Memorial Health Care System

APRIL 18, 2013

AMENDED PLAN OF CORRECTION AND ATTACHMENTS BY OVERNIGHT DELIVERY

Ms. Sandra M. Pace
Associate Regional Administrator
Department of Health and Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

Re: Memorial Health Care System, Chattanooga, TN
CMS Certification Number (CCN): 44-0091

Dear Ms. Pace:

At the request of Rosemary Wilder of the Centers for Medicare and Medicaid Services ("CMS"), Memorial Health Care System of Chattanooga, Tennessee ("MHCS") (1) attaches an updated Plan of Correction ("POC") for the alleged EMTALA deficiencies from the surveys on June 12, 2012 and August 23, 2012, and (2) clarifies the correct EMTALA regulations, and disputes certain of facts recited and alleged deficiencies in the CMS Form 2567, Statement of Deficiencies.

Our letter of April 12 provides background regarding MHCS. Based on documentation contained in the enclosed POC and its Appendices, and the matters addressed in this letter, MHCS believes that it complies with EMTALA. Accordingly, MHCS respectfully requests that CMS accept the POC and Appendices as credible evidence of correction and that CMS withdraw the April 26, 2013 notice to the public.

MHCS assumes that a resurvey will be conducted and the termination notice rescinded prior to the stated deadline.

Memorial Health Care System – EMTALA Regulations

As noted in our earlier communications, MHSC respectfully submits that the Statement of Deficiencies recites outdated EMTALA regulations for both surveys. The 2009 IPPS final rule included EMTALA revisions, effective October 1, 2008, that changed the ambiguous language regarding on-call list criteria. Specifically, the updated regulations replaced previous wording that required hospitals to maintain an on-call list "...in a manner that best meets the

needs of the hospital's patients who are receiving services...[under EMTALA] in accordance with the resources available to the hospital, including the availability of on-call physicians."

The current EMTALA regulations are outlined immediately below, and MHCS's POC follows the current regulations that provide:

> 489.20(r)(2)
> [MHCS must maintain] a list of physicians who are on call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition.
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> 489.24(j)(1) and (2)
> In accordance with the On-Call list requirements specified in 489.20(r)(2), a MHCS must have written policies and procedures in place – (1) To respond to situations in which a particular specialty is not available or the On-Call physician cannot respond because of circumstances beyond the physician's control, and (2) To provide that emergency services are available to meet the needs of individuals with emergency medical conditions if a MHCS elects to – (i) permit On-Call physicians to schedule elective surgery during the time that they are On-Call.

MHCS's expeditious and comprehensive response to the 2567 demonstrates its complete compliance with EMTALA in accordance with the EMTALA regulations cited above.

June 12, 2012 Survey

MHCS respectfully disputes certain of the findings in the Statement of Deficiencies for the June 12, 2012 survey, and disputes the determinations of an alleged EMTALA violation and "immediate jeopardy."

MHCS maintained an appropriate On-Call roster that included an orthopedic surgeon, provided necessary stabilizing treatment for the patient's emergency medical condition within the hospital's capability and capacity, and performed an appropriate transfer of the patient under EMTALA.

First, MHCS respectfully disputes the assertion that based on the findings identified in the Form 2567, the Emergency Department ("ED") physician was required to request on-call orthopedic services in this case, and the failure to do so constitutes an EMTALA violation. MHCS is aware of no rule, regulation or interpretative guidance that imposes a requirement on ED physician to contact on-call physicians in any particular situation. Rather, the ED physician has the discretion to determine whether on-call services from a particular specialty are necessary to perform an appropriate MSE and/or to provide stabilizing treatment under EMTALA. The mere fact that a patient presents to the ED with a condition that falls within a medical specialty does not mean the ED physician needs the assistance on-call services to provide the appropriate screening and treatment required by EMTALA in all cases.

In this case, Patient #3 presented with injuries consistent with a fall from height of approximately 20 feet. The ED physician and the ED staff were able to appropriately screen the patient and provide appropriate stabilizing treatment for the patient's injuries without having to request additional assistance from an on-call specialist, including the services of an on-call orthopedic surgeon. MHCS Hixson does not have a designated trauma level. The on-call orthopedic surgeon did not have orthopedic trauma privileges. Nothing in the patient record suggests that the ED physician was unable to perform an adequate MSE or provide stabilizing treatment within MHCS's capabilities without the assistance of an on-call orthopedic surgeon. Thus, MHCS respectfully disputes the finding that MHCS violated EMTALA based on the ED physician's exercise of medical judgment.

Furthermore, MHCS believes that it met the EMTALA requirements to provide appropriate stabilizing treatment to the affected patient in this case. Section 42 CFR 489.24(b) sets the standard for determining when a patient is stabilized and defines stabilized to mean:

> "... that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or with respect to an "emergency medical condition" as defined in this section under paragraph (2) of that definition, that a woman has delivered the child and the placenta."

To be considered "stable," the emergency medical condition that caused the individual to seek care in the dedicated ED must be resolved, although the underlying medical condition may persist. (State Operations Manual, Appendix V, at p. 50).

In this case, the ED physician appropriately "stabilized" the patient prior to transfer. On presentation, the patient complained of pain, presented with swollen ankles and lacerations to his lower extremities. MHCS provided IV Dilaudid for pain management. The ED physician was also able to rule out spinal injury. Thus, at the time of transfer, the patient received sufficient stabilizing treatment to confirm that no material deterioration was likely to result for the transfer. Furthermore, the ED physician was able to identify that the services the patient required to resolve the underlying medical condition were not within the capacity of MHCS.

As noted, MHCS is not a trauma center. The receiving hospital has noted that the decision to transfer the patient to a trauma center was appropriate. The decision to transfer the patient to a nearby hospital with a trauma center before setting splints was a determination made by the ED physician in the scope of his medical judgment that does not rise to the level of an EMTALA violation. The ED physician, in his medical judgment appropriately considered the patient's injuries, swelling and need for subsequent treatment to exercise his medical judgment in deciding not to place splints prior to transfer. In the physician's medical judgment, the patient's fractures were not at risk for worsening during transfer, and thus, placement of splints does not constitute "stabilizing treatment" in this case and the failure to place splints does not support an EMTALA violation.

In conclusion, MHCS disputes the allegation that certain findings cited in the Form 2567 constitute an EMTALA violation. The findings identified represent a unique, fact-specific circumstance that does not constitute a denial of treatment or a failure to provide appropriate services under EMTALA. Rather, the Form 2567 describes a situation where an ED physician exercised medical judgment and determined (1) that on-call services were not necessary to perform an appropriate screen and to provide stabilizing treatment; and (2) what treatment was necessary to properly stabilize the treatment prior to and during transfer. Furthermore, although the Form 2567 expresses disagreement with the ED physician's professional medical judgment, that disagreement does not support the conclusion that this amounts to an EMTALA violation.

Furthermore, MHCS respectfully submits there is no basis to support Immediate Jeopardy based on the situation cited in the Form 2567, as there was no risk to this patient's health or safety, and the ED physician's medical judgment did not pose a risk to any other patient's health or safety.

Notwithstanding its dispute of the matters set forth in the form 2567, MHCS submits it's enclosed POC to strengthen its policies and procedures, educate its staff and monitor performance to ensure EMTALA compliance in the future.

August 23, 2012 Survey

MHCS respectfully disputes certain of the findings in the Statement of Deficiencies for the August 23, 2012 survey, and disputes the determinations of an alleged EMTALA violation and "immediate jeopardy." Nonetheless, all actions under the enclosed POC are completed to promote EMTALA compliance prior to the anticipated publication date.

MHCS disputes the allegation under Tag A2404 that no neurologist was on-call. MHCS had arranged for neurologists to be on-call 24x7. The ED physician was prospectively aware of how to reach the on-call neurologists. When Patient #9 was in the ED, the on-call neurologist was contacted by the ED physician for telephone consultations, and responded in a timely manner. The neurologist recommended that Patient #9 be transfer to another facility. To the extent the on-call roster did not follow the guidelines of the State Operations Manual, this technical shortcoming should not form the basis for an EMTALA violation or a determination of immediate jeopardy. The POC notes the changes to the on-call list for neurology to address the matters under the Statement of Deficiencies.

The Statement of Deficiencies contains several inaccuracies based on the surveyor's misinterpretation of the patient record. These inaccuracies are clarified in the attached timeline. These clarifications are important to MHCS, as they may result in CMS reevaluating its determination of an EMTALA violation and immediate jeopardy.

- For example, the Statement of Deficiencies alleges that certain entries, including the Emergency Department Physical History, are not timed. This is not accurate, as MHCS uses an electronic time stamp in the Status Event History, and the time of this entry (1302) is reflected on the attached timeline.

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accurate. The report was given to "Lisa RN" at 1705, as reflected in the attached timeline.

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With regard to the surveyor's notes regarding the interview with M.D. #1, this interview appears to be based on the surveyor's misinterpretation of the timelines in the patient record. MHCS respectfully requests that its compliance with EMTALA be assessed on a correct reading of the patient's medical record.

MHCS disputes the allegation that it failed to evaluate Patient #9 for possible stroke or to provide appropriate stabilizing treatment. As noted, the ED physician consulted with the on-call neurologist. Patient #9 received an appropriate medical screening examination, including physician examination, ongoing nurse assessments, an EKG, laboratory tests, heart monitor, and CT scan of the brain.

MHCS followed its t-PA protocol and the neurologist felt the patient was not a candidate for t-PA because the deficit had fluctuated over more than four hours. It was only after Patient #9 experienced a dramatic change in symptoms that he was diagnosed with a stroke. Consulting neurologist and later physician review confirmed that t-PA was not appropriate under the t-PA protocol. The t-PA protocol is attached to the POC. Because Patient #9 was not appropriate for t-PA, the neurologist recommended transfer to a facility with specialized capabilities, since MHCS lacked specialized capabilities to provide mechanical thrombectomy or neurosurgery required by Patient #9.

Patient #9's preliminary diagnosis was Bell's Palsy, rather than stroke. The State Operations Manual itself notes that a misdiagnosis does not itself constitute an EMTALA violation: "The clinical outcome of an individual's condition is not a proper basis for determining whether an appropriate screening was provided or whether a person transferred was stable. ... If an individual was misdiagnosed, but the hospital utilized all of its resources, a violation of the screening requirement did not occur. "(State Operations Manual, Appendix V, p. 36).

Patient #9 was appropriately stabilized for transfer. Section 42 CFR 489.24(b) defines stabilized for transfer to mean: "... that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility . . ." The findings in the Form 2567 clearly establish that after performing extensive studies, and after consulting with neurology, the physician determined Patient #9 was stable for transfer and not likely to sustain a material deterioration during transfer. Specifically, the physician stated "The patient has been stabilized within reasonable medical care standards. No further deterioration is likely as a result of transfer."

Finally, MHCS provided an appropriate transfer for Patient #9. A patient is to be appropriately transferred pursuant to EMTALA where the individual's EMC has not been stabilized in two situations: (1) where the individual requests the transfer; and (2) where there is a physician certification that the expected benefits of the transfer outweigh the increased risks of the transfer. In either case, the transfer must also meet all four requirements of an "appropriate" transfer:

> 1. The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;
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> 2. The receiving facility (a) has available space and qualified personnel for the treatment of the individual; and (b) has agreed to accept transfer of the individual to provide appropriate medical treatment;
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> 3. The transferring hospital sends to the receiving facility all medical records related to the emergency condition which the individual has presented that are available at the time of transfer . . . . .
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> 4. The transfer is completed through qualified personnel and transportation equipment, as required, including the use of medically appropriate life support measures during the transfer.

42 CFR 489.24(e)(2); see also, State Operations Manual, Appendix V, pp. 62-63.

In this case, the transfer was pursuant to patient request (through his representative), as well as physician certification. Furthermore, MHCS met all four requirements of an appropriate transfer. First, MHCS provided medical treatment to Patient within its capacity to minimize the risks to the individual's health. As noted, t-PA was not clinically appropriate for this patient. MHCS also ensured that the receiving hospital had available space and qualified personnel and accepted the transfer. Third, MHCS sent all medical records related to the emergency condition which the individual has presented that are available at the time of transfer to the receiving

hospital. MHCS disputes the findings that the medical records transferred were incomplete. And finally, MHCS ensured the transfer was completed through qualified personnel and transportation equipment, as required, including the use of medically appropriate life support measures during the transfer.

In conclusion, MHCS disputes the findings cited in the Form 2567 constitute an EMTALA violation. The findings identified represent a unique, fact-specific circumstance that does not constitute a denial of treatment or a failure to provide appropriate services under EMTALA.

Conclusion

MHCS is a valuable and unique asset to the community it serves. MHCS provides much needed and readily available patient care services. MHCS believes that it is in complete compliance with EMTALA and has taken prompt and comprehensive actions to ensure that it remains in compliance with EMTALA. Based on the actions described above, along with the detailed responses described in the POC and the supporting Appendices, MHCS respectfully requests that CMS complete a resurvey and rescind the termination action.

If you have any questions or require additional supporting documentation with regard to MHCS compliance with EMTALA or any other related matter, please do not hesitate to contact Leigh Bertholf, RN, MS, CCEP, E/SE Division Corporate Responsibility Officer, Catholic Health Initiatives at (423) 495-8364, or Melissa Roden, VP Quality at (423) 495 5773, or Diona Brown, CNE VP Patient Care Services at (423) 495-8546.

Very truly yours,

James M. Hobson

James M. Hobson, FACHE
President and CEO

cc: Leigh Bertholf, CRO
Melissa Roden, VP Quality
Diona Brown, VP Patient Services

Enclosures (3)

Possible CVA / EMTALA Transfer - Emergency Department
2012 March 26 Timeline

1213: Patient presented to the ED Advocate Desk with stated complaint possible stroke

1223: Registration information obtained to begin setting up medical record

1225: EKG completed

1230: Triage completed for CC: neurologic symptoms / deficits; *Patient c/o onset SOB after walking to surgery waiting. Pt family reports slurred speech with this episode. Neg MEND; Pt denies pain. AAOx3 No weakness noted.* Arrival mode: Walk in; B/P 158/99; P 88; Respirations 18; O2 SpO2 99%, room air yes; Pain Assessment WNL yes; Patient has history of hypertension and amputation. Home medications: Lotrel. No known allergies. ESI-level 2

1247: Triage Reassessment: Reoccurrence of slurred speech. Equal grip strengths; left side facial droop

1249: To treatment room

1251: MEND/Neuro Assessment documented as: Speech abnormal, facial droop abnormal, motor arm drift abnormal.
MD Orders for Brain without; labs

1302: MD in room
MD documentation CC: slurring; history of present illness: onset: sudden, duration: < 1 hour, type: intermittent, worsened by: nothing, symptom: present; patient with slurring and left facial droop that has waxed and waned over last hour. No prior, no HA. Additional history: No deficits, Pt had been hurrying and got SOB, no CP, fever, sputum. Neck ABN: Neck: Difficult to assess for bruits, left facial symmetry and slurring, decrease blink on left, mild decreased raise brows, frown, s/s x 4, normal gait

1315: IV started and labs collected with IV start

1319: Heart Monitor

1317: Nurse documents - MEND/Neuro assessment: Speech abnormal, slurred; facial droop normal, arm drift normal; no numbness or tingling

1417: CT completed

1433: CT report: No acute intracranial abnormality; Atrophy. Chronic microvascular white matter ischemic changes.

No Time: MD documents reviewed radiology findings: CT: result Brain no acute; atrophic changes

1557: Nurse documents - Adult Gen Assessment: Neurologic assessment WNL: No

1602: Nurse documents - Dramatic neuro change noted: Pt without left sided neglect, increased slurred speech and left sided weakness, MD notified

1603: MD at bedside. MD documents pt acutely gaze deviated to right and (densely) hemiplegic on left, called Dr Farber stat, but onset >3hrs, recommend call to Erlanger

No Time: MD documentation - Disposition: Condition on dismissal: Discussed results with pt and family, but dysarthria seem more pronounced and I am uncertain of Bells Palsy. Discussed with Dr Farber who requests MRI

1610: MD documents: Discussed with Transfer Center who is calling neuro. BG: 92

1613: Certificate of Transfer
Diagnosis: Neurologic changes with left sided neglect
Date /Time: 3/26/12 / 1613.

1619: Ready for CTA

1629: Registration completed

1705: CTA Brain report: Occlusion of right internal carotid artery and proximal portion of the right middle cerebral artery. Peripheral middle cerebral artery branches are

partially opacified. Questionable minimal infarct in the anterior limb of the right internal capsule. Atrophy. Chronic microvascular white matter ischemic changes

No Time: Diagnosis: CVA

1718: Wife signature on transfer form for consent to transfer

1736: Departure Assessment: Temperature: 97.9, Pulse: 88, Blood Pressure: 142/88, Respirations: 16, Sp02% 98; Pain scale 0; Comfortable / No Pain; Transfer to Erlanger Baroness, ED departure time 1750, Report to Lisa, RN, report time 1705; accompanied by Memorial EMS.

1758: EMS transport departure time

1806: Arrived to transfer hospital

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2525 de Sales Avenue Chattanooga, TN 37404-1102 Phone 423.495.2525 www.Page hofal.org

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In conclusion, MHCS disputes the findings cited in the Form 2567 constitute an EMTALA violation. The findings identified represent a unique, fact-specific circumstance that does not constitute a denial of treatment or a failure to provide appropriate services under EMTALA.

Conclusion

MHCS is a valuable and unique asset to the community it serves. MHCS provides much needed and readily available patient care services. MHCS believes that it is in complete compliance with EMTALA and has taken prompt and comprehensive actions to ensure that it remains in compliance with EMTALA. Based on the actions described above, along with the detailed responses described in the POC and the supporting Appendices, MHCS respectfully requests that CMS complete a resurvey and rescind the termination action.

If you have any questions or require additional supporting documentation with regard to MHCS compliance with EMTALA or any other related matter, please do not hesitate to contact Leigh Bertholf, RN, MS, CCEP, E/SE Division Corporate Responsibility Officer, Catholic Health Initiatives at (423) 495-8364, or Melissa Roden, VP Quality at (423) 495 5773, or Diona Brown, CNE VP Patient Care Services at (423) 495-8546.

Very truly yours,

James M. Hobson, FACHE
President and CEO

cc: Leigh Bertholf, CRO
Melissa Roden, VP Quality
Diona Brown, VP Patient Services

Enclosures (3)

Possible CVA / EMTALA Transfer - Emergency Department
2012 March 26 Timeline

1213: Patient presented to the ED Advocate Desk with stated complaint possible stroke

1223: Registration information obtained to begin setting up medical record

1225: EKG completed

1230: Triage completed for CC: neurologic symptoms / deficits; *Patient c/o onset SOB after walking to surgery waiting. Pt family reports slurred speech with this episode. Neg MEND; Pt denies pain. AAOx3 No weakness noted.* Arrival mode: Walk in; B/P 158/99; P 88; Respirations 18; O2 SpO2 99%, room air yes; Pain Assessment WNL yes; Patient has history of hypertension and amputation. Home medications: Lotrel. No known allergies. ESI-level 2

1247: Triage Reassessment: Reoccurrence of slurred speech. Equal grip strengths; left side facial droop

1249: To treatment room

1251: MEND/Neuro Assessment documented as: Speech abnormal, facial droop abnormal, motor arm drift abnormal.
MD Orders for Brain without; labs

1302: MD in room
MD documentation CC: slurring; history of present illness: onset: sudden, duration: < 1 hour, type: intermittent, worsened by: nothing, symptom: present; patient with slurring and left facial droop that has waxed and waned over last hour. No prior, no HA. Additional history: No deficits, Pt had been hurrying and got SOB, no CP, fever, sputum. Neck ABN: Neck: Difficult to assess for bruits, left facial symmetry and slurring, decrease blink on left, mild decreased raise brows, frown, s/s x 4, normal gait

1315: IV started and labs collected with IV start

1319: Heart Monitor

1317: Nurse documents - MEND/Neuro assessment: Speech abnormal, slurred; facial droop normal, arm drift normal; no numbness or tingling

1417: CT completed

1433: CT report: No acute intracranial abnormality; Atrophy. Chronic microvascular white matter ischemic changes.

No Time: MD documents reviewed radiology findings: CT: result Brain no acute; atrophic changes

1557: Nurse documents - Adult Gen Assessment: Neurologic assessment WNL: No

1602: Nurse documents - Dramatic neuro change noted: Pt without left sided neglect, increased slurred speech and left sided weakness, MD notified

1603: MD at bedside. MD documents pt acutely gaze deviated to right and (densely) hemiplegic on left, called Dr Farber stat, but onset >3hrs, recommend call to Erlanger

No Time: MD documentation - Disposition: Condition on dismissal: Discussed results with pt and family, but dysarthria seem more pronounced and I am uncertain of Bells Palsy. Discussed with Dr Farber who requests MRI

1610: MD documents: Discussed with Transfer Center who is calling neuro. BG: 92

1613: Certificate of Transfer
Diagnosis: Neurologic changes with left sided neglect
Date /Time: 3/26/12 / 1613.

1619: Ready for CTA

1629: Registration completed

1705: CTA Brain report: Occlusion of right internal carotid artery and proximal portion of the right middle cerebral artery. Peripheral middle cerebral artery branches are

partially opacified. Questionable minimal infarct in the anterior limb of the right internal capsule. Atrophy. Chronic microvascular white matter ischemic changes

No Time: Diagnosis: CVA

1718: Wife signature on transfer form for consent to transfer

1736: Departure Assessment: Temperature: 97.9, Pulse: 88, Blood Pressure: 142/88, Respirations: 16, Sp02% 98; Pain scale 0; Comfortable / No Pain; Transfer to Erlanger Baroness, ED departure time 1750, Report to Lisa, RN, report time 1705; accompanied by Memorial EMS.

1758: EMS transport departure time

1806: Arrived to transfer hospital