



IOWA HOSPITAL  
ASSOCIATION

# Understanding EMTALA, HIPAA, and Other Hospital Regulations

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*We care about Iowa's health*

# EMTALA- Nuts and Bolts

# History of the Act

## Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. 1395dd

- Federal Law – Passed by Congress in 1986
- Response to concern over the availability of emergency health care services to the poor and uninsured.
- Designed to address situations in which hospital emergency rooms deny care uninsured patients by refusing to provide treatment or by transferring patients to other facilities.

<https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/>

# EMTALA – In a Nutshell

- The cornerstone of EMTALA is the requirement that requires **any hospital who receives Medicare payment must provide medical screening and stabilizing treatment to any patient who seeks care in an emergency room.**
- Hospitals with specialized capabilities **are obligated to accept transfers from hospitals who lack the capability to treat unstable emergency medical conditions.**
- A hospital **must report** to CMS or the state survey agency any time it has reason to believe it may have **received an individual who has been transferred in an unstable EMC from another hospital** in violation of EMTALA.

All 118 community hospitals in the State of Iowa receive Medicare and are subject to the mandates of EMTALA.

# EMTALA – The Details

- Applies to all hospitals that participate in Medicare
- Is a condition of participation
- Includes every individual who comes to the ED requesting care (**not limited to Medicare patients**)
- Covers non-citizens within the United States and minors.

**IF YOU HAVE A MEDICAL EMERGENCY OR ARE IN LABOR,  
YOU HAVE THE RIGHT TO RECEIVE,**  
within the capabilities of this hospital's staff and facilities:

- An appropriate Medical SCREENING EXAMINATION
- Necessary STABILIZING TREATMENT (including treatment for an unborn child) and, if necessary,
- An appropriate TRANSFER to another facility

**Even if YOU CANNOT PAY or DO NOT HAVE MEDICAL INSURANCE or YOU ARE NOT  
ENTITLED TO MEDICARE OR MEDICAID**



# EMTALA - Application

- Applies to a dedicated Emergency Department. An Emergency Department can be:
  - An entity licensed by the State as an emergency department;
  - An entity that holds itself out to the public as providing emergency care; or
  - An entity that provided at least 1/3 of its outpatient visits as Emergency Medical Conditions during the preceding calendar year.
- Covers patients anywhere on hospital property seeking emergency care.
  - Include patients coming into the wrong entrance or
  - patients in the parking lot.
  - In a hospital owned ambulance or in an ambulance on hospital property
- A hospital may divert individuals when it is in “diversionary” status because it does not have the staff or facilities to accept any additional emergency patients at that time.
- However, if the ambulance is owned by the hospital, the diversion of the ambulance is only appropriate if the hospital is being diverted pursuant to community-wide EMS protocols.

# Emergency Medical Condition

- Hospitals must determine if the patient is experiencing an Emergency Medical Condition (EMC). This is done by providing a Medical Screening Exam (MSE) - a physical or mental health evaluation used to determine if a patient has an EMC.
  - “(1) 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—
    - (i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
    - (ii) Serious impairment to bodily functions; or (iii) Serious dysfunction of any bodily organ or part;
  - or (2) With respect to a pregnant woman who is having contractions—
    - (i) That there is inadequate time to effect a safe transfer to another hospital before delivery; or
    - (ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.”
  - EMC could include things such as seizure, life threatening injury, pain, extensive bone or soft injury, vascular or nerve damage, psychiatric disturbance, or symptoms of substance abuse



# Emergency Medical Condition

- If an EMC does not exist then EMTALA does not apply.
- If it is determined that the patient is experiencing an EMC, the patient must be provided stabilizing treatment or transfer.

# Stabilizing Treatment

- Stabilization under EMTALA is **NOT** the same as medical or clinical stabilization.
- The Social Security Act mandates that stabilization, with respect to an EMC, means “that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition [in which a pregnant woman] has delivered (including the placenta).”

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-06.pdf>

# Stabilizing Treatment

What if the patient needs to be transferred from the ED for further screening? Can the patient be moved from the ED to another department for further screening or stabilization without it being a transfer?

- Bona fide reason to move the patient AND appropriate personnel accompany the patient
  - For instance, a patient needs to receive a test located in a different part of the hospital
- Can not move patients to a location off campus such as a satellite clinic or urgent care center for their MSE

# Transfer before stabilization

- If the patient has not been stabilized, then the hospital may not transfer the patient unless:
  - A physician certifies the medical benefits expected from the transfer outweigh the risks OR
  - A patient makes a transfer request in writing after being informed of the hospital's obligations under EMTALA and the risks of transfer.
- The transfer of unstable patients must be "appropriate" under the law, such that
  - (1) the transferring hospital must provide ongoing care within its capability to minimize transfer risks,
  - (2) provide copies of medical records,
  - (3) must confirm that the receiving facility has space and qualified personnel to treat the condition and has agreed to accept the transfer, and
  - (4) the transfer must be made with qualified personnel and appropriate medical equipment.

# Payment

- Explicitly requires a hospital to provide any individual who comes to the ED a medical screening examination and, if applicable, stabilizing treatment, **regardless of the individual's ability to pay.**
- Explicitly prohibits a hospital from delaying examination or treatment in order to inquire about an individual's method of payment or insurance status.



# Payment

- EMTALA still allows for reasonable administrative practices that support efficient operations without violating the spirit of EMTALA.
- There are some exceptions (42 CFR 489.24(d)(4)(ii) and (iv)) to the general prohibition on inquiring about method of payment or insurance status:
  - permits such requests for insurer authorization to be made, but only after stabilizing treatment has been initiated (cannot delay the screening examination)
  - Asking an individual for basic identifying information, emergency contact information, whether he or she is insured and if so by whom, are permitted practices, so long as there is no delay in screening or treatment.

# Payment

Until a hospital's EMTALA obligations to an individual has ended because there is no EMC or the patient's condition has been stabilized (as defined by EMTALA) or the individual with an unstabilized EMC has been admitted in good faith as an inpatient for stabilizing treatment, the individual hospital may not make payment requests.

- Requests must be consistent with the patient's right under the hospital Conditions of Participation at 42 CFR § 482.13(c)(3) to be free from all forms of abuse or harassment.

# Denial of payment irrelevant

- If the individual is determined through the MSE to have an EMC, the hospital must provide stabilizing treatment or an appropriate transfer.
- CMS has stated that the EMTALA obligations do not change even if an individual's third-party payor may refuse to pay for emergency department (ED) services because the diagnosis codes are "nonemergent".
- Hospitals **must utilize** the EMTALA definition of an EMS:
  - (1) 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—
    - (i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
    - (ii) Serious impairment to bodily functions; or
    - (iii) Serious dysfunction of any bodily organ or part; or
  - (2) With respect to a pregnant woman who is having contractions
    - (i) That there is inadequate time to effect a safe transfer to another hospital before delivery; or
    - (ii) That transfer may pose a threat to the health or safety of the woman or the unborn child

# Penalties for violation

- \$50,000 per incident
- termination of Medicare provider agreement

# Test Your Skills...

Like all federal regulations, EMTALA is all about interpretation and application.

Let's see how EMTALA has been interpreted and applied in specific scenarios....



# Air Transfer

A sixty-four-year-old uninsured woman arrived at a hospital emergency department complaining of weakness that had lasted for several weeks. The ED tried unsuccessfully to transfer her to several hospitals within 100 miles. Instead, she was transferred approximately 350 miles by air for management of Guillain-Barré syndrome, a potentially life-threatening neurologic disorder.

Was this a potential EMTALA violation?

# The Long Drive

A thirty-nine-year-old uninsured woman with multiple sclerosis and epilepsy developed intractable seizures at her home. Her husband contacted 911, and emergency medical services were sent to her home. Paramedics intubated her and administered antiepileptic medications, but she continued to experience seizures. The ambulance drove past several for-profit hospitals before arriving at a public hospital. The ambulance attendants explained that the facilities they were bypassing did not treat uninsured patients.

Could there have been an EMTALA violation?

# Golfing Surgeon

A thirty-year-old uninsured woman came to the emergency department of a nonprofit hospital, complaining of difficulty swallowing and breathing because of throat swelling. She was found to have an abscess at the base of her tongue that was encroaching on her airway. The ear, nose, and throat surgeon on call was contacted, but he refused to see the patient.

Is there a potential violation of EMTALA?

# Mental health

A suicidal patient who was involuntarily committed was treated by an emergency room physician and kept in the emergency room for 15 days waiting for placement in the state-run psychiatric facility. The hospital had on-call psychiatrists and inpatient beds available in its psychiatric unit to evaluate and stabilize the patient.

Was this an EMTALA violation?

# Bus Ride

A hospital kept the entrance door to the ED waiting room and registration area locked, and only security staff could open it. A passing psychotherapist videotaped hospital security guards escorting a woman outside the hospital dressed in only a gown and socks on a freezing night to a bus stop. The psychotherapist called 911, after which an ambulance crew took the woman back to the hospital.

Was this an EMTALA violation?



# Questions???



# HIPAA- Can They Do That?

# What is HIPAA?

Health Insurance Portability and Accountability Act (HIPAA).



- Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (1996)
- Codified at 42 U.S.C. § 300gg and 29 U.S.C § 1181 et seq. and 42 USC 1320d et seq.
  - 45 CFR 160.103 Purpose & Definitions
  - 45 CFR 164 Security and Privacy Regulations
- HITECH, <https://www.gpo.gov/fdsys/pkg/FR-2013-01-25/html/2013-01073.htm>

# History of HIPAA

- HIPAA has been around for over 20 years – became law in 1996.
- Originally known as the Kennedy-Kassebaum Bill – named after leading sponsors Sen. Edward Kennedy (D-Mass.) and Sen. Nancy Kassebaum (R-Kan.)
- Original aims of the legislation were to:
  - Promote electronic transmission standards for claims data
  - Regulate the privacy of electronic medical records
  - Regulate the security of medical data storage and transmissions
- Stemmed from concerns in the 1990s that recognized medical records were increasingly electronic and portable – how do you manage privacy and security of this information?



# HIPAA Basics - PHI

Protected Health Information (PHI): Health data that is created, received, stored, or transmitted by HIPAA-covered entities and their business associates in relation to the provision of healthcare, healthcare operations and payment for healthcare services.

Includes all individually identifiable health information, including demographic data, medical histories, test results, insurance information, and other information used to identify a patient or provide healthcare services or healthcare coverage.



# Individually Identifiable

**What could be considered “individually identifiable”?** There are 18 codified factors determined “individually identifiable that include:

- Names (Full or last name and initial)
- All geographical identifiers smaller than a state
- Dates (other than year) directly related to an individual
- Numbers – phone and fax
- Email addresses
- Social Security numbers
- Medical record numbers
- Health insurance beneficiary numbers
- Account numbers

# Covered Entities

**Covered Entities:** A health plan (such as an HMO), a clearinghouse (like WebMD), or a health care provider who transmits any health information electronically.

**Business Associates:** A person or organization, other than a member of the Covered Entity's workforce, that performs certain functions or activities on behalf of, or provides certain services to, a Covered Entity that involves the use or disclosure of PHI.

**Business Associate Agreement:** An agreement entered into between a Covered Entity and each Business Associate that ensures the Business Associate will appropriately safeguard Protected Health Information.

# Two Prongs

**HIPAA is broken out into two major categories:**

Privacy Rule: *Standards for Privacy of Individually Identifiable Health Information* establishes national standards for the protection of health information and sets rules and limits on who can look at and receive protected health information.

Security Rule: *Security Standards for the Protection of Electronic Protected Health Information* establishes a national set of security standards for protecting certain health information that is transmitted, received, or stored in electronic form.

# Privacy Rule

Rule: A Covered Entity or Business Associate may not use or disclose protected health information unless expressly permitted by the Privacy Rule or authorized by the individual.

What are permitted disclosures under the Privacy Rule? **There are a lot!**

# Awesome Attorney Disclaimer

The following is a summary of some permitted uses and disclosures allowed under the Privacy Rule. This listing does not include or define all uses and disclosures.

The Privacy Rule should always be fully reviewed and examined before determining application to a specific set of facts.

# Permitted Use and Disclosure

- To the individual
- For treatment, payment, or health care operations
- Incident to permitted use or disclosure – Safeguards and MINIMUM NECESSARY
- Facility directories listings – opt out option required
- Disclosures to family and other caregivers – opt out option required
- Required by law
- Public health activities
- Health oversight activities
- Judicial and administrative proceedings
- Serious threat to health or safety



# Covered Entity Uses

A Covered Entity can disclose PHI to another Covered Entity or that Covered Entity's Business Associate for the following subset of health care operations activities of the recipient Covered Entity (45 CFR 164.501) without needing patient consent or authorization (45 CFR 164.506(c)(4)):

- Conducting quality assessment and improvement activities
- Developing clinical guidelines
- Conducting patient safety activities as defined in applicable regulations
- Conducting population-based activities relating to improving health or reducing health care cost
- Developing protocols
- Conducting case management and care coordination (including care planning)
- Contacting health care providers and patients with information about treatment alternatives
- Reviewing qualifications of health care professionals
- Evaluating performance of health care providers and/or health plans
- Conducting training programs or credentialing activities
- Supporting fraud and abuse detection and compliance programs.

# In Addition Please Note

In general, before a Covered Entity can share Protected Health Information with another Covered Entity for a permitted reason, the following three requirements must also be met:

- Both Covered Entity's must have or have had a relationship with the patient (can be a past or present patient)
- The PHI requested must pertain to the relationship
- The discloser must disclose only the minimum information necessary for the health care operation at hand.

# Minimum Necessary

Minimum Necessary is a cornerstone of the HIPAA Privacy Rule.

- Under HIPAA's Minimum Necessary provisions, a Covered Entity must make reasonable efforts to limit Protected Health Information to the Minimum Necessary to accomplish the purpose of the use, disclosure or request. (45 CFR 164.502(b)).
- For example, in sharing information with an individual's health plan for population health programs (for example, a diabetes management program), a Covered Entity should disclose **ONLY** the Protected Health Information that is necessary for the program to be effective.

# Authorizations and Releases

A vast amount of authorizations and releases exist under HIPAA. Examples:

- Sharing with other individuals
- Sharing with other entities
- Sharing with a lawyer
- Sharing for marketing purposes
- Sharing for fundraising

# Security Rule

Security Rule: Establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a Covered Entity. The Security Rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information (ePHI).

Electronic Protected Health Information: A subset of Protected Health Information that is transmitted by electronic media or maintained in electronic media.

# Security Safeguards

Security safeguards fall into three broad categories:

- Administrative Safeguards
- Physical Safeguards
- Technical Safeguards



# Administrative Safeguards

Managing workforce to ensure security. Examples:

- Workforce Security – all employees understand security protocols
- Assigning Security – identifying the security officer responsible for policies and procedures
- Information Access Management – controlling who can access ePHI
- Security Awareness Training – education and training for workforce
- Incident Procedures – what to do if you have a disclosure, breach, or any security violation

# Physical Safeguards

Measures, policies, and procedures that protect the physical space related to security. Examples:

- Environment – limiting facility access and control
- Workstations – restricting access to unauthorized users and securing the area
- Devices – securing laptops, computers, storage media and ensuring proper disposal of these devices

# Technical Safeguards

Technology policies and procedures. Examples:

- Access controls – user IDs and passwords
- Audit controls – ensuring audit controls like logs, risk assessments, periodic reviews of systems
- Transmission – ensuring protection during transmission

# Always Ask...

- Is it Protected Health Information?
- Is the use or disclosure for a permissible purpose?
- Is there a valid authorization or release?
- Was a Business Associate Agreement executed?
- Was the disclosure the Minimum Necessary?

# Voicemail

A patient left instructions to contact her through her work number. A hospital employee left a telephone message with the daughter of the patient that detailed both the patient's medical condition and treatment plan.

Did the hospital employee violate HIPAA?

# Privacy Practices

A mental health center provided a notice of privacy practices to a father of his minor daughter - a patient at the center.

HIPAA violation?



# Pharmacy Logs

A grocery store based pharmacy chain maintained pseudoephedrine log books in a manner so that an individual's information was visible to the public at the pharmacy counter.

HIPAA violation?

# Other Examples

- “The Tweet”
- Always Check the Copy Machine
- Oooops....Wrong Number
- Facebook
- Medical Alert Stickers

# Observation Status



# What is observation?

“a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital”

Not for more than 48 hours

# Why does it matter?

- Medicare Part A
  - traditional – automatically enrolled
  - covers approved inpatient costs and some skilled care
  - yearly deductible
- Medicare Part B
  - doctors visits, DME, therapies, etc.
  - Can opt out, must pay a premium
  - Co-pays
- Medicare Part C- Medicare Advantage
- Medicare Part D- Pharmacy benefit



# Why a difference

Inpatient designation must be medically reasonable and necessary.

- RAC audits
  - After-the fact reclassification and payment recoupment
  - Short stays were targeted
  - Incentives misaligned
- Two-midnight rule
- 96 hour rule
- Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act)
  - Pub. L. 114-42, 42 U.S.C. § 1395cc(a)(1)(Y).
  - <https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf>



# Medicare Outpatient Observation Notice

- Required under federal law within 36 hours if in hospital more than 24 hours.
- “You’re an outpatient receiving observation services. You are not an inpatient because...”
- Being an outpatient may affect what you pay in a hospital:
  - When you’re a hospital outpatient, your observation stay is covered under Medicare Part B.
  - For Part B services, you generally pay:
    - A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
    - 20% of the Medicare-approved amount for most doctor services, after the Part B deductible.

# MOON

Observation services may affect coverage and payment of your care after you leave the hospital:

- If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged.
- If you have Medicaid, a Medicare Advantage plan or other health plan, Medicaid or the plan may have different rules for SNF coverage after you leave the hospital. Check with Medicaid or your plan.

Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, Part A will generally cover medically necessary inpatient services if the hospital admits you as an inpatient based on a doctor's order. In most cases, you'll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital.

# Costs of Medications

- Prescription and over-the-counter drugs, including “self-administered drugs,” from an outpatient setting (like an emergency department) are not covered by Part B.
- For safety reasons, many hospitals cannot allow you to take medications brought from home, so you will be billed for these.
- A Medicare prescription drug plan may help you pay for these drugs after submitting a claim for a refund.

# Questions?