EMTALA Compliance Checklist 2020

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I. Introduction:

"Life is short, the art long, opportunity fleeting, experience treacherous, judgment difficult." Hippocrates

The Emergency Medical Treatment and Active Labor Act (EMTALA) directly impacts the delivery of hospital based emergency services. Congress passed EMTALA to prevent "patient dumping" - hospitals and physicians denying individuals emergency care, or transferring them to public institutions for purely economic reasons. Today, however, EMTALA governs virtually all aspects of the hospital and medical staff delivery of emergency care.

EMTALA was intended to be an anti-discrimination statute. Substantively, though, it confers a federal right to emergency care and sets a standard of care that hospitals and physicians must provide under threat of draconian penalties, such as termination from Medicare, $100,000 + civil monetary fines, and civil lawsuits.

II. Brief Overview - What is EMTALA?

A. EMTALA is federal law imposing primarily three legal duties upon hospitals:

1. Emergency departments must provide an appropriate medical screening exam (MSE) to determine whether or not an emergency medical condition (EMC) exists.

2. If a hospital determines that an emergency medical condition does exist, then the hospital must either stabilize the medical condition, or, if it is unable to stabilize the individual, the hospital must transfer the patient to a hospital that is capable of stabilizing the medical condition.

3. Hospitals with specialized capabilities or facilities are required to accept appropriate transfers of patients who require such specialized services, if the hospital has the capacity to treat the individual. (EMTALA's "non-discrimination provision")

   EMTALA specifically requires hospitals to maintain a list of on-call physicians to help the ED determine if the patient has an emergency medical condition, to help stabilize emergency patients, and to treat patients the hospital accepts in transfer. Furthermore, there may be 'no delay' in access due to the patient's insurance status.

B. To what persons, what hospitals, and which physicians does EMTALA apply?

1. any individual not already a "patient" who "comes to the ED"
2. private patients of the medical staff seen in the ED
3. all hospitals that participate in Medicare (>98% of U.S. hospitals)
4. all physicians who treat patients in a hospital

C. Who is <u>not</u> covered under EMTALA?

1. patients determined by the MSE to not have an EMC, as defined by law
2. patients who are stabilized, as defined by law
3. scheduled outpatients or patients *admitted* to the hospital, as defined by law

III. Legal Definitions v. Medical Definitions

A. "The statutory definition renders irrelevant any medical definition."
Judge in *Burditt v. US Dept. of HHS*, 934 F.2d 1362 (5th Cir. 1991).

B. EMTALA's definition of "<u>transfer</u>":
"Transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

IV.EMTALA Compliance Issues Checklist

Medical staff leadership, hospital administration, legal counsel, compliance officers, risk managers, emergency physicians, and on-call physicians need to ensure that the following EMTALA issues are all adequately addressed.

1. Adopt and enforce hospital-wide EMTALA policy.

a. CMS requires written policies and procedures governing ***hospital-wide*** compliance. (An ED only EMTALA policy or ED / Hospital Transfer Policy is not sufficient.)
b. Failure to enforce policy or censure non-compliant physicians is a violation of the law.
c. Hospital is liable for all violations by hospital ***and*** physician staff. This is direct liability, not vicarious liability, and includes liability for civil monetary penalties assessed by the OIG and civil damage lawsuits brought by individuals harmed by the EMTALA violation.
d. 'Failure to follow your own rules' is a primary source of litigation under EMTALA. All EMTALA-related policies, especially the ED policies, must be critically reviewed by knowledgeable individuals able to recognize the potential medical and legal pitfalls.

2. Educate appropriate staff.

a. Emergency department personnel: physicians, nurses, and clerical staff
b. On-call physicians and all members of the medical staff
c. Physicians who transfer patients out of the hospital
d. Physicians who accept transfers into the hospital on behalf of the hospital
e. Hospital and nursing administrators responsible for ED operations and transfer acceptance systems, such as Physician Referral Lines, and off-campus facilities.
f. Medical staff leadership and by-laws committee
g. Corporate counsel, compliance officers, and risk management personnel
h. Mandatory EMTALA training for all new members of the medical staff as condition of privileges; continuous training for all staff.

3. Medical Screening Examination (MSE) Requirement

a. Identify 'Dedicated Emergency Departments' (DED). Determine which areas of the hospital are 'dedicated EDs', according to the CMS regulations, and must comply with EMTALA. Examine whether the ED, L&D, psych screening center or intake center, PEDS walk-in clinic, or an on or off-campus Urgent Care Center meet the legal definition of a DED and must comply with the law.

b. Where Can You Screen Patients? Only in a hospital identified DED. 'Redirection' from the ED to other areas of the hospital, such as rural health clinics, unattached urgent care centers (on-campus or off-campus), PEDS clinics, Federally Qualified Health Clinics, or to physician offices is fraught with potential EMTALA and civil liability. Understand the legal implication of such practices, the practicalities, and the risk management issues before undertaking any movement of patients presenting to the ED away from the ED.

   Redirection of individuals to an alternative site for the MSE off-campus may be allowed in federally declared disasters or public health emergencies (such as tornados, hurricanes, or the Covid-19 pandemic) if a blanket waiver is issued by DHHS/CMS, or the hospital seeks and is granted a waiver by the federal government.

c. Designate Qualified Medical Personnel (QMP) Who Can Do the MSEs. The governing body of the institution must formally designate who may perform screening examinations on behalf of the hospital in each of the hospital's DEDs. Physicians are the most appropriate staff to conduct screening exams - emergency physicians and members of the medical staff who see their own patients in the DED.

   In L & D, specially trained labor and delivery nurses may be able to conduct the MSE if within their scope of practice and allowed by the state's Nurse Practice Act. Otherwise, the nurses are conducting a 'nursing assessment', not a MSE, and the physician needs to be designated as the QMP responsible for the MSE and determining whether the pregnant woman has an emergency medical condition. No matter who is the QMP, the on-call obstetrician must be called for the medical-decision-making in every case. Whether the on-call obstetrician must come into L&D and personally 'face-to-face' examine the woman in each case is currently an open question with CMS.

d. Define the Hospital's Standard Screening Process. Define the hospital's "standard medical screening examination" process for patients presenting to Dedicated Emergency Departments. The scope of the MSE must be reasonably calculated to exclude the presence of an emergency medical condition; this includes utilizing necessary tests, ancillary services, and on-call specialists when necessary. Policies and procedures drafted carefully markedly help prevent civil litigation; poorly drafted ones bury hospitals. E.g., fever policies or repeat vital signs policies. Policy language is VERY important!

e. Address the Treatment of 'Non-emergencies' in the DED. CMS's regulations did NOT change anything regarding the screening of patients presenting with minor complaints that appear to be 'non-emergencies'. The purpose of the MSE is to determine whether the patient's complaint is or is not an EMC as defined by law. The *scope* of the MSE may change depending on the nature of the patient's complaints, but the actual process of screening patients should ***not*** change based on the complaint.

   Specifically address common problem scenarios such as police blood alcohols, evidence collection for alleged rape, or patients sent to the ED by their physicians for labs, x-rays, splints, Foleys, medication injections, or immunizations.

   'Scheduling' an ED visit for a non-emergent condition is illegal under EMTALA. [See Bitterman RA. 'Scheduling' an Appointment in the ED: Is it Allowable under EMTALA? *Emergency Department Legal Letter* 2012;23(5):49-55.]

f. Request for a MSE. The request for the MSE does not need to come from the patient. A request for examination or treatment of a medical condition of an individual can come from the patient's family, friends, significant other, the police, the medics, the babysitter, or ANYONE, even a random stranger. CMS also has a 'prudent layperson' standard for when the patient's appearance or behavior alone constitutes a 'request'.

g. Triage. Triage does not constitute a medical screening examination. Insurance information should be removed from triage forms or process; triage decisions should be made without knowledge of the patient's insurance status.

h. Private patients or 'VIP' patients. In some hospitals, members of the hospital's medical staff often meet their private patients in the emergency department. These patients are examined and treated by their private physicians instead of the emergency physician on duty. This practice is entirely appropriate to maintain physician-patient relationships and allowable under EMTALA.

   However, the hospital should have prearranged procedures for handling private patients that do not delay the patient's MSE or the hospital could be liable under EMTALA for failure to provide an "appropriate" MSE. Delay of treatment in such instances also frequently results in hospital liability through state malpractice actions.

i. Minors. The hospital must conduct an MSE on any unaccompanied minor who requests examination or treatment, or on any minor on whose behalf a request is made (even if it comes from the 15 year-old babysitter, police officer, or EMS staff), irrespective of whether consent has been obtained from the parent or legal guardian. Consent is a creature of state law, and it is preempted by federal law, EMTALA, under the supremacy clause of the US Constitution.

Do not make the error of allowing the triage nurse to make the child wait to see the emergency physician until parental consent is obtained whenever the triage nurse categorizes the minor as a 'non-emergency' condition. This practice is illegal under EMTALA (and just plain bad medicine).

It is of course appropriate to contact the child's parents for consent, but that process should never delay the MSE regardless of how trivial a complaint appears initially. If the MSE reveals no EMC, then the hospital can, and generally should, wait to obtain proper consent from the minor's parents or legal guardian before proceeding with further evaluation and treatment.

j. Uniformity. All patients get the ~ exact same screening process based on chief complaint and their medical condition - regardless if they are a private patient, Medicaid patient, managed-care patient, indigent, illegal alien, or member of any other protected category.

k. Labor and Delivery. If L&D is used to perform screening examinations, the process must be uniform for all patients and the interplay between L & D and the ED must be clearly defined. L&D must conform to all the same EMTALA requirements as the ED. Documentation is critical, since there is a great deal of confusion regarding 'labor', 'true labor', 'false labor' and what exactly is required to screen pregnant woman and what constitutes an EMC. (See the attached OB EMTALA MSE algorithm; and the CMS memos on 'false labor' cited in the references.)

l. Off - Campus Facilities. No longer come under the umbrage of EMTALA. Urgent Care facilities may be an exception. See below.

4. Stabilization Requirement.

a. Duty to Stabilize. If the hospital determines the patient has an emergency medical condition (EMC) it has a duty under the law "to stabilize" the patient, which means "to provide such medical treatment of the EMC as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility … "
[42 USC 1395dd(e)(3)(A).]

b. Admission ends EMTALA. Admission to the hospital ends application of the law (according to CMS; but see the Sixth Circuit's ruling in the *Moses* civil case.)

- Patient must be formally 'admitted', as defined in the Medicare manual.
- Admission to 'observation status' does not count as admission for purposes of ending application of EMTALA.
- Direct admits do count as 'admitted' for purposes of ending EMTALA.
- If an individual develops an EMC while an inpatient, EMTALA does not apply, but the hospital still must have a system to respond to inpatient emergencies.
- Must physicians on-call for the ED respond to inpatient emergencies too?

c. 'EMC must be resolved'. CMS issued confusing interpretations of when an individual with an EMC is stabilized and when the application of EMTALA ends. CMS now rules that to stabilize and individual with an EMC, the EMC must be 'resolved'. This interpretation is contrary to the plain language of the statute, all court rulings on the issue, CMS's own prior regulations and guidelines, and will create confusion and additional liability for physicians and hospitals when transferring patients with EMCs.

5. No Delay on Account of Insurance Requirement – When Can You Ask for Money?

[Review CMS's "warning" to hospitals on compliance with EMTALA in view of implementation of the Patient Protection & Affordable Care Act: CMS's S&C Letter14-06-Hospitals /CAHs, December 13, 2013: *EMTALA Requirements & Conflicting Payor Requirements or Collection Practices.* Available at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-06.pdf.]

a. Medical Screening Exam. The screening examination must not be delayed to obtain authorization for payment from a managed care plan or because of the patient's insurance.

1. Do not delay the MSE by asking questions about insurance, seeking authorization for payment from an HMO, requesting co-payments, or requesting signatures on Medicare advanced beneficiary notification forms (ABNs).

2. Do not attempt to influence the patient by bringing payment or HMO issues to the patient's attention prior to screening.

3. Triage patients, then examine and treat them in the order determined by their medical acuity. Blind the clinical staff to the patient's insurance status until disposition.

4. It is perfectly appropriate for non-urgent patients, who are waiting to be seen behind more acutely ill patients, to be registered and asked to provide insurance data (but not co-pays or down payments according CMS as of 12/13/2013). However, at no time can a patient's care be delayed, nor a patient asked to wait for authorization, prior to the medical screening examination and/or stabilizing treatment. Utilize bedside registration to obviate the issue, especially to CMS and State Survey Agencies.

5. Understand the potential risks associated with CMS's regulation of 'no-delay' due to calling the patient's personal physician or an on-call physician.

b. Stabilization. Once it is determined the patient has an emergency condition; further treatment for that condition must not be delayed while obtaining authorization from an HMO for further care, admission, or transfer of the patient. This includes involvement of on-call physicians or the hospital accepting patients in transfer.

6. Patient Refusal of the MSE, Stabilizing Treatment, or Transfer

a. Written Informed Consent. The hospital must should take all reasonable steps to obtain the patients informed written consent for refusing the examination, treatment, or transfer.

b. LBEs. Create a system to demonstrate that patients who left the ED without being seen did so voluntarily and that the hospital did not deny them a MSE. Document!

c. Avoid 'Constructive Denial' of the MSE. Nurses, particularly triage nurses, are often the target of angry or frustrated patients and must deal with patients considering or intent on leaving the ED without receiving or completing the examination or treatment. The nurses' comments must not be deemed as 'encouraging patients to leave' nor 'unduly discouraging them from staying'.

d. Refusal Form. The hospital must explain to the patient its legal obligations under the law, the risks and benefits of refusing the examination, determine if the patient is competent to refuse, and then obtain the patient's signature. The ED physician or the patient's private physician should always be involved in this process. If the patient refuses to sign the consent form, then a hospital representative should sign a statement indicating that the patient was offered but refused the examination and refused to sign the form.

Differentiate, at least in policy, the EMTALA requirements related to refusing the offered MSE from the EMTALA requirements related to refusing treatment or transfer to stabilize patients determined to have an EMC – the requirements are legally different!

7. Hospital On-Call Physician Requirement

EMTALA governs the hospital's physician on-call backup system for the ED, which is clearly one of the most difficult and contentious issues facing every hospital.

First, the hospital and the medical staff must decide which physicians must take call and how often, and provide the list of on-call coverage to the ED. This way the ED knows ***prospectively*** whether it does or does not have a particular specialty available for each 24 hour period. This is critically important information for notifying EMS in the local community of the services available, for transferring patients to other hospitals, and for accepting or rejecting patients in transfer from other hospitals.

Second, the hospital must explicitly define the duties and responsibilities of the physicians when they do take call so that everyone knows in advance exactly what it means to be 'on-call' for the hospital. Only bad things happen, particularly to the patients, if these duties and responsibilities are not clearly defined and the emergency physicians are left groping to figure them out at 3AM on Saturday night.

Under EMTALA, the on-call system is the responsibility of the hospital board, not the medical staff, though obviously the board will look to the medical staff for formulation and monitoring of the call system.

This legal duty also means the hospital is directly (not vicariously) liable under the law if harm comes to patients due to any failure of the on-call system. The enormous liability of the hospital for the call system is the most effective impetus to secure the support of the administration to provide an effective on-call system, or to address recalcitrant behavior of individual on-call physicians.

Issues that must be addressed relative to the on-call system include the following:

1. Medical staff commitment to providing on-call services to the hospital.

   - The medical staff bylaws or rules & regulations must include a commitment, in writing, to provide on-call services to the ED.
   - Mandatory EMTALA training for all new members of the medical staff as condition of privileges; continuous training for all existing staff.

2. The hospital must maintain a list of physicians on-call for the ED.

   - Determine which physicians must take call and how often. Generally, all medical specialties represented on the medical staff should provide some on-call coverage.
   - Address the issue of whether 'senior status' physicians must take call.
   - Differentiate call duties for one's private practice vs. call for the ED.
   - Align hospital privileges and on-call duties very carefully.

3. Administration of the physician on-call list.

   - The list must be posted in the ED.
   - The list must include the *name* of the *individual physician* on-call each day for each specialty. The hospital may not list only the name of the physician's practice group and/or the practice phone number, and or the name of the academic 'team' on-call.
   - The hospital must define the method by which the physicians can make changes in the call coverage, and must keep the ED continuously updated.
   - The hospital must maintain a copy of the daily on-call physician list for five years.

4. The hospital must have written policies and procedures which address the following:

- Elective surgery or simultaneous on-call duties for more than one hospital. The hospital must not let the on-call physicians' elective surgery schedules materially impact their ability to meet their on-call duties. Also, the hospital must know when one of its on-call physicians is on-call simultaneously for another hospital, and it must have written procedures to follow to ensure that patients presenting to its ED with an emergency medical condition (EMC) are provided the emergency services required under EMTALA.

- Response times. Under federal law the hospital must require on-call physician to respond 'within a reasonable period of time' for EMTALA cases, though it encourages hospitals to adopt specific time frames 'in minutes', stating that "a hospital would be well advised to establish the maximum number of minutes that may elapse between receipt of a request and a physician's appearance in the ED."

  Some states, such as Missouri, require on-call physicians to respond within 30 minutes in certain circumstances. Check your state laws.

  EMTALA governs the request to appear to help stabilize patients with emergency medical conditions, thus the EMTALA emergency response time written in the medical staff by-laws (such as '30 minutes' or '30-45 minutes') applies to these cases when the emergency physician requests the presence of the on-call physician ASAP.

  Differentiate phone response time from physical presence response times. Every on-call physicians should be able to return a page from the ED within 15 minutes.

  The conversation between the emergency physician and the on-call physician should then end with a mutual understanding on whether the on-call physician needs to physically come into the ED to attend to a patient, and if so a reasonable expected time of arrival.

- Procedure to follow when the on-call physician is unable or unwilling to respond.

  The hospital must have *written* procedures to follow when a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control.

  Written policy should also define the actions the ED should take if the on-call physician refuses to come into the ED when requested. What chain of command does the emergency physician follow? Call chief of department, chief of staff, VP of medical affairs, administrative designee on-call, etc.

  If it is necessary to transfer a patient because the on-call physician refused or failed to come to the ED, the hospital is required by federal law to send the name and address of the on-call physician on the transfer documents to the accepting facility. (See the EMTALA Transfer Form included.) Failure to send the name and address of the on-call physician under these circumstances is itself a violation of the law and the sending hospital can be fined or terminated from MC for failure to comply with the law.)

- Notification of unavailability. The on-call physicians must be required to notify the hospital or the ED promptly if they become unable to respond, for whatever reason, when on-call for the hospital.

5. The hospital must define, in writing, exactly what it means to be 'on-call'.

   - Is the on-call physician available only to 'consult', or expected to come to the ED when necessary to examine and stabilize patients with emergency conditions. Under EMTALA, the hospital must contractually or through the medical staff by-laws require the on-call physicians to physically present to the ED to help medically screen or stabilize emergency patients when requested.

   - Is the on-call physician required to respond to in-house emergencies when requested by the patient's admitting physician, or is he only required to respond to emergencies presenting to the hospital's ED? Everyone at the hospital needs to know in advance so that the staff isn't trying to figure out who's responsible while the patient's trying to die.

   - Define the role of the on-call physician in accepting or rejecting EMTALA related transfers on behalf of the hospital (and specifically differentiate this from physicians accepting patients in the capacity of their own private practice). See 'Transfers' section.

   - Does the on-call physician agree to see patients in follow-up from the ED? See below.

   - The on-call physician must carry out their EMTALA duties when on-call regardless of the patient's insurance status.

6. Define the role of Mid-Level Providers in providing on-call services to the ED.

   Some physicians, such as pediatricians, orthopedic surgeons, internists, and cardiologists use physician assistants or nurse practitioners in their practices and interactions with the ED. EMTALA and CMS's regulations distinctly require the hospital to provide on-call ***physicians***, so it is clear that the hospital may not allow a midlevel provider to take ED call ***instead of*** a physician. Critical Access Hospitals, while subject to EMTALA's requirements, may allow PAs or NPs to take ED call in certain circumstances.

   However, the on-call physicians may permit one of their associated mid-level providers to answer a call from the ED or evaluate a patient in the ED on their behalf, when deemed reasonable by the emergency physician.

   Thus, it's perfectly appropriate to list the name of the on-call physician on the call panel and the name of the physician's midlevel provider. For routine admissions or follow-up care, the emergency physician can contact the midlevel provider to arrange the necessary services. However, for true emergencies or other instances where the emergency physician wants phone consultation from the on-call specialist directly, or needs the specialist to come to the ED to evaluate and treat the patient, the emergency physician must be able to contact the specialist directly at any time.

The choice of which on-call individual to contact and which one must come to the emergency department must ***always*** rest with the physician examining the patient in the emergency department. CMS agrees, holding that the decision of whether the on-call physician must come to the ED rests with emergency physician who has personally examined the patient in the ED.

7. Determine if the ED will send patients acutely to an on-call physician's office.

   Sending patients from the ED directly to an on-call physician's office for acute intervention is considered a transfer under EMTALA. CMS looks askance at transferring patients away from the hospital to a physician's office for acute procedures that could have been handled in the ED or in the hospital.

   Ophthalmologists may be an exception, since although the ED may have rudimentary eye tools, ophthalmologist typically have much better equipment in their offices for examining patients with eye complaints to determine whether an EMC is present or to treat emergencies.

   In essence, movement to the office in these cases becomes a medically indicated transfer to receive a higher level of services than the hospital can provide. CMS accepts such movement, as long as the ED arranges a formal transfer in compliance with EMTALA.

   Sending orthopedic cases, such as displaced fractures which need reduction, to an orthopedic surgeons' office is standard practice in many hospitals. It is frowned upon by CMS, though, and subject to investigation if the process is abused. However, EMTALA only applies if the EMC is unstable at the time of transfer. Thus it is reasonable to send fracture patients to the office for further treatment, as long as the emergency physician has determined they are stable for transfer to the orthopedic surgeon. The decision rests solely on the judgment of the examining emergency physician. If the fracture can't be adequately splinted, the patient has accompanying injuries or is too uncomfortable to be moved, or if the emergency physician believes the injury is such that the patient should not travel, then the orthopedic surgeon should be required to care for the patient in the emergency department.

8. Define the on-call physician's role in providing follow-up care for ED patients.

   Obtaining follow-up care for discharged ED patients, particularly indigent persons and Medicaid recipients, is a significant problem for nearly every hospital. However, EMTALA does not reach the on-call physician's office in this scenario. If the patient does not have an EMC or is stable at the time of discharge, EMTALA does not apply from that point forward and the on-call physician has no legal duty under EMTALA to see the patient in the office.

   The real issue in ED follow-up is what level of commitment the hospital and medical staff want to make to their community. If the administration, the board, and the medical staff are comfortable with their decision, and if they have acted in the best interests of the patients they serve, they should have no trouble defending their actions to CMS or anyone else. Typically, the hospital expects the on-call physician to follow-up the ED patient to address the issues for which the patient presented to the ED, or to at least see the patient once when deemed necessary by the ED.

No matter what the hospital and physicians decide regarding ED follow-up duties, those responsibilities must be explicitly defined in the medical staff bylaws or hospital rules and regulations so that everyone understands, ***in advance***, what it means to be "on call" for the emergency department at that hospital.

For example, does the on-call physician agree to see patients in follow-up from the ED for 'just one visit' or to resolve the problem for which the patient came to the ED? For just urgent cases when the emergency physician calls the on-call physician to arrange the follow-up? For 'routine' follow-up?

Emergency department discharge instruction sheets should also include a fail-safe clause advising patients to return to the emergency department if the patient's condition deteriorates before seeing the referral specialist or if the follow-up arrangements disintegrate for any reason. Such a statement could help the hospital avoid liability when the on-call specialist fails to implement the prescribed follow-up plan.

9. Monitor the on-call system and the response of the on-call physicians.

   Every hospital knows its problem players; the hospital should act to correct the physician's behavior before it costs a patient life and the hospital adverse publicity, a government investigation, and a protracted battle in court tangling with plaintiff attorneys.

   Monitor the on-call physician response times as part of the ED/Hospital/Medical Staff on-going QI programs. The ED should objectively document the time the physician was called and the time the physician responded (time spoke to the physician). Don't editorialize in the medical record – the times speak for themselves.

10. 'Community Call. Review the IPPS rules related to utilization of 'community call' plans and the attempt to diminish hospital civil liability for the actions of its on-call physicians. Community call may be especially helpful in providing specialty services, such as orthopedic, neurosurgical, oral-maxillofacial, and hand or plastic surgical services for trauma patients. [See Bitterman RA. Inpatient Transfers and Community On-Call Programs: New Rules Finalized. *ED Legal Letter* 2008;19(10):109-112; and Shortage of on-call specialists for your ED? Help may be on the way. *ED Legal Letter* 2008;19(7):73-75.]

8. Create a System for Transferring Patients Out of the Hospital

a. Formalize. The hospital must have a formal designated system.

b. Plan Ahead. Every hospital must know the scope of its service capabilities and determine where and how it can transfer patients to other hospitals that are able to provide those services the hospital lacks. Post the names and access phone numbers of those hospitals that can accept patients in transfer. Particularly acute are neurosurgery, trauma centers, vascular surgery, and neonatal intensive cares, but advanced knowledge of where you can transfer any patient needing specialized services that your hospital lacks is critical.

c. Transfer Packets. Use transfer packet containing instructions on how to transfer patients, transfer checklists, transfer algorithm, and transfer forms.

d. Uniformity. Use transfer forms for all transfers regardless of whether the patient is stable or unstable, and for transfers out from inpatient units as well as the ED. Uniformity insures that forms are always completed on patients who are later retrospectively determined to have been unstable, and document the examining physician's judgment at the time of the transfer.

e. Economic Transfers (Includes Managed Care Transfers and Lateral Psychiatric Transfers to State Institutions). Understand and recognize the problem with transferring managed care and psychiatric patients out of the hospital after examination and treatment. The question of stability will be reviewed retrospectively, and will subject the hospital not only to malpractice claims but also to EMTALA liability and fines. Economically motivated transfers are not per se illegal, but they will be closely scrutinized by the enforcement agencies.

f. Arrange only "Appropriate Transfers". Always comply with the statutorily required transfer elements. Always reevaluate the patient, and recheck and record the patient's vital signs just before the transfer occurs.

9. Create a System for Accepting Transfers from Other Facilities

a. Formally Designate Responsibility. The hospital should designate who can accept or reject patients on behalf of the hospital as an institution. (Differentiate from physicians accepting patients in the capacity of their own private practice.) The use of 'Trauma Transfer Lines', 'Physician Referral Lines, or 'Neonatal Intensive Care Transfer Lines' all come under the umbrage of EMTALA's transfer acceptance mandate – the 'non-discrimination' section of the law.

b. Emergency Physicians and/or On-Call Physicians Accept Patients on Behalf of the Hospital? It is recommended that hospitals use a transfer center (primarily run by nurses) or their Emergency Department physicians for accepting patients transferred from other Emergency Departments or outpatient settings, not the individual physicians (alone) who are on-call for each specialty.

Physicians involved in the 'Transfer Acceptance Process' on behalf of a Medicare-Participating Hospital need to review and understand the Office of Inspector General's (OIG) new rule regarding imposing civil monetary penalties (CMPs) and/or terminating physicians from Medicare if they fail to accept an appropriate transfer from another acute care hospital. [See the citations in the OIG/CMPs section of the references.]

c. Define Capabilities. Define the resources and capacity of the institution, and the times when those resources are available. When necessary resources or capacity are not available, the hospital must inform the individuals charged with accepting or rejecting transfers.

d. EMS Diversion. Include a system for re-routing or closure to EMS (this probably has a great deal to do in defining the capacity of the institution, with some exceptions if the hospital is a formally designated trauma center).

e. Documentation. Use a transfer acceptance/rejection form to document all transfer requests from other facilities (especially document refusals and reasons for refusal). See sample form in the ACEP EMTALA book.

f. Education. Educate nearby facilities on the proper procedure to transfer patients into your facility, including informing them of who is and who is not authorized to accept patients in transfer on behalf of your institution.

g. Inpatient Transfers. Address the issue of accepting transfers of inpatients from other hospitals. Which inpatient transfers, if any, must a hospital accept? Who should accept or reject inpatient transfers? (Admitting medical staff members, not emergency physicians.)

10. Psychiatric and Behavioral Health Patients in the ED under EMTALA

There is no medical-legal issue in emergency medicine more difficult, more confusing, or more risk-prone than managing psychiatric or behavioral health patients in the emergency department. EMTALA, piles on another layer of regulatory, civil, and financial liability.

This federal law controls virtually every aspect of mental health care in the ED. The mandated 'medical screening examination' includes the nebulous concept of "medical clearance", the extent of the evaluation and diagnostic testing required, and the involvement of on-call psychiatrists or psychiatric assessment/admission teams. Stabilization issues include security, search and seizure, physical or chemical restraints, and the perplexing question of when exactly is a psychiatric patient stable for transfer. Finally, problems regarding transfer of psychiatric patients include economic considerations, boarding and in-patient bed availability, transport methodologies, and involvement of state or county sponsored mental health programs.

Hospitals and emergency department leaders simply must invest the necessary time, energy, and expertise to draft and implement sound policies and procedures to manage the care of psychiatric or behavioral health patients in the ED. The elements of a 'best practice' include the following:

a. The Initial Evaluation or 'Screening' of Mental Health Patients

1. Appropriately conduct and document the evaluation of every patient, especially a competent neurological exam and mental status exam.
2. Obtain the necessary diagnostic testing to rule out an organic cause of the patient's 'psychiatric-like' behavior.

3. Allow adequate time for intoxicants, particularly alcohol, to wear off before evaluating, discharging or transferring patients with 'behavioral' or 'psychiatric' problems.
4. Draft hospital policies that describe the process of screening and stabilizing patients, but also leave room for the physicians to use their judgment in deciding appropriate management of these patients so as to not create hospital liability for 'failure to follow your own rules'.

b. Stabilization of Mental Health Patients

1. Ensure all suicidal or homicidal patients are promptly detained and adequately searched for instruments of harm.
2. Relentlessly secure the suicidal or homicidal patient to prevent elopement.
3. Never discharge a patient against your better judgment because the state 'mental health crisis team' opined that the patient didn't meet state commitment criteria.

c. Boarding of Mental Health Patients

1. Ensure compliance with current Medicare Regulations and Joint Commission standards when boarding psychiatric patients in the ED.
2. Utilize on-call psychiatrists and/or mental health teams to evaluate, treat and manage boarded psychiatric patients while they remain in the ED.

d. Transfers of Mental Health Patients

1. Establish an effective system for accepting or rejecting transfers that complies with EMTALA and ensures safe patient care.
2. Religiously require the on-duty emergency physician to reevaluate the psychiatric patient just prior to transfer to ascertain the patient is still stable for transfer; and always repeat and document the patient's vital signs at the time of transfer.
3. In addition to the necessary EMTALA transfer forms, ***always*** provide adequate 'hold' papers, custody orders, or involuntary commitment orders for any patient transferred – and this includes "voluntary admission" patients.
4. Send all patients in a sufficiently secure manner with only qualified medical personnel (for example, 'suicidal' patients never get to ride in the back of their parent's car to an accepting facility).

10. Medical Records/Documentation Requirements

a. Central log Requirement
1. The hospital must maintain a central log of each person who presents to the hospital DED seeking medical care, whether or not the patient is actually seen in the DED.
2. The elements of the log should contain, at a minimum, the date, time of presentation, name, age, sex, presenting complaint, diagnosis, disposition, and time of discharge.

3. If labor & delivery is used to evaluate patients presenting with potential contractions, then labor & delivery must also maintain the exact same log as the DED. If off-campus facilities must comply with EMTALA, they also must keep the log.
4. CMS does not state how long the log must be kept; recommend minimum of 5 years.

b. Transfers
   1. A record of all transfers into or out of the hospital must be maintained. The hospital must be able to retrieve a listing of these transfers at CMS's request.
   2. A record of all transfers out of the hospital from inpatient settings must be included, not just transfers out of the Emergency Department.
   3. CMS requires that transfer records be kept for a minimum of 5 years.

c. On-Call Lists
   1. Maintain for 5 years.
   2. Must be named individual physician, not a group name.
   3. See "On-Call" section above.

d. Documentation. Typed ED medical records or electronic records that allow dictation are recommended to adequately document medical screening exams, stabilizing treatment, medical decision making, and course in the ED, transfer notes, and discharge instructions to ensure the hospital documents its EMTALA compliance.

11. Required Signs in areas used for Medical Screening Examinations.

a. The hospital must post signs in any area meeting the definition of a 'Dedicated Emergency Department'. These areas typically include the ED entry areas, ED registration areas, or other areas patients may seek access to emergency care at the hospital, such as L & D, psychiatric intake centers, or off-campus freestanding EDs. The signs must outline the hospital's obligations under EMTALA.
b. The content and size of the signs are specified by CMS. A sample sign is available.
c. The signs should be in all languages consistent with the hospital's service population.
d. ‘Pain management’ signs are prohibited.

12. Hospital Quality Assurance/Quality Improvement Review of EMTALA Compliance

a. As part of the standard quality assurance plan, the hospital should review its screening processes and a number of transfers out of the institution for compliance with EMTALA.
b. Quality assurance of EMTALA compliance should not be done solely within the ED, but should encompass the entire institution and should be reported to the hospital-wide QIO.
c. State Agency or CMS investigators always review the hospital’s quality assurance practices related to EMTALA.
d. Do NOT conduct QA or QIO on EMTALA related ‘incidents’ in the usual peer-review process, especially if an adverse patient outcome occurred; instead, evaluate EMTALA problems/issues under the hospital’s attorney-client ‘in anticipation of litigation’ privilege. The federal courts do not recognize state peer review protections.

13. Policy and Procedure to Report Suspected EMTALA Violations to CMS

a. Hospitals must report to CMS or the State survey agency any time "it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of the requirements of [EMTALA] section 489.24(d)." [42 CFR 489.20.]

b. The responsibility to report violations rests with the hospital; physicians who receive an unstable patient in transfer in violation of EMTALA should report the incident to the hospital's designee (legal department, risk management, or corporate compliance).

c. The hospital and legal counsel must investigate the case, obtain appropriate physician input, and decide whether to report the offending institution and physicians to CMS. It is entirely appropriate to contact the transferring institution to gather information and request its input and explanation of the events in question.

d. CMS's guidelines require the hospital to report the incident within 72 hours of when it has 'reason to believe' it received an inappropriate transfer of an unstable patient. Until a reasonable investigation of the incident has been conducted, the hospital may argue that it didn't have a 'reason to believe' it received such a transfer, so it may not have to report the case literally within 72 hours of actually receiving the patient in transfer.

e. There is no statutory or regulatory requirement that hospitals report other hospitals if they refuse to accept appropriate transfers in violation of EMTALA; and there is no duty to 'self report' under any circumstances.

f. As a general rule, it is strongly recommended that hospitals do not 'self report'; they should 'self correct' instead.

14. Potential Application to the Health Care System's Outlying Facilities, such as Free Standing EDs, Urgent Care Centers, or Psychiatric Intake Centers

a. CMS rescinded previous regulations applying EMTALA to off-campus facilities, except facilities that meet the current regulatory definition of a 'dedicated emergency department'. This definition includes freestanding EDs and psychiatric intake centers. It may also include provider-based Urgent Cares Centers that hold themselves out as accepting walk-in, unscheduled patients for evaluation and treatment. CMS intended the new regulations to include UCCs, but the actual language of the regulations coupled with the definition of an EMC in the statute may exclude them from EMTALA mandates.

   Read the CMS Interpretive Guidelines on whether UCCs are DEDs – CMS skews the regulations to increase the likely hood that UCCs constitute DEDs. The most recent regulations modified but did not eliminate the 250 yard rule.

b. Hospital must still implement written policies, protocols, and procedures at the off-campus department for addressing patients who present with or are determined to have emergency medical conditions. These facilities are not required to transfer patients back to the main campus facility or required to enter into transfer agreements with other nearby hospitals that maybe able to treat the patient's EMC.

15. Hospital Ownership, Medical Direction, or Interaction with EMS Services

a. CMS deems any patient entering a 'hospital owned and operated ambulance', including air ambulances and helicopter services, to have "come to the ED" for purposes of triggering EMTALA. 42 CFR 489.24(b). [See Bitterman RA. An Ambulance '*Owned'* by a Hospital Must Also Be '*Operated'* by the Hospital to Trigger EMTALA Obligations. *ED Legal Letter* 2013;24(5):49-53.]

b. Hospital owned ambulances, including air ambulances and helicopter services, will be considered in compliance with the law if they operate within state or local protocols, or if the ambulance is directed by a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance. [42 CFR 489.24(b)(3)(i)&(ii); See the case of Beller v. Health & Hosp. Corp. of Marion Co., Indiana, 703 F.3d 388 (7th Cir. 2012).]

c. EMS medical direction and diversion of EMS units may have EMTALA ramifications and liability and should be reviewed to ensure compliance with current regulations. West coast hospitals, must read and understand the case of Arrington v. Wong, 237 F.3d 1066 (9th Cir. 2001), and east coast hospitals the case of Morales v. Sociedad Espanola, 524 F.3d 54 (1st Cir. 2008) and CMS's response in its most recent interpretive guidelines published in the Federal Register.

d. The hospital must be careful to avoid delay in triaging EMS patients brought to the ED – what CMS terms 'EMS Parking'. The hospital's EMTALA obligation begins the moment a patient 'comes to the ED' and a 'request' for care is made; not when the hospital 'accepts' the patient. CMS does state that its guidance "should not be interpreted to mean that a hospital cannot ever ask EMS personnel to stay with the person they transported to the ED when the hospital does not have the capacity or capability to immediately assume full responsibility for the individual."

   Nonetheless, CMS mandates that "even if a hospital cannot immediately provide an MSE, it must still triage the individual's condition immediately upon arrival to ensure that an emergent intervention is not required and that the EMS provider staff can appropriately monitor the individual's condition." (See the 2006 & 2007 CMS EMS memos cited in the reference list.)

e. An EMS unit's utilization of a hospital's helipad does not trigger an EMTALA obligation on the hospital's emergency department.

16. Interaction and Compliance with State 'EMTALA' Laws and Liability Insurance.

a. Determine if your state has an 'EMTALA equivalent' law, and how it differs, particularly if it is stricter, from the federal law and may affect your compliance plan or liability. E.g., California and Florida both have somewhat different and stricter versions of EMTALA. Texas also has a state law similar to EMTALA. New Jersey requires hospital's to initiate the MSE within 4 hours of the patient's arrival to the ED.

b. Determine if your medical malpractice liability insurance covers EMTALA law suits or will cover defense costs associated with an EMTALA investigation, QIO hearing, or OIG prosecution for civil monetary penalties or termination from Medicare. (It's possible that 'add-on' special indemnity provisions may cover the actual fines.)

c. Examine the indemnity provisions in state law, common law, or contracts with physicians/hospitals.

17. Disasters and Public Health Emergencies

a. The Pandemic and All-Hazards Preparedness Act changed the EMTALA regulations in section 1135 of the Social Security Act.

b. The regulations specify that EMTALA sanctions will not apply for either inappropriate transfers of unstabilized individuals or redirection of persons to another location before a MSE in times of certain disasters or public health emergencies as defined by the Act.

c. Waiver is limited to the 72-hour period beginning upon the implementation of a hospital disaster protocol, unless when a public health emergency involves a pandemic infectious disease, in which case the duration of the waiver will be determined by section 1135(e).

d. Hospitals need to familiarize themselves with these regulations and the Act in order to understand under what circumstances CMS will allow them to forgo compliance with EMTALA.

e. Ebola or Covid-19. EMTALA still applies to individuals potentially exposed to the Ebola virus or the Coronavirus (Covid-19) who present to the hospital's emergency department. See CMS's guidelines regarding the EMTALA requirements related to Ebola or Covid-19 patients coming to the ED – both are included in the references.

18. EMTALA Forms to Consider

Draft and utilize legally approved EMTALA forms to achieve/document compliance. The key is to embed the legal elements into the forms, so that clinicians completing the forms 'do the right thing' even without knowing the essential elements of the law. These forms typically include:

EMTALA Forms

a. EMTALA Transfer Form
b. EMTALA Transfer Checklist
c. EMTALA Transfer Acceptance or Rejection Form
d. EMTALA AMA Form
e. EMTALA Medical Screening Exam (MSE) Refusal Form
f. Obstetrical MSE Algorithm for Labor and Delivery Units

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Emergency Medical Condition (EMC) Identified: (*Mark appropriate box(s), then go to Section II)* **[Dr. Bitterman - 2020]**

I. MEDICAL CONDITION: Diagnosis_____

☐ **No Emergency Medical Condition Identified:** This patient has been examined and an EMC has not been identified

☐ **Patient Stable -** The patient has been examined and any medical condition stabilized such that, within reasonable clinical confidence, no material deterioration of this patient's condition is likely to result from or occur during transfer.

☐ **Patient Unstable -** The patient has been examined, an EMC has been identified and patient is not stable, but the transfer is medically indicated and in the best interest of the patient.

I have examined this patient and based upon the reasonable risks and benefits described below and upon the information available to me, I certify that the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to this patient's medical condition that may result from effecting this transfer.

II. REASON FOR TRANSFER: ☐ Medically Indicated ☐ Patient Requested _____

☐ On-call physician refused or failed to respond within a reasonable period of time.

Physician Name: _____Address _____

III. RISK AND BENEFIT FOR TRANSFER:

Medical Benefits :	**Medical Risks :**
☐Obtain level of care/ service NA at this facility. Service _____ ☐Benefits outweigh Risks of Transfer	☐Deterioration of condition in route _____ ☐Worsening of condition or death if you stay here. There is always risk of traffic delay/accident resulting in condition deterioration.

IV. Mode/Support/Treatment During Transfer As Determined by Physician– (Complete Applicable Items):

Mode of transportation for transfer: ☐ BLS ☐ ALS ☐ Helicopter ☐ Neonatal Unit ☐ Private Car ☐Other_____

Agency:_____ Name/Title accompany hospital employee:_____

Support/Treatment during transfer: ☐ Cardiac Monitor ☐ Oxygen – (Liters): _____ ☐ Pulse Oximeter ☐ IV Pump ☐ IV Fluid: _____ Rate: _____ ☐ Restraints – Type: _____ ☐Other:_____ ☐ None

Radio on-line medical direction control *(If necessary):* ☐Transfer Hospital ☐ Destination Hospital ☐ Other

V. Receiving Facility and Individual: __The receiving facility has the capability for the treatment of this patient (including adequate equipment and medical personnel) and has agreed to accept the transfer and provide appropriate medical treatment.

Receiving Facility: /Person accepting transfer: _____Time: _____

Receiving MD_____

Transferring Physician Signature_____ Date/Time_____

Per Dr. _____ by _____RN/ Qualified Medical Personnel _____ Date/Time

VI. ACCOMPANYING DOCUMENTATION– sent via: ☐Patient/Responsible Party ☐Fax ☐Transporter
☐ Copy of Pertinent Medical Record ☐ Lab/ EKG/ X-Ray ☐ Copy of Transfer Form ☐ Court Order
☐ Advanced Directive☐ Other _____

Report given (Person/title):_____

Time of Transfer: _____Date: _____ Nurse Signature: _____Unit:_____

Vital Signs Just Prior to Transfer: T_____ Pulse _____ R _____ BP _____ Time: _____

VII. PATIENT CONSENT TO "MEDICALLY INDICATED" OR "PATIENT REQUEST" TRANSFER:

☐ I hereby **CONSENT TO TRANSFER** to another facility. I understand that it is the opinion of the physician responsible for my care that the benefits of transfer outweigh the risks of transfer. I have been informed of the risks and benefits upon which this transfer is being made.

☐ I hereby **REQUEST TRANSFER** to _____. I understand and have considered the hospital's responsibilities, the risks and benefits of transfer, and the physician's recommendation. I make this request upon my own suggestion and not that of the hospital, physician, or anyone associated the hospital.
The reason I request transfer is: _____

Signature of ☐ Patient ☐ Responsible Person_____ Relationship _____
Witness_____ Witness_____

TRANSFER FORM

White:-Receiving facility; **Yellow:** Medical Record; **Pink:**-QA

Patient Name:

Date of Birth:

Medical Record Number:

General Hospital Emergency Department [Bitterman 2020]

PATIENT DENIAL OF REQUEST FOR A MEDICAL SCREENING EXAMINATION / PHYSICIAN ORDER CONFIRMATION

Under Federal Law, the hospital's emergency department must provide a medical screening exam to determine if an emergency medical condition exists for any individual who requests examination or treatment for a medical condition. At General Hospital, this exam is performed by a physician, or a mid-level provider under the direction of a physician. If you want to receive a medical screening examination, please tell your nurse. If you do not wish to have a medical screening examination, please check the appropriate statement below and fill out the information requested. Thank you.

I am presenting to the Emergency Department for:

- Laboratory test(s) or Covid-19 test ordered by my physician, or
- Radiological procedure (x-ray, CT, MRI or nuclear medicine) ordered by my physician.
- Scheduled out-patient visit for _____, to see Dr. _____ .
- Evidence collection, or other _____ .

I do not request a medical screening examination to determine whether I have an emergency medical condition, nor do I request treatment for a medical condition at this time. I understand that the Hospital is willing to provide me with such an examination and treatment should I ask for it. Furthermore, I am not asking the Hospital, its personnel or the Emergency Department physician to analyze the laboratory test or radiological procedure results. Instead, my doctor will follow-up on the results of any tests.

Print Name: _____

Date of Birth: _____ SS#_____

Signature: _____

Parent of Guardian in case of minor:_____

Address: _____

City, State, Zip: _____

Date: _____ Time:_____

Witness: _____

<u>Confirmation of order: (to be completed by clinical staff)</u>

Ordering MD: _____

Test Ordered: _____

Select One: _____ Verbal order called to department
_____ Written order sent with patient

Confirmed by: _____

EMTALA Transfer Acceptance or Denial Form [Bitterman 2020]

Patient Name: _____ **Age:**

Patient's					
Vit	**T°**	**HR**	**RR**	**BP**	**Oximet**

Pertinent Labs \ Diagnostic Test Results \ Treatment (if

Reason for Transfer:

- ❑ Needs specialized level of _____ care (e.g., Level I Trauma, Neurosurgeon, NICU, etc.)
- ❑ Available capacity (bed space, equipment, personnel)

☐ **Patient Transfer Accepted**	☐ **Patient Transfer NOT Accepted**
Transfer by: ☐ BLS ☐ ALS ☐ Helicopter ☐ Private vehicle ☐ Other:	**Reason for NOT Accepting the Transfer:** ☐ Lateral transfer for insurance reasons ONLY ☐ Not an emergency

EMTALA Transfer

INFORMED CONSENT TO REFUSE EXAMINATION, TREATMENT, OR TRANSFER

I understand that the hospital has offered: (Check all that apply).

A. ☐ To examine me (the patient) to determine whether I have an emergency medical condition, or

B. ☐ To provide medical treatment or to provide stabilizing treatment for my emergency condition, or

C. ☐ To provide a medically appropriate transfer to another medical facility.

The hospital and physician have informed me that the ***benefits*** that might reasonably be expected from the offered services are:

_____

_____

and the ***risks*** of the offered services are: _____

_____

Physician Documentation

☐ The patient appears competent and capable of understanding risks and benefits.

☐ Alternative treatments discussed with the patient.

☐ Patient's family involved. ☐ Family not available. ☐ Patient does not want family involved.

Signature of Physician _____

Patient or Legally Responsible Person Documentation.

☐ I have declined to have the physician fully explain to me the risks, benefits, and alternatives to leaving the hospital against medical advice. I knowingly and willingly take and assume the responsibility for all risks incurred.
or
☐ The physician has fully explained to me the risks and benefits but I choose to refuse the offered services. I understand that my refusal is against medical advice, and that my refusal may result in a worsening of my condition and could pose a threat to my life, health, and medical safety. I understand that I am welcome to return at any time.

Signature/Patient or Legally Responsible Person _____

Print Name _____ Address _____

City _____ State/Zip _____ Date _____ Time _____

Witness/Signature _____ Print Name_____

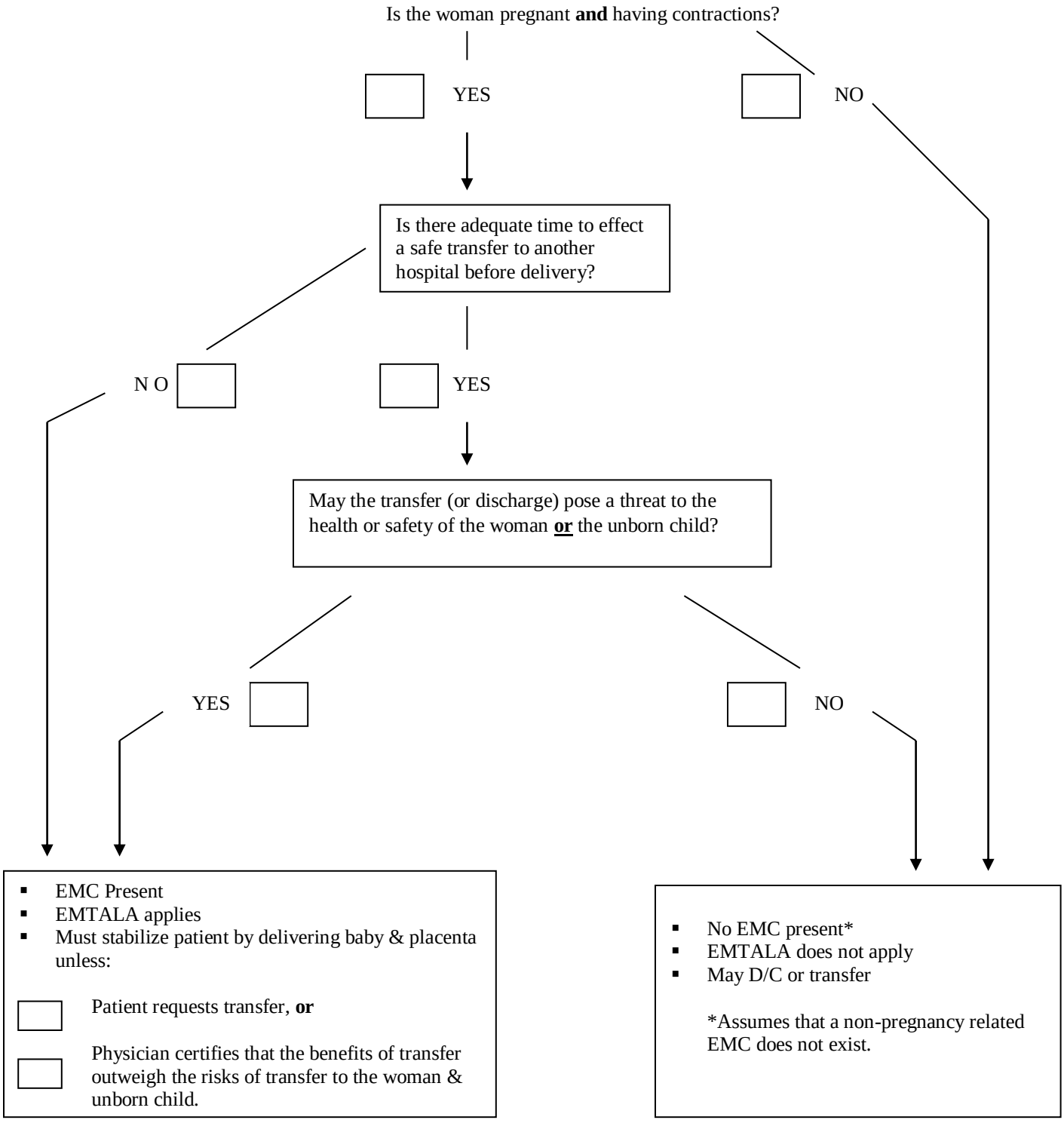
The patient or person legally responsible for the patient was offered but refused to sign form after explanation of their rights and the risks and benefits of the services offered.

Hospital representative who witnessed refusal to sign: _____

Date _____ Time _____

FIGURE 1. (OBSTETRICS Compliance with EMTALA) **[Dr. Bitterman 2020]**

Medical Screening Examination of Pregnant Women



X_____ _____

Signature of non-physician performing the MSE Date / time

X_____ _____

Signature of physician performing or responsible for the MSE Date / time