CHARTIS

Practical EMTALA Advice

Understand and address common EMTALA vulnerabilities

Monthly Webinar Series

MONTHLY INSIGHTS

Webinar schedule & topics

THE 3RD THURSDAY OF EVERY MONTH:

10AM Pacific, 1PM Eastern

JUNE 2025

Practical EMTALA Solutions

JULY 2025

Compliance Implications of Artificial Intelligence

Navigating the Zoom interface

Handouts:

Check the chat function for copies of the slides for note taking and any other handouts.

Questions and comments:

Please participate in the discussion by asking question through the Q&A function during the webinar.

There will also be a survey you will receive immediately after the webinar that will give you an opportunity to ask additional questions or make comments.

Any questions not answered during the webinar will be addressed in a follow-up email or posting.

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33 RESULTS

Webinar CLEAR ALL

Artificial intelligence in healthcare: Implications for regulatory/accreditation compliance

AI has become an increasingly critical part in healthcare, and holds many future implications. But are there regulatory or accreditation requirements that we need to be concerned about? Join our experts as they discuss where AI regulation/accreditation requirements are currently, and where they

Practical EMTALA advice

Our experts have decades of experience helping hospitals across the country resolve CMS terminations and build sustained systems to avoid future threats. This webinar is packed with common sense advice to minimize your EMTALA risks.

It's Scorecard Season: Use Leapfrog, CMS Star Ratings, and US News & World Report rankings to improve clinical quality and data accuracy

Use this scorecard season as an inflection point to ensure that your 2025-2026 rankings are even better.

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departments s
organizations,

ABOUT

As the nation's largest independent healthcare advisory firm, we work with healthcare organizations to *materially improve care delivery*

We work with health systems, medical groups, payers, investors, technology innovators, and retail companies to **develop transformative strategies, operating models, and approaches to care.**

STRATEGIC TRANSFORMATION

- Strategic Planning
- Partnerships/M&A
- Private Equity Advisory
- Academic Alignment
- Value-Based Care
- Oncology Solutions

DIGITAL & TECHNOLOGY TRANSFORMATION

- Business Optimization & Technology
- Care Delivery Innovation & Technology
- Consumer Experience
- Digital & Technology Operating Models
- Analytics & Architecture
- Innovation & AI

CLINICAL TRANSFORMATION

- Care Delivery
- Consumer Access
- High Reliability Care
- High Performing Medical Group
- Workforce Solutions
- Chartis Center for Burnout Solutions
- Medical Staff Services Optimization

COMMUNICATION & CHANGE MANAGEMENT

- Strategic Positioning
- Issues and Advocacy
- Change Management
- Digital and Creative Services

PAYER TRANSFORMATION

- Total Cost of Care
- Provider Network Management
- Health Plan Membership Growth
- Value-Based Care
- Social Determinants of Health
- Technology Enablement

FINANCIAL TRANSFORMATION

- Financial Performance Improvement
- Mergers & Integration
- Revenue Cycle Transformation
- Shared Services Optimization

Today's *discussion*

The Emergency Medical Treatment and Labor Act -- EMTALA -- triggers more threats to hospitals' Medicare certification than any other CMS requirement. We will share common sense advice to minimize your EMTALA risks, including

- Medical Staff bylaws, rules and regulations,
- The importance of patient flow through your emergency department,
- Avoiding traps for lateral transfers, and
- More

Marcia Adams

Associate Partner

Krystie Hengehold

Associate Partner

> "Keeping up with change, planning for tomorrow

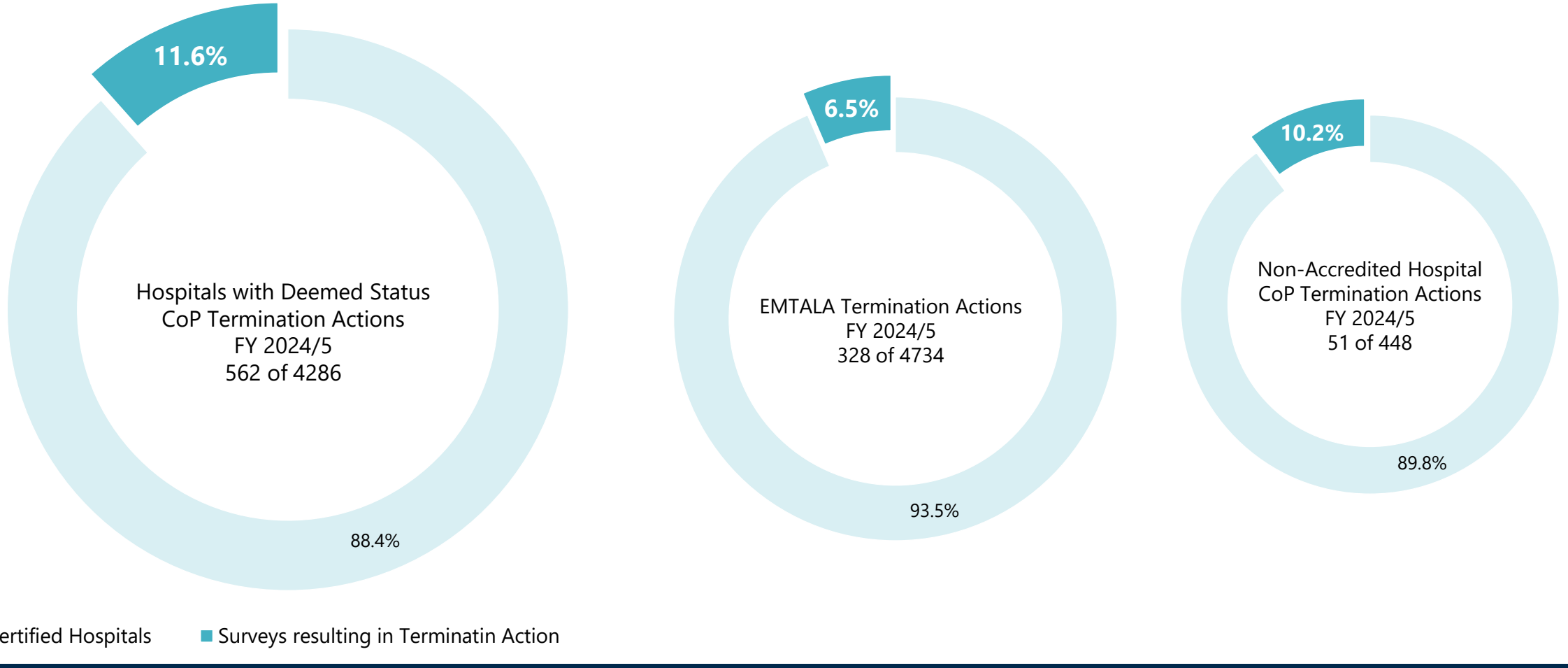
EMTALA Facts

Understanding Risks

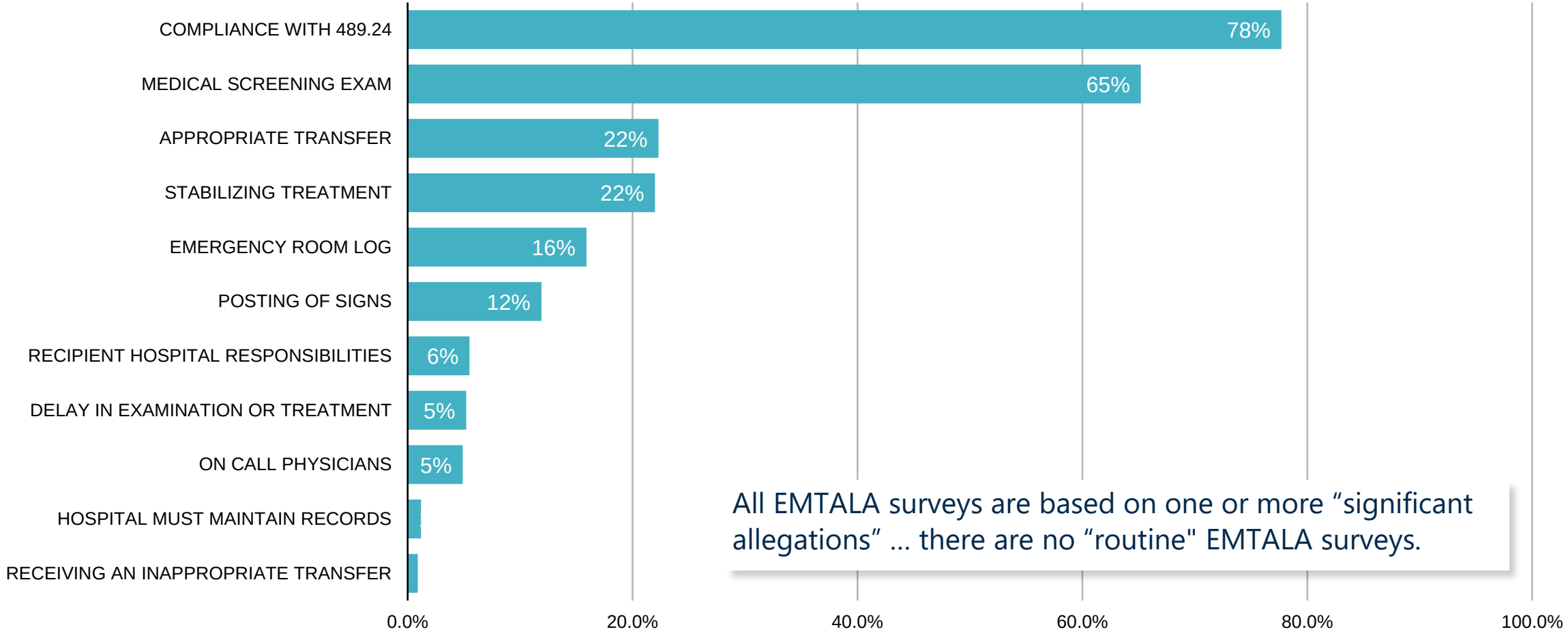
01

Likelihood of having a CMS termination action

By hospital type



Frequency of EMTALA citations



All EMTALA surveys are based on one or more “significant allegations” … there are no “routine" EMTALA surveys.

Source: CMS CQOR 2024/5

EMTALA enforcement

ABOUT 320 EMTALA investigations EACH YEAR (pre-pandemic)

ABOUT 190 60%

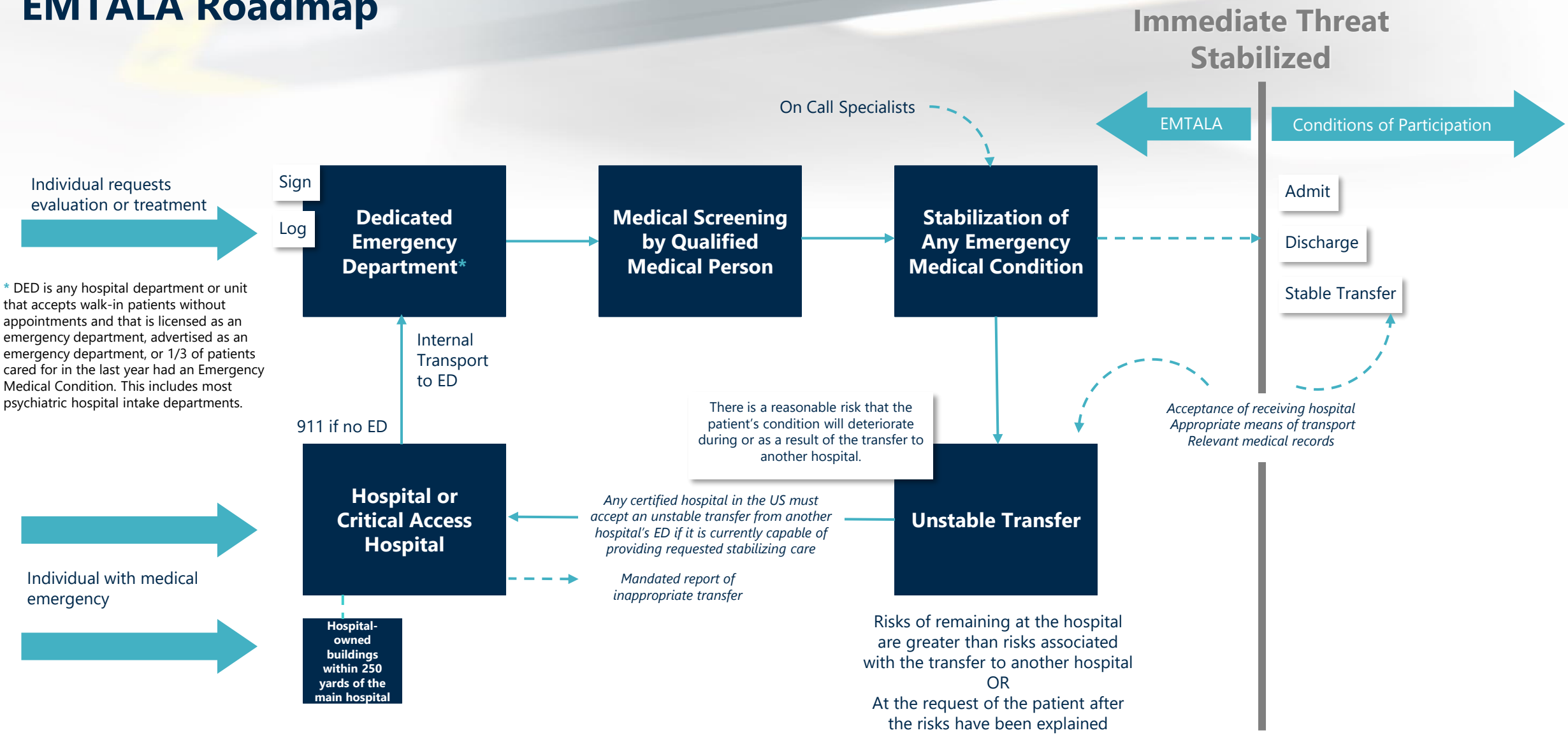
Complaints/reports related to EMTALA are investigated by the State Survey Agency on behalf of CMS … may also include review of one or more Conditions of Participation.

CMS	HHS-OIG	Individual
Termination Hospital provider agreement (strict liability) — Practitioner's provider status (flagrant or repeated violations)	Administrative fines Hospital and prover up to $133K per violation — Practitioner up to $60K per violation	Damages Hospital A "duty" for the purposes of civil liability (Negligent Tort)

ABOUT 30 15%

Handout

EMTALA Roadmap



Does your hospital* have a Dedicated Emergency Department [“DED”]?

*Includes Critical Access Hospitals

A DED is any hospital department or unit that accepts walk-in patients without appointments and

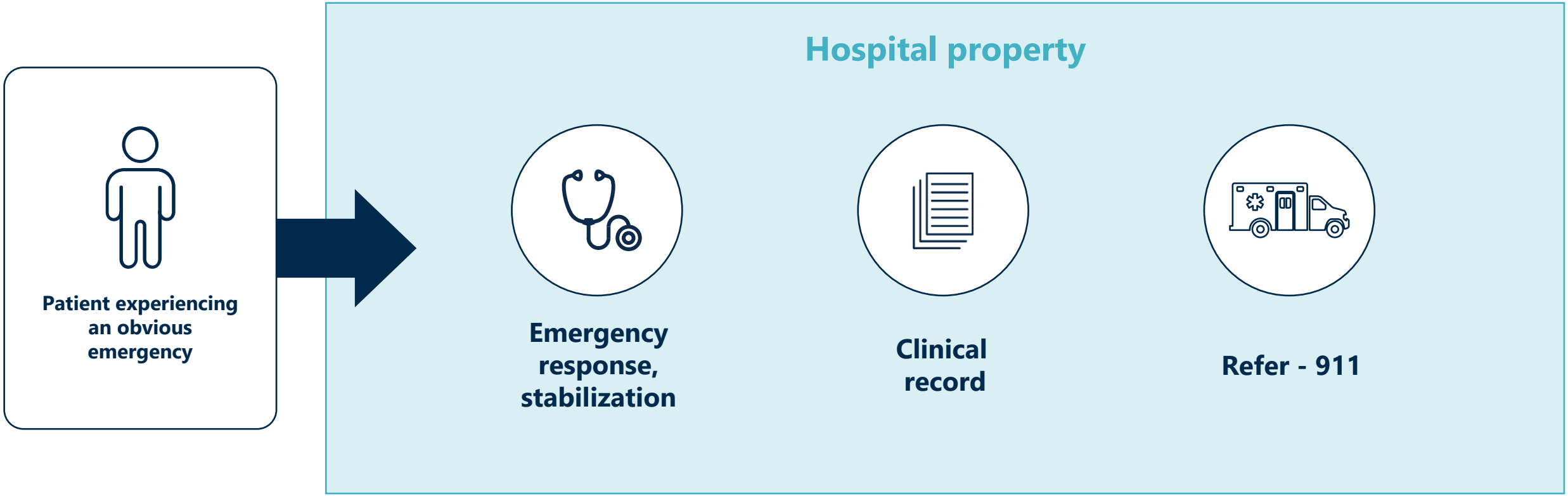
- is licensed as an emergency department,
- advertises itself as an emergency department, or
- is found to routinely care for patients presenting with an “Emergency Medical Condition” or labor [1/3 or more of patients cared for in the previous calendar year].

EXAMPLES

- Main Emergency Departments
- Labor and Delivery
- Some psychiatric walk-in evaluation/stabilization units
- Some Urgent Care departments

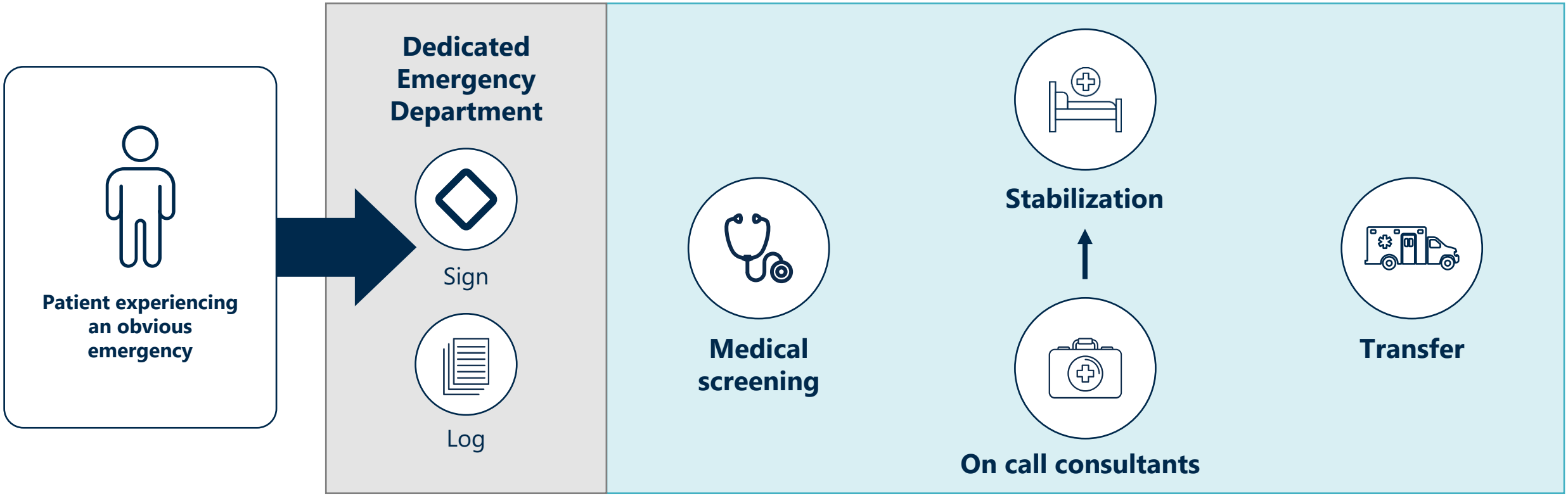
EMTALA requirements

Hospitals* **WITHOUT** a Dedicated Emergency Department (DED)



EMTALA requirements

Hospitals* WITH a Dedicated Emergency Department (DED)



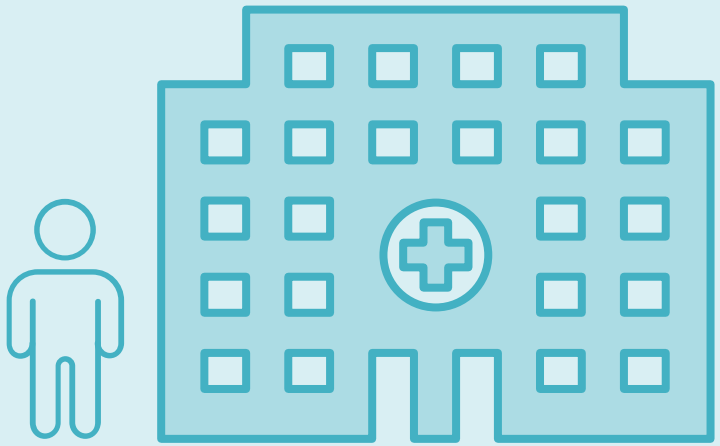
EMTALA applies when…

Trigger 1

Person requesting emergency care

…OR
apparently suffering from a life/limb threatening condition

…OR
LABOR



Anywhere on the property of a hospital

Includes hospital owned/leased buildings within 250 yards of the main hospital.

Hospitals with a Dedicated Emergency Department have obligations for Medical Screening, Stabilization, and Transfer

Hospital buildings without a Dedicated Emergency Department must "respond and refer"

EMTALA *does not* apply to inpatients*

A request for the **Transfer of an inpatient*** **does not** trigger a receiving hospital's EMTALA obligation

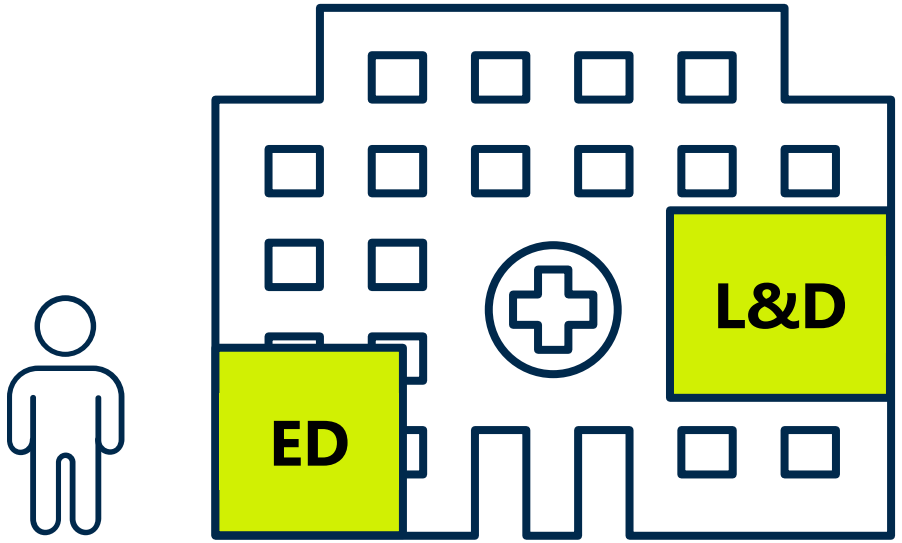
**Individuals placed in observation status are NOT inpatients. EMTALA still applies until the patient is admitted, discharged, or transferred.*

EMTALA applies when…

Trigger 2

Person comes to a **DEDICATED EMERGENCY DEPARTMENT** requesting evaluation or care for **any medical or surgical condition**

Exceptions for some visits



A unit is a "Dedicated Emergency Department" if:

- Licensed by the state as an emergency department
- Holds out to the public that it provides care for emergency medical conditions (as defined)

OR

- 1/3 of the visits in the preceding calendar year actually provided treatment for Emergency Medical Conditions.

Medical screening is NOT an isolated activity

Medical screening includes, when indicated

- Triage assessment and score [sequence of care]
- T3 Practitioner [T3 = Team Triage and Treatment]
- Main ED Practitioner
- Testing
- Consultation (also part of “stabilization”)

Can the Nurse be considered a Qualified Medical Person?

Tip: The Medical Screening Examination should not be considered complete until the qualified medical person decides on a plan of treatment for the presenting complaint/condition.

Patient may still have hypertension, diabetes, or some underlying medical or surgical condition, but the immediate threat to life or limb has been resolved and severe pain has been addressed.

Examples of the Plan of Treatment:

- **No care or stabilization required**
  - There was no problem to resolve, or
  - The complaint was fully resolved
- **The patient should see a care giver in**
  - the next few weeks
  - tomorrow
  - later today
- **Admit**
- **Transfer**

Monitors for medical screening

- What is the rate at which patients leave before treatment complete?
- Is triage accurate? Are patients with at risk triage scores seen on a timely basis?
- Is there a process for monitoring extended-wait patients in waiting room?
- Is there documentation that the presenting complaint and any abnormal conditions during the stay addressed at discharge?
- Are prolonged boarded inpatients managed like inpatients (vs. ED patients)?
- Do emergency medicine Practitioners understand the role of tele-medicine and are they clear about when on-site, in-person evaluations are necessary?
- Are hospital obligations for “frequent flyer” patients observed?

↗ CASE STUDY

Failure to provide medical screening and stabilization; Suicidal patients

It was [the Hospital's] policy that patients found to have a blood alcohol level [**BAL**] **above 100 were to be discharged to local law enforcement** and taken to jail.

Patient A was 25 years old when she called a crisis hotline, and an ambulance was dispatched to her residence. She was transported to [the Hospital's] ED for evaluation of a possible **suicide attempt** by overdose.

- Patient A's BAL was **422** and the ED physician discharged her into the custody of local law enforcement where she was detained in jail and expected to see a counselor.

Patient B was 41 years old when he presented to [the Hospital] after **attempting suicide** by overdose. The patient was depressed, had a history of psychiatric problems, and had recently been admitted for electroconvulsive therapy.

- Patient B's BAL was **288** and he was discharged into the custody of local law enforcement and taken to jail. The next day the patient was seen by a counselor in **jail** and then released from custody.
- Patient B returned to [the Hospital] that evening after again attempting suicide by overdose where he was admitted to the intensive care unit in **guarded condition.**

↗ CASE STUDY

Inappropriate plan for follow-up care — Failure to medically screen

The patient, a 22-year-old female, presented to [the Hospital's] Emergency Department via ambulance.

- The patient was diagnosed with a contusion of the face and lip abrasion and was discharged.
- The patient refused to sign the discharge forms, stating that she was **homeless**.
- She refused to exit the premises and was **escorted by security off of [the Hospital's] property wearing only a hospital gown and socks**.
- The following day the patient retuned to [the Hospital's] via ambulance after a bystander called 911. The bystander found the patient at a **bus stop outside the hospital in 30-degree weather**.
- A nurse told the patient that she would need to go to a shelter if she did not have a place to stay. The patient was then discharged without receiving a medical screening examination or being stabilized.

↗ CASE STUDY

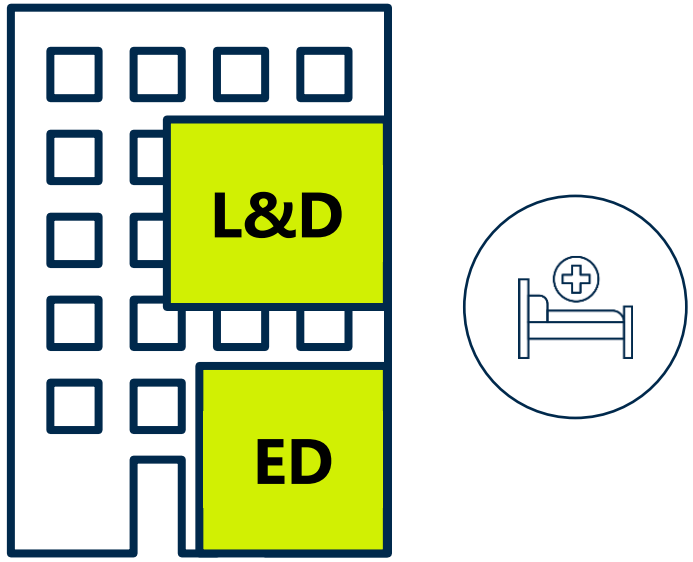
Resolution of the emergency medical condition prior to discharge

A patient, who had a kidney transplant and was on dialysis, was waiting in the parking lot of a local dialysis center when she experienced significant shortness of breath.

- The patient was transported by ambulance to [the Hospital's] emergency department, where she was diagnosed with **acute pulmonary edema and discharged to receive dialysis on an outpatient basis.**
- The patient arrived at the **dialysis center** where dialysis was started promptly, but the patient's condition **deteriorated**, and she was taken back to [the Hospital's] emergency department where she was pronounced **dead**.

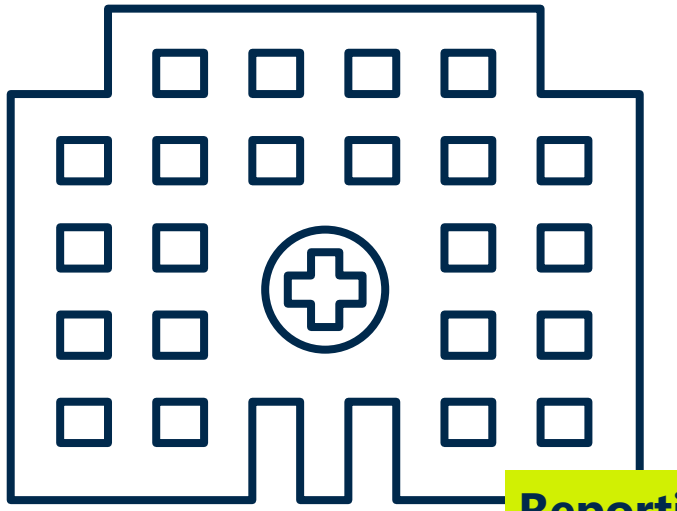
EMTALA applies when…

Trigger 3



The transferring hospital does not have the current capability and capacity to stabilize the Emergency Medical Condition

The receiving hospital must accept the transfer IF it has the current capability and capacity to provide stabilizing care (Even if it does not have a dedicated emergency department).



Reporting requirement

CAPABILITY:
currently available medical, surgical and technical services

CAPACITY:
includes services or spaces typically used for overflow.

We recommend ED transfer forms have 3 options

- Deterioration unlikely during transport
- Deterioration may happen during transport, but the risks of staying here are greater than the risk of deterioration during transport.
- Patient requests transfer against medical advice.

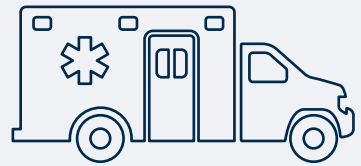
Transfer summaries may be separately required.

Stable for Transfer

Deterioration During Transfer?

UNLIKELY

"Lateral Transfer"…
not addressed by EMTALA



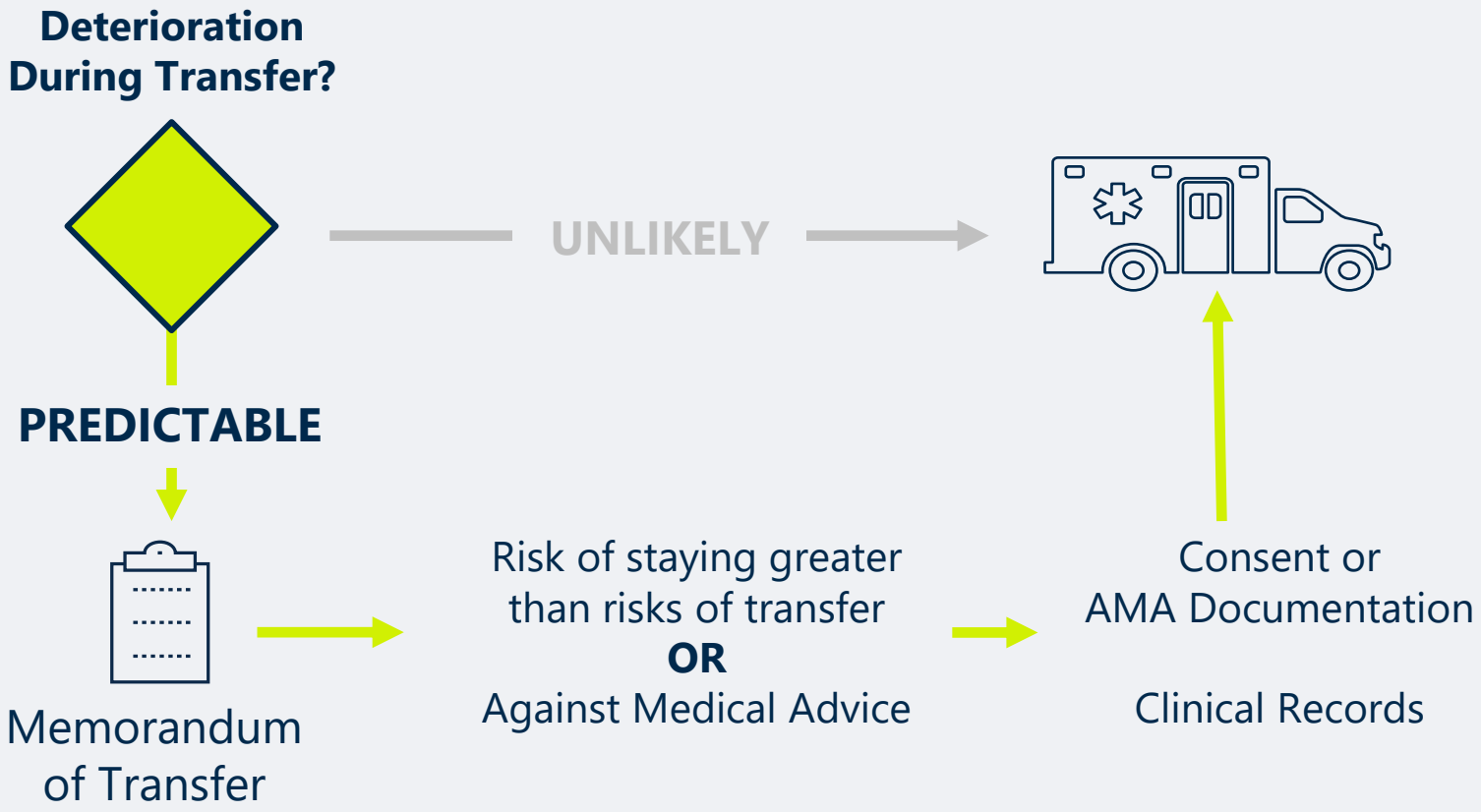
Other CMS Requirements Pertain

We recommend ED transfer forms have 3 options

- Deterioration unlikely during transport
- Deterioration may happen during transport, but the risks of staying here are greater than the risk of deterioration during transport.
- Patient requests transfer against medical advice.

Unstable Patient (AKA: Higher-Level-of-Care Transfers)

"Appropriate Transfer" of an unstable patient under EMTALA



↗ CASE STUDY

Failure to accept transfers of behavioral health patients

The HHS Office of Inspector General concluded that a freestanding psychiatric hospital violated the requirements of EMTALA on seven occasions when it failed to accept the appropriate transfer of seven individuals even though it had both the capability and capacity to do so.

- In each instance the hospital's interim CEO directed staff to refuse the transfer on the grounds that the hospital lacked the capacity to care for the patients.
- The HHS OIG determined that the hospital had the capacity and capability to accept the transfers, which were instead refused because the seven patients were uninsured and/or being transferred from a significant distance.

↗ CASE STUDY

Failure to medically screen; Labor-related inappropriate transfer

A 23-year-old pregnant woman presented to [the Hospital's] Emergency Department (ED) complaining of abdominal pain for about four hours, with some vaginal discharge and bleeding. She was approximately 25 weeks pregnant.

- [the Hospital] **did not perform a vaginal exam** and did not determine **if the patient was in labor**.
- [the Hospital's] ED physician arranged for the patient to be **transferred to another hospital for a higher level of care**.
  - ↗ The ED physician was informed that it would take 45 minutes for ambulance transport to arrive at [the Hospital's] ED, so he recommended that the patient be **transferred by private vehicle**.
  - ↗ The patient **delivered her baby in her car** on the way to the receiving hospital and the **patient self-diverted to a different hospital**, where she arrived 26 minutes later.
  - ↗ The baby was not breathing upon arrival to the hospital and the Neonatal Intensive Care Unit was unable to resuscitate the baby.

↗ CASE STUDY

Failure of a receiving hospital to accept transfers from another state

Patient A was a 64-year-old women who needed specialized capabilities to stabilize her Emergency Medical Condition.

- Unlike the requesting hospital, [the receiving Hospital] had the current capability to stabilize Patient A's Emergency Medical Condition. However, the operator at [the receiving Hospital] refused to accept the patient because of a [Hospital**] policy that prohibited the acceptance of Louisiana residents.**

↗ CASE STUDY

Requiring guarantee of payment for unstable transfers

- A hospital in the U.S. Virgin Islands contacted [the Hospital] and requested to transfer a patient who had a life-threatening Type A Aortic Dissection with Thrombus, which required immediate cardiothoracic surgical intervention.
- [The Hospital] declined to accept the transfer of the patient unless it received a **guarantee of payment**.
- The requesting hospital obtained the guarantee of payment, but [the Hospital] still declined to accept the transfer because the request needed to be approved by a supervisor who would not be in until the following business day.
- A few hours later, the patient died while still at the hospital in the Virgin Islands.

MEDICAL SCREENING EXAMINATION:

Patients who leave before discharge from the ED

- EMTALA does not consider patients who decide to leave of their own volition and without intimidation to be a violation of the Medical Screening rule.
- … However, the hospital must triage and monitor the patient as indicated. The hospital also has an obligation to encourage the patient to stay.

  - **LBTC** = Left Before Treatment Complete
  - **LBT** = Left Before Triage
  - **LWBS** = Left Without Being Seen (by a Practitioner)
  - **Elope** = Left After Being Seen but Before Discharge (Excluding AMA)
  - **AMA** = Left Against Medical Advice
  - **Presented in Error** = Not requesting evaluation

Rule of thumb	Low risk	High risk
LBCV	≤2%	>4%
LBT	Trace	Significant number
LWBS	≤1%	>4%
Elope	Trace	Significant number
AMA	No Risk	

Tip: Monitor and, when indicated, follow up on at least ESI 2 (and perhaps some ESI 3 patients) who leave before the conclusion of care.

↗ CASE STUDY

Delay in medical screening and left without being seen

An individual presented to [the Hospital's] Emergency Department (ED) at 7:37 a.m. on January 10, 2016, complaining of "chest pain since last night, also nausea, vomiting, and diarrhea." He had a normal ECG during triage.

- After the individual was returned to the **waiting room, the spouse repeatedly asked for medical assistance** because the individual was lying on the floor due to worsening chest pain. When a nurse finally responded, she told the spouse that they would have to wait. The patient was **not reassessed following triage**.
- At 11:21 a.m. [about 4 hours after presentation], the medical record noted that the individual **left without treatment**.
- The individual presented to a second hospital at 11:25 a.m. where the individual received an emergency heart catheterization and was diagnosed with triple vessel disease.
- The individual needed an urgent coronary bypass and was sent back to [the Hospital] where the individual underwent a triple coronary bypass the next day.

↗ CASE STUDY

Failure to evaluate and monitor a patient with dementia

- An assisted living facility called the police due to a psychiatric incident involving one of their residents who had a history of dementia and depression. The resident was subsequently transported by ambulance to a nearby Emergency Department (ED) for evaluation and treatment.
- The patient was scored as an ESI III during triage. After waiting 106 minutes to be seen, the patient left the ED stating he would “walk himself back” to his assisted living facility. Soon thereafter, the patient was found dead on the property of a local rehabilitation facility of which he was not a patient.
- The OIG concluded that the hospital failed to determine whether the patient was a danger to himself or competent to make decisions about his care. The hospital also failed to appropriately monitor the patient given his history of dementia.

Medical Staff Governing Documents

Common Compliance Pitfalls

02

Medical staff governing documents

Do your requirements align?

And where can you find them?

Understanding what policy and procedure details are required, where the requirements must be documented, and making sure everything matches can be challenging. If a surveyor arrives today, do you know where to locate the required information? Are you confident that your staff understand and comply with the documented requirements?

Common pitfalls

- Qualified Medical Personnel [QMPs] and Medical Screening Exams [MSEs]
  - Required to be in the Bylaws or Rules & Regulations [§489.24(a)(1)(i)].
    - *The designation of the qualified medical personnel (QMP) should be set forth in a document approved by the governing body of the hospital. If the rules and regulations of the hospital are approved by the board of trustees or other governing body, those personnel qualified to perform the medical screening examinations may be set forth in the rules and regulations, or the hospital bylaws.*
  - Frequently missing or inconsistent
    - Not in a document approved by the governing body
    - Documented inconsistently in multiple places (e.g., Bylaws, Rules & Regulations, EMTALA policy)

Common Pitfalls

Qualified Medical Personnel [QMPs] and Medical Screening Exams [MSEs]

- Frequently vague and not in compliance
- APPs
- “Approved” APPs
- “Approved” RNs
- Residents

Common Pitfalls

ED Call Lists

- List includes groups
  - Physician group names are not acceptable for identifying the on-call physician. Individual physician names are to be identified on the list with their accurate contact information.
- List include APPs
  - Section 1866[a][1][I][iii]of the Act states, as a requirement for participation in the Medicare program, that hospitals must maintain 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.
- List is outdated or inaccurate
  - The list must be up-to-date and accurately reflect the current privileges of the physicians on-call.

Common Pitfalls

Documented ED Call Requirements vs. Reality

- Bylaws frequently state that all Active Staff must participate in ED call coverage
  - Are all Active Staff actually participating in ED call coverage?
  - Is it easy to generate a list of Active Staff?

Common Pitfalls

What are physicians allowed to do while on call and where is it documented?

- Perform elective procedures?
- Serve on call simultaneously at another facility?
- Response times?
- Disagreement between the ED physician and on-call physician about physically examining the patient?

Common Pitfalls

On-Call Policies and Procedures

- What steps are taken if a particular specialty is not available or the on-call physician cannot respond due to circumstances beyond his/her control [e.g., transportation failures, personal illness]?
- How [or who] does the on-call physician update the on-call list if a back-up or replacement needs to be named?

Practical EMTALA Advice

Understand and address common EMTALA vulnerabilities

Monthly Webinar Series

More EMTALA Case Studies

HHS Inspector General

03

CASE STUDY

Failure to Medically Screen Belligerent Patients: Patient A (1 of 2)

Patient A was a 24-year-old male who presented to [the] Emergency Department (ED) complaining of weakness and exhibiting altered mental status. He was reportedly aggressive and non-compliant with staff directions.

- When he was **leaving the ED, he apparently collapsed**. A security guard, a hospital employee, put him in a wheelchair and **wheeled the patient off hospital property - where he was left on the ground**.
- Approximately four hours later the patient was found cold, with decreased responsiveness. He was transported to another hospital by ambulance. He died two weeks later.

All Case Studies are verbatim quotes from the Office of the Inspector General (HHS-OIG) notification of sanctions. HHS-OIG.gov

Source: Office of the Inspector General
U.S. Department of Health and Human Services
https://oig.hhs.gov/Fraud/enforcement/cmp/cmp-ae.asp

CASE STUDY

Failure to Medically Screen Belligerent Patients: Patient B (2 of 2)

Patient B was a 35-year-old male who presented to [the] ED accompanied by his girlfriend. The patient complained of shortness of breath and chest pain.

- The patient requested to see a physician and became **belligerent** when a nurse asked him why. That led to the patient being **escorted out of the ED by security**.
- Several minutes later, the patient returned to the ED. This time, the patient's girlfriend **drove up to the ambulance bay** and reported that the patient had suffered a seizure and was lying in her truck.
- She was informed by staff that they would not help get the patient out of the truck. In addition, the **security guard told her she had to leave**.
- The patient's girlfriend then took him to another hospital where he was pronounced dead within 20 minutes of his arrival.

Source: Office of the Inspector General
U.S. Department of Health and Human Services
https://oig.hhs.gov/Fraud/enforcement/cmp/cmp-ae.asp

CASE STUDY

Failure to Medically Screen an Ambulance Patient

- A 79-year-old female presented to [an] Emergency Department (ED) by ambulance after being involved in a motor vehicle crash with multiple injured individuals.
- EMS contacted [the] ED for guidance about disposition of the injured individuals and the ED physician at RMC directed that the patient be taken to a trauma center.
- When one of the ambulances arrived in [the ED's] ambulance bay with the patient, a hospital nurse approached the ambulance and **told the driver that the patient was supposed to go to the trauma center**.
- The ambulance then transported the patient to the trauma center **without the patient receiving a medical screening examination**.
- During the transport, the patient's condition deteriorated, and she ultimately died at the receiving hospital.

Source: Office of the Inspector General
U.S. Department of Health and Human Services
https://oig.hhs.gov/Fraud/enforcement/cmp/cmp-ae.asp

CASE STUDY

Failure to Medically Screen Belligerent Patients: Patient A 1 of 2

Mobile Infirmary Medical Center (MIMC), Mobile, Alabama

$80,000 Settlement for Two EMTALA Violations

- **Patient A** was a 24-year-old male who presented to MIMC's Emergency Department (ED) complaining of weakness and exhibiting altered mental status. He was reportedly aggressive and non-compliant with staff directions.
  - When he was leaving the ED he apparently collapsed. A security guard, a hospital employee, put him in a wheelchair and wheeled the patient off hospital property - where he was left on the ground.
  - Approximately four hours later the patient was found cold, with decreased responsiveness. He was transported to another hospital by ambulance. He died two weeks later.

… Continued

Source: Office of the Inspector General
U.S. Department of Health and Human Services
https://oig.hhs.gov/Fraud/enforcement/cmp/cmp-ae.asp

CASE STUDY

Failure to Medically Screen Belligerent Patients: Patient B [2 of 2]

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- **Patient B** was a 35-year-old male who presented to MIMC's ED accompanied by his girlfriend. The patient complained of shortness of breath and chest pain.
  - The patient requested to see a physician and became belligerent when a nurse asked him why. That led to the patient being escorted out of the ED by security.
  - Several minutes later, the patient returned to the ED. This time, the patient's girlfriend drove up to the ambulance bay and reported that the patient had suffered a seizure and was lying in her truck.
  - She was informed by staff that they would not help get the patient out of the truck. In addition, the security guard told her she had to leave.
  - The patient's girlfriend then took him to another hospital where he was pronounced dead within 20 minutes of his arrival.

Source: Office of the Inspector General
U.S. Department of Health and Human Services
https://oig.hhs.gov/Fraud/enforcement/cmp/cmp-ae.asp

CASE STUDY

Failure to Medically Screen an Ambulance Patient

Rockdale Medical Center , Conyers, Georgia

$70,000 Settlement for One EMTALA Violation

- A 79-year-old female presented to RMC's Emergency Department (ED) by ambulance after being involved in a motor vehicle crash with multiple injured individuals.
- EMS contacted RMC's ED for guidance about disposition of the injured individuals and the ED physician at RMC directed that the patient be taken to a trauma center.
- When one of the ambulances arrived in RMC's ambulance bay with the patient, a hospital nurse approached the ambulance and told the driver that the patient was supposed to go to the trauma center.
- The ambulance then transported the patient to the trauma center without the patient receiving a medical screening examination.
- During the transport, the patient's condition deteriorated, and she ultimately died at the receiving hospital.

Source: Office of the Inspector General
U.S. Department of Health and Human Services
https://oig.hhs.gov/Fraud/enforcement/cmp/cmp-ae.asp

CASE STUDY

Failure of a Receiving Hospital to Accept an Appropriate Transfer

University of Mississippi Medical Center [UMMC], Jackson, Mississippi

$50,000 Settlement for One EMTALA Violation

- Patient A was a 64-year-old women who needed specialized capabilities to stabilize her Emergency Medical Condition.
- Unlike the requesting hospital, UMMC had the current capability to stabilize Patient A's Emergency Medical Condition. However, the operator at UMMC refused to accept the patient because of a UMMC policy that prohibited the acceptance of Louisiana residents.

Source: Office of the Inspector General
U.S. Department of Health and Human Services
https://oig.hhs.gov/Fraud/enforcement/cmp/cmp-ae.asp

CASE STUDY

Failure of a Receiving Hospital to Accept an Appropriate Transfer

Jackson Health System, Miami, Florida

$50,000 settlement for One EMTALA violation

- A hospital in the U.S. Virgin Islands contacted Jackson and requested to transfer a patient who had a life-threatening Type A Aortic Dissection with Thrombus, which required immediate cardiothoracic surgical intervention.
- Jackson declined to accept the transfer of the patient unless it received a guarantee of payment.
- The requesting hospital obtained the guarantee of payment, but Jackson still declined to accept the transfer because the request needed to be approved by a supervisor who would not be in until the following business day.
- A few hours later, the patient died while still at the hospital in the Virgin Islands.

Source: Office of the Inspector General
U.S. Department of Health and Human Services
https://oig.hhs.gov/Fraud/enforcement/cmp/cmp-ae.asp

CASE STUDY

Delay in Medical Screening; Left Without Being Seen

Frye Regional Medical Center [FRMC], Hickory, North Carolina

$100,000 Settlement for One EMTALA Violation

- An individual presented to FRMC's Emergency Department (ED) at 7:37 a.m. on January 10, 2016, complaining of "chest pain since last night, also nausea, vomiting, and diarrhea." He had a normal ECG during triage.
- After the individual was returned to the waiting room, the spouse repeatedly asked for medical assistance because the individual was lying on the floor due to worsening chest pain. When a nurse finally responded, she told the spouse that they would have to wait. The patient was not reassessed following triage.
- At 11:21 a.m. (about 4 hours after presentation), the medical record noted that the individual left without treatment.
- The individual presented to a second hospital at 11:25 a.m. where the individual received an emergency heart catheterization and was diagnosed with triple vessel disease.
- The individual needed an urgent coronary bypass and was sent back to FRMC where the individual underwent a triple coronary bypass the next day.

Source: Office of the Inspector General
U.S. Department of Health and Human Services
https://oig.hhs.gov/Fraud/enforcement/cmp/cmp-ae.asp

CASE STUDY

Failure to Provide Medical Screening and Stabilization; Suicidal Patients

Southeast Missouri Hospital [SEM], Cape Girardeau, Missouri

$100,000 Settlement for Two EMTALA Violations

It was SEM's policy that patients found to have a blood alcohol level (BAL) above 100 were to be discharged to local law enforcement and taken to jail.

- **Patient A** was 25 years old when she called a crisis hotline and an ambulance was dispatched to her residence. She was transported to SEM's ED for evaluation of a possible suicide attempt by overdose.
  - Patient A's BAL was 422 and the ED physician discharged her into the custody of local law enforcement where she was detained in jail and expected to see a counselor.
- **Patient B** was 41 years old when he presented to SEM after attempting suicide by overdose. The patient was depressed, had a history of psychiatric problems, and had recently been admitted for electroconvulsive therapy.
  - Patient B's BAL was 288 and he was discharged into the custody of local law enforcement and taken to jail. The next day the patient was seen by a counselor in jail and then released from custody.
  - Patient B returned to SEM that evening after again attempting suicide by overdose where he was admitted to the intensive care unit in guarded condition.

Source: Office of the Inspector General
U.S. Department of Health and Human Services
https://oig.hhs.gov/Fraud/enforcement/cmp/cmp-ae.asp

CASE STUDY

Inappropriate Plan for Follow-up Care; Failure to Medically Screen

University of Maryland Medical Center [UMMC], Baltimore, Maryland

$106,965 Settlement for One EMTALA Violation

- The patient, a 22-year-old female, presented to UMMC's Emergency Department via ambulance.
- The patient was diagnosed with a contusion of the face and lip abrasion, and was discharged.
- The patient refused to sign the discharge forms, stating that she was homeless.
- She refused to exit the premises and was escorted by security off of UMMC's property wearing only a hospital gown and socks.
- The following day the patient retuned to UMMC's ED via ambulance after a bystander called 911. The bystander found the patient at a bus stop outside the hospital in 30-degree weather.
- A nurse told the patient that she would need to go to a shelter if she did not have a place to stay. The patient was then discharged without receiving a medical screening examination or being stabilized.

Source: Office of the Inspector General
U.S. Department of Health and Human Services
https://oig.hhs.gov/Fraud/enforcement/cmp/cmp-ae.asp

CASE STUDY

Failure to Medically Screen a Pregnant Patient

Newton Medical Center, Kansas

$45,000 Settlement for One EMTALA Violation

- A patient presented to Newton's emergency department 38-weeks pregnant and complaining of abdominal and lower back pain.
- Newton did not take the patient's medical history, take any vitals, conduct fetal monitoring, test for fetal movement, or perform any exam on the patient.
- Instead, Newton instructed the patient to see her personal physician.
- The patient left Newton by private vehicle and presented at the emergency department of another hospital where she was admitted and delivered a stillborn baby.

Source: Office of the Inspector General
U.S. Department of Health and Human Services
https://oig.hhs.gov/Fraud/enforcement/cmp/cmp-ae.asp

CASE STUDY

Resolution of the Emergency Medical Condition Prior to Discharge; Inappropriate Transfer

Palestine Regional Medical Center [PRMC], Palestine, Texas

$45,000 Settlement for One EMTALA Violation

- A patient, who had a kidney transplant and was on dialysis, was waiting in the parking lot of a local dialysis center when she experienced significant shortness of breath.
- The patient was transported by ambulance to PRMC's emergency department, where she was diagnosed with acute pulmonary edema and discharged to receive dialysis on an outpatient basis.
- The patient arrived at the dialysis center where dialysis was started promptly, but the patient's condition deteriorated and she was taken back to PRMC's emergency department where she was pronounced dead.

Source: Office of the Inspector General
U.S. Department of Health and Human Services
https://oig.hhs.gov/Fraud/enforcement/cmp/cmp-ae.asp

CASE STUDY

Failure to Medically Screen; Labor-Related Inappropriate Transfer

San Mateo Hospital, San Mateo, California

$20,000 Settlement for One EMTALA Violation

- A 23-year old pregnant woman presented to San Mateo's Emergency Department (ED) complaining of abdominal pain for about four hours, with some vaginal discharge and bleeding. She was approximately 25 weeks pregnant.
- San Mateo did not perform a vaginal exam and did not determine if the patient was in labor.
- San Mateo's ED physician arranged for the patient to be transferred to another hospital for a higher level of care.
  - The ED physician was informed that it would take 45 minutes for ambulance transport to arrive at San Mateo's ED, so he recommended that the patient be transferred by private vehicle.
  - The patient delivered her baby in her car on the way to the receiving hospital and the patient self-diverted to a different hospital, where she arrived 26 minutes later.
  - The baby was not breathing upon arrival to the hospital and the Neonatal Intensive Care Unit was unable to resuscitate the baby.

Source: Office of the Inspector General
U.S. Department of Health and Human Services
https://oig.hhs.gov/Fraud/enforcement/cmp/cmp-ae.asp

CASE STUDY

Failure of the On-Call Surgeon to Provide Stabilizing Care

DCH Regional Medical Center Tuscaloosa, Alabama

$40,000 Settlement for One EMTALA Violation

- A patient came to the DCH emergency department with a gunshot wound in his abdomen.
- The emergency department physician determined that the on-call general surgeon needed to evaluate and treat the patient and the staff contacted the on-call general surgeon multiple times.
- The on-call general surgeon indicated that he was performing a previously scheduled elective surgery in the operating room.
- DCH's emergency department was unable to find another general surgeon to evaluate and provide stabilizing treatment to the patient.
- The on-call general surgeon then performed a second previously scheduled elective surgery in the operating room without first evaluating and providing stabilizing treatment to the patient in the emergency department.
- After waiting approximately two hours at DCH, the patient died, never having received an evaluation or stabilizing treatment from a general surgeon.

Source: Office of the Inspector General
U.S. Department of Health and Human Services
https://oig.hhs.gov/Fraud/enforcement/cmp/cmp-ae.asp

CASE STUDY

Failure of an On-Call Urologist to Respond

South Georgia Medical Center [SGMC], Valdosta, Georgia

$40,000 Settlement for One EMTALA Violation

- A 27-year old male presented to SGMC's Emergency Department (ED) complaining of pain from an episode of priapism lasting five days.
- He was seen by an ED physician who contacted SGMC's on-call urologist.
- The urologist, however, did not come in to the ED to further examine or treat the patient. Instead, the urologist requested that the patient be transferred to another hospital for treatment.
- The transfer did not take place for more than eight hours and was to a hospital approximately 150 miles away.
- Priapism is a serious medical condition and delaying proper treatment can lead to penile injury, necrosis, or loss.
- The patient's transfer was medically inappropriate and put the patient at further risk by delaying needed medical treatment.

Source: Office of the Inspector General
U.S. Department of Health and Human Services
https://oig.hhs.gov/Fraud/enforcement/cmp/cmp-ae.asp

CASE STUDY

Failure to Stabilize Psychiatric Conditions

Covenant Medical Center (Covenant) Waterloo, Iowa,
$100,000 Settlement for Three EMTALA Violations

- The hospital failed to provide an appropriate psychiatric screening examination or stabilizing treatment for three patients who presented to the emergency department (ED) when an on-call psychiatrist was available.
  - **Patient A** was a woman who presented to the ED complaining of depression and suicidal thoughts, but was later discharged with instructions to follow-up with her primary care physician.
  - **Patient B** was a child who presented to the ED following violent outbursts, but was later discharged with instructions to follow-up with his primary care physician.
  - **Patient C** was man who presented to the ED stating his mind was "disturbed," but later eloped from the ED into single degree weather wearing paper scrubs while his discharge was processed. His body was found about 300 feet from Covenant with the cause of death attributed to hypothermia.

Source: Office of the Inspector General
U.S. Department of Health and Human Services
https://oig.hhs.gov/Fraud/enforcement/cmp/cmp-ae.asp

CASE STUDY

Failure to Stabilize Emergency Psychiatric Conditions

AnMed Health [AnMed], in Anderson, South Carolina

$1,295,000 Settlement for Thirty-Six EMTALA Violations

- Thirty-six individuals presented to AnMed's Emergency Department (ED) with unstable psychiatric emergency medical conditions. Instead of being examined and treated by an on-call psychiatrist, and despite empty beds in its psychiatric unit to which the patients could have been admitted for stabilizing treatment, these patients were involuntarily committed and kept in AnMed's ED for between 6 and 38 days each.
- The following is an example of one such incident.
  - A patient presented to AnMed's ED via law enforcement with psychosis and homicidal ideation and was involuntarily committed.
  - The patient did not receive psychiatric examination or treatment by available AnMed psychiatrists and was not admitted to the psychiatric unit for stabilizing treatment. Instead, the patient was kept in the ED for 38 days and at one point was seen by a psychiatrist from another facility that was familiar with her condition.
  - The psychiatrist prescribed a variety of medications for agitation. The patient eventually was discharged home.

Source: Office of the Inspector General
U.S. Department of Health and Human Services
https://oig.hhs.gov/Fraud/enforcement/cmp/cmp-ae.asp