EMTALA TRAINING

Emergency Medical Treatment and Labor Act

Sometimes called: “Anti-Dumping Law” or “COBRA”

August 2014
Overview of EMTALA

• The purpose of EMTALA is to prevent "patient dumping," the practice of refusing to provide emergency medical treatment to patients unable to pay, or transferring them before emergency conditions are stabilized.

• If an individual:
  – “comes to the emergency department” and
  – a request is made for examination or treatment of a medical condition (in the absence of a request, apply “prudent layperson observer” test), then
  – hospital must provide an appropriate medical screening exam to determine whether an Emergency Medical Condition (EMC) exists

  ▪ If no emergency, EMTALA obligation is over, but other standards apply.
  ▪ If an EMC exists, then stabilize and/or appropriately transfer.
Definition - “Comes to the ED”

An individual, **who is not a patient**, “comes to the emergency department” when he or she:

1. Presents at the hospital’s **dedicated emergency department** and requests examination or treatment (in the absence of such request, apply “prudent layperson observer” test)

2. Presents on other **hospital property** (main campus including sidewalks, parking lots, driveway within 250 yards of hospital) and requests examination or treatment for what may be EMC

3. **Ambulances**: (special rules)
   - An individual in an ambulance owned and operated by the Hospital is deemed to have "come to the Hospital's emergency department," and should be screened and stabilized and/or appropriately transferred.
   - An individual in a non-Hospital owned ambulance, **located on Hospital’s campus** is also considered to have "come to the Hospital’s emergency department" and should be screened and stabilized and/or appropriately transferred.
Ambulance Parking

- EMTALA obligations begin as soon as the ambulance arrives on hospital property, even if the patient remains on the ambulance stretcher.
- MSE (Medical Screening Exam) and stabilizing treatment may not be delayed by keeping a patient on an ambulance stretcher.

Definition - “Prudent Layperson Observer”

- Prudent layperson observer standard
  - Based on a person’s appearance and behavior, a prudent layperson observer would believe the individual needs examination or treatment for a medical condition.
“Emergency Medical Condition”

• Definition: When absence of immediate medical attention could reasonably be expected to result in:
  ▪ placing the health of an individual or unborn child in serious jeopardy  OR
  ▪ serious impairment to bodily function  OR
  ▪ serious dysfunction of any bodily organ or part

• EMC is presumed if one of the following conditions is present:
  – Intoxicated / impaired
  – psychiatric patient: suicidal / homicidal
  – Pregnant, having contractions or in labor
Hospital Obligations

• Once patient “comes to ED,” hospital must provide an appropriate Medical Screening Exam (MSE) to determine whether an “Emergency Medical Condition” (EMC) is present.

• If EMC exists:
  – must stabilize within capability and capacity and/or appropriately transfer.
Hospital Obligations

- Must provide for an appropriate MSE by Qualified Medical Personnel (QMP) within the capability of the hospital’s emergency department (ED), to determine whether or not an emergency medical condition exists.
  - Initial assessment or triage ≠ MSE
  - “Appropriate” means screening examination:
    - is suitable for the symptoms presented and
    - conducted in an unbiased and non-discriminatory fashion.
  - Qualified Medical Personnel (QMP) are individuals qualified to perform a MSE (e.g., physician, nurse practitioner or physician’s assistant, labor and delivery nurse) as designated in the Medical Staff governance documents.
Hospital Obligations

- For pregnant women, the medical records should show evidence that the MSE included ongoing evaluation of:
  - fetal heart tones,
  - regularity and duration of uterine contractions,
  - fetal position and station,
  - cervical dilation, and
  - status of the membranes (i.e., ruptured, leaking, intact)

- Should assess and reassess both woman and fetus separately to ensure the patient remains stable
Hospital Obligations

• The hospital **may not delay** MSE or necessary stabilizing treatment to inquire about an individual’s insurance coverage or method of payment.
Patient with Altered Level of Consciousness

• No matter the cause (alcohol, neurological, behavioral, etc.), if there is an altered LOC and the patient is wanting to leave prior to an MSE or treatment, they must be seen by a provider.

• Restraining the patient pending the evaluation would be appropriate ONLY if all other less restrictive measures have failed.
Psychiatric Conditions Covered by EMTALA

- History of drug ingestion in a patient with coma or impending coma
- Depression with feelings of suicidal hopelessness
- Delusions, severe insomnia, or helplessness
- History of recent assaulting, self-mutilating or destructive behavior
- Objective documentation of inability to maintain nutrition in an individual with altered mental status
- Impaired reality testing accompanied by disordered behavior (psychotic)
Suicidal Patients

- If patient expresses suicidal or homicidal thoughts/ideations to the triage nurse, he/she becomes an involuntary ED patient until determined otherwise by the MSE.
- Both the medical and mental health assessments must be cleared and documented prior to disposition.
Full Registration of ED Patients

• Patient Access Associates began full registration of ED patients \textit{once the patient is in an ED bed}. 

• If ED provider enters room to complete the MSE, Patient Access staff must \textit{stop} the registration process and allow the provider to examine the patient.

• MLH policy requires that the registration process \textit{not delay} the medical screening exam and/or treatment.
  – Registration processes also should not unduly discourage an individual from remaining for further evaluation.

• Do not ask for the patient’s copayment until after the physician has seen the patient
Definition – “Stabilize”

• Under EMTALA law, “stabilize” means no significant deterioration of condition is likely to occur during transfer:
  – Women in labor, are stable, only if: (1) provider or labor & delivery nurse has certified false labor, or (2) woman has delivered child and placenta.
    • Must screen and document condition of woman and child.
  – Psychiatric patient that is suicidal or homicidal is stable if no longer a threat to self or others.
    • Must screen and document both the medical and mental condition.

• Once stable, EMTALA obligation is over, but other standards of care still apply.
Stable v. Unstable

- **Stable patients:** When a patient no longer has an EMC, EMTALA regulations no longer apply.
  - To be considered *stable*, the EMC that caused the individual to seek care in the ED must be resolved.

- **Unstable patients (EMTALA transfer):** When a patient has an EMC that has not been resolved.
  - If a hospital is unable to stabilize an individual within its capability, an appropriate transfer should be implemented.
When can hospitals transfer?

- Hospital may transfer patient that is *unstable* if:
  - it is an “appropriate transfer” (see next slide for elements);
  - patient/legal rep requests transfer in writing, after being informed of the risks and hospital’s obligations; and
  - physician certifies benefit of transfer outweighs the risk to patient (and fetus, if applicable).

- *A physician may certify a transfer because the patient needs services that are beyond the capabilities of the transferring facility.*
“Appropriate Transfer”  
(of unstable patient with EMC)

1. Transferring hospital provides medical treatment within its capacity that minimizes risk to patient’s health (and health of fetus, if applicable).

2. Receiving facility has:
   • space and qualified personnel to treat patient
   • agreed to accept the transfer

3. Transferring hospital sends to recipient hospital all medical records at time of transfer or ASAP (including the name and the address of any on-call physician who refused/failed to appear in order to stabilize the patient being transferred).

4. Transfer is effected through qualified medical personnel and transportation equipment, including use of life support measures during transfer, if necessary.
Can a hospital refuse a transfer?

• A hospital with **specialized capabilities** or facilities and the **capacity** to treat an individual needing its specialized services **cannot refuse** to accept a proper transfer **regardless of where the transfer comes from (no matter how far away the transferring facility is)**.
  
  – Capability means that there is physical space, equipment, supplies and specialized services that the Hospital provides.
  
  – Examples of specialized capabilities included, but are not limited to, surgery, intensive care, trauma, etc.
Interfacility Transfer Process

• When transferring a patient to another facility, the *Interfacility Transfer* form must be completed.

• Page 1 of the form **must be verified by a physician**
  – This section of the form includes: diagnosis, information about the accepting facility/physician, mode of transportation, level of response, reason for transfer, risk of transfer or transport, and the physician certification
    • *A physician may certify a transfer because the patient needs services that are beyond the capabilities of the transferring facility*
  – The date and time of the physician certification should be immediately prior to the date and time of transfer
Interfacility Transfer Process

• Page 2 of the form includes:
  – Patient informed consent (to be signed by the patient or patient representative)
  – Patient condition at time of transfer (to be completed by RN or physician)
  – Transfer checklist (to be completed by RN or physician)

• ALL elements of the Interfacility Transfer form (including the transfer checklist) must be completed before the patient departs the ED.
Interfacility Transfer Process

• Transfers must be effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.
  – *EMTs may not always be “qualified personnel” for purposes of transferring an individual under these regulations. Depending on the individual’s condition, there may be situations in which a physician’s presence or some other specialist’s presence might be necessary.*

• Level of transportation must be determined by the physician
  – Included would be:
    • Type of transfer vehicle
    • Equipment
    • Attending personnel
Transfer Requests

• When making a transfer request to Centracom or the Transfer Center, it is essential to convey the correct information so that the correct mode of transportation is arranged.

• In the Fall of 2014, a web-based transfer request form will be implemented. This process will ensure that all required elements are conveyed to Centracom.
Inpatients

• EMTALA does not apply to patients admitted to the hospital (inpatients).
  – “Observation” status is considered an outpatient service and is subject to the EMTALA obligations.

• The hospital has satisfied its requirements under EMTALA:
  – Once a hospital has screened an individual and found they have an emergency medical condition, and
  – the hospital admits the patient in good faith in order to stabilize the condition
AMA or LWBS

• If an individual leaves Against Medical Advice (AMA) or Leaves Without Being Seen (LWBS) of their own free will (no coercion or suggestion), hospital is not in violation of EMTALA, if you document:
  – hospital informed individual (or person acting on behalf of individual) of risks of leaving or refusing care; and
  – individual signed the AMA/LWBS form
    • If refuses to sign ABA/LWBS form, document that hospital used its best efforts to obtain a signature.

• All AMA/LWBS cases should be reported reported in Safeguard.
Examples of Coercion

• Providing the patient/family with directions to another facility, even at their request.
• Telling the patient/family that the wait is extensive or giving approximate wait times.
• Telling the patient that we don’t provide a particular service before the completion of the MSE.
  – Example: Explaining to a pregnant patient at triage that University doesn’t provide OB services could be perceived as coercion and should not occur until time of disposition.
EMTALA’s “D” Rules

• Don’t delay or deny emergency treatment
• Don’t discriminate in providing emergency treatment
• Don’t refuse to accept transfers where we have capability and capacity to treat
• Document
“On-Call Physicians” Hospital Requirements

• If, after an initial MSE, a physician (or other QMP) determines the services of an on-call physician are required, the on-call physician should be contacted.

• On-call physicians should respond to Hospital calls/requests for emergency on-site coverage within a reasonable time,
  • MLH defines “reasonable time” as 30 minutes.

• If a scheduled on-call physician fails to respond, the ED physician or designee should attempt to obtain the services of another appropriate physician from the Hospital’s medical staff. Same applies when the on-call physician is unavailable due to elective surgeries or being on call for another hospital.

• If available call coverage and capability exists at another MHMH hospital, the patient may be transferred to that other facility for further care.
“On-Call Physicians” Hospital Requirements (cont)

• Unless otherwise contractually agreed, physicians on-call are allowed to schedule elective surgeries and take call at other facilities. If taking call at two facilities simultaneously, the physician must notify MHMH so back up call lists or specific procedures can be developed.

• Any changes to call availability shall be communicated to Medical Staff Services for corrected call coverage posting. If an unavoidable change occurs after hours or during the course of the call requirement, the physician should notify the facility ED and/or transfer center directly and also notify Medical Staff Services the next calendar day.

• An on-call physician who fails to respond within 30 minutes will be in violation of hospital policy (subject to disciplinary action) and may be found to be in violation of EMTALA.
Requests for Transfer & Documentation

• Emergency Department physicians are authorized to accept ED to ED transfers.
  – If an on-call physician is contacted by an ED MD outside of the MLH system or other outside MD, the on-call physician MUST call the MLH ED to determine capacity prior to accepting the patient on his service.

• A request for transfer should be documented along with the response to the request, and the basis for any denial of the request.
Reporting Inappropriate Refusals of Transfers

• If a transfer occurs due to an on-call physician’s refusal/failure to appear, a sending hospital must document and provide the name and address of the on-call physician who refused/failed to appear to the recipient hospital.

• Hospital medical staff and employees, in particular those who work in a dedicated emergency department, who have “reason to believe” that the Hospital may have inappropriately refused to accept the transfer of an individual from another facility should report the incident promptly for investigation:
  – Directly to the Compliance Officer at 901-516-0567
  or
  – Compliance Hotline at 1-888-220-2163
Possible Penalties for Violating EMTALA

- Possible fines between $25,000 and $50,000 per violation.
- A physician may be fined $50,000 per violation.
  - In 2012 a Physician taking call at Vanderbilt was personally fined $35,000 for refusing to see a patient.
- A hospital may be terminated from its Medicare provider agreement.
- A physician may be excluded from Medicare/Medicaid programs.
- A patient who suffers from the violation may sue in civil court.
- A receiving facility, having suffered financial loss as a result of another hospital’s violation of EMTALA, can bring suit to recover damages.