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Implementing EMTALA: Strategies for Compliance

Study Guide
Special Thanks

Sue Dill, RN, MSN, JD
Vice President of Legal Services
Memorial Hospital of Union County
Marysville, OH

Charles Keeran
Operations Manager
Kare Medical Transport Services
Maryville, OH

The emergency department staff of Memorial Hospital of Union County
Marysville, OH

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I. Introduction
The federal Emergency Medical Treatment and Labor Act, or EMTALA, is known by many names. You may know it as COBRA, the Patient Transfer Act, or perhaps as the Anti-Dumping Law. But do you understand what EMTALA is, and what your new responsibilities are under the revised federal law?

EMTALA was enacted as part of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 and has recently been revised to clarify the original language. The recently revised rule became effective November 10, 2003. It was created in an effort to prevent the dumping of patients who are unable to pay for services. It was also created to provide care to any individual, regardless of creed, citizenship or race.

EMTALA affects all Emergency Department personnel including: Attending and On-call physicians; Emergency Medical Service staff; Labor and Delivery and Behavioral Health Departments; Risk Managers; Senior hospital leadership and legal counsel.

All Medicare-participating hospitals that operate emergency departments are required to comply with EMTALA. Because EMTALA is part of the Medicare Conditions of Participation, by accepting Medicare payments, facilities with Emergency Departments agree to abide by EMTALA for all patients seeking emergency care, not just Medicare patients. It is enforced by the Centers for Medicare and Medicaid Services (CMS) and by the Office of Inspector General (OIG), which is part of the Department of Health and Human Services (DHHS). In addition, accreditation agencies such as the Joint Commission of the Accreditation on Healthcare Organizations (JCAHO) include documentation requirements in order to comply with EMTALA.

All hospital-owned and operated ambulances must comply with EMTALA, including air services such as Life Flight helicopter or fixed wings, unless they are under community wide EMS protocol.

II. Consequences of Non-Compliance
• CMS can terminate the hospital from participation in the Medicare/Medicaid program, and losing Medicare reimbursement may cause the hospital to close its doors.

• The hospital and the physician may be subject to civil money penalties of $50,000 per violation for hospitals with more than 100 beds; $25,000 for hospitals with less than 100 beds. The OIG may also exclude the physician from participation in Medicare, Medicaid, and other state programs. Other licensed professionals can have disciplinary action taken by their licensing or certifying board, such as the State Board of Nursing.

• JCAHO has EMTALA standards and their violation can result in loss of accreditation or being cited for non-compliance with a standard.

• The Civil Rights Division of the DHHS can investigate in a criminal or civil discrimination case.
• If a hospital suspends a physician’s privileges over an EMTALA violation, it is reported to the National Practitioner Data Bank or NPDB. Failure to discipline offending physicians is a violation of the law.

• Physician violations may result in an investigation or sanction against the hospital by the state Peer Review Organization or PRO (now called the Quality Improvement Organization or QIO), state licensure board, local Medicare intermediary, or state health program.

• Patients can sue the provider and facility in a civil lawsuit for punitive damages or in a malpractice suit if they are harmed.

• Any hospital that incurs financial loss as a direct result of another Medicare-participating hospital’s violation of EMTALA can sue that hospital in federal court to recover its monetary losses.

III. The Components of EMTALA
While learning the pertinent details of the rule is important, it need not be as complicated as you think. In this program, we will discuss the major components of the EMTALA rule:
• Preparing the ED for Compliance
• Understanding the Medical Screening Exam (MSE)
• Clarifying What Constitutes an Emergency Medical Condition (EMC)
• Providing Stabilizing Treatment
• Understanding the Transfer Process
• Responding to Refusal of Treatment

A. Preparing the Emergency Department for EMTALA Compliance
Your facility already has several policies and procedures in place in order to comply with the regulations. Every facility should revise their policy to be consistent with the new regulations. Here are the ones you should be aware of:

1. Definition of an Emergency Department
Under EMTALA, a person who “comes to the ED” is someone who presents to the hospital’s ED or elsewhere on the hospital property and requests examination or treatment. Hospital property includes the entire hospital campus and includes the parking lot, sidewalks and driveway. However, the new rules clarify that this does NOT include structures that are not part of the hospital, such as physician offices, skilled nursing facilities, or other “non-hospital entities” that participate separately in Medicare; or restaurants, shops or other non-medical facilities - even if
they are owned and operated by the hospital and are adjacent to the main hospital building or on the main campus. This is a very important change from the previous rule for some providers. For example, non-hospital entities were once required to provide training on how to treat patients with emergency conditions, instead of just calling 911. CMS recognized that the best procedure for a patient having a severe anaphylactic reaction who wanders into the outpatient physical therapy department might be to call 911 to summon EMS and transport the patient to the nearest hospital.

2. Ambulance Requirements
A patient must be seen if they arrive in an ambulance, whether it is owned by the facility or not. A hospital on diversionary status can turn away ambulances that are not on the grounds of the facility if the facility does not have the ability to care for the patient due to a lack of beds or staff. However, if an ambulance disregards the hospital’s instructions and brings a patient onto hospital grounds, the hospital cannot deny access. This will include a hospital that owns or operates a ground or air ambulance even if the ambulance is not on hospital grounds. However, the new rule clarifies that EMTALA does not apply if the ambulance is operating under a community wide EMS protocol that may require the ambulance to transport the patient to the nearest hospital or special level facility as opposed to the hospital that owns the ambulance.

3. National Emergencies
Under special circumstances such as a national emergency that may flood the ED with patients, the hospital is exempt from EMTALA regulations. State and local government may coordinate where patients may be seen, and it may be appropriate to refer patients to other facilities prior to an exam if they require specialized care.

4. Signage
Hospitals must conspicuously post signs of their involvement with Medicare and Medicaid in the ED and other places likely to be noticed by persons waiting for exam and treatment. These signs must be clearly understood, and readable at 20 feet. Medicare surveyors will check for the sign.

5. Education
Emergency staff and physicians must learn their responsibilities in complying with EMTALA. A recent survey conducted by the Government Accounting Office (GAO) found the following:

• Only 27% of ED nurses and physicians were familiar with the November 10, 1999 Advisory Bulletin issued by CMS and OIG. This bulletin addressed managed care issues, suggested best practices, and was discussed in detail in the revised EMTALA regulations.

• Only 65% were familiar with the 1998 interpretive guidelines.

• Only 25% of on-call physicians were trained on EMTALA.¹
It is essential that all ED personnel, including on-call physicians, participate in training on EMTALA, and familiarize themselves with the EMTALA reference book that contains all relevant information. Know your facility’s policies and procedures should CMS officials arrive at your facility for a review.

In addition, ED personnel should become familiar with the CMS Guidelines for Immediate Jeopardy issued in 2000. These guidelines, known as “triggers”, apply to all facilities that receive Medicare/Medicaid reimbursement, and are used by CMS surveyors to measure a facility’s patient safety practices and EMTALA compliance.

The CMS Guidelines for Determining Immediate Jeopardy include:

- Failure to perform medical screening exam as required by EMTALA or to stabilize or provide safe transfer
- Individual turned away from the ED without a medical screening exam
- Women with contractions not medically screened for status of labor
- Absence of ED or OB medical screening documentation
- Failure to stabilize emergency medical condition
- Failure to appropriately transfer an individual with an unstable medical condition

6. Staffing
   a. Supervision

   **There must be adequate supervision and staffing.** Every facility must have their emergency services department supervised by a physician or other qualified member of the medical or nursing staff. Also, there must be adequate medical and nursing staff to meet the needs of the facility, including on-call specialists who are available to stabilize a patient with an emergency condition.

   b. On-Call Physicians

   The facility's medical staff bylaws or policies and procedures must define the responsibility of the on-call physician to respond, examine, and treat patients with emergency medical conditions. These policies and procedures should also define how the on-call list will be handled by the facility. Under the revised rule, hospitals have the discretion to determine how best to maintain their on-call list within the hospital’s resources. For example, a hospital may decide to exempt any physician over 60 or who has been active on the medical staff for more than 20 years.
The hospital must have a daily list of on-call physicians and an on-call system. These lists must note physicians by name, not by physician group. Most hospitals have a formula for staffing physicians round the clock. However, not all hospitals need to have doctors on-call 24 hours a day, 7 days a week. For example, a hospital has four surgeons on staff but one is over 60 years old, another has been on the medical staff for more than 20 years, and the two are exempt from being on-call. EMTALA recognizes that in these types of situations, physicians cannot be required to be on-call all the time for 100% coverage. However, it is required that the one or two specialists have a reasonable call schedule, including weekends and off hours. During periods of “no coverage” when a specialist is not available, it is permissible to transfer a patient to another facility that offers the needed services. This should be spelled out in the hospital’s EMTALA policy. Hospitals that cannot maintain full time on-call coverage should keep local EMS staff advised of the times that they will not have certain specialties available.

In addition, the revised regulations recognize that physicians may serve simultaneously on-call for more than one hospital. Also, a physician can be on-call while taking office appointments or scheduling surgery or other elective procedures. The hospital must have written policies and procedures to respond to situations in which a specialty is not available or the specialist can’t respond due to circumstances beyond his or her control. A full office is not considered an excuse if the patients are stable!

On-call physicians must be available to arrive at the ED within a reasonable amount of time. A good rule of thumb for a physician called to help with an unstable emergency medical condition is 30 to 60 minutes - absent extenuating circumstances. However, in a true emergency and in big cities, CMS states that this should be within 30 minutes of the call. ED on-call physicians, CMS and the hospital and medical staff can work together to determine what will constitute a reasonable response time and have this written into the bylaws. But please note: facilities must be careful how these are written into the policies and procedures. For example, if the bylaws state that physicians must respond within 30 minutes, this will be taken literally by CMS, and can be used against the physician by JCAHO, CMS and DHHS in a court of law. Only physicians who are unavoidably detained due to other emergencies, bad weather or other reasons beyond their control are exempt from arriving within the specified time frame.

As part of the Medicare/Medicaid provider agreement, the hospital agrees to adopt and enforce a policy to ensure compliance with CMS regulations. If a physician agrees to be on-call during a certain time period, and either does not show up, or refuses to come to the ED when called, both the hospital and physician are considered in violation of the provider agreement and EMTALA. When this happens, the hospital is at risk for having its agreement terminated, depending on how it responds to the situation. Additionally, physicians need to remember that they practice in hospitals under the privileges extended to them by the facility. If a physician
either refuses to assume or carry out their on-call responsibilities, the facility can suspend, curtail, or revoke the physician’s practice privileges.

**Limiting liability when an on-call physician refuses to come:**
1) Notify the Chief of the Department, a partner, or another MD to attend or admit the patient.

2) If the patient must be transferred, send the name and address of the offender to the receiving hospital. Failure to do so will result in violation of the provider agreement.

3) The receiving hospital must report this violation or they are at risk of losing their provider agreement.

4) The hospital’s governing board should have a policy and procedure requiring that an incident report be made.

5) The medical staff rules and regulations should provide for appropriate sanctions.

6) There is no requirement for self-reporting to CMS.

As part of the review process, CMS will look for a pattern of responses by on-call physicians. In addition, it must be noted that on-call coverage must be attended by physicians, and that physician assistants and nurse practitioners may not respond to a call for a physician.

**Follow-up care:** The hospital should define the duties of the on-call physician with respect to follow-up care. According to EMTALA, once a patient is stabilized, the EMTALA obligations are over. Furthermore, in *Phipps v. Bristol*, the courts ruled that once a patient is stable and discharged, there is no legal duty to see the patient for follow up care. However, it should be noted that CMS recommends that hospitals require follow-up care for patients that present to the ED as a resolution of their problem. Therefore, patients should be referred to their doctor or a specialist for follow-up care if the physician deems it a suggested part of their recovery. As a failsafe, patients should be advised to return to the ED should their condition deteriorate prior to seeing the referring specialist for follow-up.

And finally, on-call physicians must realize that they are representing the hospital, not their private practice. EMTALA is a requirement to treat, it is not a requirement to pay; therefore, the on-call physician must respond, whether or not the patient belongs to the managed care organization that the doctor participates in.
7. Documentation
   a. The Central Log
      Each patient who comes to the ED seeking care must be represented in the central log. The central log should include information on whether the patient:
      • Refused care
      • Was refused care
      • Was transferred
      • Was admitted and treated
      • Was stabilized and transferred
      • Was discharged
      … In other words, the clinical outcome of the patient. Additionally, it is recommended that logs of patients who are transferred, discharged or admitted be kept for five years.

   b. Patient Records
      EMTALA requires the following documentation in a patient’s record:
      • The Medical Screening Exam
      • The presence or absence of an Emergency Medical Condition
      • The care given to stabilize the patient
      • The transfer process

      All of this will be discussed in detail in the remainder of this document.

8. Federal vs. State Laws
   Remember that federal laws like HIPAA and EMTALA pre-empt state law. The most notable situation likely to involve this rule is when minors present to the ED. If a 16-year-old babysitter presents to the ED with a small child who has a fever, the facility must conduct a medical exam and make sure the child does not have an emergency medical condition - even if state law would normally require the consent of an adult.

   B. Understanding the Medical Screening Exam (MSE)
   Under normal circumstances, once a patient arrives at the ED, EMTALA requires that the facility provide a Medical Screening Exam to anyone who:
   • Requests an exam or treatment for a medical condition,
• Has such a request made on his or her behalf, or

• Based on the individual’s appearance it is apparent that they need an examination or treatment.

This request for treatment can come from anyone, including the patient, a family member, a police officer, a bystander, or a minor.

A Medical Screening Exam is a physical or mental health evaluation used to determine if the patient has an emergency medical condition. The hospital must provide the medical screening exam and necessary treatment within its capabilities. This includes the services of all departments, personnel and equipment.

To illustrate EMTALA’s rule regarding the Medical Screening Exam, let’s look at a case study in which a pregnant woman arrives at the ED who thinks she is having complications.

Case Study #1: Tina
Tina, a pregnant 21 year old, reports having sharp pains to her abdomen, vaginal bleeding and dizziness. The admitting nurse asks Tina how far along she is in her pregnancy and is told she is two months pregnant. The admitting nurse leads Tina to an exam room so that a physician can evaluate Tina immediately. After the medical examination, the doctor determines that Tina’s blood pressure is low at 80/60, and that she has the classic triad of symptoms for an ectopic pregnancy. The physician is very concerned about the potential for rupture and orders an ultrasound and lab tests to help her make a definitive diagnosis.

Let’s go through this case study step by step in order to discuss several important facts concerning Medical Screening Exams.

1) Because Tina is in obvious pain and potentially has an emergency condition, she is immediately moved to the exam room. A medical screening exam must never be delayed to ask for a patient’s payment method or insurance status. The rules do state that it is all right to collect information on the patient, IF this does not cause a delay in the medical screening exam or in the necessary stabilizing treatment of an emergency medical condition. Hospitals cannot condition screening and treatment upon completion of a financial responsibility form or provision of co-pay for services because this could deter the patient from getting the care they need. If the patient asks about the obligation to pay, a well-trained staff member who is knowledgeable on EMTALA should answer the patient’s questions. This person should tell the patient that the hospital stands willing and ready to provide a medical screening exam and stabilizing treatment, and should encourage the patient to defer further discussion of financial responsibility until their condition is stabilized.
2) **EMTALA** states that the medical screening exam must be conducted by a qualified medical person (QMP), based on the patient’s condition, complaint, and history. Based on the information that Tina is two months along, the attending physician is most qualified to handle her complaint. Had Tina been over 20 weeks gestation, she would most likely have been directed to the Labor and Delivery department to have her medical screening exam performed. On the other hand, if Tina had been brought to the ED as a trauma patient, an OB nurse should have been directed to the ED to assist with the evaluation of the patient.

The medical screening exam must be conducted by a qualified medical person, designated by the hospital in its bylaws, rules or regulations and approved by the Board. While CMS strongly suggests that a physician conduct the medical screening exam, there may be others approved by the facility such as Nurse Practioners, Physician Assistants or Registered Nurses who have advanced training or resources. This professional must have access to all of the hospital’s resources; be capable of ordering any necessary diagnostic procedures without exceeding the scope of their professional license; and interpret the results to determine if an emergency medical condition is present. Nurses without advance training or resources generally do not meet these criteria. In addition, there may be circumstances that are clearly not an emergency medical condition that other qualified personnel such as obstetrical nurses may conduct the initial screening exam. For example, most hospitals allow the labor and delivery nurse to conduct medical screening on women of more than 20 weeks gestation who present with isolated pregnancy-related complaints. However, the hospital’s governing board must designate them as qualified to screen these patients. If a hospital uses registered nurses to conduct limited medical screening exams, then specific policies should be adopted addressing an RN’s qualifications and when she must consult with a physician.

Be aware, however, that it is up to the hospital to determine under what circumstances a physician is needed. In addition, CMS reserves the right to second-guess a hospital’s designation of a qualified medical person, and substitute the judgment of the regulator. In fact, CMS states that regulators do not have to accept a hospital’s specification of what constitutes a qualified medical person when determining whether an appropriate medical screening exam was conducted. CMS has cited some hospitals for not having a physician conduct the medical screening exam, even though the hospital had trained nurses capable of performing the exam.

3) When Tina is examined, **she is afforded the same level of screening as any other patient who presents with a potential emergency medical condition.** A hospital may have generalized procedures or tailored screening protocols depending on the symptom. Hospitals must ensure that screening procedures are uniformly applied, and that everyone is afforded the same level of screening. This ensures that every patient that presents to the ED will receive the same standard of care. However, if the physician feels that a test is not necessary then it is not a violation, as long as this is recorded in the medical record.
4) **The Medical Screening Exam must be appropriate.** It is the perception of the physician at the time of the medical screening exam that determines the scope and appropriateness of the medical screening exam. In our story, the physician suspects an ectopic pregnancy. His orders for an ultrasound, complete blood count, and serum pregnancy test are therefore appropriate in facilitating a proper diagnosis.

To further illustrate this important point, let’s look at a court case, *Summers v. Baptist Medical Center*, 1996. A patient presented to the ED with back and chest pain after falling out of a tree while deer hunting. No chest X-ray was conducted, but the patient did have thoracic and lumbar sacral spine x-rays and was discharged. Two days later, it was found that the patient had a fractured sternum, rib and vertebrae. The physician and hospital won the case that an appropriate medical screening exam had been conducted because the physician did not perceive the chest symptoms as sufficient enough to warrant a chest X-ray.⁴

5) Medical screening exams must follow the facility’s own policies and procedures. Failure to do so is considered a violation of EMTALA; therefore, know your facility’s policies and procedures and follow them faithfully. Let’s look at a couple of cases to illustrate this point.

In *Blake v. Richardson*, 1999, a patient presented to the ED with appendicitis. His surgery was delayed after he was asked his sexual orientation and the medical team waited for the results of an HIV test. Because the hospital’s protocol for appendicitis was immediate surgery, it was determined that the hospital violated its own customary procedure.⁵

In another case, a nine month old child was dismissed from the ED by a physician’s assistant without first consulting the ED physician. Hospital policy required that all cases involving children under 12 be consulted with a physician, and the hospital was considered in violation of EMTALA.⁶

6) **The Medical Screening Exam must be within the capability of the ED.** According to EMTALA, a hospital must provide the services of all departments, personnel and equipment that are routinely available to the ED, including such services as CT scans and ultrasound. Tina was given services that would have been available to her as an ED patient or in-patient.

   **Triage is not considered a medical screening exam!!**

7) **Pregnant Women and the Medical Screening Exam:** Pregnant patients who undergo a medical screening exam should do so under a uniform and nondiscriminatory process. In other words, all pregnant women should have the same level of examination, even if there is a lack of prenatal care. The times for screening, availability of the fetal heart monitor or ultrasound should be similar for every pregnant woman.
At a minimum, pregnant women having contractions must have:

- Ongoing evaluation of fetal heart tones

- Observation and recordation of the regularity and duration of uterine contractions, fetal position and station, cervical dilation, and status of membranes (whether leaking, intact or ruptured)

C. Clarifying What Constitutes an Emergency Medical Condition

To review, the medical screening exam is conducted to determine if the patient has an emergency medical condition. Under EMTALA, an emergency medical condition is an acute condition with symptoms of such severity that a lack of immediate medical attention could either:

- Place the health of the individual in serious jeopardy (or in the case of a pregnant woman, the mother and/or fetus)

- Cause serious impairment to bodily functions

- Result in serious dysfunction of any organ

Emergency medical conditions include:

- Heart attacks

- Strokes

- Respiratory arrest

- Seizures

- Life threatening injury

- Pain

- Extensive bone or soft tissue injury

- Vascular or nerve damage

- Substance abuse

- Psychiatric disturbance
In our case study, Tina’s ultrasound confirms the presence of an ectopic pregnancy. The results convince the physician there is an emergency medical condition. This is documented in the record, and Tina is admitted to the hospital for further treatment and possible surgery.

After the medical screening exam is conducted, **the physician must document the presence or absence of an emergency medical condition.** If the health of Tina or her unborn child were in jeopardy, this would constitute an emergency medical condition.

If the medical screening exam determines that there is **NOT** an emergency medical condition, then **EMTALA does not apply and the facility is not obligated to provide further care or treatment.** This must be documented in the patient’s medical record. For example, “A MSE was done and no EMTALA EMC was present. The patient was discharged in stable condition.”

If the medical screening exam determines that there is **IS** an emergency medical condition, and the patient is admitted for inpatient services in good faith, **EMTALA no longer applies.**

**Pregnant Women and an Emergency Medical Condition:**
EMTALA states that pregnant women who present to the ED with contractions and are in true labor are considered to have an emergency medical condition **IF:**
- There is not enough time to safely transfer the patient to another hospital before delivery, or
- The transfer may pose a threat to the health and safety of the woman or unborn child.

Labor is defined as the process of childbirth beginning with the latent phase of labor or early phase of labor, and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician certifies that after a reasonable time of observation the woman is in false labor. Be aware then, that under this definition, a physician is the only one who can certify that a pregnant woman is in true or false labor, and a physician must certify false labor before the woman can be released.7

If a pregnant woman has abdominal pain, adnexal pain, intestinal cramps or other discomfort but is **NOT** in labor, the physician should document the absence of contractions in order to eliminate the hospital’s EMTALA obligations.

**D. Providing Stabilizing Treatment**
Under EMTALA, patients who present with an emergency medical condition must receive the necessary stabilizing treatment, including further medical exams. To clarify this further, stabilization (and subsequent treatment or transfer) only applies if a patient has an emergency medical condition.
Let’s look at a second case study to illustrate this aspect of EMTALA.

**Case Study #2: Fred**
Fred has been brought into the ED by his sister out of concern for his safety. According to his sister, Fred has voiced suicidal thoughts, has a history of self-mutilation, and has refused all food and drink for several days. The physician also questions Fred himself to verify that the patient has the understanding and capacity to communicate during the exam and any treatment that may be necessary.

A psychiatric or behavioral health condition can be considered an Emergency Medical Condition IF:
- The patient is comatose or has an impending comatose condition with a history of drug ingestion
- There is depression with feelings of suicidal hopelessness
- There are delusions, severe insomnia and hopelessness
- There is a history of recent suicidal attempts or ideation
- There is a history of recent assault, self-mutilation or destructive behavior
- There is an inability to maintain nutrition in a person with altered mental status
- There is impaired reality testing with psychotic behavior
- There are impeding DT’s
- There is acute detox
- There are seizures from the withdrawal of a toxic agent, and other similar conditions

The examining physician concludes that Fred’s behavior constitutes an emergency medical condition. Under EMTALA, the facility is therefore obligated to provide care and treatment. However, while the facility has the means to stabilize Fred, it does not have an outpatient psychiatric unit, Behavioral Health Department or other available resource to adequately treat the patient. A nearby facility that specializes in psychiatric patients is contacted, and because the facility has the space, qualified personnel and resources to care for Fred, an appropriate transfer is arranged. Staff clearly document in the medical record that the receiving facility has agreed to accept the patient.
Let’s look at this case to discuss some important points. Fred has an emergency medical condition, and under EMTALA, must be stabilized prior to discharge, admission or transfer. **Stabilizing the patient means providing the treatment necessary to assure that no material deterioration of the patient’s condition is likely, within reasonable medical probability, to result from or occur during the transfer.** In our case study, Fred is given medication to stabilize his condition prior to his transfer.

Other issues to remember when it comes to psychiatric patients:
- The facility is obligated to stabilize the patient if there is an emergency medical condition, unless the patient is deemed competent and refuses care.
- If there is a surrogate decision maker, such as a guardian or Durable Power of Attorney, then treatment must be discussed with them.
- In the event of an emergency, consent is presumed.
- Remember the involuntary admission procedure, which every state has. This allows for the involuntary admission of patients who are a danger to themselves or others.
- State programs set up for the inpatient treatment of psychiatric patients are preempted by EMTALA. For example, a patient presents to the ED having suicidal ideations. The state has a program and asks the triage nurse to have the patient’s family drive him several miles to their office so they can conduct a MSE. The federal EMTALA law would be violated if this occurred.

If a patient is stabilized and this is documented in the medical record, then the hospital has satisfied its responsibility under EMTALA. However, while stabilizing a patient or admitting them into the hospital relieves the hospital of its EMTALA obligations, it does not relieve the hospital of all further responsibility to the patient as discussed under Medicare COP section 482. Stabilization or admission of the patient to the hospital does not mean that the facility has the right to improperly discharge, prematurely discharge, or transfer the patient to another hospital.

**The documentation of the patient’s stabilization is paramount from a legal standpoint.** There have been many lawsuits to settle where there was a failure to stabilize a patient. Therefore, it is important to note that there are two aspects to the definition of stabilization. First, a physician must have actual knowledge that an emergency condition exists before there can be liability for failure to stabilize. Secondly, there is a more objective question as to whether the physician should have known that there was an emergency medical condition. If the patient’s condition deteriorates, this issue will come up and there must be clear documentation on the findings of the medical screening exam to back the physician. For
example, if a child were diagnosed with an ear infection and later dies from meningitis, this would be a malpractice case rather than an EMTALA violation, since the physician did not recognize the true severity of the patient’s condition.

In Fred’s case, the physician recognized the emergency medical condition, documented this in the record, and stabilized the patient through sedation prior to the transfer to the psychiatric facility. It is important to note that CMS has not given guidance on how a psychiatric emergency medical condition should be stabilized... the physician must use his best judgment.

E. Understanding the Transfer Process

Transfer: The movement (including discharge) of a patient outside of a hospital’s facilities; or outside the direction of any person that is employed by, affiliated with, or associated with the hospital – either directly or indirectly. This does not include a person who is declared dead or a person who leaves the facility without permission. For example, all discharges from the ED are transfers; inpatients who are re-admitted through the ED are transfers; and patients going to another facility for tests such as MRI’s or are sent to another facility for admission are transfers.

As a general rule, if a patient has an emergency medical condition, the patient may not be transferred if the facility has the resources, space and physicians to manage the patient. However, if the hospital lacks the capability to treat the patient, the patient should be transferred to another medical facility. This will require an appropriate transfer that will satisfy EMTALA law. An appropriate transfer is the movement of a patient to another facility that has the space, qualified personnel and resources to care for the patient or unborn child.

Let’s continue using Fred as an example in order to discuss the transfer process as it applies to EMTALA.

In order to ensure Fred’s proper transfer, the following steps must be taken:

1) There must be proper documentation in the medical record of whether or not the patient has been stabilized prior to discharge, admission, or transfer. To satisfy Joint Commission standards this documentation should indicate:
   • If emergency care was provided to the patient prior to arrival
   • The time and means of the patient’s arrival
   • If the patient leaves before they are stabilized or treated
   • The conclusions at the termination of treatment, including the condition of the patient at discharge, and follow-up care instructions
2) **A transfer certificate must be filled out completely and signed by a qualified medical person.** If the physician is not present in the ED at the time of transfer, a qualified medical person can sign the certification after consultation with other personnel. However, the physician must countersign in a timely manner.

3) **The patient must be transferred by a qualified medical team and with the proper equipment.** This will include the use of life support measures in order to ensure the safety of the patient.

4) **All pertinent medical records must be sent with the patient.** This must include the following:
   - Medical history
   - Observations
   - Preliminary diagnosis
   - Test results
   - A copy of the transfer certificate

   Additionally, **documentation requirements by the Joint Commission** must indicate:
   - How stable the patient is
   - The responsibilities of the transferring team
   - The acceptance by the receiving organization
   - The reason for the transfer

   Any records that are not available must be sent as soon as possible to the receiving facility.

5) **Retain medical records for 5 years from the date of transfer.** This will ensure that the information is available should the records be reviewed at a later date.

   **There are limited circumstances in which a pregnant woman with contractions can be transferred:**
   - If the delivery is expected to be highly complex and will need specialized obstetrical services
   - If gestational age of the fetus near the time of viability would benefit from specialized neonatal expertise
• If examining MD certifies in writing that the benefits outweigh the risks to the mother and child

• If transfer team has everything that could possibly be needed during the trip, such as a pitocin drip, warm blankets, an obstetrical nurse, neonatal nurse, fetal heart monitor, or even an obstetrical doctor

EMTALA also addresses the question: **Can a facility turn down a transfer? The answer is yes, under limited circumstances.** First of all, the receiving hospital does not have to accept the patient if it does not have the capacity to stabilize or treat the patient. But, if the facility has specialized capabilities, such as a burn or shock trauma unit, then it must accept the patient if it is able to do so. A hospital can also deny the transfer if it is on diversionary status because it does not have the beds or staff to accept additional patients.

Another important aspect of the transfer process is when a patient cannot be stabilized, and either requests transfer, or needs a transfer for better care.

**An un-stabilized patient can be transferred IF:**

- The patient makes a written request for transfer AND the patient is informed of the hospital’s obligation to provide care and the risks associated with the transfer;

- Or, if the benefits of treatment at another facility outweigh the risk of transfer, AND the second facility agrees to accept the patient.

**F. Responding to Refusal of Treatment**

As discussed earlier, when a patient comes to the ED and it is apparent that they require a medical screening exam, one must be provided. If it is determined that the patient has an emergency medical condition, their condition must be stabilized. In the event that the patient leaves before they are offered a medical screening exam or before their condition is stabilized, there are certain steps that must be taken by the ED staff to satisfy EMTALA laws and prevent a hospital violation. Let’s look at another case study in order to discuss the proper steps to take in the event that a patient presents to the ED for care, then decides to leave prior to the medical exam or treatment.

**Case Study #3: Bob**

Bob presents to the ED with a knife wound to the arm and no other apparent injuries. When he learns that the police will be called to report the stab wound, he becomes increasingly agitated and demands to leave before the physician can adequately examine him.
If a patient refuses treatment or wishes to leave before he is stabilized:
1) Offer the patient further medical examination and treatment as needed to stabilize their condition.

2) Inform the patient of the benefits of the exam or treatment, and the risks of leaving prior to receiving such an exam or treatment.

If the patient refuses care, the medical team must:
1) Take all reasonable steps to secure written informed consent for refusal of care. This form should contain a description of the specific risks discussed with the patient, and the fact that the patient refused care and treatment. These should be documented on the form, such as bleeding, infection, tetanus and death. The burden is on the hospital to show that it has actively discouraged the patient from leaving.

2) Document in the medical record a description of the examination, treatment, or both that was refused by the individual, or on behalf of the individual; and that the individual was informed of the risks and benefits of the examination or treatment.

If the hospital offers to transfer the individual to another hospital in accordance with EMTALA, but the individual or person acting on his behalf does not consent:
1) Take all reasonable steps to secure written informed refusal

2) Write in the document that the individual was informed of the risks and benefits of the transfer and state the reasons for the individual’s refusal

3) Document in the medical record a description of the proposed transfer that was refused by the individual or on the individual’s behalf.

If a patient leaves the hospital without notifying anyone:
1) Retain the triage notes or other records

2) Document the fact that the patient was there

3) Document what time it was discovered that the patient left

This would be especially important if Bob had been kept waiting in the ED so long that he left against medical advice without being seen by a physician. This is a violation of EMTALA.
IV. Ethical Issues in EMTALA

As you can see, EMTALA law is designed to protect the health and safety of all patients who present to the ED. Therefore, it should be no surprise that it includes strong language on ethical issues related to this care.

1) **A facility cannot penalize or take adverse action against a physician or other qualified medical personnel for refusing to authorize the transfer of an unstable patient**, if they feel it would not be in the best interest of the patient.

2) EMTALA states that **in all cases, the medical judgment of the treating physician takes precedence over the judgment of an offsite physician**. While there are times that the emergency department physician and on-call specialist will need to discuss what is best for the patient, any disagreements that may arise from these discussions regarding the need for the on-call physician to come to the hospital and examine the patient himself must be resolved by deferring to the judgment of the emergency department physician who personally examined the patient.

3) **If you suspect an inappropriate transfer to your facility you are required to report it promptly to CMS or to the Department of Health and Human Services.** CMS prefers that such violations be reported within 72 hours, but this is not mandatory. It is recommended that the other facility be notified first, advised that your facility believes there was an EMTALA violation, and ask if they have documentation or clear justification as to why they believe it is not a violation.

An inappropriate transfer can occur when a patient is not properly screened, or the transfer was conducted with improper transportation, equipment or personnel. If the reason for a transfer is that the sending facility had an on-call MD who refused or failed to show up within a reasonable amount of time, then the physician’s name and address must be included in the documentation. The receiving facility is obligated to report that the physician – and the hospital - are in violation of EMTALA.

V. Responding To An EMTALA Survey

CMS conducts validation surveys of JCAHO accredited facilities. For these types of surveys, facilities are selected at random and given 10 to 14 days notice. CMS can also conduct a survey based on a complaint. These surveys by DHHS are unannounced. Generally, complaints can come from patients, families, ambulance drivers, pre-hospital providers or the hospital that was dumped on. These are filed with the DHHS, which then passes the complaint onto CMS. If CMS finds the complaint has merit, it will instruct DHHS to conduct a survey. Sometimes violations are discovered by DHHS during a routine validation survey or other investigation.

When surveyors arrive at the facility, they will ask to speak to the hospital administrator or ED Director to notify them of the survey and investigation. These hospital personnel should then immediately call
Risk Management, and legal counsel should be considered. The surveyor must never be kept waiting – they should be greeted immediately upon arrival. A high-ranking hospital manager should also introduce themselves to the surveyors to indicate that the survey is being taken seriously. One person who is deemed knowledgeable about the hospital’s EMTALA program will be assigned to the surveyor to assist them and answer any questions. Be sure to provide the surveyor with a private work area with sufficient chairs and space, and remove any confidential material from this area. The surveyor may request many different kinds of records, such as the ED control log, medical records, and the ED policies and procedures, and can ask for records at any time. Avoid delays in providing these records if at all possible.

Surveyors may look for the following:

- Patients transferred to other facilities
- Refusal of exam, treatment or transfer
- Patients who leave against medical advice
- Patients who return to the ED within 48 hours
- Gaps in entries in the log

The surveyors may wish to interview anyone working in the ED at the time of the alleged violation, especially the admitting clerk, nurse on duty and Performance Improvement director. They may ask about the patient registration process, triage, MSE delays, any contact with payors during the registration process, and may inquire into the staff’s EMTALA knowledge. At the end of the investigation the surveyor will conduct an exit interview. This will cover the scope of the investigation, the records reviewed, the COP’s investigated, the consequence of the findings, and what will be reported to CMS.

The report of the investigation must recommend one of the following:

1. No findings. The complaint is not substantiated and the facility keeps its deemed status.

2. In compliance, but previously out of compliance. A violation occurred in the past, but the hospital identified it before the visit and corrected it and reoccurrence is unlikely.

In both of the above, the investigation is concluded, and the hospital and complainants are informed of the findings.

3. Recommend termination on either a 23 or 90-day track. If CMS finds that a violation has occurred and concludes there is a serious and immediate threat to the health, safety, and welfare of patients, the hospital has 23 days to correct the problem and provide evidence of such to CMS. If
CMS finds that a violation has occurred, but that it is not an immediate or serious threat, then it initiates a slow track or 90 day termination.

4. **Request an MD review.** CMS will further review medical judgments or decision-making regarding the complaint. After this, CMS makes a decision as to its recommendation.

5. **Possible discrimination.** CMS finds that there may be discrimination based on financial basis, race, color, diagnosis or handicap.

If CMS does find that an EMTALA violation occurred, it will send the facility a deficiency statement listing each of the requirements that were violated and the basis for that judgment. The hospital must then file a plan of correction that outlines the specific measures the hospital will take or has taken to correct the problem, along with evidence of the correction.

**VI. Conclusion**

In conclusion, caring for patients in urgent need of care is a healthcare imperative. EMTALA was created as a means to protect the basic rights of a patient to receive care and treatment, while at the same time protecting the assets of the facility. In order for EMTALA to work as it should, emergency department personnel must become familiar with the components of the EMTALA regulations and associated standards. The future of your patients, and your facility, depends on it.
VII. References
All information was taken from the Federal Register, Part II Department of Health and Human Services, Centers for Medicare and & Medicaid Services, 42 CFR Parts 413, 482, and 489 Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical Conditions; Final Rule, unless otherwise noted. Available at: <http://www.cms.hhs.gov/providers/emtala/cms-1063-f.pdf>


7. S & C #02-14, Certification of False Labor, EMTALA, January 16, 2002.

VIII. Resources
1. www.bricker.com <http://www.bricker.com>, Click on Client Resources, then EMTALA for a comprehensive list of all the EMTALA documents and resources, such as Federal Statutes, Federal Regulations, CMS and OIG Bulletins and Advisories, and other documentation.


IX. Post Test and Answers

1) T or F  EMTALA affects only those healthcare professionals who work in the Emergency Department.

2) The consequences for violating EMTALA include:
   A. Terminating the hospital from the Medicare/Medicaid program
   B. Losing JCAHO accreditation
   C. Civil lawsuits
   D. All of the above

3) T or F  A dedicated ED includes a hospital department or facility that provides at least half of its outpatient visits for the treatment of an emergency medical condition on an urgent basis without requiring an appointment.

4) A person who “comes to the ED” is someone who presents to one of the following in an attempt to secure emergency care, except:
   A. A car in the ED entrance
   B. The main entrance of the hospital
   C. Physician offices adjacent to the hospital
   D. The sidewalk of the hospital

5) T or F  If an on-call physician refuses to come to the ED when called, the hospital and physician are in violation of EMTALA.

6) The following can be said about the Medical Screening Exam (MSE):
   A. An MSE can be delayed to ask for a patient’s insurance status, if the condition doesn’t look serious
   B. An EMTALA approved MSE is not subject to a hospital’s policies and procedures
   C. A qualified medical person must conduct the MSE
   D. An MSE is conducted to determine whether the patient has an admittable illness or condition.

7) T or F  If the MSE determines that there is NOT an emergency medical condition, then the facility is not obligated to provide further care or treatment.

8) T or F  If the MSE determines that there IS an emergency medical condition, and the patient is admitted for inpatient services, EMTALA will no longer apply.

9) The following can be said about stabilizing a patient:
   A. A patient must be stabilized prior to admission
   B. Stabilizing means providing treatment to assure there is no further deterioration of the patient’s condition
   C. Once a patient is stabilized, the hospital is relieved of all further responsibility
   D. All except C.

10) A patient can be transferred to another facility if:
    A. The hospital does not have the capability to care for the patient
    B. The benefits of treatment outweigh the risks of transfer
    C. The physician signs a transfer certificate
    D. All of the above
ANSWERS

1. False. EMTALA affects all personnel in the Emergency Department, including attending physicians and on-call physicians; Emergency Medical Service staff; as well as Labor and Delivery and Behavioral Health Departments; Risk Managers, Senior hospital leadership and legal counsel.

2. D. All of the above.

3. False. Under the new definition, a dedicated ED includes a hospital department or facility that provides at least 1/3 of its outpatient visits for the treatment of an emergency medical condition on an urgent basis without requiring a previously scheduled appointment.

4. C. Physician offices adjacent to the hospital. A person who “comes to the ED” is someone who presents to the hospital’s ED or elsewhere on the hospital property in an attempt to secure emergency care. This includes the parking lot, sidewalks and driveway, but does NOT include structures that are not part of the hospital, such as physician offices, skilled nursing facilities or shops.

5. True. This is because as part of the Medicare/Medicaid provider agreement, the hospital agrees to enforce a policy to comply with CMS regulations – including having their physicians arrive when called.

6. C. A qualified medical person must conduct the MSE. The other statements are false.

7. True. If there is no EMC, then EMTALA does not apply.

8. True. However, the patient must be admitted for inpatient services in good faith, not as a way to avoid EMTALA obligations.

9. D. All except C. While stabilizing a patient or admitting them into the hospital relieves the hospital of its EMTALA obligations, the hospital still has responsibilities to the patient.

10. D. All of the above.
X. Tool

25 Tips to Reduce the Risks of an EMTALA Violation

1. Adopt and enforce a policy that complies with the requirements of 42 CFR Parts 413, 482, 489.

2. Ensure there is a sign posted in the ED specifying a patient’s rights should they have an emergency medical condition or be a woman in active labor who comes for healthcare services.

3. Make sure the sign says that your hospital participates in the Medicare program.

4. Ensure that medical records are retained for five years from the date of transfer.

5. Maintain a list of on-call MD’s to provide the necessary care to stabilize patients with emergency medical conditions.

6. Maintain a central log on each patient who comes to the ED seeking care.

7. Make sure the log includes whether the patient refused care, was refused care, was transferred, admitted and treated, stabilized and transferred, or discharged.

8. Ensure that patients who come to the ED receive an appropriate medical screening exam.

9. Ensure that patients are provided stabilizing treatment for an emergency medical condition and labor.

10. Ensure that an appropriate transfer is provided for an unstable patient only after the patient is informed of the risks and the obligations of the hospital, or the patient requests a transfer. The physician must have signed the certification that the benefits outweigh the risks.

11. Ensure that a qualified medical person is truly qualified and has signed the transfer certificate, and the physician timely countersigns the certificate.

12. Ensure the patient is transferred with a qualified transport team and proper equipment.

13. Make sure the Medical Screening Exam is never delayed to ask about payment status.

14. Accept appropriate transfers of patients with emergencies if the hospital has specialized capabilities and the capacity to treat those patients.
15. Do not take action against a physician, qualified medical person or staff member who reports a violation if the patient is unstable and is transferred.

16. Make sure the facility reports promptly when it suspects it has received an inappropriate transfer.

17. Ensure that all pertinent medical records are sent with the patient.

18. Obtain the consent of the receiving hospital.

19. Ensure that all on-call physicians respond to their calls.

20. Train staff on EMTALA and consider yearly in-services as well.

21. Keep a book that contains all the relevant information on EMTALA such as:
   - The final rules
   - Interpretive Guidelines and Investigative Procedures for Responsibilities of Medicare Participating Hospitals in Emergency Cases
   - CMS & OIG Special Advisory Bulletin, November 1999
   - Prospective Payment System (PPS) rules in the Federal Register effective November 2000
   - Medicare Conditions of Participation
   - Hospital policies and procedures
   - In-services done
   - Periodical surveys by the compliance officer
   - Relevant EMTALA cases
   - Copies of forms such as patient refusal to consent to transfer; patient demand for transfer; physician certification for transfer and patient agreement to transfer; and qualified medical person certification for transfer.

22. Consider keeping portions of this book available to staff, especially in the emergency and obstetrical departments.

23. Have adequate medical and nursing staff in the emergency department to meet the needs anticipated by the facility.

24. Emergency services must be supervised by a qualified member of the medical and nursing staff.

25. Ensure there is a compliance officer who makes sure all the above tips are complied with.