Emergency Medical Treatment and Active Labor Act (EMTALA)

UPDATE

June 10, 2022

EMTALA Update

- Update to policy

  What changed?

  - Wording was brought into alignment with the regulation and standardized across the system
  - New Consent for Transfer form
  - Policy located Policy Stat: search for EMTALA
    - The new Consent for Transfer form is attached to the policy
    - https://mongeneral.policystat.com/policy/8464180/latest/

EMTALA

- **E**mergency **M**edical **T**reatment & **A**ctive Labor **A**ct
- Federally-mandated requirement
- Patient anti-dumping law

EMTALA Facts

EMTALA is tied to Medicare reimbursement, and severe violations can lead to termination of the hospital or provider's Medicare Provider Agreement. Fines can reach $100,000 per violation, and hospitals may be held liable for civil lawsuits, either from patients or from transferring or receiving hospitals.

EMTALA Facts

A person who comes to any part of the hospital or its campus and asks for, or appears to need, emergency care, triggers the requirement to provide a Medical Screening Exam, and then if warranted, stabilization or transfer.

EMTALA Facts

Medical Screening Exam (MSE)

Performed by a ‘qualified medical person’ (QMP)

MD, DO, PA, NP, midwife

Anyone defined by hospital privileges as QMP

MSE cannot be delayed to inquire about payment or insurance status.

Triage ≠ MSE

EMTALA Facts

Pregnant women with contractions are considered medically unstable (active labor).

QMP must certify that the patient is not in labor.

EMTALA Facts

Refusal of MSE or Treatment

Inform patient of risks of refusal.

Document this conversation in the medical record.

Attempt to obtain patient's written refusal.

Consent

The first section is labeled for the physician to complete. Each section should be completed.

EMTALA Transfer Consent

PHYSICIAN

Emergency Medical Condition (EMC) Identified: (Mark appropriate box, have physician certify if I.c or I.d selected and then go to Section II)

I. **MEDICAL CONDITION:** Diagnosis:____

a. ☐ **No Emergency Medical Condition Identified:** This patient and an **EMC** has not been identified.
Screening Physician Signature: ___________________Date:___/___/____ Time:________AM/PM

b. ☐ **Unstable Patient, Request for Transfer:** The Patient has been examined and an EMC has been identified and the patient is not stable. The hospital has the capability and capacity to provide the care needed but the patient has specifically requested to be transferred to another facility after being notified that the hospital can and is willing to provide the care needed to stabilize and treat the EMC.

c. ☐ **Patient Stable For Transfer:** 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.

d. ☐ **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.c and I.d Physician Certification: 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.

REASON FOR TRANSFER;

☐ Medically Indicated ☐ Patient Requested (see patient request documentation: Section VII)

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

On-Call Physician Name:_______________________ Address_______________________________

III. **RISKS AND BENEFITS FOR TRANSFER:**

Medical Benefits:	**Medical Risks:**
☐ Obtain level of care/service unavailable at this facility.	☐ Deterioration of condition in route
Service:_______________________________	☐ Worsening of condition or death if you stay here.
☐ Medical Benefits outweigh the risks.	☐ Risk of traffic delay/accident resulting in condition, deterioration or death.
☐ Other_______________________________	☐ Other_______________________________

IV. **MODE/SUPPORT DURING TRANSFER AS DETERMINED BY PHYSICIAN:**

Mode of transportation for transfer. ☐ BLS ☐ ALS ☐ Helicopter ☐ Neonatal Unit ☐ Other______________

Agency:______________ Name/Title of accompanying hospital employee if required:______________________

Support/Treatment during transfer: ☐ Cardiac Monitor ☐ Oxygen:__________ ☐ IV Pump

☐ IV Fluid:______ Rate:_______ ☐ Restraints – Type:_________ ☐ Other:________________ ☐ None

Transferring Physician Signature if different from Certifying Physician: _____________Date:_/_/__ Time:____AM/PM

Authorizing Physician Signature: Date: / / Time: AM/PM

Consent

Section two is the area for Nursing to complete

NURSING

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 TXFR:______________ Date:__/__/__ Time: ____AM/PM

Receiving MD ____ Date:__/__/__ Time: ____AM/PM

Questions may be directed to ____ or Transferring Physician.

VI. **ACCOMPANYING DOCUMENTATION** sent via: ☐ Patient/Responsible party ☐ Fax ☐ Transporter

Documentation includes: ☐ Copy of Medical Record ☐ Lab/EKG/X-Ray ☐ Copy of Transfer Form

☐ Medication Reconciliation Information ☐ Advance Directive ☐ Other______________________________

Report given to: (Person/title): __________________________________ Date:__/__/__ Time: ____AM/PM

Time of Transfer:______ Date: ______ Nurse Signature_______________ Transferring Unit: __________

Vital Signs just prior to transfer: Temp:____ Pulse ___ R____ BP______sp02%_____ FHT____ Time: _____AM/PM

Consent

Section three is where the consent to transfer is obtained. If the patient is unable to sign or a legal representative is not available, please indicate that also in this area.

PATIENT

VII. **PATIENT CONSENTS TO MEDICALLY INDICATED TRANSFER or PATIENT REQUEST FOR TRANSFER**
(Mark appropriate box a. or b.):

a. ☐ 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 of this transfer.

b. I hereby **REQUEST TRANSFER** to ____________________. I understand and have considered the hospital's EMTALA responsibilities that have been explained to me, the medical 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 with the hospital. I agree to accept the risks associated with my decision. The reason I request transfer is: ____

Signature of: ☐ Patient ☐ Responsible Person ______________ Relationship to patient____________________

Witness ___________________________ Title____________________ Date:___/___/___ Time:_____AM/PM