EMTALA and Transferring Patients to the Emergency Department

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I was an emergency medicine resident on the south side of Chicago in the mid-1980s and, truth be known, I sometimes played inappropriate practical jokes on residents at other area trauma centers. One of my favorites was calling over the "patch phone" with a report that a patient whose penis was "Lorena Bobbitted" by a pit bull was en route; the paramedics were bringing in both the patient and the dog so that a "reimplantation" could be attempted post vivisection of the dog.

My other favorite was the one where multiple severely handicapped children were coming in post minor bus accident for evaluation, with their parents not readily available.

Anyway, usually the calls concluded with the recipient resident saying things like, "Oh yeah, why don't you bite me?"

Calling emergency departments from an urgent care is sometimes a traumatic experience made worse by some ED physician giving you the third degree about "what you are dumping on us?" and muttering something about EMTALA (the Emergency Medical Treatment and Active Labor Act) and hanging up phone *while* saying "bite me!"

Urgent Care Obligations

Do urgent care centers have any obligation under EMTALA? The answer is: it depends.

If the urgent care center is owned and operated by the hospital and is under the same Medicare provider number and meets the Centers for Medicare & Medicaid Services' definition of a "dedicated emergency department" by meeting one of the following criteria: 1) is licensed by the state as an emergency department; 2) holds itself out to the public as providing emergency care; or, 3) during the preceding calendar year, provided at least one-third of its visits for the treatment of emergency conditions, then the answer is yes.

However, does EMTALA apply if the urgent care center operates independently from the hospital (different provider number) and sees less than 33% walk-in patients with emergency conditions?

Or, what if an urgent care advertises that it only treats urgent conditions and not emergent conditions; is that center exempt from EMTALA?

The answer to both these scenarios is (I hate to answer like a lawyer) more likely than not, EMTALA does not apply. CMS does retain the right to review claims on a case-by-case basis. In other words, they can use the dreaded "retrospectoscope" to evaluate the relationship and then pass judgment.

The take-home point is this: If you are working at a hospital-owned urgent care center which makes no distinction on the types of patients treated and sees patients who may qualify as an "emergency," you have some EMTALA exposure. Therefore, the same EMTALA policies used in the emergency department should be in place at the hospital urgent care center. For example, not taking insurance information until an appropriate screening exam is completed, stabilizing prior to appropriate transfers, and providing an appropriate screening exam for all comers.

Occasionally, urgent care physicians tell me that when they do call to alert an emergency physician, they are given the third degree by the recipient and are often told that the ED won't accept the patient.

Do you *need* to call an emergency department from a physician-owned urgent care prior to transfer? Absolutely not!

In a perfect world, communicating with a receiving provider should be commonplace; this direct communication facilities the continuum of care and allows the sending provider to alert the receiving provider about what has already transpired and what the concerns or issues are regarding the patient.

What should *not* occur, however, is the sending provider receiving the third degree by some overworked, burned out EM physician.

At the end of the day, the emergency department cannot refuse the patient no matter how inappropriate they believe the

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transfer, unless the ED is closed to ambulance traffic. And even if they are closed to ambulance transfers, they cannot refuse a patient who is being transferred by private vehicle.

Effective Provider-to-Provider Communication

There are other ways to communicate important facts germane to the patient who is changing venues to the emergency department.

When I work in the ED, I don't necessarily want to hear from an urgent care provider who is transferring a patient to my care. I simply don't want to be biased by their concerns.

What I do expect, however, is a written record of the history, exam, radiographs, and lab results, as well as a written statement identifying the UC provider's concern. "This 67-year-old diabetic patient presents with abdominal pain out of proportion to exam findings and I am concerned about the possibility of ischemic bowel."

If you feel more comfortable communicating directly with the receiving physician, more power to you, although don't let yourself be the recipient of any abuse.

When I transfer a patient, I call *after* the patient has already left the urgent care and I keep my communication fact-based: "I just sent you a 48-year-old man with a good story for acute coronary syndrome. His EKG, CXR and troponin are normal, as well as his d-dimer. He has hypertension and a family history for coronary artery disease and should be there is about 10 minutes."

This leaves the emergency physician no out; the patient is on his way.

Compare this method with "I'm thinking about sending a patient who may have angina. Everything else is normal but I'm not sure what else to do. Would you mind if I sent him your way?"

You get the picture. If you are constantly getting pushback from the ED, choose another receiving hospital or, if you have to use the particular ED, quit calling. After all, you are sending them a patient who will augment their income; why should you be abused?

Epilogue

You know the old saying, "what goes around...." Well, you guessed it. A short while after placing one of the calls I confessed to previously, I was on the actual receiving end of one of these scenarios.

A bus load of handicapped kids *were* involved in a minor accident and they all arrived unexpectedly—"unexpected" only because I did hang up on the University of Chicago EM resident who called on the patch phone. And I did say "bite me!"

Lesson learned. n

or to the highest-priority prospects that for the moment have little interest. The offer is usually made toward the end of the sales call when the disposition of the call is apparent.

How to Make the Offer

It is not what you say; it is how you say it. When offering a complimentary service, you need to go beyond simply offering the product/service by mentioning its value; give an honest appraisal of why the prospect should accept the free commodity.

That is, you should quantify both the dollar value of the product or service and the functional value (e.g., what's in it for the prospect) in the same breath that you are offering the complimentary service.

Your clinic should be well past the trinket era and focused on providing complimentary services of genuine value and/or offer a true hands-on experience to prospects.

Developing a plan on what to offer, who to offer, when to make the offer, and how to verbalize the offer can provide your clinic with a cost-effective yet excellent marketing tool for converting both near- and non-prospects into clients. n

to answer this is this: *If the patient has been seen in the urgent care or occupational medicine clinic in the past three years (not counting drug screens), then the patient is* ***established****.*

If the urgent care and the occupational medicine clinics are incorporated separately, you may be able to count most new patient visits to the urgent care center as new patients, even if the patient has been previously seen in the occupational medicine clinic.

One exception must always be considered: If the patient has been seen for evaluation and management by the same physician (whether it be in a private practice, emergency department, occupational medicine clinic, or any other setting), then for three subsequent years the patient is an established patient for that particular physician in any practice setting.n