The Emergency Medical Treatment and Labor Act
Audit to ensure compliance

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The Emergency Medical Treatment and Labor Act (EMTALA) guarantees the right of a person to receive treatment when they believe they have an emergency medical condition. The Act covers a wide variety of topics that affect a person's ability to receive emergency medical treatment. EMTALA noncompliance can result in significant fines and penalties and the possibility of negative publicity.

Compliance with EMTALA is critical for any organization that offers emergency medical services. Healthcare providers, including hospitals and physicians, are the primary applicable entities for compliance with the act.

Application of the rules

The EMTALA rule may become relevant in several situations. Potential EMTALA risk is triggered when a person comes to the emergency department with what they believe to be an emergency medical condition (EMC) or when a layperson would assume that they have an EMC, even if they are unable to communicate such a condition.

Once a qualified medical person (QMP) declares that a person does not, or no longer has, a medical emergency, the EMTALA requirements do not apply. Additionally, as soon as a patient is admitted as an inpatient, the EMTALA requirements no longer apply. EMTALA does not apply to individuals calling a healthcare provider on the phone claiming to have an EMC.

The concept of a patient coming to the emergency department extends beyond the actual emergency department to anywhere on the hospital's campus up to 250 yards from the main hospital buildings. Certain restrictions apply to this affected area, but the scope of risk to an organization is much broader than individuals who arrive in the emergency department itself.

The EMTALA rule also applies to transfers of patients with EMCs. The transfer requirements may occur when a patient comes to a hospital that does not have the capacity to stabilize the EMC.

Also, the transfer requirements apply to patients at other hospitals who may need a higher level of care to stabilize the condition than the sending facility has the capability to provide. Hospitals with higher level of care capabilities are required to accept such patients unless they lack the capacity to accept the patient.

No limitations apply to the distance from where a sending hospital may request such a transfer. EMTALA applies in every state and may include interstate transfer requests. EMTALA transfer obligations do not, however, apply to foreign countries.

Enforcement

The EMTALA regulations are enforced by the Centers for Medicare and Medicaid Services (CMS). CMS or state department of health offices may receive reports of violations. CMS will often delegate investigations of EMTALA violations to state department of health offices who will then report their findings back to CMS. CMS Regions may differ in their interpretation of the EMTALA regulations, so you must understand the nuances of your CMS Region.

As of 2023, fines and penalties may be assessed up to $119,942 for each violation. Hospitals or physicians guilty of systemic or gross and flagrant violations of EMTALA may be excluded from participation in federally funded programs. To avoid potential fines, penalties and other risks and to ensure

Emergency departments must screen and stabilize regardless of the ability to pay.

An appropriate medical screening examination must be provided within the capability of the ED.

patients receive appropriate emergency medical care, your organization should adopt a routine process for auditing compliance with these broad and sweeping regulations.

Laws and regulations

The underlying regulations for EMTALA can be found at United States Code (USC), Title 42, Section 1395dd and in clarifying policies. CMS has published Interpretive Guidelines that provide guidance to their surveyors when they investigate EMTALA complaints.

The Interpretive Guidelines provide important insights into how CMS surveyors will interpret the regulations to assess a healthcare provider's compliance. The Interpretive Guidelines are just as helpful, if not more so, than the actual regulatory language because they provide a more practical application of compliance strategies.

When attempting to audit compliance with EMTALA, it may be appropriate to identify whether any state laws exist that overlap or preempt the federal EMTALA requirements in the states where a hospital operates.

The EMTALA regulations include key terms that are defined in the law. Some of the terms have different meanings under the law than their common use. Terms such as *dedicated emergency department*[1], *emergency medical condition*[2], *capacity*[3], and *stable*[4], all have unique meanings in the context of the EMTALA rules and regulations.

Scope of the regulations

Unlike many regulations, EMTALA covers a wide variety of internal operational areas as well as external relations with other healthcare providers and the manner in which patients are transferred between sites to meet their emergency medical needs. Given this, conducting a single audit that covers all elements of EMTALA compliance may require significant resources and time to complete.

A prudent approach to auditing EMTALA may be to first understand the universe of the regulatory effect to your organization. You can then identify the areas that are at the greatest risk of noncompliance so you can focus on a narrower audit scope. Another approach may be to separate the EMTALA regulations into logical groupings of similar requirements and conduct the audit in phases.

Exhibit 1 identifies divisions of EMTALA for purposes of auditing compliance with the EMTALA regulations. Key sample questions are provided to guide your audit process in validating compliance with the regulations.

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[1]https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/Downloads/CMS-1063-F.pdf#:~:text=SUMMARY%3AThis%20final%20rule%20clarifies%20policies%20relating%20to%20the,the%20Emergency%20Medical%20Treatment%20and%20Labor%20Act%20%28EMTALA%29, page 41.
[2]Ibid, page 126.
[3]https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter02-06.pdf, page 2.
[4]https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf, page 17.

If I had one hour to save the world, I would spend 55 minutes defining the problem, and only five minutes finding the solution.
– Albert Einstein

Exhibit 1 – EMTALA audit program

A. Triage
The patient is triaged in a timely and appropriate manner.

1. Obtain and review policies that outline the triage process.
2. Where is triage performed and how are patients directed there?
3. When is the triage performed?
4. What happens if a patient leaves before or after triage?
5. Are patients asked to notify staff if their condition worsens or if they choose to leave?
6. Is the waiting area visible to triage staff so patients can be monitored?
7. Does a process exist to periodically check on patients in the ED waiting room to determine if their condition has changed or worsened?
8. Are refusal-of-care forms in close proximity to the waiting area?
9. How would staff handle a person who may be on the premises and needs medical attention (e.g., a person in the parking lot or outside the building)?

B. Medical screening exam
The hospital must provide an appropriate medical screening examination (MSE) within the capability of the hospital's emergency department. The examination must include ancillary services routinely available to the emergency department, to determine whether an EMC exists. The examination must be conducted by a QMP (someone who has been determined to be qualified based on hospital medical staff bylaws).

1. Obtain and review policies that outline the MSE process.
2. Do physicians or QMPs document when the MSE has been completed? Is the MSE documented in the medical record?
3. Are ancillary services used as needed to evaluate the presenting complaint and determine if an EMC exists?

C. Registration
Discussions about a patient's ability to pay for services should wait until after a patient has received an MSE and stabilizing treatment has started, if necessary.

1. Obtain and review policies that outline the registration process.
2. What information is obtained when a patient presents for treatment?
3. What if a patient is not able to provide the information? How are they registered?
4. Where is registration information documented?
5. When is the patient recorded into the central log of individuals coming to the emergency department seeking assistance?
6. Does a fast-track process exist for patients with non-urgent conditions and if so, what is the process for registering these patients? Who screens the patient and determines whether they are appropriate for fast track? Is the fast track located in the ED or elsewhere?
7. At what point is the registration staff prompted to collect insurance information from the patient?
8. Does a communication process exist between the clinical staff and registration staff so that any required prior authorizations can be obtained once stabilizing treatment has begun?

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Exhibit 1 – EMTALA audit program (continued)

D. Signage
Signage must be posted that informs patients about their right to emergency medical services.

1. Are signs posted that give information about the person's right to an MSE, regardless of their ability to pay?
2. Are the signs posted in places that are probably noticed by individuals entering the emergency department, as well as by individuals waiting for examination and treatment?
3. Do signs specify the rights of individuals with emergency conditions and/or in labor who come to the emergency department for healthcare services?
4. Are the signs clearly visible from a distance of 20 feet or of the expected vantage point of the individual?
5. Are the signs in the languages of the population(s) most frequently served by the facility?
6. Do the signs indicate whether the facility participates in state-funded healthcare programs?
7. Is the wording of signs clear and in simple terms and language that is understandable by the population served by the hospital?
8. Take pictures of applicable signs as part of your documentation process.

E. Education
Staff and other affected individuals must be educated on the requirements of EMTALA.

1. Does evidence of staff education exist for physicians, residents, nursing, security, volunteers, registration, or others who may interact with individuals coming to the emergency department?
2. What about other employees of the hospital? Do they receive training to recognize and respond at work when they see someone who appears to need emergency medical services?

F. Campus boundaries
Campus "means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis."[5]

1. Obtain and review policies that outline the 250-yard rule requirement, including the boundaries.
2. Does a campus map exist that shows where the 250-yard obligation extends? Areas that may be excluded include private residences, private businesses, public areas not otherwise owned by the hospital (e.g., public parks, public roads).
3. How is the ED made aware of situations on the hospital's campus of a person with an emergency medical condition? Who responds? How is that response determined? Would a call ever be placed to 911 for a person on the hospital's campus and, if so, under what circumstances?
4. Do separate entrances to the ED, obstetrics and/or psychiatric units exist? If a patient comes to the wrong entrance, how are they directed to the correct entrance to ensure they receive the appropriate services?

G. Physician on-call requirements
All hospitals are required to have a call panel of physician specialists who can respond to emergency medical conditions (either by way of consult or by way of accepting a transfer patient).

1. Obtain and review policies and procedures that document physician call coverage.
2. Does a list of on-call physicians and a calendar of when they are scheduled to be on call exist?
3. Are the on-call physicians listed by name, not medical group, on the call calendar?
4. Does the on-call list include any updates for substitutions? What is the process for substituting physicians when changes are made, and how is this communicated to the ED?
5. Where is the most current list kept?

[5] https://www.cms.gov/files/document/frequently-asked-questions-and-answers-emtala-part-ii.pdf, page 3.

Exhibit 1 – EMTALA audit program (continued)

H. Medical staff bylaw considerations
Policies addressing the requirements of being on call and procedures addressing physicians who inappropriately deny a transfer are necessary. The definition of a QMP who can perform a medical screening exam should be documented.

1. Obtain and review copies of the medical staff bylaws and rules and regulations that outline call coverage requirements.
2. Do the medical staff bylaws address the requirements of on-call physicians?
3. Are physicians responding in a timely manner when the ED physician requests a specialist to see the patient?
4. Does a policy address what should be done if the on-call physician cannot see the patient?

I. Emergency transfer requests to the hospital
The facility has a process for managing requests coming from other hospitals for higher-level-of-care transfers.

1. Obtain and review policies that outline the transfer process.
2. Confirm by chart audit sampling that the facility has established a transfer request log process to capture the information regarding requested transfers into the facility. The information captured should include the date and time of the request, name and facility requesting transfer, services requested and reason for transfer, and service availability at the receiving hospital. Also, record if the transfer was denied by another hospital, the reason for denial and the name and address of physician(s) who denied transfer.

J. Emergency transfers out of the hospital
If an EMC is determined to exist, the hospital must provide any necessary stabilizing treatment, or if they do not have the capacity to stabilize the EMC, they may transfer the patient to another hospital.

1. Obtain and review policies that outline the process for transferring patients out of the hospital.
2. Audit the transfer paperwork to confirm that all transfers of individuals with unstabilized EMCs are initiated by a physician certification regarding the medical necessity for transfer.
3. Documentation for the transfer must be included in the medical record and a copy sent to the receiving facility.
4. If the patient requests the transfer, do the forms allow clear documentation of the request and that the risks and benefits of transfer were discussed with the patient?
5. Do forms used to document transfers include a brief statement of the hospital's obligations under EMTALA, as well as the patient's reason for request?
6. How does the physician certify that the benefits of transfer outweigh the risks? Focus should be on the patient's complaints, symptoms and diagnosis.
7. Do facility policies and procedures define documentation standards and the person(s) responsible for:
   a. Identifying the receiving physician (name and title) at the receiving hospital
   b. Obtaining the receiving hospital's acceptance of the patient
   c. Sending pertinent medical records with the patient
8. Do available forms provide a place for the physician to write an order for the transfer and describe transportation staffing and equipment requirements?
9. If a transfer occurs due to an on-call physician's failure to appear or accept the transfer, are the name and address of the physician included in the records sent to the receiving hospital?

Exhibit 1 – EMTALA audit program (continued)

K. Central log
Maintain a central log listing each individual who comes to the emergency department seeking assistance and whether the patient refused treatment, was refused treatment, or was transferred, admitted and treated, stabilized and transferred, or discharged.

1. Confirm the existence of a central log. The record could be a physical paper log or an electronic log (e.g., an electronic medical record system).
2. Ask the emergency department to print a copy of the central log for a given day for you to audit. A CMS or state health department surveyor can make this request at a moment's notice, so staff should be able produce the log in a relatively brief period.

Resources

- American College of Emergency Physicians® – Understanding EMTALA
- American Society of Health Care Risk Management – EMTALA: A Practical Primer for Risk Professionals
- Centers for Medicare and Medicaid Services – Certification and Compliance for The Emergency Medical Treatment and Labor Act (EMTALA)
- Centers for Medicare and Medicaid Services – Know Your Rights (EMTALA)
- Health Care Compliance Association – EMTALA Compliance Checklist

Summary
Healthcare organizations with an emergency department must treat and stabilize patients, regardless of their insurance status or ability to pay. Failure to meet this requirement can result in fines, penalties and negative publicity. Audit the compliance of your emergency departments with EMTALA to help manage and mitigate these risks. **NP**

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