

Basic EMTALA Requirements

The statute imposes three basic requirements regarding “individuals” who “come to the hospital” and request treatment for a “medical condition” (not necessarily an “emergency”):

1. The hospital must conduct an appropriate medical screening examination to determine if an emergency medical condition exists.
2. If the hospital determines that an emergency medical condition exists, it must either provide the treatment necessary to stabilize the emergency medical condition or comply with the statute’s requirements to affect a proper transfer of a patient whose condition has not been established. 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.
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.

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

EMTALA sets forth requirements as to what constitutes an appropriate transfer defined as “the movement of an unstable patient with an emergency medical condition.” Under the statute (42 U.S.C. § 1395dd)(2)), an appropriate transfer has five elements that must be accomplished and documented:

9. Pending transferring, the hospital must provide medical treatment within its capability (including on-call specialists) to minimize the health risks to the patient; and for a woman in active labor, the treatment must address both the health of the woman and her unborn child.
10. The hospital receiving the transfer must have available space and qualified personnel to accept the transfer.
11. The hospital receiving the transfer must have agreed to accept the transfer and to provide appropriate medical treatment.
12. The transfer is accomplished with qualified personnel and transportation equipment, including appropriate life-support measures during the transfer.

13. The transferring hospital must send and document all relevant medical records, radiographs, etc. were sent with the patient.

NOTE: EMTALA does not apply if the patient is “stable” 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, with reasonable medical probability, to result from or occur during the transfer of their individual from a facility, or with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including placenta).

The Penalties

14. Medicare & Medicaid: Program termination for a specified period of time.
15. Per violation: Up to \$50,000 for each “violation” (not each patient encounter). A malpractice insurance carrier may cover defense of the action, but fines are almost never covered without an EMTALA rider.
16. Hospital vs. Hospital: A hospital that has been “dumped on” can recover all costs for the patient care.
17. Requirement to report: A hospital that believes a violation may have occurred must report it within 72 hours or face possible Notice of Termination.
18. Private Cause of Action: Allows the case to be brought to federal court using “strict compliance with the law.” Strict liability is less open to “expert” defense and easier for the plaintiff to prove.
19. Injunctions: Once a violation has been proven the court may impose an injunction requiring certain remedies to correct future violations or public notice of non-discrimination policies.
20. Hill-Burton Act: EMTALA violations may result in government action to recover loans and grants made to the facility.
21. Civil rights: An EMTALA violation based on discrimination may result in referral to the Civil Rights Division of the Dept. of DHHS resulting in criminal prosecution under the civil rights act.

EMTALA Compliance Principles

- Applies to all Medicare participating hospitals
- Anyone who presents in any way to anywhere on hospital property and 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 medical screening examination and necessary stabilizing treatment.
- Routine collection of demographic and insurance information is allowed as long as it does not impede the patient receiving a medical screening examination and necessary stabilizing treatment.

- 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-discriminatory Law”:
Patients must be treated the same regardless of socioeconomic status
 - 1) With or without insurance
 - a. Regardless of nationality
 - b. Regardless of complaint
- Hospitals that have the capability 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
- Certification For Transfer/ Request for Transfer/ Consent to Transfer form should be completed on any patient not otherwise being discharged home with care completed.
- Office Referrals: If contacted by the ED, you must provide follow-up services in your office necessary to further stabilize or prevent de-stabilization of an emergency medical condition without consideration of payment.
- Further Stabilization Example: Peritonsillar abscess requiring I & D that can more easily be done in the ENT’s office.
- Prevent De-stabilization Example: Orthopedic follow-up for definitive casting after ED splinting.
- It is prudent to document phone conversations detailing your understanding. In general, the calling hospital’s documentation will supercede your notes so always be sure to end the conversation with a reasonable resolution of their problem.
- Ignore the type of insurance (or lack thereof) for ANY ED consultation and for ANY incoming transfer decisions. Out going “lateral” transfers are allowable for managed care reasons but can be risky and are best limited to patients being transferred for admission. Remember to complete the necessary transfer forms if you are responsible for the transfer.

ISSUES SPECIFIC TO HOSPITAL STAFF PHYSICIANS

- Attending staff physicians are responsible for EMTALA/ COBRA regulations when they (or the physician they are covering for) are listed as an on-call physician for the emergency department.
- When on-call for the ED: If called – you are chosen and must respond appropriately. This includes:
 - Calls from the ED for which you are on-call.
 - Calls from ANY other hospital DC that does not have the capacity to care for a patient’s problem and requests transfer to the hospital where you are on-call.
 - The only reason you can legitimately refuse a patient transfer is if you or your hospital clearly is not able to provide the necessary care (i.e. no ICU beds at your hospital or you are already involved in another emergency situation). CMS/HCFA generally uses the “if you have ever before” rule: “If your hospital has ever taken care of such a patient under similar conditions before, you must accept them now unless the capacity is saturated.” (i.e. closed to all EMS/ all transfers).
 - You can NEVER refuse ED referrals if you (or the person you are covering for) are on-call for that ED. You may suggest a more appropriate specialist, BUT if ultimately requested you must come to the ED in a reasonable amount of time, evaluate and treat the patient. You may suggest that the patient be transferred if you know the hospital does not have the capacity to treat them, but (at the discretion of the emergency physician) you may still be required to come to the ED and help manage the patient until transfer.
- Physicians not complying with EMTALA/COBRA (even if by ignorance of the law) face:
 - Medical staff suspension, subsequent reports to their state medical board and the National Practitioner’s Data Bank.
 - Fines of \$50,000 per violation (not per patient) & Medicare/ Medicaid (AHCCCS) decertification.
 - Almost certain medical malpractice judgment if there is an adverse outcome.
- HOSPITALS (not physicians) are required to report suspected (i.e. “reason to believe”) violations of the law for inappropriate transfer to them within 72 hours to CMS (HCFA), but you need to know your hospital’s procedure for reporting suspected violations.
- Your best response to ANY inquiry from ANY hospital is: “How can I help you with this patient?”

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