EMTALA Primer by Todd B. Taylor, MD, FACEP
ED Director's Academy – May 2, 2019 – Dallas, TX

Who Am I?
- Former ACEP Council Speaker
- Board Certified Emergency Physician
- EMTALA Compliance Consultant
- Former Vice-President for Public Affairs, Arizona College of Emergency Physicians
- Providing Emergency Care Under Federal Law: EMTALA - 2001: Medical Staff & On-Call Physician Obligations
- 18 Years Attending Emergency Physician – Phoenix, Arizona
- Banner Good Samaritan Regional Medical Center
- 8 Years as EMTALA Consultant Arizona QIO Health Services Advisory Group
- Emergency Physicians’ Monthly Contributing Editor & Editorial Advisory Board
- EMTALA Q & A Editor

EMTALA Resources
- www.medlaw.com/faq.htm

EMTALA FAQ
Frontline Compliance Answers
By Stephen A. From JD
270+ Pages Of The Most Frequently Asked Questions From The Medlaw.com Website
www.medlaw.com/faq.htm

American College of Emergency Physicians®
Supplement to Providing Emergency Care Under Federal Law: EMTALA
April 2004

“Bible of Practical EMTALA Compliance” (newly updated)
Highlights of legal developments & regulatory changes, along with accumulated enforcement information since the 1986 inception of EMTALA.
"Flash card" reviews of individual EMTALA compliance topics, the real world application, necessary compliance documentation, & cautions on common compliance issues.
www.medlaw.com
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Specify what you want:
- PDF of lecture slides
- PDF of handout
- Anything else, please be specific

Burgeoning EMTALA Issues
- Health plan (ACA) network transfers (CMS proviso)
- Deferral of Care (“Screen & Street”)
- Opioid pain medication policy
- ED “Appointments”
- Continued on-call issues (exacerbated by ACA)
- Psych boarding & lack of inpatient services
- EMTALA training requirement
- Observation services (when does EMTALA end?)
- Telemedicine
- Documentation of declined transfers
- Stand alone EDs & hospital owned urgent care
- Regionalization of services
- Transfer for diagnostic services only

The real issue > Enforcement
- Does not matter what we think it means
- Only matters what CMS/OIG says it means & how they enforce it
- Often a disconnect between what central CMS says & how it is enforced in the field (Regions)
- Civil courts add additional complexity & confusion

Basic EMTALA Requirements
- Three statutory requirements regarding “individuals” who “come to the hospital” & request medical care:
  1) The hospital must conduct an appropriate medical screening examination (MSE) to determine if an emergency medical condition (EMC) exists.

ED Legal Letter
What is an “Appropriate” Medical Screening Examination Under COBRA?
By: Robert A. Butterworth, MD, FACEP, Director of Risk Management and Managed Care, Department of Emergency Medicine, Carolinas Medical Center, Charlotte, NC

Appropriateness, like nature, is a undefined cloud which is always and never the same.” Cramer v. Hospital of San Francisco, 61 F.4d 1184 (1st Cir. 1991) quoting, in part, Ralph Waldo Emerson in Essays. First Series (1841).
Emergency Medical Condition

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in--
(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
(ii) serious impairment to bodily functions, or
(iii) serious dysfunction of any bodily organ or part;

42USC1395dd (e)(1)(A)

Basic EMTALA Requirements

2) If the hospital determines that an emergency medical condition exists, it must either -
a) provide the treatment necessary to stabilize the emergency medical condition or
b) comply with the statute's requirements to affect an “appropriate transfer” of a patient whose condition has not been stabilized.
A hospital is considered to have met this second requirement if an individual refuses the hospital's offer of additional examination or treatment, or refuses to consent to a transfer, after having been informed of the risks and benefits.

Basic EMTALA Requirements

3) If an individual's emergency medical condition has not been stabilized, the hospital may not transfer the individual unless
(a) the individual or his or her representative makes a written request for transfer to another medical facility after being informed of the risk of transfer and the transferring hospital's obligation under the statute to provide additional examination or treatment; or
(b) a physician signed a certification summarizing the medical risks and benefits of a transfer and certifying that, based upon the information available, the medical benefits reasonably expected from the transfer outweigh the increased risk.

Non-physician certification requirements:
If a physician is not physically present when the transfer decision is made, a qualified medical person may sign the certification after the physician, in consultation with the qualified medical person, has made the determination that the benefits of transfer outweigh the increased risks. However, the physician must later countersign the certification.

Transfers

“Appropriate” Transfer
- "the movement of an unstable patient with an emergency medical condition".

Five elements must be documented:
1) Provide treatment within its capability (including on-call specialists) to minimize the health risks to the patient until transfer.
2) The receiving hospital must have space & qualified personnel to accept the transfer.
3) The receiving hospital must agree to accept the transfer & to provide appropriate treatment.
4) Qualified personnel/equipment are used during the transfer.
5) Send & document all relevant medical records, radiographs, etc. were sent with the patient.

Transfer of “Stable” Patients

- EMTALA does not apply to “stable” patients as defined in 42USC1395dd (e)(3)(B)

Definitions:
The term “stabilized” means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).
Transfer by POV

Is it ever acceptable to send a patient by private car?

- Yes, if patient is “stable” or “stable for discharge”
- No, if “unstable” &/or requires monitoring
- “Safest” is to always send “transfers” by ambulance

EMTALA Compliance Principles

- Applies to Medicare participating hospitals
- Anyone who presents in any way to any where on hospital property & in any way requests medical attention should be taken to the appropriate area of the hospital (i.e. ED, OB triage, psychiatric triage etc.) for a MSE & necessary stabilizing treatment.
- Routine collection of demographic & insurance information is allowed as long as it does not impede the patient receiving a MSE & stabilizing treatment.

EMTALA Compliance Principles

- Hospitals that have the capacity must accept appropriate transfers from facilities that do not have the capacity to provide necessary care for patients:
  1) Without consideration of insurance status
  2) Regardless of nationality or state/county of residence
  3) Regardless of complaint
  4) Regardless of closer appropriate hospital
  5) Regardless of the sending facility’s non-compliance with EMTALA

EMTALA Compliance Principles

- Patients may not be coerced into being transferred (i.e. “your insurance will not pay for your visit”) or seeking medical care elsewhere even if required by their insurance.
- EMTALA is an “Anti-Discrimination Law”:
  1) With or without insurance
  2) Regardless of nationality, race, creed, religion
  3) Regardless of complaint

EMTALA Compliance Principles

- EMTALA documentation should be completed on any patient not otherwise being routinely discharged with care completed*:
  1) Certification For Transfer
  2) Request For Transfer
  3) Consent To Transfer

*Technically only required for “unstable” patients, but stability may be questioned retrospectively.

“New” (2003) EMTALA Regs Overview

- EMTALA applicable only in “dedicated” ED & not the inpatient setting
- Depends on which “door” you enter
- Formalizes more flexible language for on-call specialists
  - Specialists can be on-call at more than one hospital simultaneously
  - Can schedule elective procedures while on-call.
- Basic requirements unchanged
  - MSE w/o delay
  - Stabilization
  - “Appropriate” transfers
Rule by Exceptions

» Dedicated ED (DED)
The law no longer applies to:
- Non-emergency services
  - "nature of request" – No real change
- In-patients (what you think it is)
- Direct admits (in-patient)
- Outpatients (once encounter begun)
- "National" emergencies
  - Not necessarily local disaster

Dedicated ED (DED)

» Dedicated ED (DED)
Any dept. or facility of the hosp., regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

1. It is licensed by the State in which it is located under applicable State law as an emergency room or ED;
2. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
3. During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

Dedicated ED (DED)

What is included?
- EDs
- OB/L&D Units
- Psychiatric Intake Unit
- Urgent Care & FSED (?)

What is not? (anything that doesn't meet the definition)
- Primary Care Clinics
- Rehabilitation Centers
- Diagnostic Centers (MRI)
- Hospital-based renal dialysis center

Still must have polices as to how to handle any emergency that occurs

EMTALA Obligation Begins?

1. An “individual” (not a “patient”) that comes to the DED; and
2. Request Rx for a medical condition
   - Implied Request = Prudent layperson would believe they need Rx for emergency medical condition
   - Unclear if you actually need to be aware they have arrived

Hospital Property?

» The entire main hospital campus
  - Within 250 yards from main building
  - Parking lot, sidewalk, & driveway
  - Common areas (hallways)

- Excluding:
  - Areas or structures of the main building that are not part of the hospital
  - Physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare
  - Restaurants, shops, other nonmedical facilities

Ambulances

» Hospital Owned
  - Hospital property
  - No real change = codified
  - If operating within community protocols not required to go to home hospital
  - Express purpose for EMC
  - Independent medical control can designate destination

» Non-Hospital Owned Ambulances
  - Applies only on hospital property
  - Request still applies (prudent layperson)
  - Telemetry contact request does not apply, but if not on diversion cannot discriminate

- May pre-empts EMS tort reform
No Delay Clause
- Codifies prior guidance
- Cannot delay MSE/stabilization
- Authorization
  - Cannot seek before MSE *
  - Allowed concurrent with stabilization
- Cannot delay MSE to call a doctor *
- Reasonable registration process allowed
  - Cannot unduly discourage
  - Previous had to encourage to stay
- Nothing about timeliness of MSE (crowding) *
  - (contrary to statute)

On-Call Physicians
- Old vs. New
  - If offered to the public must provide to ED patients: “too high of an expectation”
  - Old: Within your capabilities, resources & availability of on-call staff
  - New: “Best meets the needs of the patients & community served”
- Qualified flexibility
  - Simultaneous coverage
  - Exempt (e.g. senior medical staff)
  - Ad hoc call allowable if not discriminatory

On-Call Physicians
- Coverage:
  - No predetermined ratio: medical staff to days
  - Advance policy/plan for gaps in coverage
  - Physician (not a group, PA, etc) listed
  - May use NP/PA for initial MSE/ Rx if medically appropriate
- CMS will not say how to structure on-call
  - Lack of statutory authority
  - Political reality
  - Post hoc determination of compliance

EMTALA Compliance is:
B. Straightforward
as long as two principles are followed:
1. Always take care of the patient first
2. Your best response to ANY inquiry from ANY hospital is:
   “How can I help you with this patient?”

EMTALA Workshop:
Advanced Cases
13:00 to 14:15
For more information: ttaylor@acep.org