

EMTALA Training



Module 6: Investigations



Peer Review by CMS

CMS may also conduct an optional professional medical review (physician peer review) using information available to the hospital at the time of an alleged violation. Physician review is required prior to the imposition of CMPs or termination of a hospital's provider agreement to determine if:

- The patient had an emergency medical condition.
- The on-call physician response time was reasonable.
- The medical screening exam was appropriate. Meaning the MSE was suitable for the symptoms presented and conducted in a non disparaging fashion.
- The stabilizing treatment was appropriate within a hospital's capability.
- Transfers (if performed) were appropriate for the patient and used qualified personnel and correct equipment.
- In the case of a pregnant woman, there was adequate time to affect a safe transfer to another hospital before delivery, or the transfer posed a threat to the health and safety of the woman or unborn child.

Click on each link to view copies of the [Physician Review Document Checklist](#) and [Physician Review Worksheet](#).

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Appendix 9-11 – EMTALA Physician Review Document Checklist (Rev. 24, Issued: 02-12-16, Effective: 03-14-16, Implementation: 03-14-16)

Instructions:

- The CMS Regional Office Division of Survey and Certification will indicate whether each of the documents listed below is included in the EMTALA review package. All of the documents listed should be included in the package, if available.
- The QIO Physician Reviewer will mark “Yes” for each document reviewed and “No” for each document included in the EMTALA review package but not reviewed. The *Physician Reviewer* should review all documents included in the package.

Document Name	Included in Package? Yes/No/Not Applicable <i>(N/A)</i>	Reviewed by BFCC-QI Physician Reviewer Yes/No/Not Applicable <i>(N/A)</i>
Hospital Medical Record(s): Initial Facility		

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EXHIBIT 138

(Rev. 134, Issued: 02-20-15, Effective: 02-13-15, Implementation; 02-13-15)

EMTALA Physician Review Worksheet

5 - Day Review

60 - Day Review

NOTE: A separate Worksheet must be completed by the QIO Physician Reviewer for each medical record reviewed. To facilitate accurate completion, the CMS Regional Office (RO) will complete Section I for each medical record sent to the QIO along with the request for review. The RO must label each medical record with the unique patient identifier as found on the draft Form CMS 2567.

SECTION I

Complaint Control Number: _____ Patient *Identifier Number on Draft 2567*: _____

Name of Patient: _____ DOB: _____

Name of Alleged Violating Hospital and/or Physician: _____

City: _____ State: _____ CMS Certification Number: _____

Date and Time of Admission to Emergency Services: _____

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Medical Review by CMS

During the medical review, the medical expertise to perform the review may come from:

- the state agency
- a [Quality Improvement Organization \(QIO\)](#), or
- the [CMS](#) Regional Office's own consultant physician.

The hospital may submit written documentation in support of its position that an EMTALA violation did not occur. The hospital may also present testimony by hospital personnel and/or expert testimony, and may have counsel present.

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The program administered by CMS and designed to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. There are two types of QIOs that work under the direction of the Centers for Medicare & Medicaid Services in support of the QIO Program: (1) Beneficiary and Family Centered Care (BFCC)-QIOs, which manage all beneficiary complaints and quality of care reviews to ensure consistency in the review process while taking into consideration local factors important to beneficiaries and their families. They also handle cases in which beneficiaries want to appeal a health care provider's decision to discharge them from the hospital or discontinue other types of services. Two designated BFCC-QIOs serve all 50 states and three territories, which are grouped into ten regions; and (2) Quality Innovation Network (QIN)-QIOs bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. By serving regions of two to six states each, QIN-QIOs are able to help best practices for better care spread more quickly, while still accommodating local conditions and cultural factors.

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Medical Review by CMS

During the medical review, the medical expertise to perform the review may come from:

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- the [CMS](#) Regional Office's own consultant physician.

The hospital may submit written documentation in support of its position that an EMTALA violation did not occur. The hospital may also present testimony by hospital personnel and/or expert testimony, and may have counsel present.



The Centers for Medicare and Medicaid Services (CMS) is the division of the Department of Health and Human Services charged with administering the day to day activities of the Medicare and Medicaid programs.

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Penalties and Enforcement

When a complaint prompts an investigation and EMTALA violations are identified, the following action steps may take place. (click on the numbers below)

-  CMS Regional Office sends the hospital a statement listing the identified deficiencies.
-  The hospital must prepare a plan of correction.
-  The hospital is referred to the Quality Improvement Organization (QIO) and information is reviewed.
-  The QIO reports findings and information to the CMS Regional Office.
-  CMS refers the issue to the Office of Inspector General (OIG).
-  The OIG contacts the hospital regarding fines and other penalties.

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Fines and Other Penalties

If violations are serious, the OIG may fine a hospital for its actions. Currently, the maximum fines for each violation:

1. in excess of \$100,000 for individual physicians or hospitals with 100 or more beds
2. in excess of \$50,000 for individual physicians or hospitals with fewer than 100 beds

Fines are assessed per violation and may be adjusted annually for inflation.

Other possible penalties include exclusion from the Medicare program, patient's civil lawsuit against the hospital, and lawsuit by receiving hospital of an improper transfer to recover its costs.

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Trends in Enforcement - Common Violations

Medical Screening Examination: A common violation is the failure to provide any type of MSE, or an appropriate or complete MSE. Some combative or belligerent individuals have been turned away or escorted off the premises without a MSE only to suffer an exacerbation of their condition, resulting in death. Recent Settlements:

- ❑ A DeKalb Medical Center agreed to a \$260,000 settlement to resolve 21 alleged EMTALA violations. Patients presenting to DeKalb's Emergency Department were triaged and discharged without receiving the required medical screening examination.
- ❑ Maryland General Hospital agreed to a \$106,965 settlement to resolve an alleged EMTALA violation for failing to provide a medical screening examination.
- ❑ A homeless patient who had previously been brought to the Emergency Department and discharged after a MSE determined she did not have an EMC was discharged on her second visit to the ED without being given a MSE or stabilizing treatment.
- ❑ St. Rose Dominican Hospital entered into a \$90,000 settlement agreement to resolve an alleged EMTALA violation. The patient was transferred without receiving a MSE or stabilizing treatment before being transferred. The patient went into cardiac arrest and died shortly after arriving at the receiving hospitals.

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Trends in Enforcement - Common Violations (continued)

Psychiatric Emergencies: Inappropriate treatment of patients presenting with psychiatric emergencies is a common violation. Failure to properly examine and/or stabilize a patient with a psychiatric illness has led to improper discharge of an unstable patient. Do not delay treatment or discharge if a patient is a potential threat to him/herself or others. Recent Settlements:

- ❑ North Shore Medical Center (NSMC) agreed to a \$60,000 settlement to resolve an alleged EMTALA violation. The patient was brought to NSMC's Union Hospital by ambulance, and the physician told paramedics to North Shore's Salem hospital without performing a medical screening exam.
- ❑ AnMed Health (AnMed) entered into an almost \$1.3 million settlement to resolve 31 alleged EMTALA violations involving psychiatric emergencies. AnMed failed to satisfy its EMTALA obligations, opting to involuntarily commit the patients rather than performing a medical screening exam and providing stabilizing treatment.

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Trends in Enforcement - Common Violations (continued)

Failure to Accept Transfers: A common violation is failure of a hospital with appropriate capacity and capabilities to accept an appropriate transfer. Failure to accept transfer, or recommend transfer to another facility, when your facility has the capacity and capabilities to treat the patient will violate EMTALA. Recent Settlements:

- ❑ Doctors Hospital of Augusta (DHA) entered into a \$180,000 settlement to resolve two alleged EMTALA violations. One allegation was based on a DHA physician's refusal to accept transfer of a patient needing ICU level care. Although the transferring hospital did not have an ICU and DHA had the capacity and capability to treat the patient, the DHA physician stated the transferring facility could manage the patient.
- ❑ Park Royal Hospital entered into a settlement agreement for more than \$50,000 to resolve an allegation that the hospital failed to accept an appropriate transfer. Park Royal is a hospital with specialized psychiatric capabilities that refused the transfer of a patient with emergency psychiatric issues because the patient's insurance was out of network.

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You have completed the training material for EMTALA:
Combined Supplemental Modules

Please [click here](#) to proceed to the next screen to begin the test.

The passing score for this test is 80%.

If you would like to review the material prior to taking the test, please [click here](#).

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It is not necessary to document information about an individual who refuses examination and/or treatment.

- True
- False

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Which of the following emergency on-call requirements must be met by a hospital and its physicians?

- Require physicians to be on call 24 hours a day, 7 days a week.
- Allow on-call physicians to examine the patient by telephone.
- Prohibit physicians from selectively responding to requests to see and treat patients while on-call.
- Require all physicians, regardless of age or active years of service, to be included on the on-call list.

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Which of the following locations is considered to be on Hospital Property based on the EMTALA definition?

- A fast food restaurant located 200 yards from the main hospital building.
- A private physician's office that is across the street from the main hospital building.
- The driveway of the hospital.
- A skilled nursing facility that is connected by a skywalk to the hospital.

EMTALA Training



Patients have the right to:

- Request communications by alternative methods (a different address or phone number)
- Request an amendment to their medical record (to correct an inaccuracy)
- Request access to their medical record (the opportunity to view or get a copy)
- All of the above

EMTALA Training



Which of the following are possible fines and penalties for violating EMTALA? (Select all that apply)

- Fines for each individual violation for hospitals.
- A mandatory requirement to provide 500 hours of community service.
- Fines for individual physicians.
- Exclusion from participating in the Medicare program.

Submit

EMTALA Training



Which of the following items will likely prompt a surveyor to request records?

- Gaps in the central log.
- Patients who are kept in the facility for stabilizing treatment instead of being transferred.
- Patients seen monthly in the emergency department.
- Other individuals requesting care for an incapacitated patient.

EMTALA Training



If a patient is moved to another part of the same hospital, do EMTALA transfer requirements apply

- Only if the patient's condition is unstable.
- Yes, as long as the benefits of the transfer outweigh the risks.
- No, moving a patient to a different department of the same hospital is not a transfer under EMTALA.
- Yes, moving the patient anywhere from his or her original location is considered a transfer, so the transfer requirements apply.

EMTALA Training



If physicians do not cooperate with on-call coverage, what is a possible consequence?

- Non-physician practitioners will be required to provide all the on-call coverage at the hospital.
- Nothing. Physicians can choose whether to respond when on-call.
- The patient will have to be admitted as an inpatient to avoid an EMTALA violation.
- The physician and the hospital may be fined and/or lose its Medicare provider number.

EMTALA Training



When documenting transfers, which of the following items should be documented, if applicable? (Select all that apply)

- The patient's informed consent.
- The patient's refusal for transfer.
- A signed physician certification for transfer indicating the benefits of transfer outweigh the risks to the patient.
- Any calls to hospitals that refused the transfer.
- Copies of records for all ED and ancillary services performed.

Submit

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An example of a permissible incidental disclosure is:

- A visitor overhears two nurses discussing a Jane Doe's condition in the elevator.
- A patient overhears the doctor talking quietly with the other patient in a shared hospital room.
- A sign-in sheet with patient's name, address, phone number, chief complaint, and reason for the visit.
- None of the above

Status **Active** PolicyStat ID **12092338**

Origination 6/8/2023
 Last 6/8/2023
 Approved
 Effective 6/8/2023
 Last Revised 6/8/2023
 Next Review 6/7/2026

Owner [REDACTED]:
 Dir-Risk Mgmt
 Area Administrative -
 General
 Applicability Ascension Texas-
 Seton and
 Providence
 References Administrative

Emergency Medical Treatment and Active Labor Act (EMTALA) and Transfer

SCOPE

This policy applies to Ascension Medicare-certified hospital entities (including Critical Access Hospitals) that have an emergency department or, with respect to receiving transfers, hospitals with specialized capabilities regardless of whether they have an emergency department. This policy also applies to Urgent Care Centers that meet the definition of a Dedicated Emergency Department (see Definitions section for details). This policy applies to the following Ascension Texas Hospitals: Dell Children's Medical Center, Dell Seton Medical Center at The University of Texas, Ascension Providence, Ascension Seton Bastrop, Ascension Seton Edgar B. Davis, Ascension Seton Hays, Ascension Seton Highland Lakes, Ascension Seton Medical Center Austin, Ascension Seton Northwest, Ascension Seton Shoal Creek, Ascension Seton Smithville, Ascension Seton Southwest, and Ascension Seton Williamson.

PURPOSE/RATIONALE

Our Value of Integrity calls us to follow all laws, rules, and regulations applicable to healthcare. The Emergency Medical Treatment and Active Labor Act (EMTALA) provides guidance for appropriate screening, stabilization and transfer of emergency conditions. In accordance with the Ethical and Religious Directives (6th ed.), this policy reflects:

"1. A Catholic institutional health care service is a community that provides health care to those in need of it. This service must be animated by the Gospel of Jesus Christ and guided by the moral tradition of the Church."

"3. In accord with its mission, Catholic health care should distinguish itself by service to and

advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees. In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons."

"23. The inherent dignity of the human person must be respected and protected regardless of the nature of the person's health problem or social status. The respect for human dignity extends to all persons who are served by Catholic health care."

"36. Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum. Footnote: It is recommended that a sexually assaulted woman be advised of the ethical restrictions that prevent Catholic hospitals from using abortifacient procedures; cf. Pennsylvania Catholic Conference, "Guidelines for Catholic Hospitals Treating Victims of Sexual Assault," *Origins* 22 (1993): 810."

The purpose of this policy is to assure the appropriate provision of medical screening, stabilizing treatment and, when applicable, safe transfer of a patient to another acute care facility for the purpose of continued care of the patient.

DEFINITIONS

(Defined terms are in initial caps throughout the policy)

"Against Medical Advice" (AMA) means an individual leaving the facility without completing recommended treatment or testing, without being medically cleared or discharged. Refer to [AMA policy](#) for details.

"Capability of the Hospital" means the physical space, equipment, supplies and services, available at the Hospital as a whole, including ancillary services routinely available. The capabilities of the Hospital's staff mean the level of care that the hospital's personnel can provide within the training and scope of their professional licenses, including coverage available through the Hospital's on-call roster.

"Capacity" means the ability of the hospital to accommodate the individual requesting examination, or treatment of the transferred individual. Capacity encompasses such things as numbers and availability of qualified staff, beds, equipment, and the hospital's past practices of accommodating additional patients.

"**Central Log**" is a log the Hospital is required to maintain on each individual who comes to a Dedicated Emergency Department seeking care for an emergency medical condition. The central log documents whether the individual refused treatment, or whether the individual was admitted, transferred, or discharged. Each Hospital has the discretion to maintain the log in a form that best meets the needs of the Hospital. The central log includes, directly or by reference, patient logs from other areas of the Hospital that may be considered Dedicated Emergency Departments, such as pediatrics and labor and delivery where a patient might present for emergency services or receive a medical screening examination instead of in the "traditional" emergency department. These additional logs must be available in a timely manner for surveyor review.

"**Comes to the Emergency Department**" means an individual:

1. Has presented at a Hospital's **Dedicated Emergency Department** and requests examination or treatment **for a medical condition**, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request will be considered to exist if a prudent layperson (common sense) observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition;
2. Has presented on Hospital property, **other than the Dedicated Emergency Department**, and requests examination or treatment **for what may be an Emergency Medical Condition**, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request will be considered to exist if a prudent layperson (common sense) observer would believe, based on the individual's appearance or behavior, that the individual needs emergency examination or treatment;
3. Is in a ground or air ambulance owned and operated by the Hospital for purposes of examination and treatment for a medical condition at a Hospital's Dedicated Emergency Department, even if the ambulance is not on hospital grounds. However, an individual in an ambulance owned and operated by the Hospital is not considered to have "come to the hospital's emergency department" if:
 - a. The ambulance is operated under community wide emergency medical service (EMS) protocols that direct it to transport the individual to a Hospital other than the Hospital that owns the ambulance; for example, to the closest appropriate facility. In this case, the individual is considered to have come to the emergency department of the Hospital to which the individual is transported at the time the individual is brought on to hospital property;
 - b. The ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the Hospital that owns the ambulance; or
 - c. Is in a ground or air non hospital-owned ambulance on Hospital property for presentation for examination and treatment for a medical condition at a Hospital's Dedicated Emergency Department. However, an individual in a non hospital-owned ambulance off Hospital property is not considered to have come to the hospital's emergency department, even if a member of the ambulance staff contacts the Hospital by telephone or telemetry communications and informs the Hospital that they want to transport the individual to the Hospital for examination and treatment. The Hospital may direct the ambulance to another facility if it is in "diversionary

status," that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregards the Hospital's diversion instructions and transports the individual onto Hospital property, the individual is considered to have come to the emergency department.

4. In the case of an infant birth, the federal Born-Alive Infants Protection Act of 2002 protects and extends protections under EMTALA to any infant born alive at any stage of development.

"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. Is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; or
2. 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 prior 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.

If you have questions about whether your location meets this definition, please contact the Compliance or Legal Department.

"Designated Provider" means a provider of health care services, selected by a health maintenance organization, a self-insured business corporation, a beneficial society, the Veterans Administration, CHAMPUS, a business corporation, an employee organization, a county, a hospital, a hospital district, or any other entity to provide health care services to a patient with whom the entity has a contractual, statutory, or regulatory relationship that creates an obligation for the entity to provide the services to the patient.

"Emergency Medical Condition" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or the unborn child) in serious jeopardy; or
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. With respect to a pregnant woman who is having contractions:
 - a. That there is inadequate time to effect a safe transfer to another hospital before delivery, or
 - b. That the transfer may pose a threat to the health or safety of the woman or the unborn child.

"EMTALA" is The Emergency Medical Treatment and Active Labor Act, 42 U.S.C. sec. 1395 dd with

implementing regulations found at 42 C.F.R §489.24.

"Hospital" includes all hospitals that have a Dedicated Emergency Department, including critical access hospitals.

"Hospital Property" means the entire main campus of the Hospital, including the sidewalks, parking lots and driveways or hospital departments, including any building owned by the hospital that are within 250 yards of the hospital. The term "Hospital Property" does not include other areas or structures that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other non-medical facilities. *(If you have questions about whether your location meets this definition, please contact the Compliance or Legal Department.)*

"Labor" means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in labor unless a Qualified Medical Person certifies that the woman is in false labor.

"Mandated Provider" means a person who provides health care services, is selected by a county, public hospital, or hospital district, and agrees to provide health care services to eligible residents.

"Medical Screening Examination" (MSE) is the process required to reach with reasonable clinical confidence the point at which it can be determined whether an Emergency Medical Condition exists. Screening is to be conducted to the extent necessary, by physicians and/or other QMP, to determine whether an Emergency Medical Condition exists, and is an on-going evaluation including ancillary services available to the emergency department. The Medical Screening Examination must be consistent for every individual coming to the Hospital's emergency department with those signs and symptoms, regardless of the individual's ability to pay for medical care.

"On-Call List" refers to the list that the hospital is required to maintain that defines those physicians who are on the hospital's medical staff or who have privileges at the hospital, or who are on staff at another hospital participating in a formal community call plan and are available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions.

"Qualified Medical Person or Personnel" (QMP) refers to physician and non-physician individuals defined by the medical staff's bylaws, rules, and regulations or other document approved by the Hospital's governing body to perform the medical screening examinations for those individuals that present to a Dedicated Emergency Department and request examination and treatment.

"Stabilized" or "Stable" means with respect to an EMC, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during Transfer of the individual from the facility; or in the case of a woman in active Labor, that the woman has delivered the child and placenta.

"Stabilizing Treatment" means the medical treatment necessary to assure, within reasonable medical probability, that no material deterioration of the Emergency Medical Condition is likely to result from or occur during the transfer of the individual from the Hospital, or, with respect to a woman in active Labor, that the woman has delivered the child and placenta.

"Transfer" is the movement of a patient, including discharge, outside the Hospital's facilities at the direction of any Hospital employee or person affiliated with the Hospital. Participation with a transfer center does not remove the Hospital's obligation to meet EMTALA transfer requirements. Transfer does not include the movement of an individual who leaves the Hospital Against Medical Advice. In addition, transfer does not include where a patient is moved from an off-campus department to the Hospital main campus.

"Transport" is the movement of a patient between an off-campus department of the Hospital and the main campus of the Hospital or the movement of the patient anywhere within the main campus of the Hospital.

"Triage" is a process of prioritization to determine in which order individuals will be provided a Medical Screening Examination by a QMP. Triage is not the equivalent of a Medical Screening Examination; it is the beginning of clinical assessment, and must be followed by an MSE.

PROCEDURE

Documentation and Signage

Signage: The Hospital will conspicuously post signs in its Dedicated Emergency Departments explaining an individual's right to emergency screening and treatment, and that the Hospital participates in the Medicaid program.

Registration/Insurance: The Hospital will not delay providing an appropriate Medical Screening Exam and/or Stabilizing Treatment to inquire about the individual's method of payment. The Hospital may complete its routine registration process (collecting demographic information, consent, insurance information, etc.) as long as the completion of the registration process does not delay the completion of the Medical Screening Exam and/or Stabilizing Treatment.

Standards for Medical Screening Examinations

1. Patients who come to a Dedicated Emergency Department requesting examination and treatment will be Triageed and receive a Medical Screening Examination by a QMP.
2. The Medical Screening Examination extends until the point that the QMP determines that an Emergency Medical Condition does or does not exist. A patient should continue to be monitored based on the patient's needs, and monitoring should continue until the individual is Stabilized or admitted or appropriately transferred.
3. When an individual presents with psychiatric symptoms, the Medical Screening Exam should include an assessment of suicide or homicide attempt or risk, orientation, or assaultive behavior that indicates danger to self or others. When the Hospital determines that an individual poses a danger to self or others, this is considered an Emergency Medical Condition.
4. If the Medical Screening Examination does not reveal the existence of an Emergency Medical Condition, the patient may, if appropriate, be referred for further non-emergency treatment through the Hospital's facilities or a private physician and/or may be discharged with appropriate follow-up instructions documented according to department procedures.

Minors: A minor may request examination or treatment for an EMC. The Hospital should not delay an MSE by waiting for parental consent. If screening reveals no EMC, the Hospital may wait for parental consent before proceeding with further examination and treatment.

Stabilizing Treatment: Where the MSE reveals that the person has an EMC, the Hospital will provide Stabilizing Treatment as required to stabilize the medical condition or will transfer the patient in accordance with the Transfer provisions below. Stabilizing treatment is ongoing and must be continued until the patient is Stabilized or appropriately Transferred.

Refusal to Consent to the Medical Screening Examination or Stabilizing Treatment

- a. **Refusing MSE:** If an individual presents to the Dedicated Emergency Department and subsequently refuses an MSE, the Hospital will make its best efforts to inform the individual that the Hospital is willing to complete a medical screening exam. If the individual still refuses to consent to the examination, Emergency Department personnel shall note the patient's refusal in the Hospital's Central Log.
- b. **Refusing Further Examination or Stabilizing Treatment AFTER MSE:** In the event that an individual who has come to the Hospital's Dedicated Emergency Department refuses to consent to further medical examination and/or Stabilizing Treatment *after* the MSE, the Hospital shall inform the individual of the risks and benefits to the individual of such examination and treatment. If the individual still refuses to consent to further examination or treatment, the Hospital shall follow the process outlined in the local policy that applies to patients who want to leave against medical advice and shall note the patient's refusal in the Hospital's Central Log.

On Call Coverage

1. Each Hospital maintains a list of physician specialists who are available for additional evaluation and stabilizing treatment of individuals with EMCs. The on-call list should contain individual physician names with accurate contact information (physician group names are not acceptable for identifying the on-call physician).
2. When requested to make an in-person appearance in the Dedicated Emergency Department by the treating physician, a physician who is on-call must do so.
3. On-call physicians must respond within the time period specified in applicable bylaws, rules, or policies after receiving communication indicating that their attendance is requested.
4. The on-call list maintained for the main Hospital shall be the on-call list for the entire Hospital, including all campuses of the Hospital and any off-campus provider-based emergency departments.
5. If the Hospital is unable to provide the necessary Medical Screening Examination or Stabilizing Treatment to a patient with an Emergency Medical Condition because the hospital lacks the capability or capacity to provide the treatment necessary to stabilize the emergency medical condition or admit the individual, the hospital will transfer the patient to another nearby acute care facility according to the transfer provisions below.

Transfers

1. If a patient is Stabilized the patient may be transferred.
2. If a patient is not Stabilized, the Hospital may only transfer the patient if the transfer is appropriate (see below) **and one of the following situations exist:**
 - a. The patient requests the transfer in writing after being informed of the Hospital's obligation to provide emergency screening and stabilizing treatment and being fully informed of the risks of transferring; or
 - b. A physician signs a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of medical treatment at another medical facility outweigh the increased risks of the transfer to the patient and, where the patient is pregnant, to the unborn child. In such cases, the evaluation, treatment, and transfer of the patient will be carried out as quickly as possible; or
 - c. If a physician is not physically present to sign the certification, a QMP may sign the certification after consultation with a physician who agrees with the certification, as set forth in paragraph 2.b above, and the physician later countersigns the certification.
3. A patient should only be transferred when one of the situations in 2. above exists, and the transfer meets all the following requirements (a Transfer is then appropriate):
 - a. The Hospital provides the medical treatment within its capabilities that will minimize the risks to the individual's health and, where the individual is pregnant, to the health of the unborn child; and
 - b. The receiving facility has available space and qualified personnel for the treatment of the patient and has agreed to accept transfer of the patient and to provide appropriate medical treatment; and
 - c. Medical records related to the patient's medical condition are provided to the receiving facility; and
 - d. The transfer is completed through the appropriate medical personnel and utilizing the appropriate equipment for the patient as determined by the transferring physician who has examined and evaluated the patient prior to transfer and exercised the degree of care which a reasonable and prudent physician exercising ordinary care in the same or similar locality would use for the transfer. Prior to transfer, the Memorandum of Transfer must be completed.
4. **Refusal to Consent to Transfer or Transport.** In the event that an individual (or a person acting on the individual's behalf) refuses to consent to the transfer or transport, the Hospital shall ensure that the individual (or the person acting on the individual's behalf) has been informed of the risks and benefits of the transfer and shall take all reasonable steps to secure the individual's (or person's) written informed refusal of such transfer or transport. If a patient refuses to sign a written refusal, the physician or Qualified Medical Person shall note that the patient refused treatment and that the patient was unwilling to sign a written statement in the patient's medical record and in the Central Log.

5. **Receiving Transfers.** A hospital that has specialized capabilities or facilities including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or, with respect to rural areas, regional referral centers, may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual, regardless of whether the hospital has a Dedicated Emergency Department. The Hospital will accept or refuse requests for transfer within 30 minutes of the initial call from the transferring hospital, except when extenuating circumstances exist (in which case the Hospital will accept or refuse the patient within an hour and the reason for the delay will be documented in the Memorandum of Transfer if the patient is accepted) or when the transferring hospital and physician agree with the receiving hospital and physician to extend the time frame (in which case the agreement will be documented in the Memorandum of Transfer if the patient is accepted). The Hospital administration and receiving physician will acknowledge receipt of the Memorandum of Transfer in writing, and the Memorandum of Transfer will be retained separately from the patient's medical record in a manner that facilitates regulatory surveys. The provisions of this paragraph do not apply to the transfer of inpatients. If there is a concern that a patient has been transferred in violation of EMTALA, contact Risk Management for review.
6. This policy recognizes the right of a patient to request a transfer into the care of a physician and a hospital of the patient's own choosing. However, if a patient requests or consents to transfer for economic reasons and the patient's choice is predicated upon or influenced by representations made by the transferring hospital administration regarding the availability of medical care and hospital services at a reduced cost or no cost to the patient, the Hospital's administration shall, to the best of its abilities, fully disclose to the patient the eligibility requirements established by the patient's chosen physician or hospital.
7. The transfer of a patient must be for medical reasons and may not be predicated upon arbitrary, capricious, or unreasonable discrimination based on race, religion, national origin, age, sex, physical condition, economic status, insurance status, or ability to pay.
8. The Hospital will comply with the Indigent Health Care and Treatment Act (Chapter 61 of the Texas Health & Safety Code), specifically sections 61.030, 61.032, 61.057, and 61.059, which control the process by which Hospital may determine if a patient receiving emergency services is eligible for assistance from the county, hospital district, or public hospital service area within which the patient resides based on the patient's financial condition.
9. Licensed nurses and other qualified personnel will be available and on duty to assist with patient transfers and to provide accurate information regarding eligibility and payment practices whether the Hospital is transferring or receiving the patient.

Reporting Non-Compliance with EMTALA

If the hospital at any time has reason to believe it may have **received an inappropriate transfer** under EMTALA from another hospital, Hospital is required to report, generally within 72 hours, to CMS or the State survey agency. Contact Risk Management for review.

If the hospital at any time has reason to believe it may have **transferred an individual inappropriately** or otherwise may have violated EMTALA, contact Risk Management for review.

Regulatory Surveys

When a surveyor presents on site for an EMTALA survey local administration and Quality Accreditation should be notified. Quality Accreditation will then follow the local Survey Response Plan (following the national template for survey response).

Ensuring EMTALA Compliance

Emergency Department leaders and key stakeholders, including the Hospital's medical staff, will perform ongoing monitoring and auditing for key indicators of EMTALA compliance as needed and/or required by regulatory standards, which shall include a review of appropriate records of transferred patients. Electronic audits are preferable. Ongoing audits should be reviewed by the Market Quality/Safety Committee. Compliance may review EMTALA concerns with market stakeholders annually to determine risk and need to add an EMTALA review to the Compliance Work Plan.

Related Policies

[Consent for Treatment](#)

[Admission, Transfers, Discharges Emergency Services](#)

[Against Medical Advice \(AMA\)](#)

[Medical Screening - Labor and Delivery](#)

[Triaging Adult and Pediatric Patients in the Emergency Departments Using the Emergency Severity Index \(ESI\)](#)

[Ascension Texas Provider-Based Status](#)

[Rules of the Seton Medical Staff](#)

[Patient Transfer Policy](#)

[Code Down Persons in Need of Medical Assistance in a Non-Clinical Area](#)

References

The Emergency Medical Treatment and Active Labor Act (EMTALA), Pub. L. No. 99-272, Title IX, §9121(b), 100 Stat. 164 (codified as amended at 42 U.S.C. §1395dd). 42 C.F.R. §§ 489.20, 489.24.

CMS, State Operations Manual: Provider Certification Publication 100-07, Appendix V.

Approval Signatures

Step Description	Approver	Date
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Applicability

Ascension Providence, Ascension Seton

COPY

ASCENSION SETON

FINANCIAL ASSISTANCE POLICY

July 01, 2024

POLICY/PRINCIPLES

It is the policy of the organizations listed below this paragraph (each one being the “Organization”) to ensure a socially just practice for providing emergency and other medically necessary care at the Organization’s facilities. This policy is specifically designed to address the financial assistance eligibility for patients who are in need of financial assistance and receive care from the Organization. This policy applies to each of the following Organizations within Ascension Seton:

- Dell Children’s Medical Center of Central Texas
 - Ascension Seton Medical Center Austin
 - Ascension Seton Bastrop
 - Ascension Seton Hays
 - Ascension Seton Williamson
 - Ascension Seton Northwest
 - Ascension Seton Southwest
 - Ascension Seton Edgar B. Davis
 - Ascension Seton Highland Lakes
 - Ascension Seton Shoal Creek
 - Ascension Seton Smithville
 - Dell Seton Medical Center at The University of Texas
1. All financial assistance will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship.
 2. This policy applies to all emergency and other medically necessary care provided by the Organization, including employed physician services and behavioral health. This policy does not apply to charges for care that is not emergency and other medically necessary care.
 3. The List of Providers Covered by the Financial Assistance Policy provides a list of any providers delivering care within the Organization’s facilities that specifies which are covered by the financial assistance policy and which are not.

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- “**501(r)**” means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.
- “**Amount Generally Billed**” or “**AGB**” means, with respect to emergency and other medically necessary care, the amount generally billed to individuals who have insurance

covering such care.

- **“Community”** means geographic areas, grouped by counties, Ascension Seton uses for planning in Central Texas: 1.) Central – Travis County, 2.) South – Hays and Caldwell Counties, 3.) North – Williamson County, 4.) West – Burnet, Blanco and Llano Counties, and 5.) East – Bastrop, Fayette, Gonzales and Lee Counties, and San Saba County. A Patient will also be deemed to be a member of the Organization’s Community if the emergency and medically necessary care the Patient requires is continuity of emergency and medically necessary care received at another Ascension Health facility where the Patient has qualified for financial assistance for such emergency and medically necessary care.
- **“Emergency care”** means labor or a medical condition of such severity that the absence of immediate medical attention could reasonably be expected to result in seriously jeopardizing the health of the patient (or unborn child), serious impairment to bodily function, or serious dysfunction of any body organ or part.
- **“Medically necessary care”** means care that is (1) appropriate and consistent with and essential for the prevention, diagnosis, or treatment of a Patient’s condition; (2) the most appropriate supply or level of service for the Patient’s condition that can be provided safely; (3) not provided primarily for the convenience of the Patient, the Patient’s family, physician or caretaker; and (4) more likely to result in a benefit to the Patient rather than harm. For future scheduled care to be “medically necessary care,” the care and the timing of care must be approved by the Organization’s Chief Medical Officer (or designee). The determination of medically necessary care must be made by a licensed provider that is providing medical care to the Patient and, at the Organization’s discretion, by the admitting physician, referring physician, and/or Chief Medical Officer or other reviewing physician (depending on the type of care being recommended). In the event that care requested by a Patient covered by this policy is determined not to be medically necessary by a reviewing physician, that determination also must be confirmed by the admitting or referring physician.
- **“Organization”** means Ascension Seton which consists of:
 - Dell Children’s Medical Center of Central Texas
 - Ascension Seton Medical Center Austin
 - Ascension Seton Bastrop
 - Ascension Seton Hays
 - Ascension Seton Williamson
 - Ascension Seton Northwest
 - Ascension Seton Southwest
 - Ascension Seton Edgar B. Davis
 - Ascension Seton Highland Lakes
 - Ascension Seton Shoal Creek
 - Ascension Seton Smithville
 - Dell Seton Medical Center at The University of Texas
- **“Patient”** means those persons who receive emergency and other medically necessary care at the Organization and the person who is financially responsible for the care of the patient.

Financial Assistance Provided

Financial assistance described in this section is limited to Patients that live in the Community:

1. Subject to the other provisions of this Financial Assistance Policy, Patients with income less than or equal to 250% of the Federal Poverty Level income (“FPL”), will be eligible for 100% charity care on that portion of the charges for services for which the Patient is responsible following payment by an insurer, if any, if such Patient determined to be eligible pursuant to presumptive scoring (described in Paragraph 5 below) or submits a financial assistance application (an “Application”) on or prior to the 240th day after the Patient’s first discharge bill and the Application is approved by the Organization. Patient will be eligible for up to 100% financial assistance if Patient submits the Application after the 240th day after the Patient’s first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient’s unpaid balance after taking into account any payments made on Patient’s account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges.

2. Subject to the other provisions of this Financial Assistance Policy, Patients with incomes above 250% of the FPL but not exceeding 400% of the FPL, will receive a sliding scale discount on that portion of the charges for services provided for which the Patient is responsible following payment by an insurer, if any, if such Patient submits an Application on or prior to the 240th day after the Patient’s first discharge bill and the Application is approved by the Organization. Patient will be eligible for the sliding scale discount financial assistance if Patient submits the Application after the 240th day after the Patient’s first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient’s unpaid balance after taking into account any payments made on Patient’s account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges. The sliding scale discount is as follows:

Patients between 251% FPL and 300% FPL will receive 95% assistance
Patients between 301% FPL and 350% FPL will receive 90% assistance
Patients between 351% FPL and 400% FPL will receive 85% assistance

3. Subject to the other provisions of this Financial Assistance Policy, a Patient with income greater than 400% of the FPL may be eligible for financial assistance under a “Means Test” for some discount of Patient’s charges for services from the Organization based on a Patient’s total medical debt. A Patient will be eligible for financial assistance pursuant to the Means Test if the Patient has excessive total medical debt, which includes medical debt to Ascension and any other health care provider, for emergency and other medically necessary care, that is equal to or greater than such Patient’s household’s gross income. The level of financial assistance provided pursuant to the Means Test is the same as is granted to a patient with income at 400% of the FPL under Paragraph 2 above, if such Patient submits an Application on or prior to the 240th day after the Patient’s first discharge bill and the Application is approved by the Organization. Patient will be eligible for the means test discount financial assistance if such Patient submits the Application after the 240th day after the Patient’s first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient’s unpaid balance after taking into account any payments made on Patient’s account. A Patient

eligible for this category of financial assistance will not be charged more than the calculated AGB charges.

4. A Patient may not be eligible for the financial assistance described in Paragraphs 1 through 3 above if such Patient is deemed to have sufficient assets to pay pursuant to an "Asset Test." The Asset Test involves a substantive assessment of a Patient's ability to pay based on the categories of assets measured in the FAP Application. A Patient with such assets that exceed that exceed 250% of such Patient's FPL amount may not be eligible for financial assistance.
5. Eligibility for financial assistance may be determined at any point in the revenue cycle and may include the use of presumptive scoring for a Patient with a sufficient unpaid balance within the first 240 days after the Patient's first discharge bill to determine eligibility for 100% charity care notwithstanding Patient's failure to complete a financial assistance application ("FAP Application"). If Patient is granted 100% charity care without submitting a completed FAP Application and via presumptive scoring only, the amount of financial assistance for which Patient is eligible is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A determination of eligibility based on presumptive scoring only applies to the episode of care for which the presumptive scoring is conducted.
6. For a Patient that participates in certain insurance plans that deem the Organization to be "out-of-network," the Organization may reduce or deny the financial assistance that would otherwise be available to Patient based upon a review of Patient's insurance information and other pertinent facts and circumstances.
7. Patients that are eligible for financial assistance may be charged a nominal flat fee of up to \$30 for services. The nominal flat fee will not exceed the AGB charge for services.
8. The Patient may appeal any denial of eligibility for Financial Assistance by providing additional information to the Organization within fourteen (14) calendar days of receipt of notification of denial. All appeals will be reviewed by the Organization for a final determination. If the final determination affirms the previous denial of Financial Assistance, written notification will be sent to Patient. The process for Patients and families to appeal the Organization's decisions regarding eligibility for financial assistance is as follows:
 - a. Patients and families may submit a written appeal letter by mail to the Patient Financial Services department. The appeal letter should include financial information, not considered in the Patient's original Financial Assistance Application, important to reconsidering the Patient's eligibility for charity care. In addition to the written appeal letter, Patients and families must include documentation of reconsideration information included in the appeal letter. Without appropriate documentation, the consideration of the appeal may be delayed until appropriate documentation is received. The appeal letter and supporting documentation must be mailed to Patient Financial Services at P.O. Box 204301 Dallas TX, 75320-4301.

- b. All appeals will be considered by the Organization's financial assistance appeals committee, and decisions of the committee will be sent in writing to the Patient or family that filed the appeal.

Other Assistance for Patients Not Eligible for Financial Assistance

Patients who are not eligible for financial assistance, as described above, still may qualify for other types of assistance offered by the Organization. In the interest of completeness, these other types of assistance are listed here, although they are not need-based and are not intended to be subject to 501(r) but are included here for the convenience of the community served by the Organization.

1. Uninsured Patients who are not eligible for financial assistance will be provided a discount based on the discount provided to the highest-paying payor for that Organization. The highest paying payor must account for at least 3% of the Organization's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the Organization's business for that given year.
2. Uninsured and insured Patients who are not eligible for financial assistance may receive a prompt pay discount. The prompt pay discount may be offered in addition to the uninsured discount described in the immediately preceding paragraph.

Limitations on Charges for Patients Eligible for Financial Assistance

Patients eligible for Financial Assistance will not be charged individually more than AGB for emergency and other medically necessary care and not more than gross charges for all other medical care. The Organization calculates one or more AGB percentages using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with 501(r). A free copy of the AGB calculation description and percentage(s) may be obtained on the Organization's website or by request in any admissions area. Patients may also request a free copy of the AGB calculation and percentage by mail by calling Patient Financial Services at 800-749-7624 to request a copy be sent to the Patient's mailing address.

Applying for Financial Assistance and Other Assistance

A Patient may qualify for financial assistance through presumptive scoring eligibility or by applying for financial assistance by submitting a completed FAP Application. The FAP Application and FAP Application Instructions are available on the Organization's website or by request at the time of service. If a Patient wishes to apply for financial assistance after the day(s) of service, a Patient may access the FAP Application and FAP Application instructions and print directly from Ascension Seton's website. Patients may also request a copy of the FAP Application and FAP Application Instructions by mail. To request a copy of the documents by mail, Patients should call the Patient Financial Services department at 800-749-7624. In each of the aforementioned accessible locations, the FAP Application and FAP Application instructions are available in English, Spanish, Chinese, Vietnamese, Korean, and Arabic. The Organization will

require the uninsured to work with a financial counselor to apply for Medicaid or other public assistance programs for which the patient is deemed to be potentially eligible in order to qualify for financial assistance (except where eligible and approved via presumptive scoring). A Patient may be denied financial assistance if the Patient provides false information on a FAP Application or in connection with the presumptive scoring eligibility process, if the patient refuses to assign insurance proceeds or the right to be paid directly by an insurance company that may be obligated to pay for the care provided, or if the patient refuses to work with a financial counselor to apply for Medicaid or other public assistance programs for which the patient is deemed to be potentially eligible in order to qualify for financial assistance (except where eligible and approved via presumptive scoring). The Organization may consider a FAP Application completed less than six months prior to any eligibility determination date in making a determination about eligibility for a current episode of care. The Organization will not consider a FAP Application completed more than six months prior to any eligibility determination date.

Billing and Collections

The actions that the Organization may take in the event of nonpayment are described in a separate billing and collections policy. A free copy of the billing and collections policy may be obtained on the Organization's website or by request at the time of service. Patients may also request a free copy of the Billing and Collections policy by mail. To request a copy of the document by mail, Patients should call the Patient Financial Services department at 800-749-7624.

Interpretation

This policy, together with all applicable procedures, is intended to comply with and shall be interpreted and applied in accordance with 501(r) except where specifically indicated.