Questionable Hospitals

527 Hospitals that Violated the Emergency Medical Treatment and Labor Act: A Detailed Look at "Patient Dumping"

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EXECUTIVE SUMMARY

- This report is the sixth in a series of reports published by Public Citizen's Health Research Group tracking violations and enforcement of the federal Emergency Treatment and Labor Act. Like previous reports, this report lists the names of hospitals with HCFA confirmed violations of the Act. This report primarily covers calendar years 1997, 1998 and 1999. A few confirmed violations occurring in 1996 and 2000 are also listed. 1996 violations are confirmed violations which were not listed in Public Citizen's last report. 2000 violations are violations which appeared on HCFA central logs for 1999 and were confirmed as violations by the Regional Offices.

- Violations were confirmed for 527 hospitals in 46 states, as well as the District of Columbia and Puerto Rico (Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin). These confirmed violations have not appeared in our previous reports.

- 68 hospitals (12.9% of those hospitals in this report listed in Table 1, page 33) were also listed with violations in previous reports. Since our first report, 117 hospitals have violated the Act on more than one date.

- 90.1% of violating hospitals (475 hospitals) violated the screening, stabilizing treatment or transfer provisions, the most serious categories of EMTALA violations.

- 72.5% of hospitals violating the Act were not-for-profit hospitals (382 hospitals out of 527). 19.7 % were for-profit hospitals (104 out of 527). The profit status of 41 hospitals (8%) was unknown. In 1998, 13.7% of non-federal hospitals accepted for registration by the American Hospital Association were for-profit entities (771 hospitals).[1] Our data demonstrates a statistically significant increased risk (1.7 times higher) of violation by for-profit hospitals compared to not-for-profit hospitals.

- 164 hospitals agreed to pay civil monetary penalties to resolve alleged EMTALA violations in calendar years 1997, 1998, 1999, 2000 and through April 9, 2001. The number of settlements executed in 1998 (59) represents a four-fold increase in the number of settlements executed the previous year, 1997 (12). Dollar amounts of penalties have also increased, from a total of $130,000 in OIG Fiscal Year 1988 to totals exceeding $1,000,000 in each of OIG Fiscal Years 1998, 1999, and 2000. To date, HCFA has referred 975 cases involving violations by

hospitals and physicians to the OIG. 261 of these cases (26.7%) have resulted in the imposition of civil monetary penalties.

- 243 hospitals listed in this report have had violations confirmed before January 1, 1999 and have so far , as of April 9, 2001 not had a civil monetary penalty imposed by the HHS office of the Inspector General (see Appendix 2, page 127).

- In calendar years 1997, 1998, 1999, 2000 and through April 9. 2001 13 physicians agreed to pay civil monetary penalties to resolve alleged dumping violations. Penalty amounts ranged from $5000 to $45,000. Physician violations involved either the Act's screening, transfer or stabilizing treatment provisions (See Table 3, page 72.

- A patient's insurance status influences hospital compliance with the Act. Some insurers, such as HMOs require pre-authorization for examination or treatment or deny reimbursement when an exam rules out the presence of an emergency condition. Hospitals often must choose between providing services without reimbursement or violating EMTALA. A bill recently introduced in the United States Senate (S. 823) requires that insurers cover screening and stabilization treatment without prior authorization, whether the hospital providing these services is a participating provider or not.

- Examples of serious violations include:

  A hospital security officer at Harbor Hospital Center requested ER assistance for an individual found lying in the parking lot. ER staff refused to provide assistance. After emergency medical technicians manning a nearby private ambulance determined that the individual had no pulse and was not breathing, the security officer made a second request for assistance, this time informing the ER that the individual had no pulse and was not breathing. This request was also refused. An ER physician was brought out to assist by the security officer and the patient was eventually taken to the ER by ambulance. Shortly thereafter he was pronounced dead.

  A kidney failure patient's screening exam demonstrated fluid volume overload and probable heart failure (indications that the patient likely needed a dialysis treatment), as well as EKG abnormalities, poor oxygenation and possible pneumonia. A nephrologist (kidney specialist) contacted by the ER physician refused to admit the patient or give a dialysis treatment until the following day. The patient died at home approximately seven hours after she was discharged.

  In Granite City, Illinois (southeast of Springfield), a patient arrived at St. Elizabeth Medical Center's ER complaining of illness and seizures. Staff observed insects crawling over his body and hair. Only the patient's pulse, respiratory rate, blood pressure and temperature were taken; no other examination or diagnostic study was performed. The patient had a rapid heart rate of 142 beats per minute (a normal adult heart rate ranges from 60 –100 beats per minute). The patient was discharged with prescriptions for anti-seizure medication, anti-anxiety

medication and anti-lice shampoo. He was brought back to the same ER in cardiopulmonary arrest the following day and died there. Autopsy results attributed the death to a severe pneumonia.

An unconscious motor vehicle accident victim was brought to an ER with multiple facial fractures and brain injury--because the hospital lacked the capacity to treat neurological patients, the ER physician sought to transfer the patient to a facility where he could receive such specialized care. Memorial Medical Center of East Texas was contacted. A neurologist there agreed to examine the patient. Transfer arrangements were initiated but apparently curtailed when a hospital administrator at Memorial Medical Center refused to accept him.

I. BACKGROUND

In 1986, Congress enacted Section 1867 of the Social Security Act, often referred to as the Emergency Medical Treatment and Active Labor Act (EMTALA or "the Act").[2] The Act provides Medicare participating hospitals with statutory directives governing the provision of emergency medical services. (Virtually all hospitals in the United States participate in Medicare.) The Act protects all individuals, not just those eligible for Medicare benefits. As a result, when a hospital emergency department (ER) denies medical screening, denies stabilizing treatment it is capable of providing and/or inappropriately transfers an individual with an unstabilized emergency condition, that hospital is illegally "dumping" the patient.

A number of factors likely contribute to patient dumping. These include race, gender, politics, personal prejudice as well as a patient's financial or insurance status.[3] The Centers for Disease Control and Prevention's 1998 National Hospital Ambulatory Care Survey found that the expected primary source of payment for 15.1 percent of ER visits in 1998 was self-payment.[4] Another 17.9 percent of visits cited Medicaid as the primary expected source of payment.[5] Even privately insured patients can be financial liabilities for hospital ERs. Managed care organizations may deny or reduce payment for medical screening exams if the individual is found not to have an emergency medical condition. Thus, fiscal motives for patient dumping remain significant.

Since 1991, Public Citizen's Health Research Group has published a series of reports[6] tracking the Department of Health and Human Services' (DHHS) enforcement of the Act. Using data we obtained from the government through requests made under the Freedom of Information Act, previous reports list the names of hospitals that have

violated the law. This report updates the previous reports, presenting data on recent violations not included in earlier reports. All violations listed have been confirmed by the Health Care Financing Administration (HCFA)[7]. Not all violations confirmed by HCFA constitute serious risks to patient care. Transfer violations for example, may only involve simple documentation omissions. HCFA may confirm a screening violation in cases where the patient voluntarily left the ER prior to receiving an exam. Sign posting violations may indicate only the absence of a conspicuously placed sign specifying patients' rights. Other violations, however, involve the denial of basic services to individuals with potentially life-threatening conditions.

This report begins with a description of the DHHS enforcement process. Next, the Act's provisions are summarized and explained. Each summary includes one or more examples illustrating a violation. All examples are excerpted from HCFA "Statement of Deficiency and Plan of Correction" forms (HCFA Form 2567) for hospitals with violations confirmed by HCFA Regional Offices. (Each excerpt has been quoted directly from the HCFA Form 2567, with only minor changes to correct spelling errors, define terms or shorten a lengthy excerpt.) This report also highlights and comments on the Office of Inspector General's (OIG) recent survey on EMTALA awareness.

Table 1 (page 33) lists hospitals with violations confirmed by Regional Offices. Most of these violations were confirmed between January 1, 1997 and December 31, 1999. Violations listed as confirmed in calendar year 1996 are violations which were confirmed that year, but did not appear in Public Citizen's 1997 report. A few violations listed in this report were confirmed in calendar year 2000. Violations confirmed in 2000 appeared on central logs for calendar year 1999 or in "Statement of Deficiency and Plan of Correction" Forms (Forms 2567) sent to us by HCFA Regional Offices. They do not

represent all violations confirmed in the year 2000. Table 2 (page 63) lists hospitals that agreed during calendar years 1997, 1998, 1999, 2000 and through April 9, 2001 to pay penalties to settle a legal dispute over alleged violations. Physicians who agreed to pay penalties during those years are listed in Table 3 (page 72). Figure 1 (page 62) illustrates trends in the number of settlements between hospitals and OIG since EMTALA's enactment. Figure 2 (page 62) illustrates trends in the total sums of civil monetary penalties paid to HHS per fiscal year.

II. METHODOLOGY

Public Citizen uses two sources to identify hospitals with HCFA confirmed violations of the Act. Through requests made pursuant to the Freedom of Information Act, we obtain copies of the centrally compiled yearly logs of EMTALA violations from HCFA's central office. We also obtain "Statement of Deficiency and Plan of Correction" Forms (Forms 2567) from each of HCFA's Regional Offices. Together, these sources furnish the raw data for this report.

We strive to avoid listing a hospital in error. After collecting information from each source, violations are organized by HCFA Region. Each Regional Office is contacted. For this report, eight out of ten Regional Offices agreed to examine our list of EMTALA violations for their region and verify which violations were positively confirmed. After receiving their verification, we deleted those hospitals that were not positively confirmed. Two regions informed us that they lacked the staff to perform this additional verification. Officials at these regions assured us that Forms 2567, with the accompanying letters sent to hospitals reliably represented violations confirmed by the Regional Office. For these two regions, we excluded hospitals that were only identified as violations in the HCFA central logs—hospitals for which we did not receive Forms

2567 from the Regional Offices. We also excluded hospitals identified in Forms 2567, but lacking the accompanying letter.

A number of factors limit the scope of this study. First of all, we have no means of estimating the number of violations that go unreported. We also have almost no information on how each violation was reported to the HCFA Regional Office or by whom, making it impossible to assess compliance with the Act's reporting requirement. (One region has provided us with data that allows us to identify hospitals reporting their own violations.) We do not have access to the medical records documenting events surrounding each violation, a serious limitation as medical records sometimes refute HCFA's conclusions regarding an incident. Future reports will include HCFA's data on EMTALA violations by physicians; this one does not. Finally, objective assessment of the OIG's performance in sanctioning violating hospitals and physicians is limited by the attorney work product doctrine. Simply put, this doctrine shields an attorney's deliberative processes.[8] As a result, we cannot adequately critique OIG's consideration of the many factors involved in each decision to seek civil monetary penalties or not.

III. THE DHHS ENFORCEMENT PROCESS

Two divisions within DHHS share responsibility for enforcing the Act: the Health Care Financing Administration (HCFA) and the Office of the Inspector General (OIG). The enforcement process begins with the receipt of a complaint by a HCFA Regional Office or a State Survey Agency. Anyone encountering a potential violation may make a complaint. Hospitals occasionally "self-report" potential violations occurring within their facilities. Following receipt of a complaint, a HCFA Regional Office may authorize a State Survey Agency on contract to HCFA to investigate the complaint. As part of the unannounced investigation, State Agency investigators hold an initial conference with

representatives of the hospital, examine the complaint case and a sample of other ER records, interview staff and conduct an exit conference. The State Agency then documents its findings within a Statement of Deficiencies and Plan of Correction Form (Form 2567).

The Form is sent to the HCFA Regional Office along with supporting documentation collected by the investigators. The Regional Office reviews the form and documentation (the Regional Office may also conduct its own additional investigation) and determines if EMTALA was violated.[9] For medical issues, the Regional Office forwards medical records to the local Peer Review Organization (PRO) for its review and opinion. If the Regional Office concludes that the Act was violated and the hospital was not in compliance at the time of the survey, a termination date is set, generally 90 days from the date of the survey. (HCFA may set a termination date 23 days from the date of the survey if the Regional Office determines that the hospital is not in compliance and the violation represents an immediate and serious threat to patient health and safety.) The hospital receives a letter informing them of the confirmed violation(s) and the termination date. The hospital also receives the Statement of Deficiencies and Plan of Correction (Form 2567). If a credible allegation of compliance is received (these include detailed plans of correction addressing the identified violations), the State Agency re-surveys the facility. On re-survey, if the hospital has taken corrective action to prevent future violations and comply with the Act, the termination process is rescinded.[10]

The Regional Office also notifies the OIG and the DHHS Office of Civil Rights of the confirmed violations. HCFA sends results of the Peer Review Organization's review to OIG. The Peer Reviewer's report provides expert medical opinion regarding whether the individual involved received a screening exam, actually suffered from an

emergency medical condition, whether the individual's emergency medical condition was stabilized, and whether the individual was transferred appropriately.[11] Depending on the results of the investigation, the supporting documentation, and the opinion of the Peer Reviewer on whether a violation exists or not, OIG may decide to pursue civil monetary penalties against the hospital, or it may close the case.[12] If the Peer Reviewer concludes that the hospital or physician met the Act's requirements and its documentation supports the conclusion, OIG generally must close the case. Federal regulations currently preclude OIG from imposing civil monetary penalties on receiving hospitals for violations of the Act's reporting and on call list provisions.[13]

In the following discussion of the Act, the examples given are violations found by State Agency investigators and confirmed by HCFA. Again, some violations confirmed by HCFA are relatively minor. The examples below demonstrate more serious violations of the Act.

IV. EMTALA AND ITS REQUIREMENTS

Screening

One of EMTALA's key provisions is its screening provision. The Act requires all hospitals with ERs to provide an appropriate medical screening exam to every individual who "comes to" the ER and has a request for examination or treatment made on his or her behalf. Outright denials of requests for screening are the most obvious examples of violations. Other examples include "referrals" to other facilities and requests for payment, which prompt "refusal" of the exam by the patient. (In some cases of "refusal," patients are not told of their right to an exam regardless of their inability to pay. Less frequently, patients interviewed by investigators state that they were persuaded to forego

an exam or that they never overtly refused an exam, though documentation states that they did.) The following excerpts are examples of HCFA confirmed violations of the Act's screening requirement:

(1) In San Jose, California, a nine-month-old infant arrived at Santa Clara Valley Medical Center's ER with a history of several days of cough, fever, fussiness, discharge from the eye and two possible seizures occurring that morning. A nurse referred the child and parents to an outpatient clinic without providing any medical screening. An ambulance returned the child to the ER from the clinic after a seizure lasting four minutes occurred at the clinic. The child's temperature was 104 degrees at the clinic. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> On 9/22/98 at approximately 11:00 a.m. a nine-month-old child was brought to the hospital ED by his parents and an uncle. The child's mother told the triage nurse at the ED that the child had been ill several days with a cough, fever, fussiness and discharge from the right eye. This was accompanied by two seizure-like episodes that morning. The triage nurse then referred the mother to the facility's pediatric clinic without taking vital signs or doing a medical screening exam to rule out a medical emergency condition. The nurse also failed to enter the patient's name into the ED patient log. The mother took her son to a clinic several miles away…. At the clinic the child had a temperature of 104 degrees and a full body seizure for four minutes. The child was returned to the [original] hospital ED by ambulance. This time the patient received a medical screening examination, pediatric consultation, and was treated with antibiotics and Motrin. […] The child was discharged home after being observed seven hours. Discharge diagnosis was viral syndrome and febrile convulsion.

Santa Clara Valley Medical Center
San Jose, California

(2) In New York City, New York, it was discovered on survey January 29, 1999 that staff at St. Luke's-Roosevelt Hospital's ER informed uninsured patients seeking treatment that they would be responsible for a fee, before providing a screening exam. Many uninsured patients left without receiving an exam. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> Uninsured patients after being informed by ED registration clerks that they would be responsible for payment of a fee in excess of $400 left the ED without having had a medical screening examination.

St. Luke's-Roosevelt Hospital
New York City, New York.

(3) In St. Louis Missouri, the following patient's physician sent her to the Deaconess Medical Center-Central's psychiatric unit for evaluation and treatment, suspecting that she was suffering from an emergency medical condition and was incapable of making decisions. Because the patient had no insurance, she was transferred to the state psychiatric facility without receiving a medical screening exam at Deaconess Medical Center. This hospital agreed to pay $40,000 to resolve OIG's investigation into this and two other incidents.

> Patient A arrived on the psychiatric unit where she had been sent by her physician via ambulance for evaluation and treatment. The patient's physician on interview 10/22/97…revealed that he thought the patient had an emergency medical condition, was unstable and was not capable of making decisions. […] He was called by a nurse from the hospital who reported [Patient A] had no insurance and needed to go to the state psychiatric facility. The patient was sent away with the ambulance crew without a screening examination to determine that an emergency medical condition did not exist. Review of the ambulance report indicates that the hospital "refused tx (treatment) b/c (because) of lack of insurance.

Deaconess Medical Center-Central
St. Louis, Missouri

(4) In Granite City, Illinois (southeast of Springfield), a patient arrived at St. Elizabeth Medical Center's ER complaining of illness and seizures. Staff observed insects crawling over his body and hair. Only the patient's pulse, respiratory rate, blood pressure and temperature were taken; no other examination or diagnostic study was performed. The patient had a rapid heart rate of 142 beats per minute (a normal adult heart rate ranges from 60 –100 beats per minute). The patient was discharged with prescriptions for anti-seizure medication, anti-anxiety medication and anti-lice shampoo. He was brought back to the same ER in cardiopulmonary arrest the following day and

died there. Autopsy results attributed the death to a severe pneumonia. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> Patient presented to the ED [11/14/98] complaining of being sick for five days, with an increase in seizures during the previous week. Documentation evidenced that the patient had hundreds of brown insects over his body and hair. […] Vital signs recorded on admission was [sic] heart rate of 142, temperature of 99.1F, respirations 18 and blood pressure 105/75. The ED physician documented "detailed systemic exam deferred." The patient was given a prescription for Depakote, Xanax, and Kwell. He was given instructions for the treatment of lice. Documentation failed to evidence that there was [sic] any diagnostic test performed. On the afternoon of 11/15/99 [sic], the patient was brought to the ED by ambulance in cardiac and respiratory arrest. […] The patient was pronounced dead at 1354 hours on 11/15/98. The coroner's autopsy report and death certificate state the immediate cause of death was due to marked pneumonitis with abscess formation and hyaline membrane formation.

St. Elizabeth Medical Center
Granite City, Illinois.

The Act itself does not define an "appropriate" medical screening exam other than to state its purpose: to determine whether or not an emergency medical condition exists. Federal regulations state that "the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department…."[14] While federal courts have resisted defining a national standard for screening, two federal Circuits have stated that a hospital's screening standard can be so low as to amount to no screening at all.[15] One other Circuit has added that an "egregious" and unjustified delay in providing an exam may equal the effective denial of one.[16]

In Richmond, Virginia, a patient presented to Capitol Medical Center's ER at 4:30 am complaining of psychotic symptoms: "hearing voices." The patient was refused a screening exam or any treatment until the day admissions clerk could come in and proof of insurance could be validated. The patient left, called 911, was brought back to the ER

by ambulance and again told to wait in the waiting area. The patient walked out and the same ambulance then transported the patient to another hospital's ER. A risk manager at the second hospital filed a complaint. This hospital agreed to pay $43,000 to resolve OIG's investigation into the incident.

> Emergency room RN…stated that the patient came to the ER at approximately 0430 complaining of hearing voices. The patient requested direct admission to the psychiatric unit of the hospital. The ER nurse asked for proof of insurance…. The nurse stated that the patient did not have his Medicaid card with him and the nurse could not validate proof of insurance by computer. The nurse asked the patient to wait in the waiting room until 0630 when the day shift admissions representative could access the computer to validate the patient's insurance and he could be a direct admit. […] According to the ER nurse, the patient was not evaluated by the ER physician, was not treated, and walked out of the ER a few minutes later and went to a pay phone and called 911 to pick him up. According to the nurse, EMTs picked the patient up and took him back to the ER. The same nurse saw the patient immediately and asked him to please have a seat in the waiting room again and wait until 0630…to be a direct admit to the psychiatric unit. Within minutes, the patient…walked out again before the ambulance pulled away. According to EMT documentation, the ambulance picked up the patient at 0603 and took the patient to [another hospital's] ER, arriving at 0638.

Capitol Medical Center
Richmond, Virginia

ERs utilize a procedure known as "triage." In triage, a staff member, usually a nurse, assesses and documents a patient's chief complaint, vital signs and a brief history. Using this assessment, the nurse primarily determines the immediacy with which the patient needs to be seen, not the existence or absence of an emergency medical condition. EMTALA regulations require that individuals determined as qualified by the hospital's by-laws or rules and regulations conduct emergency medical screening exams.[17] A triage "exam" performed by a nurse may not constitute a screening exam for an emergency medical condition under the Act if the hospital's regulations do not specifically delegate that function to the nurse.[18]

Following a state investigation on December 5th, 1997, HCFA found that Legacy Good Samaritan Hospital in Portland, Oregon violated EMTALA's screening requirement through its "[f]ailure to provide initial medical screening examinations of sufficient quality to determine if an emergency medical condition existed." The HCFA Form 2567 asserts that ER staff considered the triage exam equivalent to the EMTALA-required medical screening. Investigators concluded that as a result, ER documentation did not always support a finding that the patient had been evaluated and an emergency medical condition ruled out. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation. The following is excerpted from the Statement of Deficiencies:

> Interviews with hospital staff revealed a general understanding that equates the triage process with the medical screening examination. […] The hospital's procedure for and focus on triage rather than medical screening contributes to documentation that fails to reflect an evaluation of the individual's chief complaint and fails to clearly establish that an emergency medical condition does not exist.

Legacy Good Samaritan Hospital
Portland, Oregon

Finally, confusion may occur when a patient fails to appear within the ER itself. Patients may present directly to a specialty unit, such as a labor and delivery unit or a psychiatric unit. In some cases, a seriously ill individual may collapse on hospital property, but outside the facility itself. Regulations define when a patient "comes to" a hospital emergency department for purposes of the Act. An individual effectively "comes to" the emergency department when he or she is on hospital property, including "the parking lot, sidewalk, and driveway…."[19]

The following excerpt provides an example of a HCFA confirmed screening violation involving an individual who did not present directly to the ER. In this case, a hospital security officer at Harbor Hospital Center in Baltimore, Maryland requested ER

assistance for an individual found lying in the parking lot. ER staff refused to provide assistance. After emergency medical technicians manning a nearby private ambulance determined that the individual had no pulse and was not breathing, the security officer made a second request for assistance, this time informing the ER that the individual had no pulse and was not breathing. This request was also refused. An ER physician was brought out to assist by the security officer and the patient was eventually taken to the ER by ambulance. Shortly thereafter he was pronounced dead. This hospital agreed to pay $35,000 to resolve OIG's investigation into the incident.

> The medical record indicates that on the night of 7/27/98 at approximately 7:00 p.m., a 70-year-old man accompanied his daughter to the hospital to bring in a sick child. […] On arrival at the hospital the man indicated to his daughter that he felt ill and that he would sit outside while she took the child into the hospital. During this time, several passersby noticed that something was wrong and called security…the officer arrived on the scene (hospital's south parking lot) at approximately 7:02 p.m. The officer's log indicated that he "went to investigate a male laying in the grass. 911 notified intoxicated male…ER notified <refused>" A private ambulance leaving the hospital was flagged down and the technicians initiated CPR cardiopulmonary resuscitation (CPR) and asked the officer to contact the ED for assistance. The officer's log indicated that he told the ED that the patient was in full [cardiopulmonary] arrest and the ED again refused assistance. […] A security officer went to the ED and "grabbed Dr. XX, told him what [he] had and [the doctor] came out with me." In his report, the security officer indicated that the charge nurses in the ED had apparently not told the doctors. The physician returned to the parking lot and assisted with emergency care. At this point an ambulance crew responding to a 911 call arrived. It is not clear who called 911. One report indicates that an ambulance technician gave his cell phone to the security officer and that he called 911. The ambulance transported the man to the ED. Approximately one-half hour after the man was first observed lying in the grass, he was pronounced dead of cardiac arrhythmia.

Harbor Hospital Center
Baltimore, Maryland

Stabilizing Treatment

If the hospital determines that the individual has an emergency medical condition, the hospital must provide, within its capabilities, for further treatment as required to stabilize the condition or for appropriate transfer of the individual to another facility. (In

an appropriate transfer, the expected medical benefits of the transfer outweigh its risks. The first hospital must also provide treatment within its capacity to minimize the risk before transferring the patient.) EMTALA regulations define "stabilized" to mean that no material deterioration is likely to result from or occur during transfer or discharge.[20] A hospital satisfies the requirement if it offers an individual treatment or appropriate transfer, and, after being informed of the risks and benefits, the individual refuses to consent.

(1) In Moultrie, Georgia (southeast of Columbus), a patient arrived at Colquitt Regional Medical Center's ER and received a screening exam. This patient suffered from kidney failure. Patients with kidney failure receive dialysis treatments several times a week to remove excess fluid and waste products from the bloodstream. This patient's screening exam demonstrated fluid volume overload and probable heart failure (indications that the patient likely needed a dialysis treatment), EKG abnormalities, poor oxygenation and possible pneumonia. A nephrologist (kidney specialist) contacted by the ER physician refused to admit the patient or give a dialysis treatment until the following day. The patient died at home approximately seven hours after she was discharged. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> An End Stage Renal Dialysis patient presented to the ED on 2/5/96 at 0450. […] Patient's chief complaint was "chest pain all night." Initial vital signs were BP 128/70, P 103, R 20, and temperature 99.9. Pulse oximetry was 83% and nail beds were cyanotic. ED MD saw patient at 0455. Pain medication was given, chest x-ray, lab work and EKG were ordered. Chest x-ray revealed: "lungs exhibit infiltrate, probably from pulmonary edema, but possibly pneumonia…." EKG showed "atrial fibrillation, new since 1994, incomplete right bundle branch block, possible inferior infarct age undetermined, T-wave abnormality consider lateral ischemia or digitalis effect; abnormal EKG." […] Patient had been sick for four days with nausea and vomiting, intermittent chest pain and shortness of breath. The patient had missed her last dialysis treatment on 2/3/96 because of these symptoms. […] ED physician called the attending nephrologist. Notes regarding this

> conversation state "nephrologist refuses to give dialysis treatment until tomorrow." "He refused to admit her, instead requested that she show up tomorrow for her next regularly scheduled dialysis treatment…." The final ED MD assessment was "volume overload and ESRD [end stage renal disease]." The patient was discharged from the ED at 0618. […]Patient died at approximately 1:15 p.m. this same day at home.

Colquitt Regional Medical Center
Moultrie, Georgia

(2) In Houston, Texas, a patient presented to the ER at Doctor's Hospital with symptoms of acute appendicitis, a medical emergency. On discharge her diagnosis was "possible acute appendicitis." Because she had no insurance, she was discharged and instructed to travel by private car to another hospital. She underwent surgery at the second hospital. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> Patient presented to the ED on 8/10/96 at 2200. Patient was assessed by an emergency medical technician who recorded vital signs of temperature 98.7, pulse 92, respirations 18, and blood pressure 133/55. Physical exam by physician revealed abdominal pain and positive rebound tenderness. Diagnosis was possible acute appendicitis. […] Patient was advised to go to [another hospital] for further evaluation. […] [T] he patient was discharged accompanied by a female companion and her spouse and left via car. Per interview, personnel confirmed that physician instructed the patient that as she had no insurance and no money, she should go to [other hospital] right away. […] Per review of patient's clinical record from [other hospital], it was noted that she… was taken to surgery at 0530.

Doctor's Hospital
Houston, Texas

Delay in Treatment

A hospital may not delay the provision of a screening exam or stabilizing treatment in order to inquire about the individual's method of payment or insurance status.[21] If the payment inquiry is made following a request for exam or treatment and causes the delay of the screening exam or treatment, EMTALA is violated.

(1) In Brooklyn, New York, Kings County Hospital's ER posted signs stating that the hospital required pre-authorization or a referral from a patient's Medicaid plan before treatment, adding that Medicaid patients must contact their provider or plan before seeking treatment. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> In the Adult ED Registration and Triage Area, signs indicated that Medicaid recipients cannot be treated without proper referral form or authorization number and that recipients must contact their provider or health plan before seeking care at this facility. The presence of these signs was brought to the attention of the hospital staff [by the SA investigators]. The hospital staff immediately removed the above mentioned signs.

Kings County Hospital
Brooklyn, New York

(2) In Chicago, Illinois, a patient presented to the ER of Provident Hospital of Cook County with symptoms of early pregnancy and threatened miscarriage. HMO approval for treatment was sought and denied. The patient was not provided with an exam or treatment. She began to deliver a non-viable fetus as she waited in the waiting area for a taxi to transport her to another hospital. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> A 19-year-old female presented to the ED on 10/29/96 at 9:35 a.m. with complaints of vaginal bleeding for one day. […] The nurse documented the patient's last menstrual period as 8/29/96. The triage assessment documented that the patient was alert, oriented, complaining of increased pressure with vaginal discharge…and abdominal tenderness upon palpation. […] The patient was sent to the waiting area prior to having a medical screening examination pending HMO approval. […] Patient's HMO was contacted and denied treatment stating that they would provide a taxi for the patient to be transferred to another hospital. There was no documentation of a medical exam or further assessment by the nurse until 11:50 a.m. when patient presented to the nurse's station complaining that "something is coming out of me." At 11:50 a.m. the ED physician and nurse witnessed a fetus "protruding from birth canal." The patient delivered at that time a nonviable fetus in the ED….

Provident Hospital of Cook County
Chicago, Illinois

Transfer

Generally, a hospital may not transfer an unstabilized patient to another facility unless the benefits of transfer outweigh its risks and measures are taken to minimize risk. An ER may transfer an unstabilized patient if the patient or representative requests a transfer in writing after being informed of its risks and of the hospital's obligations under the Act.[22] The following excerpts demonstrate HCFA confirmed violations of the Act's transfer provision.

(1) In Fajardo, Puerto Rico, a patient presented to Hospital San Pablo del Este's ER with severe psychiatric symptoms (hallucinations, disorientation and depression) and lab abnormalities, including an elevated blood sugar indicative of uncontrolled diabetes and a low level of potassium. He or she was diagnosed with low potassium, elevated blood sugar, "rule out" inflammation of the pancreas and transferred to another hospital. The record did not contain a physician evaluation of the benefits and risks of transfer. The transfer certification stated that the patient was transferred because he or she was not insured. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> Patient number 12 came to the ED due to depression on January 19, 1999. This patient was registered at 4:03 p.m. and triaged at 4:30 p.m. This patient came to ED with hallucination, disorientation and acute depression. Laboratory results taken on 1/20/99 at 11:39 revealed blood sugar of 300 mg/dl (normal is < 120), potassium level of 2.3mmol/L (normal values were 3.6-5.0 mmol/L). This patient was transferred to another facility at 6:20 p.m. with a diagnosis of hypokalemia (low potassium), high blood sugar and rule out of pancreatitis with a reserve prognosis. Evidence was not found with regard to the physician evaluation of the benefits and risks of transfer. The physician certification states that the patient was transferred because he/she was not covered by a health plan.

Hospital San Pablo del Este
Fajardo, Puerto Rico

(2) In Monticello, Georgia (southeast of Atlanta), the following patient presented to Jasper Memorial Hospital's ER following a motor vehicle accident. A physician documented a suspected ruptured spleen. The patient apparently chose to go to another hospital for treatment, traveling by private car. The suspected ruptured spleen was confirmed at the second hospital, where the patient died following surgery. The record lacked documentation that the patient had been informed of risks and benefits of transfer or that a receiving facility or physician had been contacted regarding a possible transfer. As of April, 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> A twenty-three-year-old male was brought to the emergency room by emergency medical service following trauma from a motor vehicle accident. At the time of discharge from the emergency room, the physician documented "suspect ruptured spleen." The hospital did not have certification that the patient had been informed of the risks and benefits of an appropriate transfer for further medical screening/stabilization or that a receiving physician or facility had been contacted prior to the patient choosing to go by private car to another hospital approximately 30 miles away. The rupture of spleen was confirmed with subsequent surgical intervention with outcome of death following surgery at the second hospital.

Jasper Memorial Hospital
Monticello, Georgia

(3) In Lake Forest, Illinois (outside of Chicago), a patient presented to Lake Forest Hospital's ER with shortness of breath and increased confusion. He was transferred to a Veteran's hospital approximately three and one half hours later. His blood oxygen saturation level approximately ten minutes prior to transfer was 84% (normal is >95%), indicating very poor respiratory status. His transfer certificate lacked documentation regarding his condition at the time of transfer. Within one hour of his arrival at the Veteran's hospital, this patient was "intubated" (had a tube placed into his trachea to allow a ventilator to assume the mechanics of breathing) and admitted to the medical

intensive care unit. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> Patient #1, a 49-year-old, was transferred from a nursing home by ambulance for evaluation of increased confusion and shortness of breath. The initial triage vital signs at 10:30 a.m. were: blood pressure 91/60, heart rate 118, respirations 26, temperature 99.5 and oxygen saturation of 73%. The physician documented a medical evaluation at 11:00 a.m. Documentation by the physician included that the patient was disoriented, does not answer questions appropriately, pupils equal and reactive to light…lungs with rhonchi. While in the ER, the patient received IV fluids, medication, a breathing treatment, oxygen, blood work, and a chest xray. The patient remained in the ER for approximately 3.5 hours without a further documented medical screening exam/evaluation. The patient's oxygen level was monitored from 10:30 a.m. until 2:51 [sic] p.m. The last oxygen saturation level at 1:51 p.m. was documented as being 84%. At 2:00 p.m. the patient was transferred by ambulance to North Chicago Veteran's Hospital. The transfer form (completed by the nurse and signed by both the nurse and MD) failed to include the patient's condition at time of transfer. The nurse, however, documented on the transfer form "unchanged from admission remains tachypneic [breathing at a rapid rate], still pulls off O2 mask." The medical record from Chicago North Veteran's Hospital [receiving hospital] revealed that the patient arrived to the facility at 2:20 p.m. by ambulance with an IV and oxygen. The patient's condition upon arrival was documented as "acute respiratory distress." Vital signs were BP 100/60, pulse 114, respirations 28, temperature 96.4 and an oxygen saturation level of 94%. The patient was admitted to the medical intensive care unit and [was] intubated approximately one hour after admission.

Lake Forest Hospital
Lake Forest, Illinois

(4) In Grand Island, Nebraska (west of Lincoln), the following patient arrived at St. Francis Medical Center's ER following a suicide attempt. The patient had swallowed 20 "Excedrin PM" tablets. She was treated with stomach suctioning and charcoal. Afterwards, she was transferred to a psychiatric hospital by private car. There was no indication in the record that the benefits of transfer outweighed the risks. The Peer Review Organization's reviewer noted the potential risk of the patient attempting suicide while traveling to the second hospital. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> Patient 18 presented to the emergency room on 6/10/97 at 3:08 a.m. with a chief complaint of taking 20 Excedrin PM and depression. The patient was treated with gastric lavage and given charcoal. Patient's counselor was called and the patient was accepted for admission to a psychiatric hospital. Patient was discharged with mother to be taken to the other hospital via private vehicle. The physician PRO reviewer stated that "the question is whether the patient would attempt a suicide gesture en route." The hospital failed to indicate that transfer by private vehicle was safe and appropriate for this patient. The hospital also failed to provide a certification, (containing a summary of the risks

Francis Medical Center
Grand Island, Nebraska

Reporting

A recipient hospital must report transfers to HCFA "any time it has reason to believe it may have received an individual" transferred in an unstable emergency medical condition in violation of the Act's requirements.[23] This reporting provision became effective in 1995. Our research revealed only one HCFA-confirmed reporting violation since that time, an extraordinarily low number considering that every transfer violation potentially involves a recipient hospital with a duty to report. (Under-reporting of this violation is impossible to confirm from the HCFA logs and forms 2567. Neither provide any information identifying the source of the complaint.) HCFA might maximize compliance with this requirement by requiring investigations of recipient hospitals as well as transfer hospitals when transfer-related complaints are received. As previously stated, OIG at present cannot impose civil monetary penalties on receiving hospitals for violations of this provision. The following excerpt is taken from HCFA's Form 2567 for the confirmed reporting violation by the receiving hospital.

In Kansas City, Missouri, a patient was transferred from an unidentified hospital directly to the psychiatric "service" at Trinity Lutheran Hospital, the receiving hospital. He arrived verbally unresponsive and lethargic. Before transfer, the patient's blood sugar had been checked five times at the initial hospital, with results ranging from 82 to 417

(normal is 80-120). His last blood sugar level prior to transfer was 300. At Trinity Lutheran Hospital, he required treatment in the intensive care unit for diabetic ketoacidosis, a life-threatening complication of diabetes. The transfer certificate completed by the initial hospital failed to document his unstable blood sugar levels, any indications for transfer, a risk versus benefit evaluation or that a report on his condition was called to Trinity Lutheran Hospital. At this time, OIG cannot impose civil monetary penalties in connection with reporting violations.

> 50-year-old diabetic male was brought by ambulance to this facility from another acute care hospital…at 1:51 p.m. on 4/12/98 for direct admission to psychiatric services. Upon arrival [to psychiatric services unit], nurses' notes state the patient "is not verbally responsive, is disoriented, confused, sedated and lethargic." […] At 3:30 p.m. a blood sugar done by accu-check shows a level of 485 (normal 80-120).…At 4:45 p.m. his blood sugar is again checked by accu-check and found to be "over 500 because it does not register on the accu-check machine." His vital signs at this time were blood pressure 150/70, pulse 120, respirations 60 [normal adult respiratory rate is 15 to 20 breaths per minute]. The patient was then transferred…to the emergency room of the facility…. Following treatment in the emergency room, he was admitted to the intensive care unit with a diagnosis of diabetic ketoacidosis. […] The transfer form did not contain any documentation of the unstable nature of the patient's blood sugars, measures taken to attempt stabilization of his medical condition, indications for transfer, statement of risks and benefits, signed request or refusal for transfer by patient's wife nor any documentation of report including his emergency medical condition being called to the accepting facility.
>
> Review of the medical record from the first hospital from which the patient was transferred, reveals the patient presented to the emergency room at that facility on 04/10/98 at 4:15 PM…. Blood sugar in the emergency room at 4:30 PM was 240. {…} the patient was admitted to 23 hour observation care which was later extended to 48 hours. […]Following admission, at 9:30 his blood sugar was 417. 25 units of insulin was administered. The record of blood sugars showed they were checked four times 04/11/98 ranging from 343 to 252 to 82 to 209. On 04/12/98 the record showed the blood sugar was checked by accu-check at 7 AM and was 300. The patient received 12 units of regular insulin at that time. His accu-check was not done again and so his blood sugar was not monitired again prior to his being transferred at 1 PM that day. […] During his stay, a psychiatric consult was ordered and completed. The recommendation for it was that the patient be transferred to the psychiatric unit at Trinity Lutheran after he is "medically stable."

Trinity Lutheran Hospital
Kansas City, Missouri

The Deficiency Statement on this violation for Trinity Lutheran Hospital concludes with this statement: "Failure to report transfers that have an emergency medical condition and are in violation of 42 C.F.R. 489.24 creates potential for continued practices that place patients at risk due to failure to receive necessary treatment and stabilization prior to being transferred."

Non-Discrimination

A hospital with specialized capabilities or facilities may not refuse to accept an appropriate transfer of an individual who requires such specialized treatment if the hospital has the capacity to treat the individual.[24] Non-discrimination violations often involve the attempted transfer of a seriously ill or injured individual to a tertiary care center.

(1) In the following example, an unconscious motor vehicle accident victim was brought to the ER of a local hospital. A CT scan revealed multiple facial fractures and brain injury. Because the hospital lacked the capacity to treat neurological patients, the ER physician sought to transfer the patient to a facility where he could receive such specialized care. Memorial Medical Center of East Texas in Lufkin, Texas (north of Houston) was contacted. A neurologist there agreed to examine the patient. Transfer arrangements were initiated but apparently curtailed when a hospital administrator at Memorial Medical Center refused to accept him. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> A twenty-eight-year-old male involved in a motor vehicle accident was found unconscious on the scene by the ambulance crew and transported to the emergency room of a local hospital. The patient slowly regained consciousness but continued to slip in and out of consciousness. A computerized tomographic scan of the head showed that he had fractures involving the left superior orbit, the anterior sphenoid bone, the lateral orbital wall, and the lateral wall of the maxillary sinus. There

> was a small subdural collection seen posteriorly to this along the left frontal lobe with a 2 centimeter area of contusion in the left frontal lobe. He had a small hematoma lateral to the left lobe without any obvious retrobulbar hematoma. The local hospital did not have neurological capabilities. The emergency room physician discussed the patient's condition with a neurologist at [Memorial Medical Center]. The neurologist informed the emergency room physician to transfer the patient…and he would examine and evaluate the neurological status of the patient…. Transfer arrangements were initiated. However, the administrator on-call of this facility refused to accept the patient.

Memorial Medical Center of East Texas
Lufkin, Texas

(2) In the next example, the ER physician sought to transfer a patient with a diagnosed brain injury to Cedars-Sinai Medical Center in Los Angeles, California. Cedars-Sinai Medical Center was the closest facility, maintained a trauma service and 24 hour neurosurgical on call coverage. The ER physician at Cedars-Sinai refused to accept the transfer, though a neurosurgeon was available and the hospital had the capacity to treat the patient. The patient experienced a three hour wait while arrangements were made to transfer him or her to a county facility. (Cedars-Sinai self-reported a potential violation. After survey, the Regional Office confirmed this incident as a violation. Corrective action had been implemented by the hospital prior to survey and the hospital was in compliance on the survey date.) This hospital agreed to pay $40,000 to resolve OIG's investigation of this incident.

> On October 9, 1997, the emergency room physician at hospital X contacted the emergency room physician in charge at this facility to request transfer of patient A who required neurosurgical evaluation. A CT scan [at hospital X] indicated that Patient A had a hyperacute left subdural hematoma with a left to right midline shift. Hospital X did not have neurosurgical on call panel. Prior to requesting a transfer, the emergency room physician at Hospital X did attempt to obtain the services of a neurosurgeon but was unable to do so. The receiving hospital, the closest facility to Hospital X has a designated trauma service and has neurosurgical on call coverage available 24 hours per day. The emergency room physician in charge at the receiving hospital refused to accept the transfer of an individual who required specialized capabilities…even though at the time of the request the receiving hospital had a neurosurgeon available on its on call panel and the capacity to accept the patient. After the transfer was refused, the emergency room physician at hospital X made arrangements to transfer

> the patient to a county facility. Because of the lack of capacity to treat a neurosurgical patient within the county hospital system, there was a three hour delay in arranging for the transfer of the patient.

Cedars-Sinai Medical Center
Los Angeles, California

(3) The patient in the following example presented to an unidentified hospital's ER with a severe infection involving (and exposing) the bones of both feet and extending to at least the knees. Lab studies also indicated two previously undiagnosed and untreated chronic diseases: diabetes and kidney dysfunction. Effective treatment would likely involve amputation, aggressive treatment of the infection and chronic conditions and a lengthy, complex rehabilitation. Transfer to a university hospital (Oregon State University in Portland, Oregon) with a broad spectrum of services was refused. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> Patient N presented to Hospital L at approximately 1607 on July 16, 1999 with a chief complaint of foot sores…. The physical examination by Physician I [at the transferring hospital] revealed: "edema and erythema extending to at least the knees bilaterally. There is frank necrosis [gangrene] of both feet. The calcenus [heel bone] is visible on the soles of both feet. The entire calcenus is visible on the right and part of the calcenus is visible on the left. The left fifth toe is reduced to bone and there is additionally a deep hole going into the 5th metatarsal. The distal phalanges of several toes are missing. The toes are obviously necrotic and smell foul." […] Xrays of both feet revealed osteomyelitis involving numerous bones of both feet and severe deep soft tissue ulceration and swelling with air deep within the soft tissues. Lab studies revealed…results indicative of infection, diabetes, and renal dysfunction. […] Documentation by Physician I reflected the following: "I contacted the University and they refused to accept this patient in transport, saying that it was the 'usual Friday afternoon dump.'"

OSHU Hospital and Clinics
Portland, Oregon

On-Call, Central Logs, Sign Posting, Medical Records, Policies and Procedures

In addition to its screening, treatment and transfer-related provisions, the Act contains a number of additional narrower requirements. Of these, the on call list

requirement is most important to direct patient care. This provision requires hospitals to maintain lists of physicians who are on call for duty after the initial exam to provide treatment necessary to stabilize an individual with an emergency condition.[25]

Other provisions require hospitals to maintain central logs that document treatment, admission, transfer and/or discharge for every patient who requests treatment.[26] The medical records of patients transferred to or from a hospital must be maintained for five years after the transfer.[27] ERs must conspicuously post signs specifying the rights of individuals under the Act. Finally, all hospitals must adopt and enforce policies and procedures to comply with the Act.[28] (Some Regional Offices appear to confirm a violation of this "policies and procedures" provision each time another provision of the Act is violated.) OIG at present cannot impose civil monetary penalties on receiving hospitals for violation of the reporting and on call requirements, even though they can impose these penalties for other violations, such as screening violations.

The following excerpt provides an example of a violation of the on call requirement. In Merced, California, a non-verbal mentally retarded patient was brought by ambulance to Mercy Hospital's ER with symptoms of abdominal distress and shortness of breath. The ER physician suspected an abdominal condition requiring surgery. As the patient continued to deteriorate, the physician twice called an on call surgeon asking that he come in immediately to examine the patient. The surgeon repeatedly refused to come in, advising that the patient be admitted for him to see in the morning. As the patient's blood pressure and pulse rate dropped to life-threatening levels, the ER physician contacted hospital administrators in an apparent effort to compel

the surgeon to come in. The patient suffered a cardiac arrhythmia and died despite a resuscitation attempt. The surgeon arrived during the resuscitation attempt. Documentation also revealed that the surgeon made disparaging remarks related to this patient's mental retardation, including the statement that "no one would miss him if he died," as he had lived in a board and care home for fifteen years. (This hospital self-reported a potential violation. After survey, the Regional Office confirmed this incident as a violation. Corrective action had been implemented by the hospital prior to survey and the hospital was in compliance on the survey date.) As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> At approximately 8:15 p.m. on October 20, 1998, patient #1 was brought to the ED with a history of sudden onset of abdominal distress; gasping and shortness of breath; "wide-eyed and staring;" sweating; and incontinence of urine for approximately 30 minutes after the patient had eaten a "good meal." The patient was a 49-year-old black male with a history of developmental delay/mental retardation, high blood pressure and recent medical treatment by a private physician for an abdominal disorder. The ED physician reported that the patient was "essentially mute," had lived in a local board and care home for fifteen years and that the patient's landlady relayed the patient's history. The patient's blood pressure was noted to be 127/64 on arrival, with a rapid heart rate of 160 beats per minute and rapid respirations of 30 breaths per minute. […] At approximately 9:50 p.m., after consulting with the radiologist, the E.D. physician called the on call surgeon and asked him to come in immediately to see the patient. The surgeon declined to come in, instead directing that a nasogastric tube be placed to decompress the patient's abdomen and that the patient be admitted to the hospital where the surgeon would see him the next day. The ED physician reported that he was unable to place an NG tube…due to the degree of the patient's abdominal distention. […] At 10:50 p.m., the ED physician consulted with a gastroenterologist who felt the patient was a surgical case…. After this, the ED physician called the on call surgeon again, requesting that he come in immediately, reporting the gastroenterologist's opinion and the patient's "grave state." The surgeon responded that the patient should be admitted to the hospital and that he would not see the patient tonight. At this point the ED physician …called the hospital's nursing supervisor to initiate a call to the surgeon's Chief of Service…. At this time, the ED physician reported that the patient's vital signs were falling, with a blood pressure of only 70/palpable and a heart rate of only 20 beats per minute, and progressed into ventricular fibrillation. Advanced cardiac life support measures were initiated, during which time the surgeon finally arrived in the ED. Despite lifesaving measures being attempted, the patient expired and was pronounced dead at 11:26 p.m. Review of other

> hospital documents revealed that the surgeon was reported to have made many "disparaging" remarks about the patient being mentally retarded and that "no one would miss him if he died" as he had lived in a board and care home for fifteen years.

Mercy Hospital
Merced, California

Enforcement: Termination, Civil Monetary Penalties and Civil Enforcement

HCFA is authorized to terminate violating hospitals from participation in Medicare. Termination is a severe penalty, as most hospitals rely on Medicare funds for a significant part of their revenue. The effect of termination on a community's access to health care is another concern that likely contributes to its rare occurrence. Hospitals are not terminated if they implement plans of correction and on resurvey are found to be in compliance with the Act. From EMTALA's enactment in 1986 through the end of Fiscal Year 1999, only six hospitals have been terminated from participation from Medicare for EMTALA violations. Terminations vary in duration, depending upon the time it takes a hospital to come back into compliance with the Act, if it chooses to do so. A community's concerns regarding access to health care should certainly be the most important consideration in terminating a hospital. Even so, in the case of hospitals that violate the Act repeatedly, implementation of a plan of correction doesn't seem to ensure long-term compliance and a harsher penalty may be required.

HCFA Regional Offices send all cases of confirmed dumping violations to the OIG Office of Civil Fraud and Administrative Adjudication in Washington, DC. The OIG may impose monetary penalties for certain categories of violations as discussed earlier. A hospital which negligently violates a requirement is subject to a civil monetary penalty (CMP) of $50,000 or less ($25,000 or less in the case of a hospital with less than 100 beds).[29] A physician responsible for the exam, treatment or transfer of an individual

who violates provisions of the Act is also subject to a CMP of $50,000 or less for each violation. If the physician's violation is gross and flagrant, or is repeated, the physician is subject to exclusion from participation in Medicare and State health care programs.[30]

In addition, EMTALA provides for "civil enforcement." Any individual who suffers harm, or any medical facility that suffers a financial loss as a direct result of a hospital's violation of the Act may bring an action in federal court against the violating hospital. Pursuant to this provision, plaintiffs may seek damages available under the law of the state in which the hospital is located.[31]

V. HOSPITALS AND PHYSICIANS VIOLATING EMTALA

The following table identifies 527 hospitals in 48 states (these include the District of Columbia and Puerto Rico) that had reported EMTALA violations confirmed by HCFA between October 10, 1996 and December 21, 2000. Most of these violations (96%) were confirmed during 1997-1999. Violations listed as confirmed in calendar year 1996 are violations which were confirmed that year but did not appear in Public Citizen's 1997 report. A few violations listed in this report were confirmed in calendar year 2000. These either appeared on central logs for calendar year 1999 or in "Statement of Deficiency and Plan of Correction" Forms (Forms 2567) sent to us by HCFA Regional Offices. These do not represent all violations confirmed in the calendar years 1996 and 2000. 68 of the 527 hospitals listed in Table 1 (12.9%) were listed with other violations in Public Citizen's previous reports. To date, 117 hospitals have been listed with confirmed violations in more than one report.

Following investigation, HCFA may confirm more than one type of violation for each hospital. Of all hospitals with confirmed violations, 90.1% (475 hospitals) violated at least one of EMTALA's three core provisions: screening, treatment and transfer. (Generally speaking, screening, treatment and transfer violations are the most serious types of violations, but even these include events such as documentation omissions or patients who voluntarily left the ER prior to receiving an exam.)

Of hospitals violating the Act, 72.5% were not-for-profit hospitals (382 hospitals out of 527) and 19.7% were for-profit hospitals (104 out of 527). The profit status of 41 hospitals (8%) was unknown. In 1998, 13.7% of non-federal hospitals accepted for

registration by the American Hospital Association were for-profit entities (771 hospitals).[32] Our data demonstrates a statistically significant increased risk of violation by for-profit hospitals. (Relative risk = 1.70, confidence interval = $1.39 < 1.70 < 2.30$) In other words, for-profit hospitals were 1.7 times more likely than not-for-profit hospitals to violate EMTALA.

Table 1

HCFA Confirmed EMTALA Violations by Hospitals

(Violations Confirmed by HCFA Between 10/10/96 and 12/21/00)

STATE	HOSPITAL NAME	CITY	VIOLATION	CONFIRMED DATE	STATUS
Alabama	Bullock County Hospital*	Union Spring	TX, TR	07/21/97	P
	Elmore County Hospital*	Wetumpka	SC	04/15/98	N
Alaska	Alaska Psychiatric Hospital*	Anchorage	SC, DT, TR, CL, SP	01/07/99	N
	Columbia Alaska Regional Hospital	Anchorage	CL, PP	03/20/97	P
	Fairbanks Hospital*	Fairbanks	SC, TR	02/05/97	N
	Ketchikan General Hospital*	Ketchikan	SC, TR	12/02/96	N
	Providence Alaska Medical Center	Anchorage	OC	10/02/97	N
	Providence Seward*	Seward	TR	06/04/99	N
	Valdez Community Hospital*	Valdez	SC, TR	11/14/96	N
	Valley Hospital	Palmer	PP	01/07/97	N
Arizona	Arrowhead Community Hospital*	Glendale	SC,TX, TR, MR, PP	09/08/98	N
	Casa Grande Regional Medical Center*	Casa Grande	SC, TR, PP	11/22/99	N
	Columbia El Dorado Hospital*	Tucson	SC, PP	03/10/99	P
	Columbia Medical Center*	Phoenix	SC, TR, CL, PP, MR	05/28/97	U
	Flagstaff Medical Center*	Flagstaff	SC, TX, TR, PP	02/05/99	N
	Kino Community Hospital*	Tucson	TX, TR, PP	11/18/99	N
	Kino Community Hospital*	Tucson	SC, DT, CL, PP	03/01/99	N

Provision(s) Violated:

SC Screening
TX Treatment
DT Delay in treatment to inquire about insurance status
TR Transfer
ND Non-discrimination (specialized facility must accept transfer)
OC On call list
RP Reporting
CL Failure to maintain central log
SP Sign Posting
MR Failure to keep medical record for five years
PP Failure to have policies and procedures in place to ensure compliance

***** Indicates hospital violated screening and/or treatment and/or transfer provisions.

Date Violation Confirmed:
Indicates the date upon which the HCFA RO confirmed the violation.

For-Profit/Not-For-Profit Hospitals:
P For-Profit **N** Not-For-Profit **U** Profit Status Unknown

R Listed with violation in prior report

Sources:
HCFA Log of Section 1867 Cases, Fiscal Years 1996, 1997, 1998, 1999
HCFA Forms 2567 from HCFA's Regional Offices
American Hospital Association, *The AHA Guide to the Health Care Field* (2000/01)

STATE	HOSPITAL NAME	CITY	VIOLATION	CONFIRMED DATE	STATUS
	Maryvale Hospital Medical Center*	Phoenix	SC, TR, PP	06/07/99	P
	Mesa Lutheran Hospital*	Mesa	SC, DT, TX, OC, TR, CL, PP	05/06/99	N
	Page Hospital*	Page	TR, CL, PP	11/22/99	N
	Phoenix Indian Medical Center*	Phoenix	TR, CL, MR, PP	08/27/97	U
	Sierra Vista Community Hospital*	Sierra Vista	SC, DT, TX, PP	11/17/99	N
	Southeast Arizona Medical Center* **R**	Douglas	SC, TX, TR, PP	04/24/98	N
	St. Joseph's Hospital and Medical Center*	Phoenix	SC, TX, TR	01/29/99	N
	Tucson General Hospital*	Tucson	SC, TR, CL, PP	11/22/99	P
	Valley Lutheran*	Mesa	SC, TX, TR, ND, SP, CL, MR, PP	04/05/99	N
	Winslow Memorial Hospital*	Winslow	SC, TX	01/13/97	N
	Yuma Regional Medical Center*	Yuma	TX, TR, CL, PP	12/03/99	N
Arkansas	Baptist Memorial Hospital	Blytheville	OC, CL, SP	12/09/99	N
	Cross County Hospital*	Wynne	SC	04/06/99	N
	North Arkansas Regional Medical Center*	Harrison	SC, DT	12/09/99	N
	St. Anthony's Healthcare Center*	Morrilton	SC	02/04/99	N
	Stone County Medical Center*	Mountain View	SC, CL	07/14/97	P
California	Anaheim General Hospital*	Anaheim	SC, TR, PP	04/09/98	P
	Anaheim Memorial Hospital*	Anaheim	SC, TR, SP, CL, PP	01/30/98	N
	Bay Harbor Hospital*	Harbor City	SC, PP	04/09/99	U

Provision(s) Violated:

SC Screening
TX Treatment
DT Delay in treatment to inquire about insurance status
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P For-Profit **N** Not-For-Profit **U** Profit Status Unknown

R Listed with violation in prior report

Sources:
HCFA Log of Section 1867 Cases, Fiscal Years 1996, 1997, 1998, 1999
HCFA Forms 2567 from HCFA's Regional Offices
American Hospital Association, *The AHA Guide to the Health Care Field* (2000/01)

STATE	HOSPITAL NAME	CITY	VIOLATION	CONFIRMED DATE	STATUS
	Bear Valley Community Hospital*	Big Bear Lake	TX, TR, PP	02/26/99	N
	Cedars-Sinai Medical Center	Los Angeles	ND	05/28/98	N
	Coast Plaza Doctor's Hospital*	Norwalk	SC, CL, PP	05/19/97	P
	Coastal Community Hospital*	Santa Ana	SC, DT, TR, CL, PP	01/22/98	P
	Columbia Good Samaritan Hospital*	San Jose	SC, TX, CL, PP	02/17/98	P
	Columbia San Jose Medical Center*	San Jose	SC, TX, CL, PP	10/15/97	P
	Community and Mission Hospital* **R**	Huntington Park	SC, DT, OC, PP	10/14/97	P
	Contra Costa Regional Medical Center*	Martinez	TR, PP	10/04/99	N
	Dameron Hospital*	Stockton	TR, CL, PP	02/26/99	N
	Doctors Medical Center*	San Pablo	SC, TR, OC, CL, PP	12/21/99	P
	Emanuel Medical Center*	Turlock	SC, TR	11/23/99	N
	Encino-Tarzana Regional Medical Center	Encino	OC	05/28/98	P
	Fresno Community Hospital* **R**	Fresno	TX, TR, PP	08/28/97	P
	Fresno Community Hospital*	Fresno	TR, OC, PP	10/07/98	P
	Garden Grove Hospital and Medical Center*	Garden Grove	TX, PP	08/27/99	P
	Garfield Hospital*	Monterey Park	SC	09/15/98	P
	Huntington Beach Hospital & Medical Center*	Huntington Beach	SC, TR, CL, PP	02/23/99	N
	Inland Valley Regional Medical Center*	Wildomar	SC	12/30/97	P
	Irvine Medical Center*	Irvine	SC, TR, PP	01/22/98	P
	John F. Kennedy Memorial Hospital*	Indio	TR	02/24/99	P
	Kaiser Foundation Bellflower*	Bellflower	SC, DT, CL, PP	06/22/99	N
	Kaiser Foundation Hospital*	Sacramento	TX, TR, MR	04/23/98	N

Provision(s) Violated:

SC Screening
TX Treatment
DT Delay in treatment to inquire about insurance status
TR Transfer
ND Non-discrimination (specialized facility must accept transfer)
OC On call list
RP Reporting
CL Failure to maintain central log
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***** Indicates hospital violated screening and/or treatment and/or transfer provisions.

Date Violation Confirmed:
Indicates the date upon which the HCFA RO confirmed the violation.

For-Profit/Not-For-Profit Hospitals:
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	Kaiser Foundation Hospital* **R**	Santa Clara	SC, TR, PP	09/30/97	N
	Kaiser Foundation Hospital*	Vallejo	TR, PP	10/31/97	N
	Kaiser Foundation Hospital East Bay Medical Center*	Oakland	SC, TX, TR, PP	05/22/97	N
	Kaiser Foundation Hospital South Sacramento*	Sacramento	SC, CL, PP	03/01/99	N
	Kaiser Foundation Hospital-Walnut Creek*	Walnut Creek	SC, TX, TR, PP	08/27/97	N
	Kaiser Hospital Riverside*	Riverside	SC, CL, PP	08/15/97	N
	Kaiser Foundation Hospital-West L.A.*	Los Angeles	SC, CL, PP	08/15/97	N
	Kaweah Delta District Hospital **R**	Visalia	OC	04/05/99	N
	LACO/Harbor UCLA Medical Center*	Torrance	SC, TR, SP, CL, MR, PP	03/04/99	N
	Lancaster Community Hospital*	Lancaster	SC, PP	03/15/99	P
	Loma Linda University Medical Center*	Loma Linda	SC, TX, TR, PP	04/23/98	N
	Los Banos Memorial Community Hospital* **R**	Los Banos	SC, TX, CL, MR, PP	04/23/98	U
	Mad River Community Hospital*	Arcata	SC, TX, TR, SP, CL,	09/15/98	P
	Martin Luther Hospital Medical Center*	Anaheim	SC, TR, CL, SP	10/03/97	U
	Mercy Hospital*	Merced	TX, OC	03/01/99	N
	Mercy Hospital*	Bakersfield	SC, TX, PP	12/30/97	N
	Mercy San Juan Hospital*	Carmichael	SC, CL	11/23/99	N
	Midway Hospital*	Los Angeles	SC, DT, TR, PP	11/16/98	P
	Monrovia Community Hospital*	Monrovia	SC, PP	10/04/99	P
	North Coast Health Care Centers*	Santa Rosa	SC, DT, TR, CL SP, MR, PP	04/22/99	N

Provision(s) Violated:

SC Screening

TX Treatment

DT Delay in treatment to inquire about insurance status

TR Transfer

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OC On call list

RP Reporting

CL Failure to maintain central log

SP Sign Posting

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	Pacifica Hospital*	Huntington Beach	SC, TX, CL, PP	04/09/98	U
	Presbyterian Intercommunity Hospital* **R**	Whittier	SC, TX, PP	01/27/97	N
	Queen of Angels/Hollywood Presbyterian Hospital*	Los Angeles	SC, CL, PP	07/22/99	P
	Redlands Community Hospital*	Redlands	TR, PP	04/28/97	N
	Redwood Memorial Hospital*	Fortuna	SC, DT, TX, OC, CL, SP, PP	08/09/99	N
	San Joaquin Community Hospital* **R**	Bakersfield	SC, OC, CL, SP, MR, PP	09/30/98	N
	Santa Clara Valley Medical Center*	San Jose	SC, CL, PP	03/01/99	N
	Santa Clara Valley Medical Center*	San Jose	SC, TR, CL, SP, PP	04/28/97	N
	Santa Teresa Community Hospital*	San Jose	SC, TX, CL, PP	03/01/99	N
	Scripps Memorial Hospital* **R**	Encinitas	TR, SP, PP	08/28/97	N
	Sequoia Hospital*	Redwood	SC, TX, TR, PP	11/20/97	N
	Sequoia Hospital	Redwood City	SP	03/24/97	N
	Sierra Kings Hospital* **R**	Reedley	SC, TR, OC, CL, PP	07/06/99	N
	Sierra Kings Hospital **R**	Reedley	SP, CL	02/28/97	N
	Sierra View District Hospital*	Porterville	TR, OC, PP	07/15/98	N
	St. Agnes Medical Center*	Fresno	TR, CL, PP	04/06/98	N
	St. Agnes Medical Center*	Fresno	TX, TR, PP	01/07/98	N
	St. Dominic's Hospital*	Yosemite	TR	11/23/99	N
	St. Joseph Hospital* **R**	Eureka	SC, TX, TR, PP	01/22/98	N
	St. Mary's Medical Center*	Long Beach	SC, TR, PP	11/23/98	N

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	St. Rose Hospital*	Hayward	SC, TX, OC, PP	04/22/99	N
	Suburban Medical Center*	Paramount	SC	06/27/97	P
	Sutter Center For Psychiatry*	Sacramento	TX, CL, PP	03/01/99	N
	Sutter Lakeside Hospital*	Lakeport	SC, TX, TR, SP, PP	07/22/99	N
	Sutter Medical Center of Santa Rosa*	Santa Rosa	SC, CL, SP, MR, PP	07/06/99	N
	Thompson Memorial* **R**	Burbank	SC, PP	03/21/97	U
	Torrance Memorial Medical Center*	Torrance	SC, PP	04/04/97	N
	Tuolumne General Hospital*	Sonora	SC, SP, CL	05/04/99	N
	U.S. Family Medical Care Center*	Montclair	SC, PP	01/07/98	U
	University Medical Center*	Fresno	DT, TR, CL, PP	10/07/98	P
	University of California Medical Center*	San Francisco	SC, TX, SP, PP	04/03/97	N
	USCD Medical Center	San Diego	ND	01/08/97	N
	Victor Valley Community Hospital* **R**	Victorville	SC, CL, PP	05/04/99	N
	Warrack Hospital*	Santa Rosa	SC, DT, TX, TR, PP	04/05/99	P
	Watsonville Community Hospital*	Watsonville	SC, CL, PP	11/17/98	P
	West Side District Hospital	Taft	SC, TX, TR	01/08/97	N
	Whittier Hospital Medical Center* **R**	Whittier	SC, TR, PP	02/02/98	P
Colorado	Centura St. Thomas More Hospital*	Cannon City	SC, TX	11/06/97	N
	Denver Health Medical Center	Denver	SP	10/10/96	N
	Denver Health Medical Center*	Denver	SC, TX	04/07/97	N
	Denver Health Medical Center*	Denver	TX	07/15/99	N
	Lincoln Community Hospital*	Hugo	TR	01/26/99	N

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	Memorial Hospital of Colorado Springs*	Colorado Springs	SC, TX	11/06/97	N
	Pioneers Hospital of Rio Banco*	Meeker	SC, TR	03/02/99	N
	Springs Center for Women*	Colorado Springs	SC, TR	05/12/99	U
	Centura St. Anthony Central Hospital*	Denver	TR	11/12/99	N
	Centura St. Anthony North Hospital	Westminster	OC	12/16/99	N
	University of Colorado Hospital* **R**	Denver	SC	09/17/98	N
Connecticut	Bridgeport Hospital*	Bridgeport	SC	05/16/97	N
	Day Kimball Hospital*	Putnam	TR	10/20/98	N
	St. Vincent's Medical Center*	Bridgeport	TR	12/16/97	N
	Waterbury Hospital*	Waterbury	TR, CL	03/16/98	N
District of Columbia	Washington Hospital Center*	Washington	DT, TX, TR	07/21/97	N
Florida	Baptist Hospital* **R**	Miami	SC, TX	02/18/98	N
	Broward General Medical Center*	Fort Lauderdale	SC	12/03/98	N
	Cedars Medical Center* **R**	Miami	TR	03/03/97	P
	Citrus Memorial Hospital*	Iverness	SC, DT	02/26/97	N
	Columbia Aventura Hospital	Aventura	CL, SP	06/19/97	P
	Columbia Clearwater Community Hospital*	Clearwater	SC	03/04/97	U
	Columbia Gulf Coast Medical Center*	Panama City	TX	11/10/97	P
	Columbia Lake City Medical Center*	Lake City	TR	02/13/97	P
	Columbia NW Medical Center	Margate	CL	05/22/97	U
	Columbia University Hospital Medical Center*	Tamarac	SC, TX, CL	04/01/99	P
	Columbia University Pavillion Hospital*	Tamarac	SC, TR	04/01/99	P

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	CPC Fort Lauderdale Hospital*	Fort Lauderdale	SC, TR	03/18/97	P
	Doctor's Memorial Hospital*	Perry	TX	05/09/97	N
	Edward White Hospital*	St. Petersburg	TX	02/11/97	P
	Florida Hospital Waterman*	Eustis	SC	07/02/97	N
	Health Central*	Ocoee	SC	05/21/99	N
	Heart of Florida Hospital*	Haines City	SC	04/17/97	P
	Highlands Regional Medical Center	Sebring	SP	01/31/97	P
	Hollywood Medical Center*	Hollywood	TR	06/25/97	P
	Jackson Memorial Hospital* **R**	Miami	TR, CL,	01/13/97	N
	Leesburg Regional Medical Center, Inc.*	Leesburg	SC	04/23/97	N
	Memorial Hospital of Tampa* **R**	Tampa	TR	01/07/98	P
	Memorial Hospital West Volusia*	De Land	SC	02/24/97	N
	Memorial Regional Medical Center	Hollywood	CL	11/16/97	N
	Monroe Regional Medical Center* **R**	Ocala	SC, TX	11/05/97	N
	North Florida Regional Medical Center*	Gainesville	SC	05/02/97	P
	North Okaloosa Medical Center*	Crestview	SC	11/30/99	P
	North Ridge Medical Center*	Fort Lauderdale	SC	02/03/97	P
	Plantation General Hospital* **R**	Plantation	SC	03/05/97	P
	St. Joseph's Hospital* **R**	Tampa	TR	07/29/97	N
	West Florida Regional Medical Center*	Pensacola	SC	02/06/97	P
	Westchester General Hospital*	Miami	SC	01/02/97	P
Georgia	Barrow Medical Center*	Winder	SC, TX	12/20/97	P
	Cobb Memorial Hospital	Royston	OC, CL, PP	12/10/99	N
	Colquitt Regional Medical Center*	Moultrie	SC, TX, CL	12/10/99	N
	Columbia Doctor's Hospital*	Columbus	TR	02/04/97	P
	Flint River Community Hospital*	Montezuma	SC	11/18/99	P
	Habersham County Medical Center*	Demorest	TX	07/14/97	N

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	Houston Medical Center* **R**	Warner Robbins	SC, TX	09/04/98	N
	Jasper Memorial Hospital*	Monticello	SC	12/10/99	N
	Newnan Hospital*	Newnan	SC	06/24/97	N
	Northeast Georgia Medical Center*	Gainesville	SC, TX, TR, ND	04/14/97	N
	Peach County Hospital*	Fort Valley	SC	03/20/97	N
	Peachtree Regional Hospital*	Newnan	SC, CL	04/06/99	P
	Satilla Park Hospital*	Waycross	SC	01/05/98	N
	Taylor Telfair County Hospital*	McRae	SC	12/10/99	P
	Walton Medical Center* **R**	Monroe	SC	06/18/97	N
	Wills Memorial Hospital*	Washington	SC, TX, TR, OC	02/26/97	N
Idaho	Bingham Memorial Hospital*	Blackfoot	SC	03/05/99	N
	Eastern Idaho Regional Medical Center*	Idaho Falls	SC, TR, SP	03/03/99	P
	St. Benedict's Medical Center*	Jerome	SC	08/18/99	N
	Twin Falls Clinic and Hospital*	Twin Falls	SC, DT, TR, SP	08/06/98	P
Illinois	Carle Foundation Hospital*	Urbana	SC, TX, CL, PP	04/23/99	N
	Children's Memorial Hospital* **R**	Chicago	SC, TX,TR, CL, PP	12/03/99	N
	Condell Medical Center*	Libertyville	SC, TX, TR	03/25/99	N
	Decatur Memorial Hospital*	Decatur	SC, TX, TR, CL, PP	11/06/98	N
	Forest Hospital*	Des Plaines	SC, PP	04/27/98	U
	Highland Park Hospital*	Highland Park	SC, TX, TR, OC	07/16/98	N

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	Holy Cross Hospital*	Chicago	SC, TR	04/20/98	N
	Holy Cross Hospital*	Chicago	SC, TX	06/27/97	N
	Jackson Park Hospital*	Chicago	SC, TX	11/09/99	N
	Jackson Park Hospital*	Chicago	SC, TX, PP	03/11/99	N
	Lake Forest Hospital*	Lake Forest	SC, TX, TR, SP	04/14/98	N
	Marion Memorial Hospital*	Marion	SC, TR, CL, SP	08/13/98	P
	Memorial Medical Center*	Woodstock	SC, TR	12/10/96	N
	Mercy Center Health Care Service*	Aurora	SC, CL	04/21/97	N
	Mercy Hospital and Medical Center*	Chicago	SC, CL	08/29/97	N
	Michael Reese Hospital and Medical Center* **R**	Chicago	SC, TX, ND, CL, PP	04/14/99	P
	Northwest Suburban Community Hospital*	Belvidere	SC, TX, TR, PP	02/11/99	N
	Our Lady of the Resurrection Medical Center* **R**	Chicago	SC, SP	10/22/98	N
	Provident Hospital of Cook County*	Chicago	SC, DT, TR, CL, PP	07/02/98	N
	Provident Hospital of Cook County*	Chicago	SC, DT	01/29/97	N
	Ravenswood Medical Center*	Chicago	SC	05/29/98	N
	Roseland Community Hospital* **R**	Chicago	SC, TX, PP	04/07/99	N
	Sacred Heart Hospital*	Chicago	TX, TR, PP	11/08/99	P
	Silver Cross Hospital	Joliet	CL, PP	01/16/98	N
	South Shore Hospital* **R**	Chicago	SC, TX	01/26/98	N
	St. Anthony Medical Center*	Rockford	SC, TX, CL, PP	12/02/99	N
	St. Bernard Hospital* **R**	Chicago	SC	01/06/99	N
	St. Elizabeth Medical Center*	Granite City	SC, TX, CL, SP, PP	12/15/99	N

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	St. Francis Hospital	Evanston	CL	06/22/99	N
	St. Mary's Hospital*	Decator	SC, CL, SP, PP	12/21/99	N
	Swedish American Hospital*	Rockford	SC, TX, TR	03/24/99	N
	Swedish American Hospital*	Rockford	SC, TX, CL, PP	11/08/99	N
	University Hospital of Chicago* **R**	Chicago	SC, SP	08/25/97	N
	University of Illinois Medical Center*	Chicago	SC, DT	12/11/97	N
Indiana	Charter South Bend Behavioral Health System*	Granger	SC, DT, TX, TR, ND	07/16/97	U
	Elkhart General Hospital*	Elkhart	TR	08/30/99	N
	Goshen General Hospital*	Goshen	SC, TR, PP	06/08/99	N
	St. Anthony Memorial Health Center*	Michigan City	SC, DT, TX, TR	12/14/99	N
	St. Francis Hospital and Health Center*	Beech Grove	SC	01/11/99	U
	St. John's Health System*	Anderson	SC, DT, CL	09/17/98	N
	St. Joseph's Regional Medical Center*	South Bend	SC, TR	01/10/00	N
	St. Vincent Hospital* **R**	Indianapolis	TR	12/14/99	N
	St. Vincent Mercy Hospital*	Elwood	SC, CL	09/17/98	N
Iowa	Allen Memorial Hospital	Waterloo	OC	05/08/98	N
	Burlington Medical Center	Burlington	ND	05/12/99	U
	Clarinda Regional Medical Center*	Clarinda	SC	11/25/97	N
	Decatur County Hospital	Leon	ND	04/05/99	N
	Green County Hospital*	Jefferson	SC, TR	03/04/98	N
	Iowa Lutheran Hospital* **R**	Des Moines	SC	10/16/98	N
	Keokuk Area Hospital	Keokuk	ND	05/12/99	N
	Manning General Hospital*	Manning	SC	10/01/98	N
	Mercy Hospital*	Corning	TR	04/22/99	N

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	Palmer Lutheran Health Center*	West Union	TX	04/16/97	N
Kansas	C. F. Menninger Memorial Hospital	Topeka	ND	7/21/98	N
	Cushing Memorial Hospital* **R**	Leavenworth	SC, TX, TR, SP, PP	01/11/99	N
	Edwards County Hospital*	Kinsley	TX, TR	10/29/96	N
	Hutchinson Hospital*	Hutchinson	TR	03/17/98	N
	Mercy of Manhattan*	Manhattan	SC, TR	10/15/98	N
	Norton County Hospital*	Norton	SC	02/12/97	N
	Olathe Medical Center*	Olathe	SC, TX, TR	08/05/97	N
	Republic County Hospital*	Belleville	SC, TX, TR	03/10/98	N
	Shawnee Mission Medical Center*	Shawnee	SC	12/22/97	N
	Stormont-Vail Hospital*	Topeka	SC, TX, TR	02/26/97	N
	University of Kansas Medical Center*	Kansas City	TR	05/29/97	N
	University of Kansas Medical Center	Kansas City	ND	06/03/98	N
Kentucky	Caldwell County Hospital*	Princeton	SC, TX, TR	03/21/97	N
	Columbia Lake Cumberland Regional Hospital	Somerset	ND	03/19/97	P
	Columbia Pinelake Medical Center*	Mayfield	SC	04/28/97	U
	Williamson Appalachian Regional Hospital **R**	South Williamson	SP	05/20/98	N
Louisiana	A. J. Mullen Memorial Hospital*	Shreveport	SC, TR, OC, CL, SP, MR	12/09/99	U
	Advance Care Hospital*	Metairie	TX, TR, SP	07/31/00	U
	Ascension Hospital*	Gonzales	SC	08/08/00	N
	Charter Brentwood	Shreveport	ND	07/28/00	P
	Columbia Lakeview Regional Medical Center	Covington	ND	08/20/98	P

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	Crossroads	Alexandria	ND	02/04/00	U
	Lane Memorial	Zachary	ND	01/10/97	N
	Methodist Psychiatric Pavillion*	New Orleans	TR	12/21/99	P
	St. Tammany Parish Hospital	Covington	ND	02/04/99	N
	Stonewall Medical Center	Stonewall	ND	07/28/00	P
	West Calcasieu Cameron Hospital*	Sulphur	TR	02/29/00	N
	West Jefferson Medical Center*	Marrero	SC, TX, TR	03/14/00	N
	Willis Knighton Medical Center **R**	Shreveport	ND	03/28/97	N
Maine	Cary Medical Center*	Caribou	SC, TR	06/16/99	N
	Central Maine Medical	Lewiston	SP	01/25/99	N
	Penobscot Bay Hospital*	Rockport	TX, TR	08/14/98	N
	Penobscot Bay Hospital*	Rockport	SC,TR	05/26/98	N
	Spring Harbor Hospital*	South Portland	TR	05/10/99	P
Maryland	Atlantic General Hospital* **R**	Berlin	SC, CL	06/04/97	N
	Harbor Hospital Center*	Baltimore	SC	08/11/98	N
	Howard County General Hospital*	Columbia	SC,TR, DT, SP	03/31/97	N
	Liberty Medical Center*	Baltimore	SC	04/08/98	U
	Peninsula Regional Medical Center **R**	Salisbury	ND	01/24/97	N
	Physician's Memorial Hospital*	La Plata	SC, DT, SP	04/22/97	N
Massachusetts	Cambridge Hospital*	Cambridge	SC	12/03/98	N
	Good Samaritan Medical Center*	Brockton	SC	04/28/99	N
	Hallmark Health System*	Malden	SC, TR	01/27/00	N
	Haverhill (Hale) Municipal Hospital*	Haverhill	SC, DT	12/24/97	N
	Milton Memorial Hospital*	Milton	SC, TR, SP	10/08/98	N
	St. Vincent Hospital*	Worcester	TR	06/23/97	P
	University of Massachusetts Medical Center*	Worcester	SC	09/22/98	N

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TX Treatment

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Michigan	St. Joseph's Mercy Hospital*	Clinton Township	TX, ND	11/18/97	N
Minnesota	Buffalo Hospital*	Buffalo	TR, OC, CL, SP, PP	03/11/98	N
	Fairview Northland Regional Hospital*	Princeton	TR	06/17/99	N
	Fairview University Medical Center*	Minneapolis	SC, ND	06/11/97	N
	Methodist Hospital*	Minneapolis	TX, TR, SP	01/27/97	N
	North Memorial Medical Center*	Robbinsdale	SC, TX, DT, TR, ND	10/27/97	N
	Regina Medical Center*	Hastings	SC, TR, CL, SP	10/14/99	N
	Weiner Memorial Medical Center*	Marshall	TR	12/17/97	N
Mississippi	Hillcrest Hospital*	Calhoun City	TX	04/01/99	N
Missouri	Audrain Medical Center*	Mexico	SC, DT. SP, PP	10/20/99	N
	Baptist Medical Center*	Kansas City	SC, DT, TR, ND, CL, SP, MR, PP	03/22/99	N
	Barnes-Jewish Hospital* **R**	St. Louis	SC, TX, TR, CL, SP, PP	11/02/98	N
	Bates County Memorial Hospital*	Butler	SC, TX, TR, PP	09/23/98	N
	Boone Hospital Center*	Columbia	SC, DT, TX, TR, SP, PP	06/22/99	N
	Bothwell Regional Medical Center*	Sedalia	TX, TR, OC, PP	07/12/99	N

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	Breech Regional Medical Center* **R**	Lebanon	SC, TX, TR, CL, PP	09/01/99	N
	Capital Region Medical Center*	Jefferson City	SC, TR, OC, PP	06/17/98	N
	Cardinal Glennon Children's Hospital*	St. Louis	SC, TX, TR	03/16/99	N
	Carroll County Memorial Hospital*	Carrollton	SC, TX, SP, PP	02/19/99	N
	Cedar County Memorial* **R**	El Dorado Springs	SC, TX, TR	11/12/98	N
	Charter Behavioral Health System*	Columbia	SC, TX, TR, MR, PP	06/01/99	U
	Children's Mercy Hospital	Kansas City	ND, PP	08/31/98	N
	Christian Hospital NE*	St. Louis	SC	10/16/97	U
	Christian Hospital NW*	Florissant	SC	10/16/97	N
	Cooper County Memorial Hospital*	Boonville	TR, PP	12/24/97	N
	Cooper County Memorial Hospital* **R**	Boonville	SC, PP	03/23/98	N
	Deaconess Medical Center -Central*	St. Louis	SC, TR, PP	08/27/98	U
	Deaconess Medical Center - Central*	St. Louis	SC, DT, TR, PP	11/21/97	U
	Deaconess Medical Center - Central*	St. Louis	TX	01/28/98	U
	Doctor's Hospital of Wentzville*	Wentzville	SC, DT, TR, SP	11/05/97	P
	Doctor's Regional Medical Center*	Poplar Bluff	SC, CL, PP	09/02/99	P
	Doctor's Regional Medical Center	Poplar Bluff	DT	10/04/99	P
	Ellett Memorial Hospital*	Appleton City	TR, PP	06/05/98	N
	Fitzgibbon Memorial Hospital*	Marshall	SC	01/12/00	N
	Harrison County Community Hospital*	Bethany	SC, TX, TR, PP	04/13/99	N
	Heartland Behavioral Health Services*	Nevada	SC, CL, SP, MR, PP	09/23/98	P

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	Heartland Regional Medical Center*	St. Joseph	SC, TX, TR	11/08/99	N
	Hedrick Medical Center*	Chillicothe	SC, OC, SP, MR, PP	07/29/99	N
	Jefferson Memorial Hospital*	Crystal City	SC, TX, TR, PP	08/24/98	N
	Lafayette Grand Hospital*	St. Louis	SC, TR	10/29/99	U
	Lee's Summit Hospital*	Lee's Summit	TX, TR	04/04/97	N
	Lincoln County Memorial Hospital*	Troy	SC, DT, MR, PP	06/03/98	N
	Lincoln County Memorial Hospital*	Troy	SC, TX, TR	08/19/98	N
	Metropolitan St. Louis Psychiatric Center*	St. Louis	SC, SP, PP	10/06/98	N
	Mid-Missouri Mental Health*	Columbia	SC, TX	01/05/00	N
	Missouri Baptist Hospital of Sullivan*	Sullivan	SC, TR,SP, PP	04/30/99	N
	Missouri Baptist Medical Center*	Town & Country	SC, TX, PP	11/15/99	N
	Moberly Regional Medical Center*	Moberly	TX, TR	03/19/00	P
	Nevada Regional Medical Center* **R**	Nevada	SC, TX	11/15/99	N
	Nevada Regional Medical Center*	Nevada	TR, PP	07/30/98	N
	Northeast Regional Medical Center*	Kirksville	TX, TR	01/17/97	P
	Park Lane Medical Center*	Kansas City	SC, TX, TR, PP	11/22/99	U
	Perry County Memorial Hospital*	Perryville	SC, DT, TX, TR, SP, PP	07/12/99	N
	Pershing Memorial Hospital*	Brookfield	SC, TX, TR, CL, SP, MR, PP	11/22/99	N
	Phelps County Regional Medical Center* **R**	Rolla	SC, TX, TR, OC, PP	02/18/99	N
	Research Medical Center*	Kansas City	TX, TR, CL, PP	07/31/98	N
	Reynolds County Memorial Hospital* **R**	Ellington	SC, TX, TR,	07/12/99	U

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			PP		
	Royal Oaks Hospital*	Windsor	TR	04/02/99	U
	Sac-Osage Hospital*	Osceola	SC, TX	07/30/99	N
	Salem Memorial District Hospital*	Salem	TR	06/21/99	N
	Samaritan Memorial Hospital*	Macon	TX, TR, PP	04/09/99	N
	Skaggs Community Hospital*	Branson	TR	06/03/97	N
	St. Anthony's Medical*	St. Louis	TR	08/05/97	N
	St. Francis Hospital*	Maryville	SC, TX, OC, TR	09/11/97	N
	St. John's Mercy Hospital*	St. Louis	SC	11/10/97	N
	St. John's Mercy Hospital*	Washington	SC, DT, TR	08/26/97	N
	St. John's Regional Medical Center	Springfield	ND, PP	11/12/98	N
	St. Louis Connect Care*	St. Louis	SC, PP	11/12/98	U
	St. Louis University Hospital*	St. Louis	SC, TR	12/17/97	U
	St. Luke's Northland Hospital*	Kansas City	SC, TR	12/01/97	N
	St. Mary's Health Center*	Jefferson City	SC, TX, TR, PP	10/22/98	N
	Trinity Lutheran Hospital*	Kansas City	TR, RP, CL	09/30/98	N
	Truman Medical Center East*	Kansas City	SC, DT, TR, ND, CL, SP, PP	03/19/98	N
	Truman Medical Center West*	Kansas City	TR, ND, PP	11/12/98	N
	Twin Rivers Regional Medical Center* **R**	Kennett	TX, TR, PP	10/07/98	P
	Two Rivers Psychiatric Hospital*	Kansas City	SC, TX, TR, CL, SP, PP	10/02/98	P
	University of Missouri Hospital and Clinic*	Columbia	TX, TR, CL, SP, PP	11/02/98	N
	Washington County Memorial Hospital*	Potosi	TX, TR, PP	09/21/98	N
	Western Missouri Mental Health Center*	Kansas City	DT, TX, TR PP	07/28/98	N

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Montana	Missouri River Medical Center-MAF* **R**	Fort Benton	TX, TR	11/19/97	N
	St. Joseph's Hospital*	Polson	SC, TX	08/03/98	N
Nebraska	Allegent Health-Bergan Mercy Medical Center*	Omaha	SC, TX, TR, SP, PP	09/02/97	N
	Alegent Health-Midlands Community Hospital*	Papillion	SC, TR, PP	10/06/98	N
	Box Butte General Hospital*	Alliance	SC, TX, TR, PP	01/12/98	N
	Bryan Memorial Hospital*	Lincoln	SC, TR	03/18/97	N
	Children's Hospital*	Omaha	SC, TR, PP	09/21/98	N
	Community Memorial Hospital*	Syracuse	SC	03/12/99	N
	Douglas County Hospital*	Omaha	SC, TR, OC, SP, PP	08/27/98	N
	Fremont Area Medical Center*	Fremont	SC, TX, TR, PP	06/09/98	N
	Henderson Healthcare*	Henderson	SC, OC	8/16/99	N
	Howard County Community*	St. Paul	SC, TR, PP	01/20/98	N
	Jefferson Community Hospital*	Fairbury	SC, TR, OC, PP	07/31/97	N
	Kearney County Health Services*	Minden	SC, TX, TR, PP	04/14/98	N
	Mary Lanning Memorial Hospital*	Hastings	TR	01/15/99	N
	Memorial Health Center*	Sidney	SC, TR, PP	07/14/97	N
	Nebraska Methodist Hospital*	Omaha	SC, PP	09/02/98	N
	Niobrara Valley Hospital Corporation*	Lynch	SC, TX, TR, PP	11/16/98	N
	Oakland Memorial Hospital*	Oakland	SC, TX, TR, PP	09/25/98	N
	Rock County Hospital*	Bassett	SC, TX, PP	09/29/98	N

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	St. Elizabeth Community Health Center*	Lincoln	SC, TX, PP	04/30/98	N
	St. Francis Medical Center*	Grand Island	SC, TR, PP	08/25/97	N
	St. Joseph Hospital*	Omaha	SC, TR, SP, PP	07/01/98	P
	St. Mary's Hospital*	Nebraska City	SC, TX, TR, CL, PP	10/29/98	N
	Thayer County Memorial Hospital*	Hebron	SC	10/10/97	N
	University of Nebraska Medical Center*	Omaha	SC, DT, TR, PP	11/18/97	U
	York General Hospital*	York	SC, TX, TR	10/28/97	N
Nevada	Lake Mead Medical Center*	N. Las Vegas	SC, DT, CL, SP, PP	08/25/97	P
	Valley Hospital Medical Center*	Las Vegas	TX, TR, PP	11/17/99	P
New Hampshire	Frisbee Memorial Hospital*	Rochester	TR	05/10/99	N
	Hampstead Hospital*	Hampstead	TR	06/08/98	P
	Monadnock Community Hospital*	Peterborough	SC	06/08/99	N
	Valley Regional Hospital*	Claremont	SC, TX, TR	01/15/98	N
New Jersey	Bayonne Hospital*	Bayonne	SC, TR, SP, PP	09/23/99	N
	Community Medical Center*	Tom's River	TX, TR, SP, PP	05/07/99	N
	Englewood Hospital*	Englewood	SC, TR, CL, SP, PP	06/01/99	N
	Jersey Shore Medical Center*	Neptune	SC, PP	11/16/97	U
	Kimball Medical Center*	Lakewood	SC, TX, SP, PP	11/16/98	N

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	Medical Center of Ocean County*	Point Pleasant	SC, TX, TR, SP, PP	09/14/99	N
	Mercer Medical Center* **R**	Trenton	TX, TR, SP, PP	12/02/99	N
	Riverview Medical Center* **R**	Red Bank	SC, TR, DT, CL, PP	11/30/99	N
	South Amboy Memorial*	South Amboy	SC, TX, OC, SP, PP	11/23/98	U
New York	Community General Hospital*	Syracuse	SC	01/14/99	N
	Faxton Hospital*	Utica	SC, SP	01/16/98	N
	Kings County Hospital*	Brooklyn	SC, DT, TR, CL, PP	11/17/98	N
	Kings County Hospital*	Brooklyn	SC, CL	01/07/98	N
	Mary McClellan Hospital*	Cambridge	TR	09/18/97	N
	Olean General Hospital*	Olean	TX, TR	04/06/99	N
	St. Elizabeth's Medical Center*	Utica	SC, OC	03/10/98	N
	St. John's Episcopal Hospital*	Smithtown	SC, CL, PP	10/01/98	N
	St. Luke's-Roosevelt Hospital*	New York	SC, TX, TR, CL, PP	03/08/99	N
	St. Mary's Hospital*	Rochester	SC, TR, CL, MR	03/18/97	U
North Carolina	Bladen County Hospital*	Elizabethtown	TR	04/01/99	N
	Columbia Brunswick Hospital* **R**	Supply	TR	05/04/99	P
	Halifax Regional Medical Center	Roanoke Rapids	SP	10/21/98	N
	Margaret R. Pardee Memorial Hospital*	Hendersonville	TR, SP	04/05/99	N
	Presbyterian Hospital*	Charlotte	TX, TR, CL, SP	05/04/99	N
	The McDowell Hospital*	Marion	TR	11/24/98	N

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	US PHS Indian Hospital*	Cherokee	SC, TR	02/10/98	N
	Wake Med-Western Wake Medical Center*	Cary	SC, TR	08/31/98	N
North Dakota	Dakota Heartlands Hospital*	Fargo	SC, TR, CL	05/28/99	P
Ohio	Madison County Hospital*	London	TR	11/23/98	N
	Mercy Medical Center of Springfield*	Springfield	SC, TX, TR, CL, MR	02/27/98	N
	Mercy Memorial Hospital*	Urbana	TR	08/27/99	N
	Meridia Euclid Hospital*	Meridia	TX	03/10/98	U
Oklahoma	Columbia Tulsa Regional Medical Center* **R**	Tulsa	SC, DT, CL, SP	07/09/98	N
	Community Hospital Lakeview* **R**	Eufala	SC, DT, TR, CL	12/09/99	P
	Deaconess Hospital*	Oklahoma City	SC, DT	03/08/99	N
	Drumright Memorial Hospital*	Drumright	SC, DT, TX, TR	03/10/00	N
	Hillcrest Medical Center* **R**	Tulsa	SC, DT, TR	03/16/99	N
	Integris Bethany Hospital*	Bethany	SC, DT	04/20/99	U
	Latimer County General Hospital* **R**	Wilburton	SC, DT, TR, OC, CL	08/11/99	N
	McCurtain Memorial Hospital*	Idabel	SC, DT, CL	11/30/99	N
	Memorial Hospital* **R**	Stillwell	SC, TX	08/11/99	U
	Rolling Hills Hospital*	Ada	SC, DT, CL, SP	08/13/99	P
	Southwestern Memorial Hospital*	Weatherford	SC, DT	08/11/99	N
	Stillwater Medical Center* **R**	Stillwater	TX, OC	03/28/97	N
	USPHS Lawton IHS Hospital*	Lawton	SC	08/06/99	N

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Oregon	Central Oregon District Hospital*	Redmond	SC	07/17/97	N
	Curry General Hospital*	Gold Beach	TR, CL	08/25/98	N
	Eastmoreland Hospital*	Portland	SC, TR, CL	12/01/99	P
	Kaiser Sunnyside Medical Center*	Clackamas	SC, TR, SP	12/03/98	N
	Legacy Good Samaritan Hospital and Medical Center*	Portland	SC, TR, CL	02/04/98	N
	Legacy Mt. Hood Medical Center*	Gresham	SC, TR	05/06/97	N
	North Lincoln Hospital* **R**	Lincoln City	SC	05/26/99	N
	OSHU Hospital and Clinics*	Portland	SC, TR, ND, SP	09/22/99	N
	Pacific Communities Hospital	Newport	DT	06/30/98	N
	Providence Hospital*	Milwaukie	TX, TR	06/30/98	N
	Providence Medford Medical Center*	Medford	SC, TR, CL	11/09/98	N
	Providence Newberg Hospital*	Newberg	SC, TR	08/28/98	N
	Providence Portland Medical Center*	Portland	SC, TR, CL, SP	05/01/97	N
	Providence Portland Medical Center*	Portland	TR	08/05/98	N
	Sacred Heart Medical Center*	Eugene	SC, CL, PP	11/04/97	N
	Southern Coos General Hospital*	Bandon	SC	01/14/97	N
	Tuality Community Hospital*	Hillsboro	SC, TR, CL	08/26/98	N
	Tuality Forest Grove Hospital*	Forest Grove	SC, TR	07/22/97	N
	Valley Community Hospital*	Monmouth	SC	07/02/99	U
	Willamette Valley Medical Center*	McMinnville	SC	10/04/99	P
Pennsylvania	Temple Lower Bucks Hospital*	Bristol	SC, TR	12/21/98	N
Puerto Rico	Caguas Regional Hospital*	Caguas	SC, TX, TR, CL, PP	10/29/99	N

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	Dr. Guberns Hospital*	Fajardo	SC, DT, TX, TR, CL, PP	06/10/99	P
	H.I.M.A. Hospital	Caguas	SP, PP	12/29/99	P
	Hospital Dr. Dominguez*	Humacao	DT, TX, TR, CL, SP, PP	12/15/99	P
	Hospital San Cristobal*	Coto Laurel	SC, DT, TX, TR	09/20/99	U
	Hospital San Pablo del Este*	Fajardo	DT, TX, TR, OC, CL, SP, PP	05/27/99	P
	Humacao Area Hospital Dr. Victor Rincon-Nunez Hosp.*	Humacao	SC, TR, CL, PP	12/17/98	N
Rhode Island	Kent County Memorial Hospital*	Warwick	SC, TR	10/20/99	N
	Roger Williams Hospital*	Providence	TR	05/16/97	N
South Carolina	Allen Bennett Memorial Hospital*	Greer	TR, SP	03/19/99	N
	Bamberg County Memorial Hospital*	Bamberg	SC	09/05/97	N
	Columbia Providence Hospital*	Columbia	TR, CL, SP	11/03/98	P
	Roper Hospital	Charleston	SP	08/04/98	N
	St. Francis Hospital	Greenville	SP	07/24/97	N
South Dakota	Lookout Memorial Hospital*	Spearfish	SC	03/14/97	N
	Mid-Dakota Hospital*	Chamberlain	SC, TR	08/12/98	N
	St. Michael's Hospital*	Tyndall	SC	05/12/98	N
Tennessee	Coffee Medical Center*	Manchester	SC	07/21/97	N
	Columbia STMC-Emerald Hodgson*	Winchester	SC, OC	02/13/97	P
	Crockett General Hospital*	Lawrenceburg	TR	11/30/99	P

Provision(s) Violated:

SC Screening
TX Treatment
DT Delay in treatment to inquire about insurance status
TR Transfer
ND Non-discrimination (specialized facility must accept transfer)
OC On call list
RP Reporting
CL Failure to maintain central log
SP Sign Posting
MR Failure to keep medical record for five years
PP Failure to have policies and procedures in place to ensure compliance

***** Indicates hospital violated screening and/or treatment and/or transfer provisions.

Date Violation Confirmed:
Indicates the date upon which the HCFA RO confirmed the violation.

For-Profit/Not-For-Profit Hospitals:
P For-Profit **N** Not-For-Profit **U** Profit Status Unknown

R Listed with violation in prior report

Sources:
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HCFA Forms 2567 from HCFA's Regional Offices
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STATE	HOSPITAL NAME	CITY	VIOLATION	CONFIRMED DATE	STATUS
Texas	All Saints Health System	Fort Worth	ND	01/13/98	N
	Bayou City Medical Center*	Houston	SC, TX, TR	04/06/00	P
	BrazoSport Memorial Hospital*	Lake Jackson	DT, TX, TR, OC	03/06/98	N
	Colorado-Fayette Medical Center*	Weimer	SC, TX, TR, MR	01/13/98	N
	Columbia Ft. Bend* **R**	Missouri City	SC	2/10/97	N
	Columbia Longview Regional Medical Center*	Longview	SC, CL	03/14/97	P
	Comanche Community Hospital*	Comanche	SC, TR, CL	03/11/97	N
	Doctor's	Corpus Christi	DT	01/10/97	U
	Doctor's Hospital (formerly Yale Clinic and Hosp.)*	Houston	SC, TX, TR, SP, MR	02/11/98	U
	East Texas Medical Center*	Jacksonville	SC, CL	08/21/00	N
	Good Shepard Medical Center*	Longview	SC, CL	11/26/97	N
	Harris Methodist HEB* **R**	Bedford	SC, SP, CL	12/09/99	N
	Medical Center of Mesquite*	Mesquite	TR	03/18/97	P
	Memorial Hospital of Center*	Center	SC, TX, TR, CL	01/13/98	P
	Memorial Hospital-Memorial City* **R**	Houston	SC	03/14/97	N
	Memorial Medical Center*	San Augustine	SC, SP, CL	08/08/00	N
	Memorial Medical Center of East Texas	Lufkin	ND	01/13/98	N
	Nacogdoches Medical Center*	Nacogdoches	SC, DT	05/06/99	P
	Nacogdoches Memorial Hospital*	Nacogdoches	SC, DT	05/06/99	N
	North Bay Hospital*	Aransas Pass	SC, TX, TR, CL	12/09/99	P
	Sisters of Charity-Jasper Memorial Hospital* **R**	Jasper	SC, CL	08/20/97	N
	Spohn Hospital*	Corpus Christi	DT, TX, MR	02/11/98	N
	Spohn Memorial Hospital*	Corpus Christi	SC, TX, TR	02/11/98	N

Provision(s) Violated:

SC Screening

TX Treatment

DT Delay in treatment to inquire about insurance status

TR Transfer

ND Non-discrimination (specialized facility must accept transfer)

OC On call list

RP Reporting

CL Failure to maintain central log

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	University of Texas Medical Branch **R**	Galveston	DT, ND, SP, CL	12/08/99	N
	West Oaks Hospital*	Houston	SC, TR, SP	12/08/99	P
Utah	American Fork Hospital*	American Fork	SC, TR	07/20/97	N
	Columbia Ashley Valley Medical Center*	Vernal	TR, CL	01/12/00	P
	Jordan Valley Hospital*	West Jordan	SC, TR	06/22/99	P
	McKay Dee Hospital*	Ogden	TR	06/28/99	N
	Milford Valley Memorial Hospital*	Milford	TX, TR, SP, CL	10/06/98	N
	San Juan Hospital*	Monticello	SC, DT, TX, OC	08/05/99	N
	University of Utah Hospital	Salt Lake City	CL	01/12/99	N
	Wasatch County Hospital*	Heber City	SC, TX, TR, ND, PP	04/07/98	N
Vermont	Fletcher Allen Hospital*	Burlington	SC	04/23/97	N
Virginia	Capitol Medical Center*	Richmond	SC, DT	04/08/98	P
	Chippenham Medical Center*	Richmond	SC, PP	12/07/99	P
	Columbia Peninsula Center for Behavioral Health*	Hampton	SC, TX, TR	06/16/97	P
	Dickenson County Medical Center* **R**	Clintwood	TR, OC	07/08/99	P
	Henrico Doctors' Hospital*	Richmond	TX, TR, OC, SP	08/16/99	P
	Johnston Memorial Hospital*	Abington	SC	06/28/99	N
	Lee County Community Hospital*	Pennington Gap	TX, TR	02/22/99	N
	Lonesome Pine Hospital* **R**	Big Stone Gap	SC	11/18/97	N
	Mary Immaculate Hospital*	Newport News	SC	08/12/99	N
	Southside Community Hospital* **R**	Farmville	SC, TR	07/19/99	N

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Washington	Deaconess Medical Center	Spokane	ND	09/16/98	N
	Mid-Valley Hospital* **R**	Omak	SC, OC, CL, SP	07/17/97	N
	Okanogan-Douglas District Hospital*	Brewster	TX	10/20/99	N
	Providence St. Peter Hospital	Olympia	DT	03/18/97	N
	Pullman Memorial Hospital*	Pullman	SC, CL	07/10/97	N
	St. Joseph Hospital	Bellingham	SP	03/17/97	N
West Virginia	Boone Memorial Hospital*	Madison	SC, TX, OC CL	11/01/99	N
	Braxton County Memorial*	Gassaway	SC, TX, TR, PP	02/13/97	N
	Charleston Area Medical Center **R**	Charleston	ND, PP	08/05/99	N
	Grant Memorial Hospital	Petersburg	CL, PP	06/18/98	N
	Herbert J. Thomas Memorial Hospital*	South Charleston	SC, DT, CL	08/28/97	N
	Man Appalachian Regional Hospital*	Man	SC, TX, TR, CL	01/04/99	N
	Monongalia General Hospital*	Morgantown	TR, PP	07/01/98	N
	Plateau Medical Center	Oak Hill	OC	10/26/98	N
	Summersville Memorial Hospital*	Summersville	SC	02/25/99	N
	Williamson Memorial Hospital* **R**	Williamson	SC, TX, PP	07/22/99	P
Wisconsin	Baldwin Area Hospital*	Baldwin	TX, TR, CL, SP, PP	12/03/98	N
	Mercy Health System*	Janesville	SC, CL, SP, PP	10/28/99	N
	Milwaukee County Mental Health Complex*	Wauwatosa	SC, TR	07/22/98	U

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STATE	HOSPITAL NAME	CITY	VIOLATION	CONFIRMED DATE	STATUS
	River Falls Hospital*	River Falls	SC, TX, TR, CL	12/13/99	N
	Riverside Medical Center*	Waupaca	SC, TX, TR, SP, PP	06/30/98	N
	Theda Clark Medical Center	Neenah	SP	11/13/98	N
	West Allis Memorial Hospital*	West Allis	SC, TX,	11/13/98	N
	West Allis Memorial Hospital*	West Allis	TR	08/10/99	N

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VI. CIVIL MONETARY PENALTIES

HCFA Regional Offices are required to refer all confirmed EMTALA violations to the OIG. The OIG evaluates each case and determines whether to impose civil monetary penalties against violators, as well as the amount of any such penalties. A number of factors affect OIG's decision on whether to seek civil monetary penalties against confirmed violators. The Peer Review Organization's report is one such factor. In most cases involving medical judgement, HCFA is required to consult with a Peer Review Organization.[33] Regional Offices send results of the Peer Review to OIG. OIG has previously noted that in some regions, peer reviewers disagreed with the HCFA decision about a case as much as 33% of the time.[34] If the Peer Reviewer concludes that the hospital or physician met the Act's requirements and its documentation supports the conclusion, OIG generally must close the case without imposing penalties.

Federal law and regulations require OIG to consider several other factors as well. EMTALA explicitly states that section 1320a-7a (d) of title 42 of the U.S. Code applies to the imposition of civil monetary penalties.[35] This statutory provision requires OIG to take into account the nature of claims and the circumstances under which they are presented, the degree of culpability, the history of prior offenses, the financial condition of the "person" presenting the claim, and "such other matters as justice may require."[36] The federal regulation specifically addressing penalties for EMTALA violation restates the above and adds two other factors. These are: 1) the seriousness of the condition of the individual seeking emergency medical treatment; and 2) the prior history of (EMTALA) offenses of the respondent.[37] Federal case law has incorporated these standards for civil monetary penalties.[38]

Since EMTALA's enactment through March 31, 2001, HCFA has referred 975 cases (these include violations by both hospitals and physicians) to the OIG.[39] During the same time period, 261 cases against hospitals and physicians have resulted in the imposition of civil monetary penalties, a number equal to 26.7 % of cases referred.[40]

Penalties Paid By Hospitals

During OIG calendar years 1997, 1998, 1999, 2000 and through April 9, 2001, 164 hospitals agreed to pay civil monetary penalties to resolve alleged dumping violations. These settlements involved alleged violations of five of the Act's provisions: screening, stabilizing treatment, transfer, non-discrimination and delay in treatment. Of hospitals listed in this report, 243 have had violations confirmed before January 1, 1999 and have so far avoided the imposition of a civil monetary penalty (see Appendix 2, page 127).

The rate at which OIG fines hospitals for EMTALA violations appears to be increasing. The number of settlements executed in 1998 (59) represents a four-fold increase over the number of settlements executed in each of the two previous years, 12 in 1997, 14 in 1996 (see Figure 1, page 62). (The number of settlements executed in calendar years 1999 and 2000 demonstrate a decrease, however). Dollar amounts of penalties have also increased, from a total of $130,000 in OIG Fiscal Year 1988 to totals exceeding $1,000,000 in each of OIG Fiscal Years 1998 ($1,822,500), 1999 ($1,725,500), and 2000 ($1,189,250). The average settlement amount for the period was $29,631. In contrast, during calendar year 1996 the average penalty was $17,904. The maximum settlement penalty in 1996 was $55,000., while four of the 164 hospitals listed in this report paid penalties in excess of $100,000. The sum of penalties assessed per

OIG fiscal year also shows an increase, beginning in 1998 ($1, 822,500) as compared to 1997 ($391,500) (see Figure 2).

Figure 1

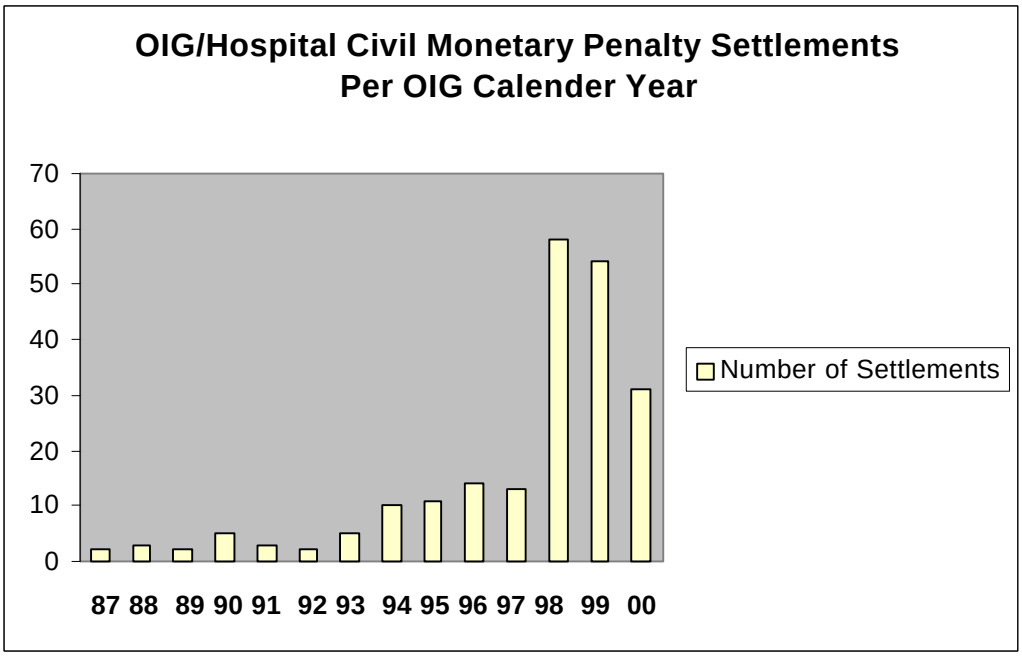
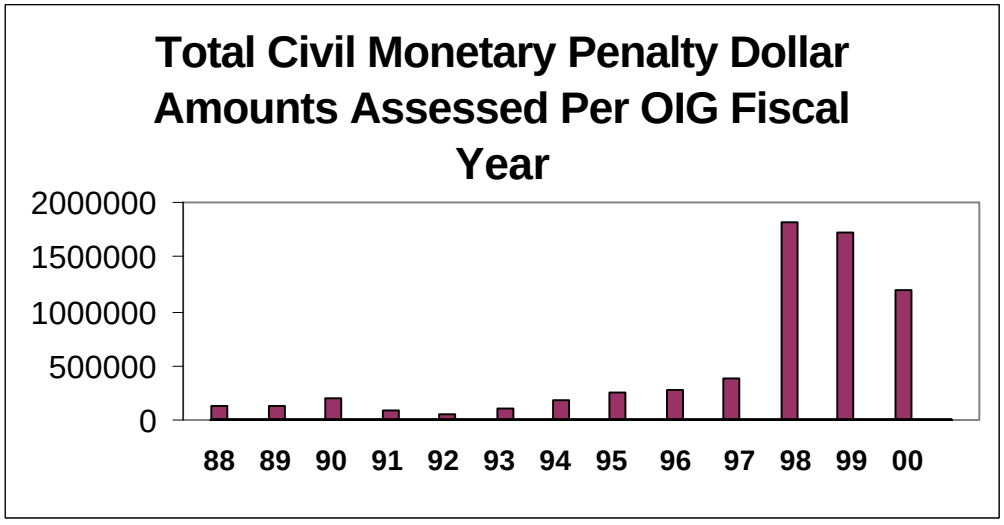


Figure 2



Source: Office of the Inspector General, U.S. Department of Health and Human Services

Table 2

Hospitals That Paid Fines (OIG CMP) To Resolve Alleged Dumping Violations

(Settlements Completed in Calendar Years 1997, 1998, 1999, 2000 and through April 2001)

STATE	HOSPITAL NAME	CITY	STATUS	VIOLATION	OIGCMP	OIG YEAR
Arizona	Arrowhead Community Hospital and Medical Center*	Glendale	N	SC, TX	$20,000	00
	Columbia Medical Center*	Phoenix	U	SC	$30,000	98
	Southeast Arizona Medical Center*	Douglas	N	SC	$5,000	99
	St. Joseph's Hospital and Medical Center*	Phoenix	N	TX, TR	$10,000	00
	Winslow Memorial Hospital*	Winslow	N	SC (3 patients)	$12,000	98
Arkansas	Crittenden Memorial Hospital*	West Memphis	N	SC	$15,000	99
	Randolph County Medical Center*	Pocahontas	P	SC	$7,500	00
	St. Vincent Infirmary Medical Center*	Little Rock	N	SC, TX or TX	$30,000	98
California	Adventist Health Redbud Community Hospital*	Clearlake	N	TR (multiple)	$40,000	99
	Alexian Brothers Hospital*	San Jose	U	SC (2 patients)	$37,500	98
	Anaheim General Hospital*	Anaheim	P	SC	$10,000	00
	Bellwood General Hospital*	Bellflower	P	SC (2 patients)	$30,000	98
	Cedars-Sinai Medical Center	Los Angeles	N	ND	$40,000	99
	Citrus Valley Medical Center-Queen of the Valley Campus*	West Covina	N	SC (8 patients)	$45,000	98
	Community Hospital of Huntington Park*	Huntington Park	P	SC (7 patients)	$70,000	00
	Doctors Medical Center*	Modesto	P	SC, TX, TR	$13,000	98

Provision(s) Violated:

SC Screening
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OC On call list
RP Reporting
CL Failure to maintain central log
SP Sign Posting
MR Failure to keep medical record for five years
PP Failure to have policies and procedures in place to ensure compliance

***** Indicates hospital violated screening and/or treatment and/or transfer provisions.

OIGYEAR:
Indicates the year in which the OIG fined for the violation.

Source:
Settlement Agreements, Office of the Inspector General, U.S. Department of Health and Human Services

STATE	HOSPITAL NAME	CITY	STATUS	VIOLATION	OIGCMP	OIG YEAR
	El Camino Hospital*	Mountain View	N	SC and/or TX or TR (2 patients)	$35,000	98
	Garfield Medical Center*	Monterey Park	P	SC (multiple)	$36,000	99
	Hanford Community Medical Center*	Hanford	N	TR	$10,000	99
	Huntington Beach Hospital*	Huntington Beach	N	SC, TX or TR	$25,000	00
	Kaiser Foundation Hospital & Rehabilitation Center*	Vallejo	N	TX, TR	$22,000	98
	Kaiser Foundation Hospital- South Sacramento*	Sacramento	N	SC (6 patients)	$61,000	00
	Kaiser Foundation Hospital, East Bay Medical Center*	Richmond	N	SC, TX or TR (one patient) and TR (2 patients)	$25,000	00
	Kaiser Foundation Hospital-Bellflower*	Bellflower	N	SC	$15,000	00
	Kaiser Foundation Hospitals, Santa Theresa Community Hospital*	San Jose	N	SC, TX or TR (2 patients)	$35,000	01
	Kaiser Foundation Hospital-Santa Clara*	Santa Clara	N	SC	$25,000	99
	Kaiser Foundation Hospital-West Los Angeles*	Los Angeles	N	SC	$14,000	99
	Lancaster Community Hospital*	Lancaster	P	SC (2 patients)	$9,000	00
	Martin Luther Hospital Medical Center*	Anaheim	U	SC	$7,500	99
	Mercy Hospital*	Bakersfield	N	SC (multiple)	$12,500	99
	Midway Hospital Medical Center*	Los Angeles	P	TX, TR	$30,000	00
	O'Connor Hospital*	San Jose	N	SC (2 patients)	$55,000	98
	San Joaquin Community Hospital*	Bakersfield	N	SC (7 patients)	$67,000	99
	Santa Clara Valley Medical Center*	San Jose	N	SC, TX or TR	$10,000	99
	Santa Monica-UCLA*	Santa Monica	N	SC (multiple)	$55,000	98

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STATE	HOSPITAL NAME	CITY	STATUS	VIOLATION	OIGCMP	OIG YEAR
	Scripps Memorial Hospital*	Chula Vista	N	SC	$30,000	98
	Sharp Memorial Hospital Center*	San Diego	N	SC	$25,000	98
	St. Dominic's Hospital*	Manteca	N	SC, TX (2 patients)	$7,500	01
	St. Joseph Hospital Of Eureka*	Eureka	N	TX or TR	$12,500	98
	Suburban Medical Center*	Paramount	P	SC	$13,000	00
	Torrance Memorial Medical Center*	Torrance	N	SC, DT (6 patients)	$67,500	99
	Tuolumne General Hospital*	Sonora	N	SC, TX	$10,000	00
Florida	Baptist Medical Center-Beaches*	Jacksonville Beach	N	SC (multiple)	$75,000	97
	Cedars Medical Center*	Miami	P	SC, TR	$20,000	97
	Central Florida Regional Hospital*	Sanford	P	TR	$35,000	99
	Columbia Clearwater Community Hospital*	Clearwater	U	SC	$6,000	98
	Coral Gables Hospital*	Coral Gables	N	SC	$27,500	99
	Halifax Medical Center*	Daytona Beach	N	SC (multiple)	$34,000	98
	North Florida Regional Medical Center*	Gainesville	P	SC	$25,000	98
	North Ridge Medical Center*	Fort Lauderdale	P	SC (2 patients)	$70,000	98
	Plantation General Hospital*	Plantation	P	SC	$40,000	99
	Public Health Trust-Jackson Memorial Hospital*	Miami	N	SC, TR	$30,000	98
	Tampa General Hospital*	Tampa	N	SC, TX, TR	$35,000	99
	West Florida Regional Medical Center*	Pensacola	P	SC	$42,500	98
Georgia	Barrow Medical Center*	Winder	P	SC	$18,000	98
	Columbia Doctor's Hospital*	Columbus	P	SC, TR	$23,000	98

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	Meadows Regional Medical Center*	Vidalia	N	SC and/or TX or TR	$7,500	98
	Northeast Georgia Medical Center*	Gainesville	N	SC, TX or TR	$45,000	98
	Screven County Hospital*	Sylvania	N	SC (4 patients)	$5,000	98
	Southwest Hospital & Medical Center*	Atlanta	N	SC (3 patients)	$10,896	97
	St. Francis Hospital*	Columbus	N	TX	$25,000	00
	Walton Medical Center*	Monroe	N	SC	$20,000	98
Illinois	Children's Memorial Hospital*	Chicago	N	SC and TX	$10,000	00
	Decatur Memorial Hospital*	Decatur	N	SC	$5,000	99
	Doctor's Hospital Hyde Park*	Chicago	U	SC, DT (multiple), TR	$39,000	99
	Highland Park Hospital*	Highland Park	N	TX and/or TR	$50,000	98
	Holy Cross Hospital *	Chicago	N	SC (6 patients)	$50,000	99
	Jackson Park Hospital*	Chicago	N	SC	$7,000	99
	Memorial Medical Center*	Woodstock	N	SC, TX or TR	$20,000	98
	North west Suburban Community Hospital*	Belvidere	N	SC (3 patients)	$60,000	00
	Northwestern Memorial Hospital*	Chicago	N	TX	$17,000	00
	Provident Hospital *	Chicago	N	SC, TX or TR	$7,500	99
	Ravenswood Hospital Medical Center-Advocate*	Chicago	N	SC, TX	$40,000	99
	Roseland Community Hospital*	Chicago	N	SC (7 patients)	$5,000	00
Indiana	Charter South Bend Behavioral Health*	Granger	U	SC, DT	$30,000	99
Iowa	Iowa Lutheran Hospital*	Des Moines	N	SC	$12,500	99

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Settlement Agreements, Office of the Inspector General, U.S. Department of Health and Human Services

STATE	HOSPITAL NAME	CITY	STATUS	VIOLATION	OIGCMP	OIG YEAR
	Marshalltown Medical & Surgical Center*	Marshalltown	N	SC, TR	$43,000	98
	Palmer Lutheran Health Center*	West Union	N	TX, TR	$15,000	98
	St. Anthony Regional Hospital*	Carroll	N	SC, TX, TR	$10,000	98
Kansas	University of Kansas Hospital*	Kansas City	N	ND (3 patients), TR	$148,000	99
Kentucky	Caldwell County Hospital*	Princeton	N	TR	$10,000	99
	Columbia Lake Cumberland Hospital	Somerset	P	ND	$27,500	98
	Westlake Regional Hospital*	Columbia	N	SC	$15,000	99
Maryland	Atlantic General Hospital*	Berlin	N	SC (multiple)	$64,290	99
	Carroll County General Hospital*	Westminster	N	SC (4 patients)	$32,500	97
	Fallston General Hospital*	Fallston	N	SC (multiple)	$150,000	98
	Good Samaritan Hospital*	Baltimore	N	SC (3 patients)	$20,000	97
	Harbor Hospital Center*	Baltimore	N	SC	$35,000	99
	Howard County General Hospital*	Columbia	N	SC	$7,500	98
	Liberty Medical Center*	Baltimore	U	SC (2 patients)	$33,000	99
	Peninsula Regional Medical Center*	Salisbury	N	SC (4 patients), ND	$72,000	98
	Washington County Hospital Association*	Hagerstown	N	SC (5 patients)	$20,000	98
Massachusetts	Caritas Good Samaritan Medical Center*	Brockton	N	SC, TX or TR	$5,000	00
	Harrington Memorial Hospital*	Southbridge	N	SC, TX	$17,500	00
	UMass Memorial Medical Center, Inc.*	Worcester	N	SC	$20,000	00

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STATE	HOSPITAL NAME	CITY	STATUS	VIOLATION	OIGCMP	OIG YEAR
Missouri	Cooper County Memorial Hospital*	Boonville	N	SC, TX	$5,000	00
	Deaconess Medical Center-Central*	St. Louis	U	SC and/or TX (3 patients)	$40,000	01
	Doctor's Hospital of Wentzville*	Wentzville	P	SC	$20,000	99
	Skaggs Community Health Center*	Branson	N	TR	$6,000	99
	St. John's Mercy Medical Center*	St. Louis	N	SC	$5,000	00
	St. Louis ConnectCare*	St. Louis	U	SC	$5,000	00
Nebraska	Alegent Health-Bergan Mercy Medical Center*	Omaha	N	SC (multiple)	$22,500	99
	Box Butte General Hospital*	Alliance	N	SC	$3,750	01
	Bryan Memorial Hospital*	Lincoln	N	SC (multiple)	$47,000	98
	York General Hospital*	York	N	SC (multiple)	$8,000	99
Nevada	Valley Hospital Medical Center*	Las Vegas	P	TX, TR	$10,000	01
New Jersey	Carrier Foundation*	Belle Mead	N	SC	$20,000	98
	East Orange General Hospital*	East Orange	N	SC (multiple)	$85,000	99
	Mercer Medical Center*	Trenton	N	SC (multiple)	$50,000	98
	Muhlenberg Regional Medical Center*	Plainfield	N	SC	$15,000	98
	Underwood Memorial Hospital*	Woodbury	N	SC, TX or TR	$12,500	98
New Mexico	Presbyterian Hospital*	Albuquerque	N	SC	$15,000	99
New York	Bertrand Chaffee Hospital*	Springville	N	TR (2 patients)	$26,000	99
	Cortland Memorial Hospital*	Cortland	N	SC , TX and/or TR	$50,000	99
	Crouse Hospital *	Syracuse	N	SC (multiple)	$99,000	97
	Erie County Medical Center*	Buffalo	N	TR	$35,000	98
	Kenmore Mercy Hospital*	Kenmore	N	SC	$20,000	99

Provision(s) Violated:

SC Screening

TX Treatment

DT Delay in treatment to inquire about insurance status

TR Transfer

ND Non-discrimination (specialized facility must accept transfer)

OC On call list

RP Reporting

CL Failure to maintain central log

SP Sign Posting

MR Failure to keep medical record for five years

PP Failure to have policies and procedures in place to ensure compliance

***** Indicates hospital violated screening and/or treatment and/or transfer provisions.

OIGYEAR:

Indicates the year in which the OIG fined for the violation.

Source:

Settlement Agreements, Office of the Inspector General, U.S. Department of Health and Human Services

STATE	HOSPITAL NAME	CITY	STATUS	VIOLATION	OIGCMP	OIG YEAR
	Kings County Hospital*	Brooklyn	N	SC, TX	$32,000	99
	Kings County Hospital*	Brooklyn	N	SC, TR (2 patients)	$82,000	99
	Lake Shore Hospital*	Irving	N	SC (2 patients)	$10,000	97
	Mercy Hospital*	Buffalo	N	SC (2 patients)	$15,375	97
	Olean General Hospital*	Olean	N	SC	$15,000	99
	Olean General Hospital*	Olean	N	TX, TR	$7,000	00
	Rome Memorial Hospital*	Rome	N	TR	$35,000	97
	Samaritan Medical Center*	Watertown	N	SC and/or TX or TR	$89,142	97
	St. John's Episcopal Hospital*	Smithtown	U	SC, TX	$25,000	99
	St. Luke's Hospital *	Newburgh	N	SC, TX and/or TR (5 patients)	$10,000	98
	United Health Services Hospitals, Inc.*	Johnson City	N	SC	$7,500	00
	Unity Health System-St. Mary's Hospital*	Rochester	U	SC	$10,000	98
	Westfield Memorial Hospital*	Westfield	N	SC (multiple)	$15,500	98
North Carolina	Frye Regional Medical Center*	Hickory	P	SC, TR	$15,000	97
Ohio	East Liverpool City Hospital*	East Liverpool	N	SC, TX or TR	$20,000	00
Oklahoma	Integris Baptist Medical Center	Oklahoma City	N	ND	$30,000	01
	Mercy Health Center, Inc.	Oklahoma City	N	ND	$18,250	00
	University Hospital	Oklahoma City	P	ND (twice)	$40,000	00
Oregon	Douglas Community Hospital*	Roseburg	U	SC, TR (multiple)	$60,000	98
	Good Samaritan Hospital*	Corvallis	N	SC (multiple)	$50,000	98

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Settlement Agreements, Office of the Inspector General, U.S. Department of Health and Human Services

STATE	HOSPITAL NAME	CITY	STATUS	VIOLATION	OIGCMP	OIG YEAR
	Legacy Good Samaritan Hospital & Medical Center*	Portland	N	SC (multiple)	$125,000	99
	McKenzie-Williamette Hospital	Springfield	N	SC and/or DT (multiple)	$175,000	98
	Mercy Medical Center*	Roseburg	N	SC (multiple)	$75,000	98
	Rogue Valley Medical Center*	Medford	N	SC	$25,000	98
	Salem Hospital *	Salem	N	SC (8 patients)	$20,000	99
	Silverton Hospital*	Silverton	N	SC	$7,500	98
	Tuality Forest Grove Hospital*	Forest Grove	N	SC (3	$12,000	99
	Valley Community Hospital*	Dallas	N	SC (3 patients)	$5,000	01
Pennsylvania	Episcopal Hospital*	Philadelphia	N	SC	$40,000	00
Puerto Rico	Cayetano Coll Y Toste Hospital*	Arecibo	U	SC	$15,000	98
South Carolina	Bamberg County Memorial Hospital*	Bamberg	N	SC	$18,000	99
Tennessee	Coffee Medical Center*	Manchester	N	SC	$20,000	98
	Laughlin Memorial Hospital*	Greeneville	N	SC	$30,000	99
Texas	Brownsville Medical Center*	Brownsville	P	SC	$20,000	98
	Comanche Community Hospital*	Comanche	N	SC	$14,500	99
	Paracelcus Santa Rosa Medical Center*	Houston	U	SC (multiple)	$15,000	98
	Southwestern General Hospital*	El Paso	P	SC	$20,000	99
Virginia	Bon Secours-St. Mary's Hospital*	Richmond	N	SC	$30,000	01
	Capitol Medical Center*	Richmond	P	SC	$43,000	99
	Charter Behavioral Health*	Charlottesville	P	SC and/or TX or TR (2 patients)	$40,000	99

Provision(s) Violated:

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PP Failure to have policies and procedures in place to ensure compliance

***** Indicates hospital violated screening and/or treatment and/or transfer provisions.

OIGYEAR:

Indicates the year in which the OIG fined for the violation.

Source:

Settlement Agreements, Office of the Inspector General, U.S. Department of Health and Human Services

STATE	HOSPITAL NAME	CITY	STATUS	VIOLATION	OIGCMP	OIG YEAR
	Columbia Peninsula Center for Behavioral Health*	Hampton	P	TR	$36,000	98
	Lonesome Pine Hospital*	Big Stone Gap	N	SC, TX or TR	$13,500	98
	Wellmont Lonesome Pine Hospital*	Big Stone Gap	N	SC	$20,000	98
Washington	Deaconess Medical Center	Spokane	N	ND	$22,000	01
	Mid-Valley Hospital*	Omak	N	SC (5 patients}	$20,000	99
West Virginia	Hampshire Memorial Hospital*	Romney	P	SC (multiple)	$5,000	98
	Jackson General Hospital Center*	Ripley	N	SC (2 patients)	$15,000	97
	Welch Emergency Hospital*	Welch	U	TR	$10,000	00
Wisconsin	Mercy Health System*	Janesville	N	SC	$17,500	01

Provision(s) Violated:

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Indicates the year in which the OIG fined for the violation.

Source:

Settlement Agreements, Office of the Inspector General, U.S. Department of Health and Human Services

Penalties Paid By Physicians

In calendar years 1997, 1998 and 1999, 2000 and through April 9, 2001, 13 physicians paid civil monetary penalties to resolve alleged dumping violations. All of the alleged violations involved either the Act's screening, transfer or stabilizing treatment provisions. Penalties ranged from $5,000 to $45,000, averaging $19,967. In contrast, physician penalties averaged $11,250 in OIG calendar years 1995 and 1996.

TABLE 3

Physicians Who Paid Fines To Settle Alleged EMTALA Violations
(Settlements Completed in Calendar Years 1997, 1998, 1999, 2000, through April 2001)

State	Name	City	VIOLATION	OIGCMP	OIGYEAR
	Robert Wolfensperger*		TR	$5,000	98
Arkansas	David McKelvey *	Little Rock	SC, TX or TR	$37,500	98
California	Matthew Mullarkey*	Irvine	TX, TR	$6,000	00
Florida	Joseph Goldberg *	Miami	SC, TR	$16,074	97
	Uzi Bodman*	Ft. Lauderdale	SC, TX and TR	$15,000	00
Georgia	Colin Bryant*		SC, TX and TR	$22,500	00
	Ronald Hunt*	Columbus	OC, TX	$20,000	01
Iowa	Kenneth Miller*	West Union	TX, TR	$22,500	98
New Jersey	Kahn Brown *	Morristown	SC	$20,000	98
New York	Monica Applewhite *	Buffalo	SC, TX, TR	$45,000	99
	Kenneth Wu*	Olean	TX, TR	$20,000	00
Tennessee	Timothy Duffin*	Clarksville	TX, TR	$15,000	99
West Virginia	Julito Sultan*	Welch	TR	$15,000	00

Provision(s) Violated:

SC Screening

TX Treatment in

DT Delay in treatment to inquire about insurance status

TR Transfer

ND Non-discrimination (specialized facility must accept transfer)

OC On call list

RP Reporting

CL Failure to maintain central log

SP Sign Posting

MR Failure to keep medical record for five years

PP Failure to have policies and procedures place to ensure compliance

***** Indicates doctor violated screening and/or treatment and/or transfer provisions.

OIGYEAR:

Indicates the year in which the OIG fined for the violation.

Sources:

Settlement Agreements, Office of the Inspector General, U.S. Department of Health and Human Services

VII. OIG's SURVEY

OIG's Office of Evaluation and Inspections (OEI) recently conducted a survey to determine ER staff awareness of EMTALA requirements.[41] The following discussion highlights and comments on a number of their findings.

Hospital Compliance with EMTALA

Results indicated that ER staff members are generally familiar with EMTALA requirements. Still, a few of the survey's findings lead to concern. Within a sample of 123 hospitals, up to 30% of surveyed ER registration staff reported that patients might be asked for insurance information before a screening exam is provided, or while it is taking place.[42] If the request delays the provision of the exam or stabilizing treatment, the Act is violated. A number of other findings also bear mention. Thirty-five percent of surveyed registration staff reported that they contact health plans for authorization of screening exams at some point. Twenty-five percent reported that they seek authorization for stabilizing treatment.[43] Calling for such authorization does not violate the Act if it does not delay or preclude the exam or stabilizing treatment. Yet, 15% of surveyed staff in those hospitals that seek authorization for screening and 10% of surveyed staff in those that seek authorization for stabilizing treatment believe that screening or treatment is not provided when authorization is denied.[44] The denial of screening or stabilizing treatment is in direct violation of the Act and contradictory to its purpose.

EMTALA investigations had been conducted at 47 of the 123 valid hospitals in OEI's survey sample.[45] Violations were confirmed in one-third of these 47 investigations, yet almost half of the 47 hospitals investigated reported changing some

aspect of their ER's operation as a result.[46] An investigation alone may increase an ER's compliance with the Act.

EMTALA and State Law

Requirements of state law may conflict with EMTALA's requirements.[47] OEI found that some states require any adult candidate for involuntary psychiatric commitment to be transferred to the State hospital, though these patients may not be "stable" for transfer under EMTALA. It must be noted that the Act explicitly preempts state law in direct conflict with its requirements.[48] Courts have found direct conflict between state sovereign immunity statutes and EMTALA's civil enforcement provision.[49] In the example given above, state law may require that a patient be transferred to the state hospital in an unstable condition, despite the initial hospital's capacity to treat the patient. Such a requirement is in direct conflict with the Act and preempted by it. Unless the appropriate transfer is documented as the informed choice of the patient, such a transfer violates EMTALA.

Managed Care and EMTALA

Americans with health insurance are frequently insured through some type of managed care plan.[50] Requirements of these plans sometimes create financial difficulty for hospitals that comply with EMTALA. The Act requires hospitals to screen all patients who come to the ER seeking care. If an emergency medical condition exists, the Act further requires the hospital to stabilize the patient before transfer, unless the benefits of transfer outweigh its risks. The Act prohibits ERs from delaying a screening exam or treatment to inquire about insurance or payment. Yet some managed care organizations (MCOs) require pre-authorization for examination and/or treatment. Additionally, MCOs

may deny or reduce payment for exams when the patient is ultimately found not to have an emergency condition. MCOs may also attempt to control costs by directing patients to the least expensive venue for treatment, by limiting the spectrum of diagnostic procedures or treatments or by requiring these to be pre-authorized. When an MCO denies or reduces reimbursement for emergency services, the hospital is still obligated to meet the Act's requirements and in doing so, bears the cost of complying with federal law for an insured patient.[51] Such a situation is patently unfair and also provides the hospital with a strong disincentive to compliance.

In the following excerpt, an ambulance brought a thirteen-month-old infant to the ER at Leesburg Regional Medical Center in Leesburg, Florida (northeast of Orlando). The infant was acutely ill with a possible asthma attack and was immediately taken back to the treatment area and placed on oxygen. Before the physician saw the baby, staff spoke to the HMO, which denied reimbursement for the visit. Documentation on the chart revealed that the mother was told she must sign that she accepted responsibility for self-pay or the baby could not be seen. The mother left with the child, without receiving a screening and without a means of transportation. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> A 13-month-old child presented to the emergency room…with a chief complaint of possible asthma. […] The patient was brought straight back to a treatment room and placed on oxygen but before the patient could be screened by the physician, the HMO had been called and denied the visit. Per the clinical record, the patient's mother was informed that if she wanted the baby to be seen she must sign responsibility for self-pay. [T]he mother refused to sign and left with the baby without being screened by the physician and with no means of transportation….

Leesburg Regional Medical Center
Leesburg, Florida

A number of states have enacted statutory "prudent layperson" standards.[52] (In addition, the Social Security Act includes "prudent layperson" standards applicable to Medicare+ Choice plans and Medicaid Managed Care Organizations.)[53] These laws generally require insurers to pay for the ER visits of their enrollees when the symptoms would lead a prudent layperson to believe that an emergency condition existed. A recent study conducted by the University of North Carolina found that 86% of ER visits initially denied by one insurer and 62% of ER visits initially denied by another insurer on grounds that the condition was not a medical emergency actually met the state's prudent layperson standard.[54] Hospitals and health care consumers should be aware that these statutes exist in 13 states. Any appeal of a coverage denial should refer to the state's statute. In the University of North Carolina study, most claims resubmitted as meeting the state "prudent layperson" standard were eventually paid.

Senators Graham (D- Florida) and Chaffee (R-Rhode Island) recently introduced the "Access to Emergency Medical Services Act of 2001."[55] The proposed legislation would require insurers to cover screening and stabilization treatment without prior authorization, whether the provider furnishing these services is a participating provider or not.[56] DHHS should make every effort to support this valuable legislation.

On Call Panels

Medicare provider agreements require participating hospitals to maintain a list of physicians on call for duty after the initial exam to provide necessary stabilizing treatment to an individual with an emergency medical condition.[57] The Act extends EMTALA responsibilities to encompass the performance of some physicians serving on on call panels.[58] OEI's survey results indicate that many hospitals experience difficulty

filling these panels.[59] Reasons cited include a specialty physician's fear of not being reimbursed for services they are required to provide. It should be noted that, in the case of hospitals that advertise specialty services, repeated incidents of specialists' unavailability may constitute violations of state consumer protection acts.[60]

VIII. CIVIL ENFORCEMENT (ENFORCEMENT BY PRIVATE LAWSUIT)

Civil actions can serve as a tool for improving compliance with EMTALA. Any individual who suffers harm, or any medical facility that suffers a financial loss as a direct result of a hospital's violation of the Act may bring an action in federal court against the violating hospital. The action may seek any damages available for personal injury under the law of the state in which the hospital is located.[61] Federal courts can exercise supplemental jurisdiction over closely related state law claims, such as medical malpractice claims arising from the same events.[62]

Plaintiffs bringing private actions under EMTALA must take care in drafting a complaint. Courts construe liability under the statute more narrowly than liability under state medical malpractice law. This is particularly true for EMTALA's screening requirement. Courts generally hold that the statute's appropriate screening requirement is satisfied when an ER uses a standard screening procedure reasonably calculated to detect an emergency medical condition.[63] Under this standard, the failure to diagnose an emergency condition during an "appropriate" screening exam may not state a claim under the Act. A number of Circuits additionally require that plaintiffs show they received disparate treatment from other patients presenting with the same or similar symptoms or conditions.[64]

In *Morrison v. Colorado Permanente Group*, the patient, a mother of two minor children, presented to the ER three times, first complaining of severe headache and high fever and the following day presenting twice with complaints of intense pain in her abdomen, hips and legs. On the first two occasions she was discharged from the ER. Her first examination on the second day revealed large blood and fluid filled blisters on her left flank and right hip. She returned to the ER on the evening of the second day and was diagnosed with necrotizing fasciitis, a life-threatening infection. She died the following morning. Her surviving husband brought a civil action in the District Court alleging EMTALA violations against the hospital. The complaint asserted two violations of the Act: 1) the hospital failed to provide an appropriate screening examination; and 2) the hospital had actual knowledge during both ER visits that the patient was suffering from an unstabilized emergency medical condition before it discharged her. A District Court within the Tenth Circuit held that the allegations sufficiently stated a claim under the Act, refusing to grant the defendant hospital's motion to dismiss.[65]

IX. CONCLUSION

EMTALA violations continue to occur in hospitals throughout the United States. Some violations represent only minor deviations from the letter of the law, others are dramatic illustrations of the very practices Congress sought to prohibit. OIG survey results indicate that the majority of hospital ER staff members are familiar with EMTALA's requirements. Still, problem areas persist.

Some compliance problems, particularly those involving on call specialist panels, may be related to individual hospital practices and deficiencies. Federal legislation and/or the promulgation of new federal regulations could remedy other areas. To date, the

Act fails to provide for insurer liability under EMTALA or to require insurers to cover EMTALA-related services. As a result, hospitals bear the costs of complying with EMTALA for some insured patients. (Reimbursement practices may also affect the willingness of physicians to serve on hospital on call panels.)[66] Section (d) of the Act could be amended to create liability for insurers that require pre-authorization or that refuse to reimburse hospitals for EMTALA related services. Legislation could also be enacted independently of EMTALA. Senators Graham (D- Florida) and Chaffee (R-Rhode Island) recently introduced the "Access to Emergency Medical Services Act of 2001."[67] The proposed legislation would require insurers to cover screening and stabilization treatment without prior authorization, whether the provider furnishing these services is a participating provider or not.[68] DHHS should make every effort to support this valuable legislation.

Loopholes exist in the statutory and regulatory framework authorizing OIG enforcement of the Act. EMTALA, in its statutory language extends civil monetary penalty liability only to on call physicians serving the hospital that provides the initial screening exam.[69] A federal regulation, 42 C.F.R. ' 1003.100, addresses the imposition of civil monetary penalties. Section 1003.100 limits the imposition of monetary penalties to violations of the Act itself and violations of 42 C.F.R. ' 489.24, thereby excluding violations of the on call list requirement by hospitals that receive transferred patients, as well as excluding violations of the reporting requirement.[70] Amending section 1003.100 to allow the imposition of penalties against violators of 42 C.F.R. ' 489.20 would extend liability to on call physicians at receiving hospitals and violators of the reporting requirement.

Civil enforcement of EMTALA remains a tool for increasing compliance. Medical facilities, as well as private individuals may bring actions in federal courts to recover financial losses resulting from a hospital's violation of the Act. If recipient hospitals in particular made use of this provision, one foreseeable result might be a decrease in the incidence of transfer violations.

X. REGIONAL OFFICES TO REPORT EMTALA VIOLATIONS

Region 1 (serves Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont)
John F. Kennedy Federal Building
Room 2325
Boston, Massachusetts 02203-0003
(617) 565-1232

Region 2 (serves New Jersey, New York, Puerto Rico, the Virgin Islands)
26 Federal Plaza Room 3811
New York, New York 10278-0063
(212) 264-3657

Region 3 (serves Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia)
Suite 216, The Public Ledger Building
150 South Independence Mall
Philadelphia, Pennsylvania 19106
(215) 861-4140

Region 4 (serves Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi, Tennessee)
Atlanta Federal Center
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303-8909
(404) 562-7500

Region 5 (serves Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin)
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601
(312) 886-6432

Region 6 (serves Arkansas, Louisiana, New Mexico, Oklahoma, Texas)
1301 Young Street, 8th Floor
Dallas, Texas 75202
(214) 767-6423

Region 7 (serves Iowa, Kansas, Missouri, Nebraska)
Richard Bolling Federal Building
601 East 12 Street, Room 235
Kansas City, Missouri 64106-2808
(816) 426-2866

Region 8 (serves Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming)
Federal Office Building, Room 522
1961 Stout Street
Denver, Colorado 80294-3538
(303) 844-4024

Region 9 (serves American Samoa, Arizona, California, Commonwealth of Northern Marianas Islands, Guam, Hawaii, Nevada)
75 Hawthorne Street, 4th and 5th Floors
San Francisco, California 94105-3903
(415) 744-3501

Region 10 (serves Alaska, Idaho, Oregon, Washington)
2201 Sixth Avenue, MS/RX-40
Seattle, Washington 98121-2500
(206) 615-2354

APPENDIX 1

This appendix presents excerpts from HCFA Forms 2567. Hospitals located in the 24 more populous states are featured.

ARIZONA

Glendale, Arizona

A pregnant patient presented to the ER of Arrowhead Community Hospital in Glendale, Arizona (near Phoenix) on July 10, 1997. The hospital's written policy required that all patients presenting to the ER be seen by a physician, "in compliance with COBRA laws…." The record for this patient contained no documentation of a screening exam performed by a physician. She was discharged approximately four hours after she presented. This patient presented the following day in active labor and was admitted to the hospital. Her unborn child had died. The patient herself died the day following readmission. Autopsy results revealed that she died of internal hemorrhage resulting from dissection of an aortic aneurysm. (An aneurysm is an abnormal dilatation of an artery, which carries a risk of rupture or dissection.)

This hospital agreed to pay $20,000 to resolve OIG's investigation into this incident.

> The Emergency care Policy E-1 stated:
> "…POLICY: All patients presenting themselves to the Emergency Department will be seen by the Emergency Physician or a physician on staff…PURPOSE: To provide emergency care to all patients presenting themselves for care, in compliance with COBRA laws…PROCEDURE:…Patients will be seen by the Emergency Department Physician and triaged as appropriate…"
>
> The Maternal/Neonatal Triage and/or Transfer Policy WI-18 stated:

"[…] A medical screening examination shall be provided to any mother who comes to the hospital requesting treatment beginning within 30 minutes of arrival…"

During interview on 08/21/98 a staff member stated:
"[…] No, the doctor does not have to come in (to see a patient)…the doctor may give labor instructions or discharge orders over the phone…"

During interview on 08/20/98 a staff member stated:
"[…] A physician is supposed to see all patients, but they don't always do it…"

During interview on 08/21/98 a staff member stated:
"[…] No, the physician doesn't always come in to see them (patients) in a routine case…"

The MR [medical record] of patient #1 documented an admitting diagnosis "R/O (Rule Out) Labor 37 wks (weeks)" on the Outpatient Services Record Registration Form (Registration Form) dated 7/10/97 at 1857 hours. This labor patient was in the care of an RN without any MSE [medical screening exam] by an MD documented for the 7/10/97 hospital admission. This MR documented the patient's discharge from the hospital 7/10/97 at 2245 hours.

The MR of patient #1 documented readmission to the hospital 7/11/97 in active labor. Principle diagnosis of "Term pregnancy-fetal demise" was documented. This MR documented the patient expired 7/12/97 in the hospital. The "REPORT OF AUTOPSY PATHOLOGIC DIAGNOSES" dated 7/14/97 stated:
"…TYPE OF DEATH: Suspicious, unnatural, unusual…
I. Circumferential dissecting aortic aneurysm;
A. Total dissection of thoracic and lumbar aorta.
B. Retroperitoneal hemorrhage.
C. Atelectasis left lung.
D. Bilateral hemothoraces, left 2100 ml. right 100 ml.
E. Hemopericardium, 20 ml.
II. History of ruptured uterus:
A. History of stillborn. (07/11/97) 36 weeks.
B. Hemoperitoneum…"

Arrowhead Community Hospital
Glendale, Arizona

CALIFORNIA

San Jose, California

In San Jose, California, a nine-month-old infant arrived at Santa Clara Valley Medical Center's ER with a history of several days of cough, fever, fussiness, discharge from the eye and two possible seizures occurring that morning. A nurse referred the child and parents to an outpatient clinic without providing any medical screening. An

ambulance returned the child to the ER from the clinic after a seizure lasting four minutes occurred at the clinic. The child's temperature was 104 degrees at the clinic. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> On 9/22/98 at approximately 11:00 a.m. a nine-month-old child was brought to the hospital ED by his parents and an uncle. The child's mother told the triage nurse at the ED that the child had been ill several days with a cough, fever, fussiness and discharge from the right eye. This was accompanied by two seizure-like episodes that morning. The triage nurse then referred the mother to the facility's pediatric clinic without taking vital signs or doing a medical screening exam to rule out a medical emergency condition. The nurse also failed to enter the patient's name into the ED patient log. The mother took her son to a clinic several miles away…. At the clinic the child had a temperature of 104 degrees and a full body seizure for four minutes. The child was returned to the hospital ED by ambulance. This time the patient received a medical screening examination, pediatric consultation, and was treated with antibiotics and Motrin. The child was discharged home after being observed seven hours. Discharge diagnosis was viral syndrome and febrile convulsion.

Santa Clara Valley Medical Center
San Jose, California

Merced, California

In Merced, California, a mentally retarded patient was brought by ambulance to Mercy Hospital's E.D with symptoms of abdominal distress and shortness of breath. The ER physician suspected an abdominal condition requiring surgery. As the patient continued to deteriorate, the physician twice called an on call surgeon asking that he come in immediately to examine the patient. The surgeon repeatedly refused to come in, advising that the patient be admitted for him to see in the morning. As the patient's blood pressure and pulse rate dropped to life-threatening levels, the ER physician contacted hospital administrators in an apparent effort to compel the surgeon to come in. The patient suffered a cardiac arrhythmia and died despite a resuscitation attempt. The surgeon arrived during the resuscitation. Documentation also revealed that the surgeon

made disparaging remarks related to this patient's mental retardation, including the statement that "no one would miss him if he died," as he had lived in a board and care home for 15 years. (This hospital self-reported a potential violation. After survey, the Regional Office confirmed this incident as a violation. Corrective action had been implemented by the hospital prior to survey and the hospital was in compliance on the survey date.) As of April, 2001, no civil monetary penalty had been imposed against the hospital in connection with this HCFA-confirmed violation. (Because the on call physician is not identified, it is difficult to determine if the physician was fined.)

> At approximately 8:15 p.m. on October 20, 1998, patient #1 was brought to the ED with a history of sudden onset of abdominal distress; gasping and shortness of breath; "wide-eyed and staring;" sweating; and incontinence of urine for approximately 30 minutes after the patient had eaten a "good meal." The patient was a 49 year old black male with a history of developmental delay/mental retardation, high blood pressure and recent medical treatment by a private physician for an abdominal disorder. The ED physician reported that the patient was "essentially mute," had lived in a local board and care home for fifteen years and that the patient's landlady relayed the patient's history. The patient's blood pressure was noted to be 127/64 on arrival, with a rapid heart rate of 160 beats per minute and rapid respirations of 30 breaths per minute. […] At approximately 9:50 p.m., after consulting with the radiologist, the E.D. physician called the on-call surgeon and asked him to come in immediately to see the patient. The surgeon declined to come in, instead directing that a nasogastric tube be placed to decompress the patient's abdomen and that the patient be admitted to the hospital where the surgeon would see him the next day. The ED physician reported that he was unable to place an NG tube…due to the degree of the patient's abdominal distention. […] At 10:50 p.m., the ED physician consulted with a gastroenterologist who felt the patient was a surgical case…. After this, the ED physician called the on-call surgeon again, requesting that he come in immediately, reporting the gastroenterologist's opinion and the patient's "grave state." The surgeon responded that the patient should be admitted to the hospital and that he would not see the patient tonight. At this point the ED physician …called the hospital's nursing supervisor to initiate a call to the surgeon's Chief of Service…. At this time, the ED physician reported that the patient's vital signs were falling, with a blood pressure of only 70/palpable and a heart rate of only 20 beats per minute, and progressed into ventricular fibrillation. Advanced cardiac life support measures were initiated, during which time the surgeon finally arrived in the ED. Despite lifesaving measures being attempted, the patient expired and was pronounced dead at 11:26 p.m. Review of other hospital documents revealed that the surgeon was reported to have made many "disparaging" remarks about the patient being mentally

> retarded and that "no one would miss him if he died" as he had lived in a board and care home for fifteen years.

Mercy Hospital
Merced, California

FLORIDA

Miami, Florida

On September 18, 1995, a patient presented to the ER of Baptist Hospital in Miami, Florida with abdominal pain. She was found to have a large mass in her lower abdomen as well as an elevated white blood cell count, possibly indicating infection. She was admitted for surgery. Before the surgery took place, the surgeon visited the patient and requested a deposit prior to his performing the procedure. The patient stated she did not have the deposit, so the surgeon gave orders to discharge her. She left without receiving treatment.

As of April 2001, no civil monetary penalty has been imposed in connection with this HCFA confirmed violation.

> Based on review of a patient's clinical record it was determined that the hospital failed to provide further medical examination and treatment as required to stabilize the patient's emergency medical condition. The patient presented to the emergency department on 9/18/95 [letter notifying hospital of violation is dated 2/18/98] at approximately 10:00 P.M. with pain in right lower abdomen.
>
> 1. After the patient received a medical screening examination the gynecologist on-call requested that the patient be admitted for surgery for a large mass (cyst) in lower right quadrant. The patient was admitted to the hospital at 4:15 A.M. on 9/19/95.
> 2. The patient was in acute pain and had a white blood [cell] count of 17000+. [Normal level is less than 10,000] Prior to the surgery the surgeon visited the patient and according to the patient, the surgeon requested a deposit prior to his performing the surgery.

> The patient stated she did not have the deposit and the surgeon gave orders to the nurse to discharge the patient. The patient subsequently left the hospital without stabilization of the patient's emergency medical condition.

Baptist Hospital
Miami, FL

Fort Lauderdale, Florida

A pregnant patient presented to the ER of Broward General Medical Center in Fort Lauderdale, Florida on April 8, 1997. Labor and delivery staff refused to examine her because she was not registered at the hospital. The patient then traveled by private automobile to another hospital where she gave birth 34 minutes after her arrival there.

As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA confirmed violation.

> Based on information submitted as a result of a complaint and review of the medical record at the receiving hospital for patient # 1, it was determined that patient # 1 did not receive a medical screening examination as required by regulation.
> The findings include:
> A delivery note in the medical record for patient #1, showed that the pregnant female patient presented to Broward General Medical Center (BGMC) on April 8, 1997, in labor. The record states that since patient was not "registered" L and D (labor and delivery) refused to examine the patient. The medical record noted that the husband told the personnel at L and D she was going to have the baby if she was having contractions.
> Through information submitted in a complaint against BGMC, it was learned that the patient then arrived by private automobile at another hospital on April 8. 1997, at approximately 3:09 p.m. in active labor with contractions two to three minutes apart, fully dilated and had bulging membranes. She delivered a baby at 3:43 p.m., 34 minutes after arrival. The patient and husband both informed the hospital that they originally went to BGMC to the labor and delivery department and were told they were at the wrong hospital and were directed to another hospital. The patient and husband said the BGMC personnel knew she was having painful contractions and that no examination or screening was offered.

Broward General Medical Center
Ft. Lauderdale, FL

Leesburg, Florida

In Leesburg, Florida, (near Ocala) an ambulance brought a 13-month-old infant to Leesburg Regional Medical Center's ER. The infant was acutely ill with a possible asthma attack and was immediately taken back to the treatment area and placed on oxygen. Before the baby was seen by the physician, staff spoke to the family's HMO. The HMO denied reimbursement for the ER visit. As documented on the medical record the mother was told she must sign that she accepted responsibility for self pay or the baby could not be seen. The mother left with her child, without receiving a screening and without a means of transportation.

As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> A 13 month old child presented to the emergency room via ambulance on 3/12/96 at 8:45 a.m. with a chief complaint of possible asthma. Clinical record documents that patient was diagnosed with a head cold 4 days previously. Per interview with the treatment nurse, the patient was brought straight back to a treatment room and placed on oxygen but before the patient could be screened by the physician, the HMO had been called who denied the patient's ER visit. Per the clinical record, the patient's mother was informed that if she wanted the baby to be seen she must sign responsibility for self pay. Per the clinical record, the mother refused to sign and left with the baby without being screened by the physician and with no means of transportation stating "I'll get a ride to Dr.'s office now." Per interview and facility's written policy, all ambulance arrivals are considered as Category 1 patients and are to have a medical screening completed by the Emergency Department physician.

Leesburg Regional Medical Center
Leesburg, Florida

GEORGIA

Moultrie, Georgia

In Moultrie, Georgia, (near Waycross) a patient arrived at Colquitt Regional Medical Center's ER and received a screening exam. This patient suffered from long term kidney failure. Kidney failure patients receive dialysis treatments several times a

week to remove excess fluid and waste products from the bloodstream. The patient's screening exam demonstrated fluid volume overload and probable heart failure (indications that the patient likely needed a dialysis treatment), EKG abnormalities, poor oxygenation and possible pneumonia. A nephrologist (kidney specialist) contacted by the ER physician refused to admit the patient or give a dialysis treatment until the following day. The patient died at home approximately seven hours after she was discharged from the ER. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> An End Stage Renal Dialysis patient presented to the ED on 2/5/96 at 0450. […] Patient's chief complaint was "chest pain all night." Initial vital signs were BP 128/70, P 103, R 20, and temperature 99.9. Pulse oximetry was 83% and nail beds were cyanotic. ED MD saw patient at 0455. Pain medication was given, chest x-ray, lab work and EKG were ordered. Chest x-ray revealed: "lungs exhibit infiltrate, probably from pulmonary edema, but possibly pneumonia…." EKG showed "atrial fibrillation, new since 1994, incomplete right bundle branch block, possible inferior infarct age undetermined, T-wave abnormality consider lateral ischemia or digitalis effect; abnormal EKG." […] Patient had been sick for four days with nausea and vomiting, intermittent chest pain and shortness of breath. The patient had missed her last dialysis treatment on 2/3/96 because of these symptoms. […] ED physician called the attending nephrologist. Notes regarding this conversation state "nephrologist refuses to give dialysis treatment until tomorrow." "He refused to admit her, instead requested that she show up tomorrow for he next regularly scheduled dialysis treatment." […] The final ED MD assessment was "volume overload and ESRD." The patient was discharged from the ED at 0618. […]Patient died at approximately 1:15 p.m. this same day at home.

Colquitt Regional Medical Center
Moultrie, Georgia

Warner Robbins, Georgia

On February 17, 1997 a patient presented to the ER of Houston Medical Center in Warner Robbins, Georgia (near Macon) complaining of loss of appetite, a swollen and painful stomach, and of vomiting blood. During his stay in the ER, his pulse rate increased to 140 beats per minute (normal range is 60-100 beats per minute). At

discharge, his pulse rate was 133. His blood count revealed a hemoglobin level of 9.1 (normal range is 14-18). An elevated pulse rate combined with a low hemoglobin level may indicate blood loss. Lab results also revealed a low potassium level, 3.2 (normal range is 3.5 – 5.1). The patient was diagnosed with alcoholic liver disease and portal hypertension. He was treated with infusion of an IV solution, given prescriptions and discharged. An ambulance returned him to the same ER approximately five hours later, in full cardiopulmonary arrest. He was pronounced dead six minutes later. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA confirmed violation.

> Patient numbered 20 presented to the emergency room on 2/17/97 at 1049 with complaints of his stomach being swollen, hurting and vomiting blood and not eating for three days. Diagnostic studies were done inclusive of a complete blood count (CBC), Amylase, SMA 20 (biochemical profile), EKG (electrocardiogram), urinalysis, CKMB and Digoxin level. The patient's pulse rate was noted to be 96 [normal range is 60-100] on admission; however, documentation on the nurse's notes indicated that the pulse rate increased to 140 (irregular) and the patient was discharged with a rate of 133. There was no other documentation that the pulse rate was addressed. The patient's potassium level was documented as being 3.2 with the normal being 3.5-5.1. One liter of Lactated Ringers [I.V. solution with electrolytes] was ordered to be given intravenously to the patient. There was no documentation that the symptoms of the stomach being swollen and hurting was addressed. The hemoglobin level of 9.1 (normal, 14-18 g/dl) was not addressed. The patient was discharged with a diagnosis of Alcohol Liver Disease and Portal Hypertension. The patient was given two prescriptions, one was for Aldactone [a diuretic] and the other one was for Cipro [an antibiotic]. Instructions were given to the patient to follow-up with his physician next week. The patient was also instructed to call or return if there were significant changes in his condition. The patient was discharged at 1800. At 2316, the patient presented to the emergency room via Emergency Medical Services in full arrest status. The patient was pronounced dead at 2322.

Houston Medical Center
Warner Robbins, GA

ILLINOIS

Granite City, Illinois

In Granite City, Illinois (southeast of Springfield), a patient arrived at St. Elizabeth Medical Center's ER complaining of illness and seizures. Staff observed insects crawling over his body and hair. Only the patient's pulse and respiratory rates, blood pressure and temperature were taken; no other examination or diagnostic study was performed. The patient had a rapid heart rate of 142 beats per minute (normal adult heart rate ranges from 60 –100 beats per minute). The patient was discharged with prescriptions for anti-seizure medication, anti-anxiety medication and anti-lice shampoo. He was brought back to the ER in cardiopulmonary arrest the following day and died. Autopsy results attributed the death to a severe pneumonia. As April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> Patient presented to the ED [11/14/98] complaining of being sick for five days, with an increase in seizures during the previous week. Documentation evidenced that the patient had hundreds of brown insects over his body and hair. […] Vital signs recorded on admission was [sic] heart rate of 142, temperature of 99.1F, respirations 18 and blood pressure 105/75. The ED physician documented "detailed systemic exam deferred. "The patient was given a prescription for Depakote, Xanax, and Kwell." He was given instructions for the treatment of lice. Documentation failed to evidence that there was [sic] any diagnostic test performed. On the afternoon of 11/15/99 [sic], the patient was brought to the ED by ambulance in cardiac and respiratory arrest. […] The patient was pronounced dead at 1354 hours on 11/15/98. The coroner's autopsy report and death certificate state the immediate cause of death was due to marked pneumonitis with abscess formation and hyaline membrane formation.

St. Elizabeth Medical Center
Granite City, Illinois.

Lake Forest, Illinois

In Lake Forest, Illinois (outside of Chicago), a patient presented to Lake Forest Hospital's ER with shortness of breath and increased confusion. He was transferred to a

Veteran's hospital approximately three and one half hours later. His blood oxygen saturation level about ten minutes prior to transfer was 84% (normal is >95%), indicating poor respiratory status. His transfer certificate lacked documentation regarding his condition at the time of transfer. Within one hour of his arrival at the Veteran's hospital, this patient was "intubated" (had a tube placed into his trachea to allow a ventilator to assume the mechanics of breathing) and admitted to the medical intensive care unit. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA confirmed violation.

> Patient #1, a 49 year old, was transferred from a nursing home by ambulance for evaluation of increased confusion and shortness of breath. The initial triage vital signs at 10:30 a.m. were: blood pressure 91/60, heart rate 118, respirations 26, temperature 99.5 and oxygen saturation of 73%. The physician documented a medical evaluation at 11:00 a.m. Documentation by the physician included that the patient was disoriented, does not answer questions appropriately, pupils equal and reactive to light…lungs with rhonchi. While in the ER, the patient received IV fluids, medication, a breathing treatment, oxygen, blood work, and a chest xray. The patient remained in the ER for approximately 3.5 hours without a further documented medical screening exam/evaluation. The patient's oxygen level was monitored from 10:30 a.m. until 2:51 [sic] p.m. The last oxygen saturation level at 1:51 p.m. was documented as being 84%. At 2:00 p.m. the patient was transferred by ambulance to North Chicago Veteran's Hospital. The transfer form (completed by the nurse and signed by both the nurse and MD) failed to include the patient's condition at time of transfer. The nurse, however, documented on the transfer form "unchanged from admission remains tachypneic [breathing at a rapid rate], still pulls off O2 mask." The medical record from Chicago North Veteran's Hospital [receiving hospital] revealed that the patient arrived to the facility at 2:20 p.m. by ambulance with an IV and oxygen. The patient's condition upon arrival was documented as "acute respiratory distress." Vital signs were BP 100/60, pulse 114, respirations 28, temperature 96.4 and an oxygen saturation level of 94%. The patient was admitted to the medical intensive care unit and intubated approximately one hour after admission.

Lake Forest Hospital
Lake Forest, Illinois

Chicago, Illinois

At approximately 6:20 p.m. on May 16, 1998, friends dragged a fifteen- year-old boy suffering from an abdominal gunshot wound to the alley next to Ravenswood

Hospital in Chicago, Illinois. They left the boy in the alley, next to the wall of the hospital and the ER's driveway, ran into the ER and requested help for him. A police officer on the scene also notified the triage nurse of the situation at approximately the same time. The triage nurse stopped what she was doing, went to report the situation and gather supplies to treat the boy. She was stopped by the nurse in charge and told that the police "knew to call 911/CFD [Chicago Fire Department] and that they [facility staff] were to stay with current patients." The physician on duty was not apprised of the fact that the patient needed care. The triage nurse told another employee to call 911. Other ER staff members were under the impression that a police officer who had gone out to the scene had already called 911. Approximately five minutes later, an employee in the registration area phoned 911 and notified dispatchers (for the first time) of the situation. Documentation reveals that between 6:20 p.m. and 6:35 p.m., police officers came into the ER multiple times requesting that someone come out to the alley to assist. Finally, two police officers entered the ER demanding to see whoever was in charge. They were told to call 911 or bring the child into the ER. At 6:40 p.m., a police officer wheeled the child into the ER in a wheelchair. Despite resuscitation efforts, he died at 7:25 p.m.

This hospital agreed to pay $40,000 to resolve OIG's investigation into this incident.

> An interview with the facility's Chief Operating Officer (COO) on 5-18-98 revealed that his preliminary investigation resulted in the following scenario:
> On 5-16-98, in the alley behind 4546 N. Wolcott, a 15 y/o male (Pt. #1) was playing basketball at approximately 6:00 p.m.
> A confrontation occurred and the patient was shot in the left upper quadrant of the abdomen. Juvenile friends of the patient carried the patient down the alley (approximately ¾ of a city block) and the patient collapsed in the alley adjacent to the emergency room (ER) ramp/driveway. At 6:20 p.m., the friends left the patient in the alley and ran into the ER and requested help of the ER staff for the wounded patient. The clerk and the triage nurse advised the friends that staff could not leave the ER. A Chicago Police Department (CPD)

uniformed officer was on site for non-related police business. The officer equipped with a police radio, exited the ER and called back to the staff an incomplete statement that was understood by staff that the officer had called 911 (Emergency/Police/Fire). ER staff did not assist the victim. At 6:30 p.m. someone (identity unknown) from Ravenswood Hospital called 911. At 6:40 p.m., the victim was brought by wheelchair into the ER by a police officer. Cardio Pulmonary Resuscitation (CPR) and emergency treatment was provided, however the patient expired at 7:25 p.m. (The Emergency [Room] Record reveals that the patient was pronounced dead at 19:33 [7:33 p.m.]. An interview conducted on 5-20-98 with CPD Officer J#1, indicated that the officer was at the scene, next to his partner, who carried the patient to the ER. He stated that the patient was in the alley, next to the wall of the facility, when his partner placed the individual in a wheelchair and took him into the ER.

A review of the incident report written 5-17-98 by the triage nurse working the 3-11 shift on May 16, 1998, showed that the triage nurse documented:
"While checking the vital signs of patient in triage at 18:20, 5/16/98, Chicago Policeman entered E.R. stating that help was needed because a child was "shot in the head" outside in the alleyway. The triage nurse also documented that she stopped triage of her current patient and went to report the situation and obtain help and gather supplies that might be necessary. She (the triage nurse) was told by the charge nurse that the CPD knew to call 911/CFD and that they (facility staff) were to stay with current patients. She also documented that she told a fellow employee to notify CPD to call 911. She was told 5 minutes later by the same employee that CPD knew to call 911, and approximately 10 minutes had passed without an ambulance arriving. The employee in registration phoned 911 and learned that 911 had not been notified of the incident. The interview with the triage nurse, as well as the ER medical director and the ER physician on duty on 5/16/98, revealed that the physician in the ER was not apprised of the incident and/or the fact that the patient was in need of emergency care. The triage nurse further documented in the incident report that 3-5 minutes after 911 was notified by registration, 2 CPD walked into the ER demanding to see who was in charge. The CPD were told again to call 911 or bring the child into the ER. The triage documented in her concluding statement "Child to ER #12 per CPD per WC (wheelchair) @ 18:40 (6:40 p.m.)."

Upon review of the narrative statement in the incident report dated on 5/17/98 by the Charge Nurse of the 3-11 shift on 5/16/98, the Charge Nurse documented "on 5/16/98 at about 18:20 (6:20 pm) she was informed by the triage nurse that a police officer came into the hospital saying a kid was shot in the alley and for the ER to come out to help." The charge nurse further documented that she informed triage nurse "that we don't go outside to treat pts. on the street-that police should call for the CFD."

Additional documentation revealed that between 6:20 p.m. and 6:35 p.m., police officers came into ER multiple times requesting someone to come out to the alley to assist.

By all accounts, the facility ER staff were notified of the patient in the alley at 6:20 p.m. on 5-16-98 however, the patient did not receive

> emergency treatment for approximately 20 minutes when he was brought into the ER.

Ravenswood Medical Center
Chicago, Illinois

INDIANA

Granger, Indiana

In Granger, Indiana (outside of South Bend), a patient arrived at Charter South Bend Behavioral Health System Hospital in Granger, Indiana the day after discharge from the same facility. This patient was experiencing extra-pyramidal symptoms (involuntary bodily movements), side effects of an anti-psychotic medication he was taking. The record contained no evidence that the patient received a screening exam. Instead, documentation revealed that inpatient admission to the hospital was advised. When the patient could not come up with a $2000 down payment, he was instructed to go elsewhere. The hospital agreed to pay $30,000 to resolve OIG's investigation of this incident.

> The 6/6/97 record of the emergency visit of patient #5…indicated that the patient returned the day after discharge with extra-pyramidal symptoms from Haldol [an anti-psychotic medication] he received while an inpatient. On 7/2/97 there was no documentation that a physician examined the patient. [….]
> Documentation on the Comprehensive Assessment Tool regarding the patient's return the day following discharge states: "Inpatient (admission) is advised, but patient (is) self pay and was unable to come up with the $2000 down payment. [….] Instructed to go to ER for Cogentin (possibly), then try XX (another local psychiatric center)."

Charter South Bend Behavioral Health System
Granger, Indiana

KENTUCKY

Princeton, Kentucky

A patient arrived at the ER of Caldwell County Hospital in Princeton, Kentucky suffering from a gunshot wound to the right thigh. This patient's treatment at Caldwell

County Hospital consisted of only an exam and x-rays, despite the availability of services such as lab workup, an on-call general surgeon, and type O negative blood for transfusion. (O negative blood is often transfused into hemorrhaging patients when there is no time to determine their blood type.) A lab technician requested that blood be drawn for testing and the physician refused. The physician documented that at transfer this patient started bleeding and his blood pressure dropped, an indication of rapid, high volume blood loss. The patient's blood pressure drop was treated with rapid infusion of IV fluids and medication. An emergency medical technician assisting in the transfer of this patient stated that the physician told him, "I want him out of here now. Get him on the road." The patient arrived at the ER of another hospital in cardiopulmonary arrest ("with no blood pressure, pulse or respirations"), having suffered a catastrophic blood loss.

This hospital agreed to pay $10,000 to resolve OIG's investigation into this incident.

> Review of the medical record's emergency department record revealed that on January 4, 1997 at 2230 a patient arrived at the emergency department by ambulance with a gunshot wound to the right thigh. The physical findings noted on this record indicated "pulses intact distally at DP/PT (dorsal pedial/posterior tibial) medial entrance wound to thigh. R (not legible) No obvious exit wound." "Upper leg x-ray PA/Lat."
> [….]
> [I]nterviews with the hospital administrator, emergency department director, and the emergency department nurse manager revealed that readily available ancillary services such as lab workup, x-rays, local physician backup, and services of the general surgeon on call were not requested by the attending physician.
> Interview with the on site lab tech revealed that he did inform the attending physician of the availability of O negative blood in the facility. He further stated that he did request that the physician draw blood for any possible blood testing. He stated that the physician replied, "I don't have time. I'm not going to do anything like that."
> An interview on February 3, 1997 with the general surgeon on call on January 4 and 5, 1997 revealed that he was available but had not been called to examine or consult with the emergency room physician concerning the patient with the gunshot wound.

> [….]
> Based on record review, and interviews with emergency room staff, ambulance staff, lab and x-ray personnel, and the attending emergency room physician it was determined that a patient was transferred from the emergency [room] was not in a stable condition.
> A review of the progress note by the attending physician revealed "Upon transfer his BP dropped (as indicated by a downward arrow) to 80-90/40-60. We used rapid infusion of LR [IV fluid] and also initiated Dopamine [medication used to raise blood pressure] to increase (as indicated by an upward arrow) the BP. Started him on 7 mcg/Kg/min. His BP started to stabilize 80-90/50-60. Wa redded [was ordered?] (1) urgent transfer (2) titrate Dopamine for BP 100 systolic (3) Will continue with…plan to get to Trauma Center ASAP.
> Interviews with the EMTs revealed that the patient was bleeding profusely upon transfer to the receiving facility. An EMT stated that he did request the use of MAST trousers [used as a treatment for shock]. He stated that the attending emergency room physician asked why he wanted to use them and he replied to help constrict the leg, as a tourniquet. The physician stated that "if you want to put them on go ahead." The EMT further stated that the physician said "I want him out of here now. Get him on the road."
> During an interview with the attending emergency physician on January 31, 1997 he stated that five to eight minutes before transfer of the patient from the emergency room the patient began bleeding while being transferred to a stretcher. He stated that he did not call the receiving physician, surgeon, or facility regarding a change in the patient's condition. He further stated that he believed the patient's max treatment had been reached and that "we did the best we could."
> On January 30, 1997 interviews with the receiving physician, and the receiving surgeon at the receiving acute care hospital and review of the medical record from that facility revealed that the patient arrived at the emergency room with no blood pressure, pulse, or respirations. The receiving surgeon stated that the patient was hypovolemic and exsanguinated [virtually bloodless].

Caldwell County Hospital
Princeton, Kentucky

LOUISIANA

Shreveport, Louisiana

In Shreveport, Louisiana, Willis Knighton Medical Center refused to accept the transfer of a 17-year-old patient who had attempted suicide. The documented reason for refusal was "non coverage of this facility." As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> In 4 of 19 intake records reviewed, the facility refused acceptance of patients to their behavior unit either because the patients had no insurance or there were no observation beds available.
>
> On 10/4/96 a 17 year old patient who attempted suicide by overdose was denied admission. The patient was medically stabilized at another hospital. This receiving facility was contacted by the referring facility regarding the availability of bed space on their adolescent unit. Review of the intake record revealed the physician "will not accept patient due to non coverage of this facility."

Willis Knighton Medical Center
Shreveport, Louisiana

MARYLAND

Baltimore, Maryland

In Baltimore, Maryland, a hospital security officer requested assistance from Harbor Hospital Center's ER for an individual found lying in the parking lot. The ER refused to provide assistance. After emergency medical technicians manning a nearby private ambulance determined that the individual had no pulse and was not breathing, the security officer made another request for assistance, informing the ER that the individual had no pulse and was not breathing. This request was also refused. An ER physician was brought out to assist by the security officer and the patient was eventually taken to the ER by ambulance. Shortly thereafter he was pronounced dead. This hospital agreed to pay $35,000 to resolve OIG's investigation into the incident.

> The medical record indicates that on the night of 7/27/98 at approximately 7:00 p.m., a 70-year-old man accompanied his daughter to the hospital to bring in a sick child. […] On arrival at the hospital the man indicated to his daughter that he felt ill and that he would sit outside while she took the child into the hospital. During this time, several passersby noticed that something was wrong and called security…the officer arrived on the scene (hospital's south parking lot) at approximately 7:02 p.m. The officer's log indicated that he "went to investigate a male laying in the grass. 911 notified intoxicated male…ER notified <refused>" A private ambulance leaving the hospital was flagged down and the technicians initiated [cardiopulmonary resuscitation] CPR and asked the officer to contact the ED for assistance. The officer's log indicated that he told the ED that the patient was in full [cardiopulmonary] arrest and the ED again refused assistance. […] A security officer went to the ED and "grabbed

> Dr. XX, told him what [he] had and [the doctor] came out with me." In his report, the security officer indicated that the charge nurses in the ED had apparently not told the doctors. The physician returned to the parking lot and assisted with emergency care. At this point an ambulance crew responding to a 911 call arrived. It is not clear who called 911. One report indicates that an ambulance technician gave his cell phone to the security officer and that he called 911. The ambulance transported the man to the ED. Approximately one-half hour after the man was first observed lying in the grass, he was pronounced dead of cardiac arrhythmia.

Harbor Hospital Center
Baltimore, Maryland

MASSACHUSETTS

Worcester, Massachusetts

In Worcester, Massachusetts, St. Vincent Hospital's ER transferred a pregnant woman to another facility despite an unstable fetal heart rate. The fetal heart rate reportedly fluctuated from 80 beats per minute to 170 or more beats per minute at the transferring hospital. (A normal fetal heart rate range is 120 to 160 beats per minute.) The transferring physician was aware of the unstable fetal heart rate, but failed to notify the receiving hospital. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> During the investigation of complaint #97-0242, it was noted in the applicable patient record and during interviews with staff, the physician failed to ensure the fetal heart rate was stable prior to transfer of the patient to another acute care facility on 7/8/96.
> The physician told the surveyors the patient (Mother) was stable at the time of transfer, but the fetal heart rate fluctuated from the low 80's to the high 170's beats per minute at the time of transfer at 10:50 PM on 7/8/96. [….]
> The physician told the surveyors at the time of the complaint investigation that he was aware of the decline in the fetal heart rate after his initial conversation with the physician at the receiving hospital at 10:30 PM, on 7/8/96. The physician stated he saw the monitor and noted the fetal heart rate was seriously unstable. The physician stated to the surveyors that he should have called the receiving hospital back to update the physician on the changes in the fetal heart rate but failed to do so, and instead, transferred the patient to the receiving hospital at 10:50 PM.
> The RN assisting with the transfer stated she was aware of the changes in the fetal heart rate and that the changes were serious. Knowing this,

> the RN failed to bring a doppler with her in the ambulance to monitor the fetal heart rate. Standards of nursing practice recommend an unstable fetal heart rate be monitored every five (5) minutes.

St. Vincent Hospital
Worcester, Massachusetts

Worcester, Massachusetts

An individual experiencing an asthma attack arrived at the ER of the University of Massachusetts Hospital in Worcester, Massachusetts on July 21, 1998. His difficulty in breathing also made it difficult for him to speak. When a clerk asked for his identification, he presented a driver's license and his insurance card. He was told that the hospital did not accept his insurance and that he should call his primary care physician. He left without receiving an exam or treatment and drove to his physician's office.

This hospital agreed to pay $20,000 to resolve OIG's investigation into this incident.

> Review of the ER central log for July 21, 1998 revealed that there was no entry for an individual who stated he arrived at the emergency room on July 21, 1998 at approximately 8:50 AM requesting treatment of his severe asthma attack. The patient told surveyors that due to his difficulty speaking, the clerk asked for his identification. He said when he presented his HMO card (Health Maintenance Organization) insurance card and out-of-state driver's license, he was told the hospital did not accept his insurance and that he should call his primary care physician. The individual said he was so frustrated, and in such physical distress that he left and drove to his primary care physician's office.

University of Massachusetts Hospital
Worcester, Massachusetts

MICHIGAN

Clinton Township, Michigan

In Clinton Township, Michigan (north of Big Rapids) a 64-year-old patient arrived at St. Joseph's Mercy Hospital's ER with shoulder and arm pain on both sides of her body. Her electrocardiogram revealed "ST changes." Such changes often indicate

myocardial infarction or heart attack. Despite these signs, the physician discharged her home. Following a cardiologist's review of the EKG, the patient was called at home and instructed to go immediately to the emergency room for treatment. She was treated for a heart attack at another emergency room. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA confirmed violation.

> On 8/30/96 at approximately 12:45 PM, the patient in question, a 64 year old obese woman presented to the urgent care center with complaints of bilateral shoulder and arm pain, and a burning sensation in the anterior chest and both breast areas as documented in the clinical records by the attending physician. At the time of examination, the patient was noted to deny any history of trauma, paresthesia or tingling of the fingers and did not appear in any distress. However, the patient reported having the aforementioned symptoms for approximately 3 days. [….] The EKG results revealed a normal sinus rhythm with a rate of 79. However, there was some right axis deviation in V1 or V2. Anterolateral ST abnormalities and inferior ST elevations were also present at the time. The EKG was sent out for cardiology review as required. […] The patient was discharged to go home at 2:45 PM. […] At approximately 8:20 PM the attending physician was notified by the clinical director that the cardiology reading revealed an abnormal EKG and that the patient should be advised to go immediately to the emergency room for treatment. […] At 11 PM on 8/30/96, the patient was treated in [another] emergency room for myocardial infarction.

St. Joseph's Mercy Hospital & Health Services
Clinton Township, Michigan

MISSOURI

Kansas City, Missouri

In this case, HCFA found that Trinity Lutheran Hospital, in Kansas City, Missouri violated the Act's reporting requirement. Trinity Lutheran Hospital received a patient transferred from an unidentified hospital directly to its psychiatric "service." The patient arrived verbally unresponsive and lethargic. Before transfer, the patient's blood sugar had been checked five times at the initial hospital, with results ranging from 82 to 417 (normal is 80-120). His last blood sugar level prior to transfer was 300. At Trinity Lutheran Hospital, he required treatment in the intensive care unit for diabetic

ketoacidosis, a life-threatening complication of diabetes. The transfer certificate completed by the initial hospital failed to document his unstable blood sugar levels, any indications for transfer, a risk versus benefit evaluation or that a report on his condition was called to Trinity Lutheran Hospital. At this time, OIG cannot impose civil monetary penalties in connection with reporting violations.

> 50-year-old diabetic male was brought by ambulance to this facility from another acute care hospital…at 1:51 p.m. on 4/12/98 for direct admission to psychiatric services. Upon arrival [to psychiatric services unit], nurses' notes state the patient "is not verbally responsive, is disoriented, confused, sedated and lethargic." […] At 3:30 p.m. a blood sugar done by accu-check shows a level of 485 (normal 80-120)…. At 4:45 p.m. his blood sugar is again checked by accu-check and found to be "over 500 because it does not register on the accu-check machine." His vital signs at this time were blood pressure 150/70, pulse 120, and respirations 60 [normal adult respiratory rate is 15 to 20 breaths per minute]. The patient was then transferred…to the emergency room of the facility…. Following treatment in the emergency room, he was admitted to the intensive care unit with a diagnosis of diabetic ketoacidosis. […] The transfer form did not contain any documentation of the unstable nature of the patient's blood sugars,… indications for transfer, statement of risks and benefits, signed request or refusal for transfer by patient's wife nor any documentation of report including his emergency medical condition being called to the accepting facility.
>
> Review of the medical record from the first hospital from which the patient was transferred, reveals the patient presented to the emergency room at that facility on 04/10/98 at 4:15 PM…. Blood sugar in the emergency room at 4:30 PM was 240. {…} the patient was admitted to 23 hour observation care which was later extended to 48 hours. […]Following admission, at 9:30 his blood sugar was 417. 25 units of insulin was administered. The record of blood sugars showed they were checked four times 04/11/98 ranging from 343 to 252 to 82 to 209. On 04/12/98 the record showed the blood sugar was checked by accu-check at 7 AM and was 300. The patient received 12 units of regular insulin at that time. His accu-check was not done again and so his blood sugar was not monitored again prior to his being transferred at 1 PM that day. […] During his stay, a psychiatric consult was ordered and completed. The recommendation for it was that the patient be transferred to the psychiatric unit at Trinity Lutheran after he is "medically stable."

Trinity Lutheran Hospital
Kansas City, Missouri

Kansas City, Missouri

On December 22, 1997, staff at an unnamed hospital contacted HCFA's Regional Office for Region 7 requesting help in averting a possible EMTALA violation. A nurse manager at this hospital had been attempting to transfer a suicidal patient from their ER to Truman Medical Center–East, a facility with specialized psychiatric capabilities unavailable at the first hospital. Records revealed that the Unit Coordinator at Truman Medical Center twice stated to the nurse manager that the patient did not have insurance and would not be accepted.

After staff contacted HCFA, a Regional Office (RO) consultant spoke to the Unit Coordinator at Truman Medical Center. The Unit Coordinator verified non-acceptance of the patient. The RO consultant explained that the patient was suicidal, currently in danger, experiencing an emergency medical condition and needed immediate transfer to a locked psychiatric unit unavailable at the transferring hospital. The Unit Coordinator told the RO consultant that the patient would not be accepted due to insurance purposes.

As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA confirmed violation.

> Based on interview, record review, and Peer Review Organization (PRO) review, it was determined that Truman Medical Center East (TMC-E) refused to accept, from a referring hospital, the appropriate transfer of an individual who required the specialized psychiatric capabilities the hospital had available.
>
> This is evidenced by the following:
>
> On 12/22/97, The Health Care Financing Administration (HCFA) Regional Office (RO) received a call regarding the attempted transfer of a suicidal patient. In the spirit of partnership, a request was made of the RO to assist in helping avert a probable EMTALA violation.
>
> At approximately 4:15 p.m. on 12/22/97, the RO consultant contacted the transferring hospital and spoke with the nurse manager who had been attempting to transfer a suicidal patient since 11:45 a.m.

The patient had been admitted to the transferring hospital the day before with seizure like activity, diagnosed as Pseudo Seizures and Asthmatic Bronchitis. At 11:00 a.m. on 12/22/97, this 32 year old patient was admitted to the ED post seizure-like activity […] on the hospital sidewalk. In the ED the patient became belligerent and began talking of ending her life.

At 4:30 p.m. on 12/22/97, after contacting the transferring hospital for information, the RO consultant placed a call to the administrator at TMC-E. The administrator was unavailable and the call was transferred to the unit coordinator (UC) of the psychiatric unit. The UC was aware of the situation, verified non-acceptance of the patient, and said that she had talked with the transferring hospital and encouraged then to call the insurance company. It was explained by the RO that the patient was suicidal, currently in danger, was experiencing an emergency medical condition (EMC), and needed immediate transfer to a psychiatric unit; such as hers, which was locked. The UC was emphatic that she was aware of the patient's condition, that the transferring hospital did not have a psychiatric unit, and was familiar with EMTALA guidelines. The UC told the RO consultant that the patient would not be accepted due to insurance purposes.

The UC said that the insurance needed to be checked to see if her insurance would be covered at TMC-E. She stated, "it would need to go though an insurance company, see where insurance is paid for." "She is probably locked into a certain hospital, locked into her psych benefits."

[…]

Interview with the ED physician and record review reveals that the patient was a danger to herself and in need of in-patient psychiatric care. The nurse manager of Critical Care Services at the transferring hospital, contacted the facility determined most suited for this patient's care, TMC-E. The intake nurse and the nurse supervisor of the unit inquired about the insurance the patient [sic] prior to gathering other information. […]
Upon further questioning regarding the intake of patients, the referral form was discussed. The form is used by the intake nurse on the unit to gather information about the patient. It was acknowledged by both the staff intake nurse and the nurse supervisor on interview, that the information on insurance is gathered prior to other information on the patient, such as diagnosis, presenting conditions, considered dangerous to self / others, and medical problems requiring treatment.

Interview with the nurse manager at the transferring hospital on 1/22/97, and record review reveals that TMC-E refused to accept the patient due to insurance purposes and medical stability. Record review reveals that the UC of TMC-E stated twice to the nurse manager of the transferring hospital that the patient did not have insurance and would not be accepted.

Sedalia, Missouri

On February 8, 1999, an ambulance brought a 35-year-old woman from a correctional facility to the ER of Bothwell Regional Health Center in Sedalia, Missouri (near Jefferson City). The patient suffered from alcohol intoxication (on arrival she was unresponsive to painful stimuli or fumes from an ammonia capsule) and had tried to choke herself with panty hose. During her evaluation at Bothwell Regional Medical Center, an x-ray technician reported that she tried again to "choke herself by wrapping IV tubing around her neck and pulling it tight." Two hours after her arrival, the patient was transferred back to the custody of the police with orders to "taper alcohol consumption and see her physician in two days."

As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA confirmed violation.

> A 35 year-old female was admitted on 2/8/99 at 5:57 AM by ambulance on backboard with C-collar, unresponsive to pain stimuli or Ammonia capsule. Her diagnosis was alcohol intoxication. The patient was in jail, and attempted to choke herself with panty hose. C spine, chest xray, urinalysis, Electrocardiogram, Lab work were negative. The drug screen resulted in alcohol level of 295, acetaminophen less than 1. It was documented in the record at 7:18 PM when the patient from x-ray [sic], the x-ray technician reported the patient tried to choke herself by wrapping IV tubing around her neck and pulling it tight. At 7:50 PM the patient was discharged back to the custody of the police. Instructions were to taper alcohol consumption, and see her physician in two days.
>
> Review of the hospital physician's admission policy regarding incarcerated patients indicates the patient needing psychiatric in-patient care, who is incarcerated and needs law enforcement personnel with him/her, will be admitted to a lock-up or private room on the medical service of the hospital.
>
> By not providing further evaluation and treatment or implementing the facility policies, these patients are discharged to seek treatment in another facility or the county jail, placing patients at a high risk for negative outcomes.

Bothwell Regional Health Center
Sedalia, Missouri

Columbia, Missouri

On April 13, 1999, a 54-year-old male admitted to Charter Behavioral Health System in Columbia, Missouri for treatment of alcoholism was found to have a life-threateningly low blood potassium level of 2.2 MM/L (normal is 3.5 – 5.1 MM/L). In addition, he was found to have an abnormal electrocardiogram reading. A physician at Charter Behavioral Health System ordered the patient transferred to another hospital's intensive care unit for treatment. The patient was transported to Columbia Regional Hospital in a van accompanied by a "Mental Health Worker." The Mental Health Worker stated that he had a Cardio-Pulmonary Resuscitation certification, but no other training. He also reported that the van is not equipped with medical equipment. The patient's record contained no summary of risks versus benefits. The Director of the ER at Columbia Regional, the receiving hospital, reported that the patient arrived at the admission/registration area (as opposed to the ER) for admission to their intensive care unit. Staff at Columbia Regional had received no paper work or calls from Charter concerning the transfer of this patient.

As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> In-patient record number 17732 was a 54 year old male admitted to Charter Hospital on April 12, 1999 at 7 p.m. for treatment of alcoholism and withdrawal. On the second day of hospitalization, the patient was found to have a life threatening low potassium level of 2.2 MM/L (Normal potassium level 3.5-5.1 MM/L) and an abnormal EKG (Electrocardiogram). As per interview with nurse caring for patient, she was directed by the medical physician to send patient to Columbia Regional Hospital Intensive Care Unit for treatment. She additionally reported the medical physician would make the arrangements for the patient's transfer to Columbia Regional Hospital, therefore she did not notify staff at Columbia Regional Hospital. In interview with the medical physician who cared for the patient [at Columbia Regional Hospital], he reported he found the patient to be seriously ill and had a life threatening condition. He further indicated the patient should have been transported by ambulance. Patient was sent to Columbia Regional

> via Charter Hospital Van accompanied by a Mental Health Worker. Interview with the mental health worker reported he has a Cardio-Pulmonary Resuscitation Certification but no other training. He reported the Van is not equipped with medical equipment. The memorandum of transfer indicated only the results of the EKG were forwarded to Columbia Regional, not the life threatening potassium level results. There was no summary of risks and benefits documented.
>
> Interview with the Director of the Emergency Department at Columbia Regional Hospital it was reported that the patient arrived at the admission/registration area for admission to the Intensive Care Unit. Staff reported that they concluded patient had blood work drawn due to a bandage observed on his arm. They received no paper work or any calls from Charter concerning the transfer of this patient.
>
> By not conducting appropriate transfers, the facility placed the patients at a higher risk for negative outcomes, placed the receiving facility in a compromised situation, prevented adequate protection of patient rights, prevented adequate communication with the patient/family and the receiving hospital, and placed the continuity of patient care at risk.

Charter Behavioral Health System
Columbia, Missouri

NEBRASKA

St. Paul, Nebraska

On May 9, 1997, a 26-year-old patient was admitted to the ER of Howard County Community Hospital in St. Paul, Nebraska (west of Lincoln) with a "severe laceration to [the left] forearm…." The record further stated that the laceration was 4.5 centimeters in length, "gaping open [with] definite bleeding from artery." Less than two hours after this patient's arrival at the ER, the hospital sent the patient by private automobile to another hospital approximately 60 miles away for further treatment. The record did not include information to indicate that Howard County Community Hospital had obtained the agreement of the receiving hospital to accept the transfer. There was also no indication that Howard County Community Hospital sent the receiving hospital all medical records related to the patient's condition.

The physician PRO reviewer stated: “An arterial bleed had been identified. Continuous IV fluids would have been appropriate – the bleeding should have been monitored. The [patient’s] life could have been in jeopardy if bleeding started again.” The reviewer went on to say “continuous I.V. (intravenous) & ambulance transport would have been more appropriate.”

As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> At 12:25 p.m. on 5/9/97, 26 year old, patient #19 was admitted to the ED with “severe laceration to [left] forearm [with] utility knife.” Assessment revealed laceration to be 4.5 c.m. in length “gaping open [with] definite bleeding from artery.” The record indicated that there was “a large arterial bleed that was clamped very briefly and found to have involvement of the flexor tendons and muscles underneath and it also looked like the bone was involved of the ulna [forearm bone].”
>
> At 2:00 p.m. the hospital sent the patient by private automobile to another hospital approximately 60 miles away for further treatment.
>
> The physician PRO reviewer stated: “An arterial bleed had been identified. Continuous IV fluids would have been appropriate – the bleeding should have been monitored. The pts (patient’s) life could have been in jeopardy if bleeding started again.” The reviewer went on to say that “continuous I.V. (intravenous) & ambulance transport would have been more appropriate.”
>
> The PRO reviewer indicated that at the time of transfer, the patient’s emergency medical condition had not been stabilized and that deterioration of the condition was likely to occur during the transfer.
>
> The record did not include information to indicate that the hospital had obtained the agreement of the receiving hospital to accept the transfer and to provide appropriate medical treatment.
>
> There was no indication that the hospital sent to the receiving facility all medical records related to the medical condition.
>
> The physician PRO reviewer indicated that the transportation, equipment and personnel provided was not appropriate to the transferred individual’s needs. The reviewer stated: “No transfer via ambulance with fluid resuscitation.”

Howard County Community Hospital
St. Paul, Nebraska

NEW HAMPSHIRE

Hampstead, New Hampshire

On March 28, 1998, a patient who appeared anxious and had obviously been crying presented to the ER of Hampstead Hospital in Hampstead, New Hampshire (near Concord), requesting admission. This patient had contemplated suicide and experienced auditory hallucinations in the past. A shift supervisor stated, "I didn't have time to see her as I was interviewing another patient." The patient was told to go (by herself) to the ER of another hospital.

As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA confirmed violation.

> Patient #25 presented to the hospital on 3/28/98 requesting admission. Based on record review and interview with nursing and administrative staff
> 1. The patient appeared "anxious and had obviously been crying", she had been "contemplating suicide in the past and had been hearing voices in the past" but was not "thinking about suicide or hearing voices at the present".
> 2. The shift supervisor was seeing another patient when patient #25 walked into the hospital lobby by herself, and the supervisor stated, "I didn't have time to see her as I was interviewing another patient"
> 3. The patient was told to go to the ER of the nearby Hale, Exeter, or Parkland Hospitals, and left on her own.
>
> [….]
> The facility failed to provide documented evidence for Patient #25 that an appropriate medical screening was done.

Hampstead Hospital
Hampstead, NH

NEW JERSEY

Lakewood, New Jersey

In Lakewood, New Jersey (near Trenton) a patient presented to Kimball Medical Center's ER complaining of abdominal pain for two weeks. The physician ordered x-rays, noting on the order that an aortic aneurysm was suspected. (An aneurysm is an

abnormal dilatation of an artery, which carries a risk of rupture. The rupture of an aneurysm results in internal hemorrhage, often fatal.) X-rays revealed a probable aneurysm of the aorta. Surprisingly, the patient was diagnosed with a urinary tract infection and discharged home in "improved condition." The patient returned to the ER at her physician's advice the next day. A sonogram and CT scan performed after her return confirmed the presence of an aortic aneurysm and also indicated that the aneurysm was leaking. The patient was transferred directly to the operating room to repair the aneurysm. Her recovery was lengthy and complicated. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA confirmed violation.

> Patient #5 presented to triage area on 9/27/97 at 5:50 pm with complaints of abdominal pain off and on for two weeks. The nursing assessment was not completed. The past medical history was significant for hypertension and Hodgkins disease. Results of the abdominal x-rays ordered by the physician revealed " large curvelinear calcification seen along the left side of the abdomen and probably represents a large abdominal aortic aneurysm." The physician did not document the results, however, his history and physical stated "all remaining labs, EKG, x-ray results recorded on the ED chart." Those results were not found in the ED record when reviewed. Copies of the results were obtained at a later time. Documentation by the physician stating "suspected AAA" [abdominal aortic aneurysm] was found on the x-ray order sheet. The patient was discharged to home in improved condition with a diagnosis of UTI (urinary tract infection).
>
> The patient returned to the ED on 9/28/97 at the request of her primary physician for a sonogram. The primary physician's history and physical indicated a palpable aortic abdominal pulse. Results of the sonogram revealed a "large abdominal aortic aneurysm measuring 5.9 cm in maximum diameter below the renal arteries."
> A CT scan of the abdomen revealed a "large aortic aneurysm measuring approximately 6.2 x 5.6 cm originating below the level of the renal arteries." "A large hematoma in the left psoas muscle region with some fluid in this vicinity is also seen indicating the aneurysm is leaking."
>
> The patient was transferred directly to the operating room for an abdominal aneurosectomy with tube graft. The patient's hospital course prior to the discharge was lengthy with multiple medical complications.

Kimball Medical Center
Lakewood, New Jersey

NEW YORK

Brooklyn, New York

In the following example, Kings County Hospital's ER in Brooklyn, New York posted signs stating that the hospital required pre-authorization or a referral from a patient's Medicaid plan before treatment, adding that these patients must contact their provider or plan before seeking treatment at the ER. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> In the Adult ED Registration and Triage Area, signs indicated that Medicaid recipients cannot be treated without proper referral form or authorization number and that recipients must contact their provider or health plan before seeking care at this facility. The presence of these signs was brought to the attention of the hospital staff [by the SA investigators]. The hospital staff immediately removed the above mentioned signs.

Kings County Hospital
Brooklyn, New York

New York City, New York

Investigators discovered that prior to the survey date (1/29/99) staff at St. Luke's-Roosevelt Hospital's ER in New York City informed uninsured patients seeking treatment that they would be responsible for a fee. Many uninsured patients left without receiving an exam. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> Uninsured patients after being informed by ED registration clerks that they would be responsible for payment of a fee in excess of $400 left the ED without having had a medical screening examination.

St. Luke's-Roosevelt Hospital
New York City, New York

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NORTH CAROLINA

Supply, North Carolina

In Supply, North Carolina (south of Wilmington) a patient arrived at Brunswick Community Hospital's ER after suffering a series of life-threatening irregular heart rate patterns and with a history of heart failure, high blood pressure and diabetes. In the ER the patient underwent diagnostic studies and received medications to support heart function and blood pressure. The patient was transferred to another hospital in an unstable condition. As the reason for transfer, the physician certified that "[f]urther treatment is beyond the scope of this facility." A transfer for this reason can be an appropriate transfer under the Act. In this case, however, documentation indicated that the transfer was effected through unqualified personnel and without necessary equipment, such as a ventilator and a "doppler" amplifier (used to detect otherwise inaudible pulse and blood pressure sounds). The patient arrived at the second hospital with a barely detectable blood pressure and without spontaneous breathing. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> Patient #3404 presented to the ED via ambulance on 4/23/97 at 23:40 with documented complaint of shortness of breath, positive chest pressure and was diaphoretic. Patient had a past medical history of congestive heart failure, diabetes and hypertension. According to the ambulance call report (ACR), upon arrival to the ED, patient had "gone through a series of cardiac drugs following asystole, 3rd degree heart block, ventricular fibrillation, ventricular tachycardia and shocked a total of six times. Patient was intubated and on a respirator at 12 breaths per minute." ED care included numerous cardiac and blood pressure sustaining medications, cardiac monitoring, labs and x-rays. At 00:55 ED physician progress note indicated that patient went into a "Wenkebach and dropped pressure and heart rate." ED physician documented a diagnosis of pulmonary edema, cardiogenic shock and 3rd degree heart block. Patient was transferred by ambulance to another hospital in unstable condition at 02:32, unresponsive, with a blood pressure 52/31 (monitored by a doppler) and a pulse of 52. ACR indicated that EMS (emergency medical services) notified hospital that a Doppler was not available for use during transport to monitor patient.

> EMS interviews verified the patient was receiving Dopamine, a medication the paramedics were not experienced in administering. Receiving hospital communications and EMS interviews revealed that Dopamine was infusing on a pump that paramedics were not knowledgeable of operating. According to the receiving hospital's RN, "patient presented being bagged on 100% oxygen. One rescue member stated last blood pressure was 80/palpable, which was done at transferring hospital and none was done in route secondary to need of Doppler. Upon transfer to bed, patient was found to have no pulse, face blue and the medication was not infusing." The nurse indicated the paramedics could not work the pump on which the Dopamine was infusing and were not aware the patient had no pulse.
> […]
> The reason for transfer documented on the physician's transfer certification form was, "The patient's condition had not stabilized. Further treatment is beyond the scope of this facility." The certification was signed by family member indicating risks and benefits of transfer were discussed; however, there were no risks documented on the the [sic] certification

Brunswick Community Hospital
Supply, North Carolina

OKLAHOMA

Eufaula, Oklahoma

A fifteen-month-old infant presented to the ER of Community Hospital Lakeview in Eufaula, Oklahoma (south of Tulsa) on February 27, 1999. Staff did not provide a medical screening exam. Instead, family members were told that the hospital "did not take medical cards" and that unless they paid before the patient was seen, they would have to take the patient to her private physician or to another facility. Family members took the baby to another facility 36 miles away. She arrived with a temperature of 105.3 degrees.

As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> Patient # 1, a 15-month old, presented to the ER on 2/27/99 (no time is given). The record contained only demographic and insurance information and a notation that read: "decided to go to (city's name) to clinic." The record did not contain the nature of the patient's complaint or evidence that a medical screening examination was performed. Interviews with hospital staff and family members indicated the patient

> was told the hospital "did not take medical cards" and they (the family) would have to take the patient to her regular doctor or to another facility. Also "in order for them (the hospital) to take care of them (the patient and mother), she (the mother) would have to pay before being seen." Family members stated the patient was taken to another facility 36 miles away. The medical record from the other facility recorded the patient's arrival at 1445 with a temperature of 105.3 degrees.

Community Hospital Lakeview
Eufaula, Oklahoma

Stillwell, Oklahoma

On August 30, 1996, a patient with a history of diabetes and heart disease presented to the ER of Memorial Hospital in Stillwell, Oklahoma (near Tulsa) in an unresponsive state. The patient's blood sugar was 43 (normal range is 80 to 115) and his respirations were irregular. The patient was assessed by a nurse, but never seen by a physician. He received treatments ordered over the telephone by a physician. He was discharged home approximately four hours after he arrived without ever being seen by a physician. He died the following day.

As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> Patient #1 presented to the ED on 08/30/96 at 1345 unresponsive. The patient's FSBS (finger stick blood sugar) was 43; his respirations were irregular; and he had a history of diabetes and heart disease with 3 prior heart attacks. The patient was assessed on site by the RN (registered nurse). The physician was called at 1415, but did not come to the ED to examine the patient. All treatments received were by way of verbal orders from the physician. The patient was discharged home at 1740 without being seen by the physician. The patient expired 08/31/96.

Memorial Hospital
Stillwell, Oklahoma

PENNSYLVANIA

Bristol, Pennsylvania

In Bristol, Pennsylvania (near Philadelphia), a mother brought a two-week-old infant recently discharged from Temple Lower Bucks Hospital's neonatal ICU back to

the same ICU. The infant had developed signs of opiate withdrawal (the mother had used methadone during her pregnancy) which had apparently worsened. The baby was crying inconsolably, refusing to eat and suffering from diarrhea. A physician and nurse "looked" at the child and recommended that the mother take the child to an ER in a hospital with a pediatric department. The baby was not provided with a screening exam or treatment nor was the family assisted in obtaining an appropriate transfer to another facility. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> On September 4, 1998 at approximately 9:00 A.M. a 2 week old infant was brought to Temple Lower Bucks hospital. This child was recently discharged from the NICU where he was hospitalized for 5 or 6 days post delivery from a mother who had used methadone her entire pregnancy. Following discharge, he developed signs and symptoms suggestive of opiate withdrawal, including, shakiness, diaphoresis, diarrhea, inconsolability, irritability and weight loss. The mother stated that she had been in contact with the child's pediatrician, and he did not want to see the infant. On the morning of 9/4/98, the mother felt that his symptoms had deteriorated (inconsoled crying, diarrhea, and he refused to eat.) She reported that she was "very scared and did not want to waste any time." She obtained transportation from a friend and took him to the NICU where he was a recent patient. A neonatologist "briefly" looked at the child. Upon interview, the physician stated that the child appeared "shaky and warm." Both the NICU nurse and the neonatologist recommended that the child be seen at an emergency department. She was told that since Temple Lower Bucks Hospital did not have an adequate pediatric department, she should take him elsewhere, such as Temple University Children's Medical Center. She was not given an opportunity to [sic] or escorted to the Temple Lower Bucks Hospital Emergency Department to obtain an appropriate medical screening, stabilizing treatment or a transfer to another facility that would be able to treat the infant.

Temple Lower Bucks Hospital
Bristol, Pennsylvania

TENNESSEE

Manchester, Tennessee

In Manchester, Tennessee (southeast of Nashville), an unidentified "visitor" to Coffee Medical Center's ER advised a woman experiencing intense labor contractions

that the hospital did not "deliver babies." An admitting clerk overheard the conversation, but did not inform the patient that she nevertheless had a right to be screened and treated. The clerk also failed to advise ER staff of the incident or of the patient's arrival. The woman left the ER and gave birth in the parking lot. This hospital agreed to pay $20,000 to resolve OIG's investigation into this incident.

> On the night of May 19th, 1997 a woman of Mexican descent and who did not speak English was brought into the emergency room by an English speaking woman who was acting as an interpreter. On interview with the interpreter she stated that this woman was having intense labor contractions and upon entering this ER was told by an unidentified visitor that this hospital did not deliver babies and they immediately left the ER. This statement was overheard by the admitting clerk on duty that night. On interview with this clerk, she verified hearing this statement and admitted to "pausing to consider whether she should go get these people." By not alerting the ER nurse to the situation or pursuing the people who had left, the woman subsequently gave birth to her baby on the ground in the parking lot.

Coffee Medical Center
Manchester, Tennessee

TEXAS

Houston, Texas

The next patient presented to Doctor's Hospital's ER in Houston, Texas with symptoms of acute appendicitis, a medical emergency. On discharge her diagnosis was "possible acute appendicitis." Because she had no insurance, she was discharged and instructed to travel by car to another hospital where she underwent surgery. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> Patient presented to the ED on 8/10/96 at 2200. Patient was assessed by an emergency medical technician who recorded vital signs of temperature 98.7, pulse 92, respirations 18, and blood pressure 133/55. Physical exam by ED physician revealed abdominal pain and positive rebound tenderness. Diagnosis was possible acute appendicitis. […] Patient was advised to go to [another hospital] for further evaluation [tonight]…. [T] he patient was discharged accompanied by a female companion and her spouse and left via car. Per interview, personnel

> confirmed that physician instructed the patient that as she had no insurance and no money, she should go to [other hospital] right away. […] Per review of patient's clinical record from [other hospital], it was noted that she… was taken to surgery at 0530.

Doctor's Hospital
Houston, Texas

Lufkin, Texas

An unconscious motor vehicle accident victim was brought to an unidentified hospital's ER. A CT scan revealed multiple facial fractures and brain injury. Because this hospital lacked the capacity to treat neurological patients, the ER physician sought to transfer the patient to a facility where he could receive such specialized care. A neurologist at Memorial Medical Center in Lufkin, Texas agreed to examine the patient. Transfer arrangements were initiated but apparently curtailed when a hospital administrator at Memorial Medical Center refused to accept him. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> A twenty-eight year old male involved in a motor vehicle accident was found unconscious on the scene by the ambulance crew and transported to the emergency room of a local hospital. The patient slowly regained consciousness but continued to slip in and out of consciousness. A computerized tomographic scan of the head showed that he had fractures involving the left superior orbit, the anterior sphenoid bone, the lateral orbital wall, and the lateral wall of the maxillary sinus. There was a small subdural collection seen posteriorly to this along the left frontal lobe with a 2 centimeter area of contusion in the left frontal lobe. He had a small hematoma lateral to the left lobe without any obvious retrobulbar hematoma. The local hospital did not have neurological capabilities. The emergency room physician discussed the patient's condition with a neurologist at [Memorial Medical Center]. The neurologist informed the emergency room physician to transfer the patient…and he would examine and evaluate the neurological status of the patient…. Transfer arrangements were initiated. However, the administrator on-call of this facility refused to accept the patient.

Memorial Medical Center of East Texas
Lufkin, Texas

VIRGINIA

Richmond, Virginia

In Richmond, Virginia a patient presented to Capitol Medical Center's ED at 4:30 am complaining of psychotic symptoms, "hearing voices." The patient was refused a screening exam or any treatment until the day admissions clerk came in and proof of insurance could be validated. This patient left, called 911, was brought back to the ER and again told to wait in the waiting area. The patient walked out and the same ambulance then transported the patient to another ER. A risk manager at the second hospital filed a complaint against Capitol Medical Center. This hospital agreed to pay $43,000 to resolve OIG's investigation into the incident.

> Emergency room RN…stated that the patient came to the ER at approximately 0430 complaining of hearing voices. The patient requested direct admission to the psychiatric unit of the hospital. The ER nurse asked for proof of insurance…. The nurse stated that the patient did not have his Medicaid card with him and the nurse could not validate proof of insurance by computer. The nurse asked the patient to wait in the waiting room until 0630 when the day shift admissions representative could access the computer to validate the patient's insurance and he could be a direct admit. […] According to the ER nurse, the patient was not evaluated by the ER physician, was not treated, and walked out of the ER a few minutes later and went to a pay phone and called 911 to pick him up. According to the nurse, EMTs picked the patient up and took him back to the ER. The same nurse saw the patient immediately and asked him to please have a seat in the waiting room again and wait until 0630…to be a direct admit to the psychiatric unit. Within minutes, the patient…walked out again before the ambulance pulled away. According to EMT documentation, the ambulance picked up the patient at 0603 and took the patient to [another hospital's] ER, arriving at 0638.

Capitol Medical Center
Richmond, Virginia

WASHINGTON

Spokane, Washington

A patient arrived at an unidentified ER having fallen out of a moving car the previous day. He was diagnosed with a skull fracture and brain injury. Neurosurgical

treatment was not available at the first hospital. Staff attempted to transfer the patient to Deaconess Medical Center in Spokane, Washington where he could receive these specialized services. Deaconess Medical Center refused to accept the transfer of this patient, despite having the capacity to care for patients with neurological injury. As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> Medical record documentation revealed that P1 had fallen out of a moving car the day before his ED visit at LCH (first hospital). He had awakened the morning after the accident and noticed blood coming out of his ear. P1, accompanied by a friend, arrived at LCH's ED on 4/19/98 at 11:00 A.M. The medical screening examination documented P1's vital signs as blood pressure 140/80, pulse 80, respirations 16, temperature 97.8 and a Gloscow [sic] coma score of 15. Dried blood was observed in P1's right ear. A CT scan was ordered and showed a basiliar [sic] skull fracture and a frontal lobe bleed. The LCH's plan was to stabilize and transfer P1 for neurosurgery intervention not available at LCH. […]
> LCH then contacted Deaconess Medical Center (DMC) asking MD to accept the transfer of P1 for neurosurgery intervention. MD4 who was on call and acting on behalf of DMC, declined to accept the patient in transfer. (The patient was eventually transferred to HVMCH5 a level 1 trauma center…) for further neurosurgery intervention.

Deaconess Medical Center
Spokane, Washington

Brewster, Washington

On July 28, 1999, a patient presented to the ER of Okanogan Douglas County Hospital in Brewster, Washington (north central Washington) following an archery accident. The physician's assistant who performed a medical screening exam documented that a splintered section of arrow shaft protruded from the patient's hand. An x-ray revealed "possible joint capsule involvement." The physician's assistant contacted an on call orthopedic surgeon who offered a telephone consultation only. Physicians at a nearby hospital agreed to accept the patient, but were involved in emergency surgery and unable to see the patient for some time. The patient chose to go

home and return to the ER the next morning for definitive treatment. Before he or she left, the physician assistant cut off the protruding section of the arrow shaft, applied a dressing and administered pain medication.

The patient returned to the ER at Okanogan Douglas early the next morning with severe pain. Staff tried several times to contact the same orthopedic surgeon and received no response. An ER nurse stated that s/he paged the physician every five minutes, called his/her cell phone numerous times, and left messages on his/her home answering machine over a period of at least 40 minutes. The nurse stated that the physician never responded to these attempts to contact him/her. The patient left the ER and sought treatment at another hospital where he or she received surgical intervention as well as intravenous antibiotics and pain medication.

As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> Patient # 1, received a medical screening examination in the Emergency Department on July 28, 1999 at 2000 hours following an archery accident. The physician's assistant (PA) performed the medical screening examination and described the injury on the outpatient/ER medical record in the following manner: "multifragment-splinter at exit of thenar web with multiple exit ports. Multiple extra fragments of carbon fiber into second phalanges at multiple angles. Xray = bones appear stable but possible joint capsule involvement."
>
> The PA documented contact with the on-call orthopedic surgeon [D-1] who offered telephone consultation only. The orthopedic surgeon failed to meet the on-call obligations to respond within 30 minutes for requested assistance to stabilize the orthopedic emergency condition. […]
> Failing to get the on-call orthopedic physician to respond, a request was made to another nearby hospital to accept transfer for Patient #1. The trauma surgeons at the receiving facility agreed to accept the patient, but were involved in emergency surgery and were unable to see and treat Patient #1 until 0100. Given the risks and benefits, Patient #1 elected to return to the ER the next morning for definitive orthopedic care. The medical record documented that prior to discharge from the ER, the PA cut off the 8-10 inch section of arrow shaft that was protruding from the patient's hand, applied a Xeroform dressing, and administer [sic] pain medications.

> Patient #1 returned to the ED on July 29, 1999, seeking medical treatment for the injury and severe pain at 0600 hours. The ED tried several times to contact D-1 [orthopedic surgeon mentioned above], who was the on-call physician and received no response. Through interview, an ER nurse stated and documented in a signed statement, that s/he paged D-1, the on-call physician, every 5 minutes, called his/her cell phone numerous times, and left messages on his/her home answering machine over a period of at least 40 minutes. The nurse stated that D-1 never responded to these attempts to contact him/her.
>
> Patient #1 left the hospital in the company of his spouse, and sought orthopedic care and treatment at another hospital. Review of the medical record from the receiving hospital revealed Patient #1 was admitted July 29, 1999 at 0815 hours and was treated with intravenous Penicillin G, Ancef, Gentamycin (antibiotics), and intravenous Morphine Sulfate (a narcotic analgesic). Patent #1 received surgical intervention for an "arrow shaft {that} had entered from the top of the first web-space and exited on the bottom of the first web-space and then shattered into approximately 200 fragments, which then went into the area of the base of the index finger and the palm of the hand."

Okanogan Douglas County Hospital
Brewster, Washington

WISCONSIN

River Falls, Wisconsin

In River Falls, Wisconsin (central western Wisconsin), River Falls Hospital's ER failed to arrange for an appropriate transfer, allowing a patient with a diagnosed brain tumor and recent seizures to travel by private car to another facility. Individuals transporting the patient were instructed by a physician that "if she had another seizure, they will stop and call for help." As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> Based on a review of facility records and interview with staff, the facility failed to comply with all the EMTALA requirements for transfer effected through qualified personnel and transportation equipment to another medical provider for further medical treatment. Findings include:
> R1 – a 27 y/o ["year old"] patient with onset of generalized seizures. Head CT in ER revealed a large right frontal mass with edema. R1 was given Decadron PO to decrease edema. R1 was sent to the Mayo clinic in a private car. Individuals transporting R1 were instructed by an MD "if she had another seizure, they will stop and call for help."

River Falls Hospital
River Falls, Wisconsin

Janesville, Wisconsin

On September 27, 1999 a patient arrived at Mercy Health System in Janesville, Wisconsin (near Madison) requesting a medical screening exam. Staff refused to provide an exam because the patient was not covered by health insurance accepted by the hospital. When the patient offered to pay for services privately, he or she was again refused. The patient went to the ER of another hospital where he or she was found to have an elevated temperature, heart and respiratory rates and diagnosed with "fever of possible viral etiology." Mercy Health System had been certified as a Medicare provider just over two months prior to this incident. After certification, reception staff were not instructed that they could no longer turn away patients based on insurance coverage or ability to pay.

This hospital agreed to pay $17,500 to resolve OIG's investigation into this incident.

> An interview with staff "1" on 9/27/99 revealed "B" brought patient "A" to the UCC requesting medical screening on 8/17/99. Patient "A" was not covered by health insurance accepted at the UCC, and "B" was told by the receptionist to take the patient to another hospital ER. "B" offered to pay for services privately, but was still refused a medical screening by the receptionist. Patient "A" did not receive an appropriate medical screening examination. This was verified by the internal investigation conducted by staff 1 and 2. The patient went to another area hospital ER where she did receive medical screening and treatment. Patient "A's" vitals upon admission to the other area hospital was [sic] Temperature 102.4F, Pulse 120, and respirations 44 [normal adult rate is 16-20]. Patient "A" was diagnosed with fever with possible viral etiology. This was verified on 9/27/99 via record review at the receiving hospital.
> According to staff 1 and 2, before Medicare certification was extended to the UCC, patients were not seen if they presented with insurance not accepted at the UCC. After Medicare certification was extended to the UCC effective 7/1/99, receptionist staff were not instructed they can no longer turn anyone away based on insurance coverage or ability to pay. The facility failed to provide patient "A" with a medical screening.

Mercy Health System
Janesville, Wisconsin

Waupaca, Wisconsin

A pregnant patient arrived at Riverside Medical Center in Waupaca, Wisconsin (near Green Bay) experiencing labor contractions. Her water had broken at home and she had noted brown amniotic fluid, a possible sign of fetal distress. Because of this and the severity of her contractions, she chose to come to Riverside Medical Center, a closer facility than the hospital at which she had planned to give birth. Staff discharged the patient, advising her to proceed to the hospital at which she had planned to give birth. The patient and spouse argued with a staff member for one half hour, insisting that they be allowed to stay at Riverside Medical Center. A staff member stated, "If you want me to, I would call an ambulance for you." The patient traveled by private automobile to another hospital 29 miles away. The patient's records do not contain a transfer certificate or any physician documentation that the benefits of the transfer outweighed the risks to the mother and fetus. Medical treatment to minimize the risks of transfer was not provided. Permission to transfer this patient was not obtained from the receiving facility. (The receiving facility was not contacted until after the patient was en route.) No medical records were sent to the receiving facility until the receiving facility requested them. The transfer was not effected through qualified personnel and equipment.

As of April 2001, no civil monetary penalty had been imposed in connection with this HCFA-confirmed violation.

> Patient B did not receive an appropriate medical screening examination, based on the following data:
>
> The hospital did not render care similar to that provided to any patient under similar circumstances.
> […]
> Interview with patient B revealed that her membranes ruptured at home and she noted the color of the fluid to be a "brown puddle on the floor." She immediately left her residence with her spouse and they both

decided that the onset of her membranes rupturing and the severity of her contractions were signs that she was in labor. These symptoms were so severe that they chose the nearest medical facility for care, choosing not to take the time to call their own physician and hospital. She also stated that during the 10 minute drive to RMC her fluid loss thoroughly soaked a maxipad and also her underpants. Staff D made note on the ER record that fluid was clear to brown; however, no Nitrazine test was done.
[…] Based on review of documentation on the ER record of Patient B, and interviews with staff D and with Patient B, the nurse's vaginal examination of patient B took place prior to the physician's examination, and it is not clear that the nurse received an order from the physician to proceed with the vaginal examination. […]
The medical screening examination performed resulted in discharging of Patient B; the physician's advice was to proceed on to the physician and hospital which she had originally chosen for the birth of her child. There is a verbal order for discharge on the ER record (now signed). Patient B was driven by her husband in his truck to Hospital E, a distance of twenty-nine miles on a two lane road in truck. Her labor pains were so intense that she lay down in the truck on her side.
1)[...]Physician did not document that the medical benefits of the transfer did not outweigh the risks to the mother and unborn child. Per medical record review, no transfer documents exists [sic]. Per interview with BB, staff D, in attempting to persuade the family to leave and go to Steven's Point for the delivery, said "I'm the only guy here and I'm working the ER and I have another baby (to deliver)." Staff D also spoke of not having the prenatal records available. BB told staff D that they had a copy of the prenatal records in their truck outside in the parking lot. Staff D appeared to disregard this information and continued coaxing them to leave, saying "Oh you have plenty of time." Patient B stated both she and her spouse were adamant about staying at RMC to deliver – they did not want to leave RMC. Was told by staff D that in order to deliver at RMC staff F would have to be called by patient B. "You can call staff F at home if you want to". Couple argued with staff D for one half hour and decided to leave. Patient B's spouse talked to staff D out of the observation room in the hallway within earshot of B – spouse made one last protest about B having to leave. Staff D asked "If you want me to, I would call an ambulance for you.' Spouse replied "I'm not a doctor. I'm depending on you for that. You're telling me we've got all night (before the baby comes) and now you're asking me about an ambulance." (No ambulance was called). No discharge time is documented. Approximately left 2240 (10:40 PM).

Couple did complain to RMC and were told by staff G 'The hospital is not responsible for the doctors'.

Based on interview, medical record review, and policy and procedure review:
The four requirements of an appropriate transfer were not met e.g.

a) medical treatment to minimize the risks of transfer was not provided,
b) the receiving facility was contacted after the patient was en route – transferring hospital did not obtain permission from the receiving hospital to transfer the patient. Per written statement by staff H at facility E, a phone call at 2305 on 2/19/98 from staff C at

RMC was received relaying information about patient B. Phone call was made by RMC staff after patient B left RMC.

c) No medical records were sent at the time of transfer. Facility E requested the medical records and same were faxed at 4:23 PM on 2/20/98.

d) The transfer was not effected through qualified personnel and transportation equipment. Patient B was driven to Facility E by her spouse in his truck over 29 miles of a two lane road.

Riverside Medical Center
Waupaca, Wisconsin

APPENDIX 2

Table 4

Violating Hospitals Not Fined By OIG

(Violations Confirmed by HCFA Before 01/01/99, With No Civil Monetary Penalty Imposed As Of April 9, 2001)

STATE	HOSPITAL NAME	CITY	VIOLATION	CONFIRMED DATE	STATUS
Alabama	Bullock County Hospital*	Union Spring	TX, TR	07/21/97	P
Alaska	Columbia Alaska Regional Hospital	Anchorage	CL, PP	03/20/97	P
	Fairbanks Hospital*	Fairbanks	SC, TR	02/05/97	N
	Ketchikan General Hospital*	Ketchikan	SC, TR	12/02/96	N
	Providence Alaska Medical Center	Anchorage	OC	10/02/97	N
	Valdez Community Hospital	Valdez	SC, TR	11/14/96	N
	Valley Hospital	Palmer	PP	01/07/97	N
Arkansas	Stone County Medical Center*	Mountain View	SC, CL	07/14/97	P
California	Anaheim Memorial Hospital*	Anaheim	SC, TR, SP, CL, PP	01/30/98	N
	Coast Plaza Doctor's Hospital*	Norwalk	SC, CL, PP	05/19/97	P
	Coastal Community Hospital*	Santa Ana	SC, DT, TR, CL, PP	01/22/98	P

Provision(s) Violated:

SC Screening
TX Treatment
DT Delay in treatment to inquire about insurance status
TR Transfer
ND Non-discrimination (specialized facility must accept transfer)
OC On call list
RP Reporting
CL Failure to maintain central log
SP Sign Posting
MR Failure to keep medical record for five years
PP Failure to have policies and procedures in place to ensure compliance

***** Indicates hospital violated screening and/or treatment and/or transfer provisions.

Date Violation Confirmed:
Indicates the date upon which the HCFA RO confirmed the violation.

For-Profit/Not-For-Profit Hospitals:
P For-Profit **N** Not-For-Profit **U** Profit Status Unknown

R Listed with violation in prior report

Sources:
HCFA Log of Section 1867 Cases, Fiscal Years 1996, 1997, 1998, 1999
HCFA Forms 2567 from HCFA's Regional Offices
Settlement Agreements, Office of the Inspector General, U.S. Department of Health and Human Services
American Hospital Association, *The AHA Guide to the Health Care Field* (2000/01)

STATE	HOSPITAL NAME	CITY	VIOLATION	CONFIRMED DATE	STATUS
	Columbia Good Samaritan Hospital*	San Jose	SC, TX, CL, PP	02/17/98	P
	Columbia San Jose Medical Center*	San Jose	SC, TX, CL, PP	10/15/97	P
	Community and Mission Hospital* **R**	Huntington Park	SC, DT, OC, PP	10/14/97	P
	Encino-Tarzana Regional Medical Center	Encino	OC	05/28/98	P
	Fresno Community Hospital* **R**	Fresno	TX, TR, PP	08/28/97	P
	Fresno Community Hospital*	Fresno	TR, OC, PP	10/07/98	P
	Inland Valley Regional Medical Center*	Wildomar	SC	12/30/97	P
	Irvine Medical Center*	Irvine	SC, TR, PP	01/22/98	P
	Kaiser Foundation Hospital-Walnut Creek*	Walnut Creek	SC, TX, TR, PP	08/27/97	N
	Kaiser Hospital Riverside*	Riverside	SC, CL, PP	08/15/97	N
	Loma Linda University Medical Center*	Loma Linda	SC, TX, TR, PP	04/23/98	N
	Los Banos Memorial Community Hospital* **R**	Los Banos	SC, TX, CL, MR, PP	04/23/98	U
	Mad River Community Hospital*	Arcata	SC, TX, TR, SP, CL,	09/15/98	P
	Pacifica Hospital*	Huntington Beach	SC, TX, CL, PP	04/09/98	U
	Presbyterian Intercommunity Hospital* **R**	Whittier	SC, TX, PP	01/27/97	N
	Redlands Community Hospital*	Redlands	TR, PP	04/28/97	N
	Scripps Memorial Hospital* **R**	Encinitas	TR, SP, PP	08/28/97	N
	Sequoia Hospital	Redwood City	SP	03/24/97	N
	Sierra Kings Hospital	Reedley	SP, CL	02/28/97	N

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STATE	HOSPITAL NAME	CITY	VIOLATION	CONFIRMED DATE	STATUS
	Sierra View District Hospital*	Porterville	TR, OC, PP	07/15/98	N
	St. Agnes Medical Center*	Fresno	TR, CL, PP	04/06/98	N
	St. Agnes Medical Center*	Fresno	TX, TR, PP	01/07/98	N
	St. Mary's Medical Center*	Long Beach	SC, TR, PP	11/23/98	N
	Thompson Memorial* **R**	Burbank	SC, PP	03/21/97	U
	U.S. Family Medical Care Center*	Montclair	SC, PP	01/07/98	U
	University Medical Center*	Fresno	DT, TR, CL, PP	10/07/98	P
	University of California Medical Center*	San Francisco	SC, TX, SP, PP	04/03/97	N
	USCD Medical Center	San Diego	ND	01/08/97	N
	Watsonville Community Hospital*	Watsonville	SC, CL, PP	11/17/98	P
	West Side District Hospital*	Taft	SC, TX, TR	01/08/97	N
	Whittier Hospital Medical Center* **R**	Whittier	SC, TR, PP	02/02/98	P
Colorado	Centura St. Thomas More Hospital*	Cannon City	SC, TX	11/06/97	N
	Denver Health Medical Center	Denver	SP	10/10/96	N
	Denver Health Medical Center*	Denver	SC, TX	04/07/97	N
	Memorial Hospital of Colorado Springs*	Colorado Springs	SC, TX	11/06/97	N
	University of Colorado Hospital* **R**	Denver	SC	09/17/98	N
Connecticut	Bridgeport Hospital*	Bridgeport	SC	05/16/97	N
	Day Kimball Hospital*	Putnam	TR	10/20/98	N
	St. Vincent's Medical Center*	Bridgeport	TR	12/16/97	N
	Waterbury Hospital*	Waterbury	TR, CL	03/16/98	N

Provision(s) Violated:

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TX Treatment
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American Hospital Association, *The AHA Guide to the Health Care Field* (2000/01)

STATE	HOSPITAL NAME	CITY	VIOLATION	CONFIRMED DATE	STATUS
District of Columbia	Washington Hospital Center*	Washington	DT, TX, TR	07/21/97	N
Florida	Baptist Hospital* **R**	Miami	SC, TX	02/18/98	N
	Broward General Medical Center*	Fort Lauderdale	SC	12/03/98	N
	Citrus Memorial Hospital*	Iverness	SC, DT	02/26/97	N
	Columbia Aventura Hospital	Aventura	CL, SP	06/19/97	P
	Columbia Gulf Coast Medical Center*	Panama City	TX	11/10/97	P
	Columbia Lake City Medical Center*	Lake City	TR	02/13/97	P
	Columbia NW Medical Center	Margate	CL	05/22/97	U
	CPC Fort Lauderdale Hospital*	Fort Lauderdale	SC, TR	03/18/97	P
	Doctor's Memorial Hospital*	Perry	TX	05/09/97	N
	Edward White Hospital*	St. Petersburg	TX	02/11/97	P
	Florida Hospital Waterman*	Eustis	SC	07/02/97	N
	Heart of Florida Hospital*	Haines City	SC	04/17/97	P
	Highlands Regional Medical Center	Sebring	SP	01/31/97	P
	Hollywood Medical Center*	Hollywood	TR	06/25/97	P
	Leesburg Regional Medical Center, Inc.*	Leesburg	SC	04/23/97	N
	Memorial Hospital of Tampa* **R**	Tampa	TR	01/07/98	P
	Memorial Hospital West Volusia*	De Land	SC	02/24/97	N
	Memorial Regional Medical Center	Hollywood	CL	11/16/97	N
	Monroe Regional Medical Center* **R**	Ocala	SC, TX	11/05/97	N
	St. Joseph's Hospital*	Tampa	TR	07/29/97	N
	Westchester General Hospital*	Miami	SC	01/02/97	P
Georgia	Habersham County Medical Center*	Demorest	TX	07/14/97	N

Provision(s) Violated:

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ND Non-discrimination (specialized facility must accept transfer)

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CL Failure to maintain central log

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STATE	HOSPITAL NAME	CITY	VIOLATION	CONFIRMED DATE	STATUS
	Newnan Hospital*	Newnan	SC	06/24/97	N
	Peach County Hospital*	Fort Valley	SC	03/20/97	N
	Satilla Park Hospital*	Waycross	SC	01/05/98	N
	Wills Memorial Hospital*	Washington	SC, TX, TR, OC	02/26/97	N
Idaho	Twin Falls Clinic and Hospital*	Twin Falls	SC, DT, TR, SP	08/06/98	P
Illinois	Forest Hospital*	Des Plaines	SC, PP	04/27/98	U
	Lake Forest Hospital*	Lake Forest	SC, TX, TR, SP	04/14/98	N
	Marion Memorial Hospital*	Marion	SC, TR, CL, SP	08/13/98	P
	Mercy Center Health Care Service*	Aurora	SC, CL	04/21/97	N
	Mercy Hospital and Medical Center*	Chicago	SC, CL	08/29/97	N
	Our Lady of the Resurrection Medical Center* **R**	Chicago	SC, SP	10/22/98	N
	Provident Hospital of Cook County*	Chicago	SC, DT, TR, CL, PP	07/02/98	N
	Provident Hospital of Cook County*	Chicago	SC, DT	01/29/97	N
	Silver Cross Hospital	Joliet	CL, PP	01/16/98	N
	South Shore Hospital* **R**	Chicago	SC, TX	01/26/98	N
	University Hospital of Chicago*	Chicago	SC, SP	08/25/97	N
	University of Illinois Medical Center*	Chicago	SC, DT	12/11/97	N
Indiana	St. John's Health System*	Anderson	SC, DT, CL	09/17/98	N

Provision(s) Violated:

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STATE	HOSPITAL NAME	CITY	VIOLATION	CONFIRMED DATE	STATUS
	St. Vincent Mercy Hospital*	Elwood	SC, CL	09/17/98	N
Iowa	Allen Memorial Hospital	Waterloo	OC	05/08/98	N
	Clarinda Regional Medical Center*	Clarinda	SC	11/25/97	N
	Green County Hospital*	Jefferson	SC, TR	03/04/98	N
	Manning General Hospital*	Manning	SC	10/01/98	N
Kansas	C. F. Menninger Memorial Hospital	Topeka	ND	7/21/98	N
	Edwards County Hospital*	Kinsley	TX, TR	10/29/96	N
	Hutchinson Hospital*	Hutchinson	TR	03/17/98	N
	Mercy of Manhattan*	Manhattan	SC, TR	10/15/98	N
	Norton County Hospital*	Norton	SC	02/12/97	N
	Olathe Medical Center*	Olathe	SC, TX, TR	08/05/97	N
	Republic County Hospital*	Belleville	SC, TX, TR	03/10/98	N
	Shawnee Mission Medical Center*	Shawnee	SC	12/22/97	N
	Stormont-Vail Hospital*	Topeka	SC, TX, TR	02/26/97	N
Kentucky	Columbia Pinelake Medical Center*	Mayfield	SC	04/28/97	U
	Williamson Appalachian Regional Hospital **R**	South Williamson	SP	05/20/98	N
Louisiana	Columbia Lakeview Regional Medical Center	Covington	ND	08/20/98	P
	Lane Memorial	Zachary	ND	01/10/97	N
	Willis Knighton Medical Center **R**	Shreveport	ND	03/28/97	N
Maine	Penobscot Bay Hospital*	Rockport	TX, TR	08/14/98	N
	Penobscot Bay Hospital*	Rockport	SC,TR	05/26/98	N

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Maryland	Physician's Memorial Hospital*	La Plata	SC, DT, SP	04/22/97	N
Massachusetts	Cambridge Hospital*	Cambridge	SC	12/03/98	N
	Haverhill (Hale) Municipal Hospital*	Haverhill	SC, DT	12/24/97	N
	Milton Memorial Hospital*	Milton	SC, TR, SP	10/08/98	N
	St. Vincent Hospital*	Worchester	TR	06/23/97	P
Michigan	St. Joseph's Mercy Hospital*	Clinton Township	TX, ND	11/18/97	N
Minnesota	Buffalo Hospital*	Buffalo	TR, OC, CL, SP, PP	03/11/98	N
	Fairview University Medical Center*	Minneapolis	SC, ND	06/11/97	N
	Methodist Hospital*	Minneapolis	TX, TR, SP	01/27/97	N
	North Memorial Medical Center*	Robbinsdale	SC, TX, DT, TR, ND	10/27/97	N
	Weiner Memorial Medical Center*	Marshall	TR	12/17/97	N
Mississippi	Rush Foundation Hospital*	Meridian	SC	10/07/97	N
MIssouri	Barnes-Jewish Hospital* **R**	St. Louis	SC, TX, TR, CL, SP, PP	11/02/98	N
	Bates County Memorial Hospital*	Butler	SC, TX, TR, PP	09/23/98	N
	Capital Region Medical Center*	Jefferson City	SC, TR, OC, PP	06/17/98	N

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	Cedar County Memorial* **R**	El Dorado Springs	SC, TX, TR	11/12/98	N
	Children's Mercy Hospital	Kansas City	ND, PP	08/31/98	N
	Christian Hospital NE*	St. Louis	SC	10/16/97	U
	Christian Hospital NW*	Florissant	SC	10/16/97	N
	Ellett Memorial Hospital*	Appleton City	TR, PP	06/05/98	N
	Heartland Behavioral Health Services*	Nevada	SC, CL, SP, MR, PP	09/23/98	P
	Jefferson Memorial Hospital*	Crystal City	SC, TX, TR, PP	08/24/98	N
	Lee's Summit Hospital*	Lee's Summit	TX, TR	04/04/97	N
	Lincoln County Memorial Hospital*	Troy	SC, DT, MR, PP	06/03/98	N
	Lincoln County Memorial Hospital*	Troy	SC, TX, TR	08/19/98	N
	Metropolitan St. Louis Psychiatric Center*	St. Louis	SC, SP, PP	10/06/98	N
	Nevada Regional Medical Center*	Nevada	TR, PP	07/30/98	N
	Northeast Regional Medical Center*	Kirksville	TX, TR	01/17/97	P
	Research Medical Center*	Kansas City	TX, TR, CL, PP	07/31/98	N
	St. Anthony's Medical*	St. Louis	TR	08/05/97	N
	St. Francis Hospital*	Maryville	SC, TX, OC, TR	09/11/97	N
	St. John's Mercy Hospital*	Washington	SC, DT, TR	08/26/97	N
	St. John's Regional Medical Center	Springfield	ND, PP	11/12/98	N
	St. Louis University Hospital*	St. Louis	SC, TR	12/17/97	U
	St. Luke's Northland Hospital*	Kansas City	SC, TR	12/01/97	N
	St. Mary's Health Center*	Jefferson City	SC, TX, TR, PP	10/22/98	N
	Trinity Lutheran Hospital*	Kansas City	TR, RP, CL	09/30/98	N

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	Truman Medical Center East*	Kansas City	SC, DT, TR, ND, CL, SP, PP	03/19/98	N
	Truman Medical Center West*	Kansas City	TR, ND, PP	11/12/98	N
	Twin Rivers Regional Medical Center* **R**	Kennett	TX, TR, PP	10/07/98	P
	Two Rivers Psychiatric Hospital*	Kansas City	SC, TX, TR, CL, SP, PP	10/02/98	P
	University of Missouri Hospital and Clinic*	Columbia	TX, TR, CL, SP, PP	11/02/98	N
	Washington County Memorial Hospital*	Potosi	TX, TR, PP	09/21/98	N
	Western Missouri Mental Health Center*	Kansas City	DT, TX, TR PP	07/28/98	N
Montana	Missouri River Medical Center-MAF* **R**	Fort Benton	TX, TR	11/19/97	N
	St. Joseph's Hospital*	Polson	SC, TX	08/03/98	N
Nebraska	Alegent Health-Midlands Community Hospital*	Papillion	SC, TR, PP	10/06/98	N
	Children's Hospital*	Omaha	SC, TR, PP	09/21/98	N
	Douglas County Hospital*	Omaha	SC, TR, OC, SP, PP	08/27/98	N
	Fremont Area Medical Center*	Fremont	SC, TX, TR, PP	06/09/98	N
	Howard County Community*	St. Paul	SC, TR, PP	01/20/98	N
	Jefferson Community Hospital*	Fairbury	SC, TR, OC, PP	07/31/97	N
	Kearney County Health Services*	Minden	SC, TX, TR, PP	04/14/98	N
	Memorial Health Center*	Sidney	SC, TR, PP	07/14/97	N

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	Nebraska Methodist Hospital*	Omaha	SC, PP	09/02/98	N
	Niobrara Valley Hospital Corporation*	Lynch	SC, TX, TR, PP	11/16/98	N
	Oakland Memorial Hospital*	Oakland	SC, TX, TR, PP	09/25/98	N
	Rock County Hospital*	Bassett	SC, TX, PP	09/29/98	N
	St. Elizabeth Community Health Center*	Lincoln	SC, TX, PP	04/30/98	N
	St. Francis Medical Center*	Grand Island	SC, TR, PP	08/25/97	N
	St. Joseph Hospital*	Omaha	SC, TR, SP, PP	07/01/98	P
	St. Mary's Hospital*	Nebraska City	SC, TX, TR, CL, PP	10/29/98	N
	Thayer County Memorial Hospital*	Hebron	SC	10/10/97	N
	University of Nebraska Medical Center*	Omaha	SC, DT, TR, PP	11/18/97	U
Nevada	Lake Mead Medical Center*	N. Las Vegas	SC, DT, CL, SP, PP	08/25/97	P
New Hampshire	Hampstead Hospital*	Hampstead	TR	06/08/98	P
	Valley Regional Hospital*	Claremont	SC, TX, TR	01/15/98	N
New Jersey	Jersey Shore Medical Center*	Neptune	SC, PP	11/16/97	U
	Kimball Medical Center*	Lakewood	SC, TX, SP, PP	11/16/98	N
	South Amboy Memorial*	South Amboy	SC, TX, OC, SP, PP	11/23/98	U

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New York	Faxton Hospital*	Utica	SC, SP	01/16/98	N
	Mary McClellan Hospital*	Cambridge	TR	09/18/97	N
	St. Elizabeth's Medical Center*	Utica	SC, OC	03/10/98	N
North Carolina	Halifax Regional Medical Center	Roanoke Rapids	SP	10/21/98	N
	The McDowell Hospital*	Marion	TR	11/24/98	N
	Wake Med-Western Wake Medical Center*	Cary	SC, TR	08/31/98	N
Ohio	Madison County Hospital*	London	TR	11/23/98	N
	Mercy Medical Center of Springfield*	Springfield	SC, TX, TR, CL, MR	02/27/98	N
	Meridia Euclid Hospital*	Meridia	TX	03/10/98	U
Oklahoma	Columbia Tulsa Regional Medical Center* **R**	Tulsa	SC, DT, CL, SP	07/09/98	N
	Stillwater Medical Center* **R**	Stillwater	TX, OC	03/28/97	N
Oregon	Central Oregon District Hospital*	Redmond	SC	07/17/97	N
	Curry General Hospital*	Gold Beach	TR, CL	08/25/98	N
	Kaiser Sunnyside Medical Center*	Clackamas	SC, TR, SP	12/03/98	N
	Legacy Mt. Hood Medical Center*	Gresham	SC, TR	05/06/97	N
	Pacific Communities Hospital	Newport	DT	06/30/98	N
	Providence Hospital*	Milwaukie	TX, TR	06/30/98	N
	Providence Medford Medical Center*	Medford	SC, TR, CL	11/09/98	N
	Providence Newberg Hospital*	Newberg	SC, TR	08/28/98	N

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	Providence Portland Medical Center*	Portland	SC, TR, CL, SP	05/01/97	N
	Providence Portland Medical Center*	Portland	TR	08/05/98	N
	Sacred Heart Medical Center*	Eugene	SC, CL, PP	11/04/97	N
	Southern Coos General Hospital*	Bandon	SC	01/14/97	N
	Tuality Community Hospital*	Hillsboro	SC, TR, CL	08/26/98	N
Pennsylvania	Temple Lower Bucks Hospital*	Bristol	SC, TR	12/21/98	N
Puerto Rico	Humacao Area Hospital Dr. Victor Rincon-Nunez Hosp.*	Humacao	SC, TR, CL, PP	12/17/98	N
Rhode Island	Roger Williams Hospital*	Providence	TR	05/16/97	N
South Carolina	Columbia Providence Hospital*	Columbia	TR, CL, SP	11/03/98	P
	Roper Hospital	Charleston	SP	08/04/98	N
	St. Francis Hospital	Greenville	SP	07/24/97	N
South Dakota	Lookout Memorial Hospital*	Spearfish	SC	03/14/97	N
	Mid-Dakota Hospital*	Chamberlain	SC, TR	08/12/98	N
	St. Michael's Hospital*	Tyndall	SC	05/12/98	N
Tennessee	Columbia STMC-Emerald Hodgson*	Winchester	SC, OC	02/13/97	P
Texas	All Saints Health System	Fort Worth	ND	01/13/98	N
	BrazoSport Memorial Hospital*	Lake Jackson	DT, TX, TR, OC	03/06/98	N
	Colorado-Fayette Medical Center*	Weimer	SC, TX, TR,	01/13/98	N

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			MR		
	Columbia Ft. Bend* **R**	Missouri City	SC	2/10/97	N
	Columbia Longview Regional Medical Center*	Longview	SC, CL	03/14/97	P
	Doctor's	Corpus Christi	DT	01/10/97	U
	Doctor's Hospital (formerly Yale Clinic and Hosp.)*	Houston	SC, TX, TR, SP, MR	02/11/98	U
	Good Shepard Medical Center*	Longview	SC, CL	11/26/97	N
	Medical Center of Mesquite*	Mesquite	TR	03/18/97	P
	Memorial Hospital of Center*	Center	SC, TX, TR, CL	01/13/98	P
	Memorial Hospital-Memorial City* **R**	Houston	SC	03/14/97	N
	Memorial Medical Center of East Texas	Lufkin	ND	01/13/98	N
	Sisters of Charity-Jasper Memorial Hospital* **R**	Jasper	SC, CL	08/20/97	N
	Spohn Hospital*	Corpus Christi	DT, TX, MR	02/11/98	N
	Spohn Memorial Hospital*	Corpus Christi	SC, TX, TR	02/11/98	N
Utah	American Fork Hospital*	American Fork	SC, TR	07/20/97	N
	Milford Valley Memorial Hospital*	Milford	TX, TR, SP, CL	10/06/98	N
	Wasatch County Hospital*	Heber City	SC, TX, TR, ND, PP	04/07/98	N
Vermont	Fletcher Allen Hospital*	Burlington	SC	04/23/97	N
Washington	Providence St. Peter Hospital	Olympia	DT	03/18/97	N
	Pullman Memorial Hospital*	Pullman	SC, CL	07/10/97	N
	St. Joseph Hospital	Bellingham	SP	03/17/97	N

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West Virginia	Braxton County Memorial*	Gassaway	SC, TX, TR, PP	02/13/97	N
	Grant Memorial Hospital	Petersburg	CL, PP	06/18/98	N
	Herbert J. Thomas Memorial Hospital*	South Charleston	SC, DT, CL	08/28/97	N
	Monongalia General Hospital*	Morgantown	TR, PP	07/01/98	N
	Plateau Medical Center	Oak Hill	OC	10/26/98	N
Wisconsin	Baldwin Area Hospital*	Baldwin	TX, TR, CL, SP, PP	12/03/98	N
	Milwaukee County Mental Health Complex*	Wauwatosa	SC, TR	07/22/98	U
	Riverside Medical Center*	Waupaca	SC, TX, TR, SP, PP	06/30/98	N
	Theda Clark Medical Center*	Neenah	SP	11/13/98	N
	West Allis Memorial Hospital*	West Allis	SC, TX,	11/13/98	N

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FOOTNOTES

[1] STATISTICAL ABSTRACT OF THE UNITED STATES 2000, TABLE 194 (2000) (this number excludes long term general and special hospitals and tuberculosis hospitals).
[2.] Section 1867 of the Social Security Act, 42 U.S.C. ' 1395dd (1986). Additional requirements are included in section 1866 of the Social Security Act, 42 U.S.C. " 1395 cc (a)(1)(l) and (N) and ' 1395cc(b). The Act was originally called the "Emergency Medical Treatment and Active Labor Act." A 1989 amendment eliminated references within the statute to the term "active labor," substituting "labor."
[3.] Roberts v. Galen of Virginia, Inc., 111 F.3d 405, 409 (6th Cir. 1997).
[4.] McCaig, LF., VITAL AND HEALTH STATISTICS 2000; 313: 1-24, NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY: 1998 EMERGENCY DEPARTMENT SUMMARY.
[5.] *Id*.
[6.] Most recently Dame, L., Wolfe, S. M., *Hospital Violations of the Emergency Medical Treatment and Active Labor Act: A Detailed Look at Patient Dumping*, Public Citizen's Health Research Group, December 1997.
[7.] On June 14, 2001, the Secretary of HHS changed the name of the Health Care Financing Administration to the Centers for Medicare and Medicaid Services, abbreviated "CMS." Due to the public's familiarity with the name "Health Care Financing Administration" or HCFA, we refer to the agency as "HCFA" in this report.
[8.] *E.g.*, Hickman v. Taylor, 329 U.S. 495, 508-510, 91 L. Ed. 451, 460-461 (1947).
[9.] HCFA, STATE OPERATIONS MANUAL, " 3012-3413 (2000).
[10.] *Id*.
[11.] 42 C.F.R. 489.24 (g) (2000).
[12.] *See* 42 C.F.R 1003.102 (2000) (negligent violation of the Act by a participating hospital or physician is the basis for imposition of a civil monetary penalty).
[13.] *See* 42 C.F.R. 1003.100(b)(vi) (2000) (permitting OIG to impose civil monetary penalties only for violations of section 1867 or 42 C.F.R. 498.24).
[14.] 42 C.F.R. ' 489.24(a) (2000).
[15.] Baber v. Hospital Corp. of America, 977 F.2d 872, 879 n. 7 (4th Cir. 1992); Eberhardt v. City of Los Angeles, 62 F. 3d 1253, 1258 (9th Cir. 1995); *but see* Repp v. Anadarko Municipal Hosp., 43 F. 3d 519, 522 n. 10 (10th Cir. 1994) (asserting that courts should inquire as to whether a hospital adhered to its own procedures, not whether these were adequate).
[16.] Correa v. Hospital San Francisco, 69 F.3d 1184, 1192-93 (1st Cir. 1995).
[17.] 42 C.F.R. ' 489.24(a) (2000).
[18.] *Cf*. Repp v. Anadarko Municipal Hospital, 43 F.3d 519 (10th Cir. 1994) (asserting that the proper inquiry is whether the hospital adhered to its own standard procedures); *but see* Anadumaka v. Edgewater Operating Co., 823 F. Supp. 507 (N.D. Ill. 1993) (finding that a triage exam satisfied the Act's screening requirement).
[19.] 42 C.F.R. ' 489.24(b) (2000).
[20.] 42 C.F.R. ' 489.24(b) (2000)
[21.] 42 C.F.R ' 489.24 (c) ii (3) (2000).
[22.] 42 C.F.R. ' 489.24 (d) (ii) (A) (2000).
[23.] 42 C.F.R ' 489.20 (m) (2000).
[24.] 42 C.F.R. ' 489.24 (e) (2000).
[25.] 42 C.F.R 489.20(r)(2) (2000) (effective Sept. 1995).
[26.] 42 C.F.R. 489.20(r)(3) (2000) (effective Sept. 1995).
[27.] 42 C.F.R. 489.20(r)(1) (2000) (effective July 1994).
[28.] 42 C.F.R. 489.20 (l) (2000) (effective July 1994).
[29.] 42 U.S.C. 1395dd(d)(1)(A) (1999).
[30.] 42 U.S.C 1395dd(d) (1) (B) (1999).
[31.] 42 U.S.C 1395dd(d)(2)(1999).
[32.] STATISTICAL ABSTRACT OF THE UNITED STATES 2000, TABLE 194 (2000) (this number excludes long term general and special hospitals and tuberculosis hospitals).

[33.] 42 C.F.R. 489.24 (g) (2000).

[34] DHHS OIG THE EMERGENCY MEDICAL LABOR AND TREATMENT ACT, THE ENFORCEMENT PROCESS, 2001 at 16.
[35] 42 U.S.C. ' 1395dd (d) (1999).
[36] 42 U.S.C. ' 1320a-7a (d) (1999).
[37] 42 C.F.R. ' 1003.106 (a) (4) (2000).
[38] *See* Burditt v. U.S. Dept. of Health and Human Services, 934 F. 2d 1362, 1376-76 (5th Cir. 1991).
[39] Letter from Office of the Inspector General, U.S. Department of Health and Human Services to Kaija Blalock, Attorney Researcher, *Public Citizen's Health Research Group* (Apr.27, 2001) (on file with *Public Citizen's Health Research Group).*
[40] *Id*.
[41] DHHS OIG THE EMERGENCY MEDICAL LABOR AND TREATMENT ACT, SURVEY OF HOSPITAL EMERGENCY DEPARTMENTS, 2001 at 12-13 (results found by HCFA's Acting Dep. Dir. to be "largely consistent with our own assessments of EMTALA compliance issues….").
[42] *Id*. AT 12.
[43] *Id*. at 13.
[44] *Id*.
[45] *Id*. at 15.
[46] *Id*. at 16.
[47] *Id*. at 14.
[48] 42 U.S.C. ' 1395dd (f) (1999).
[49] Root v. New Liberty Hospital District, 209 F. 3d 1068 (8th Cir. 2000); Helton v. Phelps County Regional Medical Center, 817 F. Supp. 789, 791 (E.D. Mo. 1993) (finding that preclusion of damage actions directly conflicts with Congressional intent behind the Act).
[50] STATISTICAL ABSTRACT OF THE UNITED STATES 2000, TABLE 176 (1999) (30% of the United States population were enrolled in Health Maintenance Organizations).
[51] 64 Fed. Reg. 61353 (1999) (OIG/HCFA Special Advisory Bulletin on the Patient Anti-Dumping Statute).
[52] *See* CONN. GEN. STAT. ' 38A-478R (2000); ILL. REV. STAT. CH. 215, PARA. 134/10, 134/65 (2001); KY. REV. STAT. ' 304.17A-580 (2000); LA. REV. STAT. ANN. ' 22:657 (2000); N.C. GEN. STAT. ' 58-3-190 (2000); OHIO REV. CODE ANN. ' 3923.65 (2001); OR. REV. STAT. ' ' 743.699, 743.801 (1999); S.C. ANN. ' '38-71-1520, 38-71-1530 (2000) ; S.D. CODIFIED LAWS ANN. ' 58-17C-27 (2000); TENN. CODE ANN. ' 56-7-2355 (2001); UTAH CODE ANN. ' 31A-22-627 (2000); WASH. REV. CODE ' 48.43.093 (2001); W. VA. CODE ' 33-25A-8D (2001); WIS. STAT. ' 632.85 (2001).
[53] 42 U.S.C. ' 1395w-22 (d) (1999) (in the Medicare+Choice program, Medicare enrollees receive care through a managed care organization); 42 U.S.C. ' 1396u-2 (b) (2) (1999) (applicable to Medicaid managed care organizations).
[54] Tintinalli, JE *Analysis of Insurance Payment Denials using the Prudent Layperson Standard*, ANNALS OF EMERGENCY MED., (2000) Vol. 35 (3) 291-294.
[55] S. 823, 107th Cong., 1st Sess. (2001) (introduced May 3, 2001 and referred to the Committee on Finance).
[56] S. 823, 107th Cong., 1st Sess. ' (a) (2001)
[57] 42 C.F.R ' 489.20 (r) (2000).
[58] 42 U.S.C. ' 1395dd (d)(1)(C), (1999) (extending liability only to on call physicians serving the hospital that provides the initial screening exam. While 42 C.F.R 489.20 (r) requires all hospitals to maintain lists of on call physicians, 42 C.F.R. 1003.100 (a) fails to provide for the imposition of civil monetary penalties for violations of this regulatory requirement).
[59] DHHS OIG THE EMERGENCY MEDICAL LABOR AND TREATMENT ACT, SURVEY OF HOSPITAL EMERGENCY DEPARTMENTS, 2001, at 17.
[60] See *E.g*, MD CODE ANN. COM. LAW '13-301 (2000) (prohibiting unfair or deceptive trade practices, applicable to for-profit hospitals).
[61] 42 U.S.C. ' 1395dd(d)(2) (2000). EMTALA invokes federal court jurisdiction under 28 U.S.C ' 1331.
[62] 28 U.S.C. 1367(a) (1999).
[63] *See e.g.* Correa v. Hospital San Francisco, 69 F.3d 1184 (1st Cir. 1995); Gatewood v. Washington HealthCare Corp., 933 F. 2d 1037 (D.C. Cir. 1991).
[64] Vickers v. Nash General Hosp., Inc., 78, F.3d 189 (4th Cir. 1996); Williams v. Birkeness, 34 F. 3d 695 (8th Cir. 1994); Correa v. Hospital San Francisco, 69 F.3d 1184 (1st Cir. 1995).

[65] Morrison v. Colorado Pemanente Medical Group, 983 F. Supp. 937 (D. Colo. 1997).
[66] DHHS OIG THE EMERGENCY MEDICAL LABOR AND TREATMENT ACT, SURVEY OF HOSPITAL EMERGENCY DEPARTMENTS, 2001 at 17.
[67] S. 823, 107th Cong., 1st Sess. (2001) (introduced May 3, 2001 and referred to the Committee on Finance).
[68] S. 823, 107th Cong., 1st Sess. ' (a) (2001)
[69] 42 U.S.C. 1395dd (d) (1) (B) (1999).
[70] These two types of violations are listed in 42 C.F.R. ' 489.20. Currently, 42 C.F.R. ' 1003.100 does not permit the imposition of penalties for violation of 42 C.F.R. ' 489.20.