty to examine the patient within the time limit. Is this an EMTALA violation?
Scenario

- The consultant asks emergency department staff to send the patient to his or her office. "The physician contacts the consultant, and they say, That’s no big deal, send them to the office tomorrow,"
Scenario

- The physician responds, "Admit the patient and I’ll come over and see them later."
Scenario

- You are the administrator on call for a local hospital and you receive a call at 2:00 a.m. from another local hospital regarding a patient with a broken upper arm.
- The ED physician's assistant is calling to arrange an EMTALA transfer from his hospital to yours, but the orthopedic physician on call at your hospital is refusing to accept the transfer, stating that the patient doesn't need a higher level of care.
- When you ask him about that, he tells you the fracture is not displaced, and can be splinted and seen in the office.
- The ED physician at your hospital is very nervous about the possibility of an EMTALA violation.
Thank you

Dann W. Brown, RN, JD, CPPS, CPHRM, FASHRM
Senior Healthcare Risk Management Consultant
The Zurich Services Corporation

dann.brown@zurichna.com
I can also be contacted via LinkedIn
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