EMTALA Compliance Checklist

	Entrances and Signage
	1. Identify and review all entrances to the Emergency Department that can be used by persons presenting for treatment.
	2. Are signs posted that give information about the person's right to a Medical Screening Examination (MSE) regardless of ability to pay? Note: CMS has specific language that must be used.
	3. Are signs posted in the entrances, waiting areas, registration, triage and treatment areas?
	4. Are entrance signs clearly ledgible from a distance of 20 feet or the expected vantage point of the individual?
	5. Are signs in the languages of the population(s) most frequently served by the facility?
	6. Is the waiting area visible to triage staff so that patients can be monitored?
	Triage
	1. Where is triage performed and how are patients directed there?
	2. When is triage performed? [Best practice is prior to full registration]
	3. What happens if someone leaves before or after triage?
	4. Are patients informed to notify staff if condition worsens or if they choose to leave (so that Informed Refusal of Care can be documented)?
	5. Confirm that Informed Refusal of Care forms are located in close proximity to waiting area.
	Registration
	1. What information is obtained?
	2. Where is it documented?
	3. When is the central log initiated?
	4. Confirm that MSE and treatment not being delayed for registration; however, if patient triaged non-emergent, reasonable registration process can begin.
	5. Do registration staff have scripts or training to address patients who insist on discussing insurance coverage prior to MSE?
	6. Confirm that preauthorization of services with insurers is not occurring until after MSE.
	7. Scripting—are staff trained on appropriate standards for scripts? And do those scripts comport with EMTALA? Consistency of message for all patients.
	Medical Screening Examination
	1. Do physicians or Qualified Medical Personnel (QMPs) document when the MSE has been completed?
	2. Are ancillary services used as needed to evaluate the presenting complaint and determine if an Emergency Medical Condition (EMC) exists?

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	Stabilizing Treatment
	1. Is it performed within the capability of the facility and staff?
	2. Confirm that all on-call physicians are presenting to the facility when called and in compliance with timeframe set forth in facility policy.
	3. Is there a communication process between the clinical staff and registration staff so that any required prior authorization can be sought once stabilizing treatment has begun?
	Transfers Out
	1. Audit the transfer paperwork to confirm that all transfers of individuals with unstabilized EMCs are initiated either by (a) a written request for transfer or (b) a physician certification regarding the medical necessity for the transfer.
	2. Documentation for the foregoing must be included in the medical record and a copy sent to the receiving facility.
	3. If the transfer is requested by the patient, do your forms allow clear documentation of the request and that the risks and benefits of transfer were discussed with the patient?
	4. Forms used to document requested transfers should include a brief statement of the hospital's obligations under EMTALA, as well as the patient's reason for request.
	5. How does the physician certify that the benefits of transfer outweigh the risks? Focus should be on the patient's complaints, symptoms and diagnosis.
	6. Do facility policies and procedures define documentation standards and the facility person(s) responsible for:
	a. Identifying a receiving physician and that individual's title at the receiving hospital;
	b. Obtaining the receiving hospital's acceptance of the patient; and
	c. Sending pertinent medical records with the patient.
	7. Do available forms provide a place for the physician to write an order for the transfer and describe transportation staffing and equipment requirements?
	8. If a transfer occurs due to an on-call physician's failure to appear, are the name and address of the physician included in the records sent to the receiving hospital?
	Transfers In
	Confirm that the facility established a transfer request log to capture the following information regarding requested transfers into the facility: 1. Date and time of request; 2. Name of Facility requesting transfer; 3. Services requested/reason for transfer; 4. Service availability at receiving hospital; 5. Whether transfer accepted or denied; and 6. If applicable, reason for denial?

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	Documentation Review
	Audit central log for disposition and compliance with additional state law requirements (e.g., documentation of chief complaint, time of arrival and time of disposition).
	Review Bylaws (or Rules and Regulations) to confirm indication of who may perform an MSE. If a non-physician is authorized to perform an MSE, confirm that the required credentials, competencies and practices standards/protocols have been identified.
	Review physician on-call list to verify that it reflects coverage of services available to inpatients. Physicians must be listed by name rather than solely by practice group.
	Does On-call list include any updates for substitutions?
	Review triage and reassessment policy.
	Confirm that EMTALA policy has been updated to reflect regulatory changes and interpretive guidance changes, for example:
	1. Definition of "comes to the emergency department;" 2. Definition of "dedicated emergency department:" (DED) 3. Concept of "prudent layperson observer;" 4. Changes in obligations for non-DED off-campus departments; 5. Cessation of EMTALA obligations upon inpatient admission; and 6. Requirement that back-up arrangements for on-call coverage be documented in policies.
	Best Practices
	Does the hospital avoid "ED Wait Time Clocks" types of advertising?
	Does ED Log contain Name, Date, Time, and Disposition? Does it answer the question "why are patients leaving without being seen?"
	Does ED round regularly in ED Waiting Room/Lobby?
	Does Hospital participate in a Community Call Plan Agreement with other hospitals? Is this agreement shared with CMS?