The Emergency Medical Treatment & Labor Act (EMTALA)

By Todd B. Taylor, MD

SUMMARY OF EMTALA

- The original intent of EMTALA is consistent with standards of medical care and the public trust held by emergency physicians.

- EMTALA creates a duty that otherwise would not exist on the part of hospitals to individuals that arrive on hospital property and request examination or treatment for a medical condition. The EMTALA obligation is voluntarily accepted by hospitals as part of the Medicare Certificate Participation Agreement. Physicians are duty-bound by EMTALA by virtue of their voluntary agreement with the hospital to serve on-call &/or by agreement or contract with the hospital to provide emergency services.

- EMTALA requires Medicare participating hospitals with emergency departments to provide screening for and treatment of emergency medical conditions in a non-discriminatory manner to any individual regardless of ability to pay, insurance status, national origin, race, creed, color, etc.

- EMTALA requires individuals with similar medical complaints or conditions to be treated similarly. It applies to all individuals at Medicare participating hospitals, not just those covered by Medicare.

- As a federal statute EMTALA supersedes state and local laws, including peer-review protections, certain tort reform limitations, and statute of limitations. It grants every individual a federal right to emergency care and creates additional rights when hospitals or physicians fail to comply.

- EMTALA violations can result in significant penalties for hospitals and physicians, including civil monetary penalties of up to $50,000 per violation and/or Medicare participation termination.

- Congress has expanded the scope of EMTALA five times resulting in increasing regulatory burden for hospitals and physicians. Over the years, compliance has often been complicated by incomplete, inconsistent, and conflicting CMS guidance. Additional sources of confusion result from disparities in interpretation of EMTALA by federal administrative courts, state civil courts, and the Circuit Court of Appeals.

- EMTALA is an unfunded mandate and does not require health insurance companies, governments, or individuals to pay for mandated emergency services. Escalating unfunded mandated care in the face of declining overall reimbursement continues to threaten the ability of emergency departments to serve as America’s health care safety net.

- Emergency physicians on average provide $138,300 of uncompensated EMTALA-related medical care each year and one-third of emergency physicians provide more than 30 hours of EMTALA-related care each week.

- On November 10, 2003, CMS published a final rule revising the 1994 EMTALA Code of Federal Regulations. In large part, these new rules simply codified interim CMS guidance, but in addition CMS revised the definition of an “emergency department,” clarified what is considered “hospital property”, recognized certain limitations of on-call specialists and on-call panels, added a “prudent layperson” standard with regard to the request for services and clarified applicability to hospital-owned ambulances. Although EMTALA has never applied to inpatients, the new rules draw a “bright-line” at admission for when the EMTALA obligation ends.

- The following CMS “Guidance to Surveyors” is contrary to the plain language of the statute and not authorized by the Code of Federal Regulations:

  “To be considered stable the emergency medical condition that caused the individual to seek care in the dedicated ED must be resolved, . . .”

INTRODUCTION AND HISTORY OF EMTALA

EMTALA's Original Intent:
"A hospital is charged only with the responsibility of providing an adequate first response to a medical crisis" which "means the patient must be evaluated and, at a minimum, provided with whatever medical support services and/or transfer arrangements that are consistent with the capability of the institution and the well-being of the patient."

Senator Bob Dole (R-KS), Co-Sponsor of EMTALA
Congressional Record 28569 (1985)

The Emergency Medical Treatment & Labor Act (EMTALA) was enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42USC§1395dd). Often referred to as the patient “anti-dumping” law, it was originally designed to prevent hospitals from transferring uninsured or Medicaid patients to public hospitals without, at a minimum, providing a medical screening examination and treatment to assure that such transfers could be done safely.

The concern for patient safety at that time was not unwarranted. Studies showed that in the early 1980’s of transfers to public or Veteran’s Administration (VA) hospitals, 87% were for economic reasons, only 6% gave informed consent, 24% were unstable at the time of transfer, mortality was 3 times that of other patients, and there were 250,000 such transfers occurring annually3,4,5,6.

Congress has amended and expanded the scope of EMTALA five times. For example, until 1989, EMTALA did not require hospitals or physicians to provide on-call services nor did it require hospitals with specialized services to accept patients in transfer. Over the years additional amendments enhanced the ability to impose fines, increased penalties, provided whistleblower protections, and expand the reach of the law and mandated duties of providers.

Despite passage in 1986, there was little enforcement of EMTALA for the first 10 years7,8. Enforcement increased significantly after the Centers for Medicare & Medicaid Services (CMS, formerly the Health Care Financing Authority or HCFA) published rules for the enforcement of EMTALA in the Code of Federal Regulations (CFR) in 1994 [42CFR§482.xx]. By 1999 there had been more than 2000 EMTALA investigations and more than 1000 confirmed violations9.

In June 1996 a diverse national EMTALA Task Force was formed to clarify the regulations with new Interpretive Guidelines published in July 1998. Interpretive Guidelines do not carry the force of law and, while well-intention, left many issues vague. As a result, federal and state civil courts continued to have a significant influence on EMTALA interpretation. Consequently EMTALA now has little resemblance to its original intent of regulating economically motivated transfers.10

On November 10, 2003, CMS published a final rule revising the 1994 EMTALA Code of Federal Regulations. In large part, these new rules simply codified interim CMS guidance, but in addition they revised the definition of an “emergency department,” clarified what is considered “hospital property”, recognized certain limitations of on-call specialists and on-call panels, added a “prudent layperson” standard with regard to the request for services and clarified applicability to hospital-owned ambulances. In addition, although EMTALA has never applied to inpatients, the new rules drew a “bright-line” at admission for when the EMTALA obligation ends11. Once a patient is admitted, other Medicare Certificate of Participation (CoP) requirements apply making EMTALA superfluous for hospital inpatients12.

While EMTALA is a complex law with many ambiguities, one would need to read no further if only one principle was adopted for EMTALA compliance, “Take care of the patient”. EMTALA is a “medical anti-
discrimination” law. Any time one considers treating any patient differently for other than a good medical reason, EMTALA is in jeopardy of being violated. The difficulty comes in properly documenting such reasoning and in achieving technical compliance. EMTALA is of special concern to hospitals with limited, focused and special capabilities such as pediatric only hospitals and general hospitals that provide “specialized” pediatric services (e.g. a pediatric ED).

This chapter will present the basics of EMTALA drawing heavily upon the actual statutory language. It has been written primarily for physicians and additional references are provided for more detailed reading and study.

**IMPLICATIONS OF EMTALA FOR AMERICAN HEALTHCARE**

"Patient dumping is but a symptom of a much larger problem. Thirty-seven million Americans are without health insurance. Low income sick people are finding it increasingly difficult to get needed health care, and the burden of caring for them is falling on fewer and fewer hospitals."

Rep. Pete Stark (D-CA), Co-Sponsor of EMTALA
Congressional Record 13903 (October 23, 1985)

"Access should be the government's responsibility at the federal, state, and local levels. We cannot and should not expect hospitals to be this nation's National Health Service."

Sen. David Durenberger (R-MN)
Congressional Record 13903 (October 23, 1985)

From a legal perspective EMTALA’s original purpose was simply to create a duty to provide a medical screening examination (MSE) to assure that either no emergency medical condition (EMC) exists or if an EMC is present that it is “stabilized” prior to transfer to a public hospital. With significant changes in payment mechanisms in the early 1980’s, such as “diagnostic related groups” (DRGs), the onslaught of managed care and increasing numbers of uninsured, private hospitals felt compelled to limit their exposure to revenue losses from the uninsured and Medicaid. This led to the proverbial “wallet biopsy” being performed prior to offering even emergency care. Ultimately, this mistreatment of patients prompted the creation of a clever “voluntary” governmental solution we now know as EMTALA.

EMTALA was the first time Congress had used the Medicare statute to create public policy that extended beyond Medicare recipients. As a result, it became a national standard of care for emergency services and a federal right to emergency care. While noble in its intent, and is what most would find to be ethical and a standard of medical care obligation, in the ensuing years the EMTALA statute and regulations resulted in many unintended and even untoward consequences.

EMTALA now regulates virtually every aspect of care provided on hospital property, but by design has no bearing on payment. It allowed local and state governments to abdicate responsibility for charity care thereby shifting this public responsibility to the private sector. Subsequently, many public “free” clinics were closed due to budgetary concerns and public hospitals use EMTALA as a shield against accepting indigent patients. In essence, EMTALA made every Medicare participating hospital a “public” hospital. EMTALA has become the de facto national healthcare policy for emergency care and for the uninsured. It also forced America’s emergency departments to become the safety net of the health care safety net.

Until recently the Federal government had never accepted any direct financial responsibility for EMTALA. The Medicare Modernization Act of 2003 for the first time provides financial relief to hospitals burdened with undocumented aliens due to EMTALA. Nevertheless, the financial strain of EMTALA continues to plague hospitals and their associated physicians with over $25 billion in
uncompensated care annually and “55 percent of emergency services go[ing] uncompensated”.

Further, the traditional cost-shifting mechanism to compensate for this burden has largely been eliminated by managed care and many managed care practices are irreconcilable with the requirements of EMTALA.

The direct and indirect impact of EMTALA continues to mount. Specialists are fleeing hospital medical staffs to avoid ED on-call duties; hospitals are limiting the scope of services or creating “specialty” hospitals to carve out a niche with less EMTALA exposure; efforts to “manage” the financial risk with ED “triage-out” procedures for “non-urgent” conditions; and medical repatriation programs for foreign nationals are but a few examples.

After more than two decades of EMTALA, two fundamental principles are clear:

1) How healthcare is funded (and litigated) drives healthcare availability and delivery.

2) America cannot solve the EMTALA conundrum until it addresses the reason EMTALA exists – a failure to appropriately fund and provide for indigent and uncompensated emergency medical care.

**GENERAL EMTALA DUTY**

EMTALA creates a duty for hospitals to “individuals” (i.e. any person regardless of nationality, county of residence, economic status, etc.) that otherwise would not exist. Ethical duty aside, prior to enactment of EMTALA, there was no legal duty for a hospital to provide medical care (even emergency care) to anyone not already accepted as a patient. EMTALA was specifically design to create such a duty for any “individual” that arrived on hospital property and requested treatment for a “medical condition”. Note, the statute does not say “emergency medical condition”. Whether the medical condition is an “emergency” must be determined by a medical screening examination, and if present additional EMTALA obligations are imposed.

Under EMTALA, hospitals voluntarily accept this duty by virtue of their “contract” with Medicare called the Medicare Certificate of Participation. In doing so, they agree to be investigated, sanctioned and fined for non-compliance without due process. Physicians do not have a similar Medicare requirement therefore EMTALA is the sole burden of Medicare participating hospitals. Non-participating hospitals, such as Veterans Administration, certain military hospitals, non-hospital owned urgent care centers, etc. are not obligated under EMTALA.

Since EMTALA applies only to hospitals, administration must make arrangements to provide physician services as part of this duty. Ironically, EMTALA provides no formal mechanism or requirement for this to be accomplished. So, while the law mandates hospitals provide on-call physicians, it does not require physicians to provide on-call services. As a result, most hospitals do so via contract (e.g. emergency physicians or employed physicians) or by imposing duties by voluntary participation in the medical staff and the ED on-call roster. Because EMTALA is “voluntary” (i.e. hospitals can choose not to participate in Medicare and physicians can choose not to be on the medical staff or choose not to take ED call), it avoids the US Constitution’s XIII Amendment prohibition against involuntary servitude and slavery.

Voluntary or not, EMTALA often creates opportunities for discord between hospitals, between hospitals and its medical staff, and among the medical staff itself, particularly between the ED and on-call physicians. This discord is often exacerbated by the threat of fines and sanctions which are equally onerous for physicians as they are hospitals.
STATUTORY DEFINITIONS [42CFR§489.24(b)]

More than ever before EMTALA is now controlled by statutory definitions which often have little basis in medical science. While this has been true ever since the very first EMTALA case where the judge stated, “The statutory definition renders irrelevant any medical definition”\textsuperscript{21}, there are now many more definitions.

These definitions are more than mere words. They have become a new lingo necessary to appropriately document and assure EMTALA compliance. The commonly stated patient condition at disposition of “improved” should now be replaced with some combination of “EMC”, “No EMC”, or “EMC Resolved” plus “Stable” or “Unstable” depending upon the situation. Table 1 lists common medical condition combinations based on disposition:

<table>
<thead>
<tr>
<th>Disposition</th>
<th>Emergency Medical Condition?</th>
<th>Stability?</th>
<th>Transfer Due to Lack of Capability/Capacity?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged</td>
<td>EMC Resolved (or No EMC)</td>
<td>Stable</td>
<td></td>
</tr>
<tr>
<td>Transferred*</td>
<td>EMC (or EMC Resolved)</td>
<td>Stable</td>
<td>*No</td>
</tr>
<tr>
<td>Transferred**</td>
<td>EMC</td>
<td>Stable or Unstable</td>
<td>**Yes</td>
</tr>
<tr>
<td>Admitted</td>
<td>EMC</td>
<td>Stable or Unstable</td>
<td></td>
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These definitions must be understood before one can begin to understand EMTALA, so they have been placed at the beginning of this chapter. Emphasis has been added to highlight nuances where they appear and extraneous detail and definitions have been deleted for brevity and clarity. The full statutes are available at: www.gpoaccess.gov/cfr/index.html

**Capacity:** “the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses such things as numbers and availability of qualified staff, beds and equipment and the hospital's past practices of accommodating additional patients in excess of its occupancy limits.”

**Comes to the emergency department:** “the individual . . .

(1) “has presented at a hospital's dedicated emergency department . . . and requests examination or treatment for a medical condition”

(2) “has presented on hospital property . . . other than the dedicated emergency department, and requests examination or treatment for what may be an emergency medical condition . . .”

(3) “is in a ground or air ambulance owned and operated by the hospital . . . even if the ambulance is not on hospital grounds.” [However, this individual] “. . . is not considered to have “come to the hospital's emergency department if-- (i) The ambulance is operated under communitywide emergency medical service (EMS) protocols that direct it . . . to the closest appropriate facility . . . (ii) The ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance”

(4) “is in a ground or air nonhospital-owned ambulance on hospital property . . . However, an individual . . . is not considered to have come to the hospital's emergency department, even if . . . the ambulance staff contacts the hospital by telephone [en route] . . . and informs the hospital that they want to transport the individual to the hospital . . . if it is in “diversionary status” . . . If, however, the ambulance . . . transports the individual onto hospital property [anyway], the individual is considered to have come to the emergency department.”

Among other things, the above definition of “come to the emergency department” attempts to clarify CMS policy with regard to hospital and non-hospital owned ambulances. The basic principle is that hospitals cannot preferentially refuse to accept ambulance patients unless certain conditions apply. Unfortunately it does not fully resolve the issue of redirecting a patient to another hospital for medical reasons such as continuity of care as occurred in Arrington v. Wong\textsuperscript{22}. In this case, a hospital providing
medical control to a non-hospital owned ambulance, redirected the patient to a hospital where the patient had received prior medical care and had an established physician. The 9th Circuit Court held that EMTALA had been violated because “comes to” is commonly defined as “to reach by moving toward” vs. actually having arrived. Unless further clarified, hospitals providing medical control should be advised not to redirect patients unless they are in diversionary status.

**Request for examination or treatment includes:** “a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition;”

The above item has been extracted from the statutory definition of “comes to the emergency department” for clarity and is a new concept added in the 2003 CFR revisions. It remains unclear how broadly this “prudent layperson” concept will be interpreted. For example, an otherwise awake and alert individual with an obvious facial laceration from a car crash who has not requested an MSE may be required to sign a refusal merely by arriving to the ED with another family member.

**Dedicated emergency department:** “any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:
(1) It is licensed by the State . . . as an emergency room or emergency department;
(2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment;
(3) During the calendar year immediately preceding . . . it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.”

In combination with the “comes to the emergency department” definition above, this definition (recently added in the new CFRs) attempts to better differentiate between patients who come to the hospital for emergency care vs other various reasons (e.g. scheduled outpatient visit, outpatient surgery, outpatient diagnostic testing, etc.).

**Emergency medical condition:**
(1) “A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in-- (i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) Serious impairment to bodily functions; or (iii) Serious dysfunction of any bodily organ or part; or
(2) With respect to a pregnant woman who is having contractions-- (i) That there is inadequate time to effect a safe transfer to another hospital before delivery; or (ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.

Part of the original statute, this is an often poorly understood definition even by CMS officials. It is perhaps the best example of the divergence between medical and legal definitions. The EMC definition is qualified by a medical condition requiring immediate medical attention. This is a very high bar to satisfy from a legal perspective, but for practical purposes providers should err on considering almost anything an “emergency” until proven otherwise. While not required by EMTALA, this approach may be necessary to avoid being investigated.

**Hospital property:** “the entire main hospital campus . . . including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the hospital's main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities.

**Inpatient:** “an individual who is admitted to a hospital . . . for purposes of receiving inpatient hospital services . . . with the expectation that he or she will remain at least overnight . . .”
**Labor:** “the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician certifies that, after a reasonable time of observation, the woman is in false labor.”

**Patient:** (1) An individual who has begun to receive outpatient services as part of an encounter . . ., other than an encounter that the hospital is obligated by this section to provide; (2) An individual who has been admitted as an inpatient . . .

**Stabilized:** “with respect to an “emergency medical condition” . . . that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, . . . (2) . . . the woman has delivered the child and the placenta.

**To stabilize:** “. . . to provide . . . medical treatment of the condition necessary to assure . . .” [the condition is stabilized as above].

**Transfer:** “the movement (including the discharge) of an individual outside a hospital's facilities . . ., but does not include . . . an individual who (i) has been declared dead, or (ii) leaves the facility without . . . permission . . .”

**EMTALA-MANDATED RESPONSIBILITIES FOR HOSPITALS & PHYSICIANS**

As a federal statute EMTALA supersedes conflicting and contradictory state and local laws, including peer-review protections, certain tort reform limitations, and statute of limitations. It grants every individual a federal right to emergency care and creates additional rights when hospitals or physicians fail to comply.

**Duty to Provide an “Appropriate” Medical Screening Examination (MSE)**

[42CFR§489.24(a)(1) & (a)(1)(i)]

“. . . if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) “comes to the emergency department”, . . . the hospital must . . . provide an appropriate medical screening examination within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations . . .”

The sole purpose of the MSE is to determine if an emergency medical condition (EMC) exists. If the ED has the ability to rule out an EMC and documents it in the medical record, then EMTALA no longer applies. At that point the patient may be dispositioned in accordance with community standards of medical care, hospital policy, and local regulations. It is important to recognize that even if EMTALA no longer applies, other regulations may and many states have passed similar and even more stringent regulations regarding emergency care.

The MSE is all encompassing and includes all the available hospital resources necessary to make a determination with regard to an EMC including on-call specialists. However, hospitals are not required to provide all services 24 hours per day, if not routinely provided after hours. Since EMTALA is an anti-discrimination statute, a rule of thumb is if a VIP patient can get the service then it must be available to all other patients as well.

Application of the EMTALA MSE requirement now depends upon “where” the individual presents on hospital property. If they present to the “dedicated emergency department” (DED) and request examination or treatment for a “medical condition”, this duty applies. If they present anywhere else, the duty only applies if the request is for what may be an emergency medical condition. In actual practice this differentiation is only important for legal defense purposes, but documentation to that effect may assist in
such defense. Although not necessarily required by EMTALA, the safest course of action may be to take any individual that requests anything remotely resembling a request for medical care to the appropriate area in the hospital (i.e. ED, pediatric ED, OB triage, psychiatry, etc.) for formal MSE.

Perhaps the easiest way to train staff in this regard is to instruct them to ask such individuals, “Do you want to see a doctor?” If the answer is “yes”, then take them to the ED or other appropriate department. If the answer is “no”, then inquire further as to what they want or need. If there is any uncertainty, the safest course of action is to let the ED sort it out.

Pediatric emergency departments, particularly those as part of a pediatric hospital, must understand well their obligation to medically screen and stabilize any “individual” (regardless of age) that “comes to the emergency department” and requests evaluation for a medical condition. While such a facility is only required to provide such screening and stabilization that is within their capacity and capability, it is assumed that any hospital emergency department can and will do as much as they can while making arrangements for transfer to a more appropriate facility. If an EMC cannot be ruled out, then the patient should be considered “unstable” for the purposes of transfer and an “appropriate” formal EMTALA transfer accomplished.

**Special Circumstances Related to the Medical Screening Examination**

**No Delay in Providing a Medical Screening Examination or Treatment:**

[42CFR§489.24(d)(4)]

(1) A participating hospital may not delay providing an appropriate medical screening examination . . . in order to inquire about the individual’s method of payment or insurance status.

(2) A participating hospital may not seek . . . authorization from the individual’s insurance company for screening or stabilization services . . . until after . . . the appropriate medical screening examination . . . and treatment that may be required to stabilize the emergency medical condition . . .

(3) A . . . practitioner is not precluded from contacting the individual’s physician at any time to seek advice regarding the individual’s medical history and needs that may be relevant to the medical treatment and screening of the patient, as long as this consultation does not inappropriately delay services . . .

(4) Hospitals may follow reasonable registration processes . . . including asking whether an individual is insured and, if so, what that insurance is, as long as that inquiry does not delay screening or treatment. Reasonable registration processes may not unduly discourage individuals from remaining for further evaluation.

The “no delay” provision is an often misconstrued requirement. Some hospitals have taken the approach that to be completely “safe” no insurance information may be obtained until the MSE has been initiated. Clearly this is not a requirement and may, in fact in itself, delay treatment since managed care often utilizes certain specialty consultants that may be unknown until insurance information is available. Nevertheless, whatever information is obtained cannot alter the usual course of examination and treatment.

This provision also clearly prohibits prior authorization for at least the initial MSE and treatment. Also the determination as to whether a patient has an EMC or is stable remains the purview of the on-site examining physician. Therefore, it is not appropriate for an off-site managed care gatekeeper to make such a determination.

Once the MSE has determined that there is no EMC or the EMC has been stabilized, then authorization (i.e. for admission or non-emergent testing) may be obtained if necessary. However, this may become a very delicate situation when authorization for admission is denied and an “economic transfer” is requested by the health plan. For truly “stable” patients this should not be an EMTALA issue, but “stability” is often reviewed retrospectively when anything adverse occurs during or even after the transfer. Under strict EMTALA statute an “economic transfer” is allowable, but the physician must always be right about
“stability”. In the current EMTALA and medical-legal climate, such transfers should be severely limited (i.e. to the absolutely most stable patients) or initiated after admission once stability is assured and EMTALA clearly no longer applies.

If such “economic transfers” are to be contemplated, it is prudent to identify additional legitimate reasons for the transfer such as “continuity of care” and assess the patient’s desire to be transferred to an in-network facility by their formal request to be transferred. Emergency physicians compelled by the hospital to initiate economic transfers for the hospital’s benefit, may wish to seek indemnification by hospital for any untoward EMTALA or other legal action.

Regardless, it is always prudent to clearly document that the patient is “stable” and they are aware of the reasons for transfer along with the risks and benefits. The following acknowledgment has been recommended: The physician has determined that my condition is stable and that there is no significant risk to my being transferred. I want the cost of further treatment to be covered by my health plan. My health plan has agreed to cover the cost of treatment at the receiving facility, but denied payment for services at this facility.

Availability of on-call physicians
[42CFR§489.24(j)]
(1) Each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients . . . in accordance with the resources available to the hospital, including the availability of on-call physicians.
(2) The hospital must have written policies and procedures in place — (i) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control; and (ii) To provide that emergency services are available to meet the needs of patients with emergency medical conditions if it elects to permit on-call physicians to schedule elective surgery during the time that they are on call or to permit on-call physicians to have simultaneous on-call duties.

This CFRs was revised November 2003 to clarify hospital requirements regarding on-call specialty physician services and whether on-call physicians could schedule elective surgery &/or simultaneously take call at multiple hospitals. While touted as “easing this requirement”, in the opinion of this author, in reality it broadened the requirement significantly by using a “best meets the needs of the patient” standard. It also reiterates that hospitals must have a plan to deal with gaps in on-call coverage for any reason.

On-call specialty coverage for EDs and hospital inpatients has emerged as a major healthcare issue but is beyond the scope of this chapter. While EMTALA is neither the cause nor the solution, along with other stresses in the healthcare system it continues to have a significant impact on ED specialty coverage. Increasingly, hospitals are finding it necessary to compensate or employ physician specialists in order to comply with this EMTALA mandate. Under EMTALA, the hospital and not its medical staff or individual physicians is responsible for maintaining an on-call roster for the emergency department. EMTALA case law requires hospitals to cajole, force, or otherwise negotiate and procure physician services to operate their emergency departments and provide on-call specialty care.

Use of dedicated emergency department for nonemergency services
[42CFR§489.24(c)]
If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not an emergency condition, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.
The CFR was added in November 2003 to clarify that hospitals are not required to provide EMTALA-related services for “non-emergencies”. However, this is a “chicken and egg” conundrum and in no way alleviates hospitals from performing an appropriate MSE for what may seem at triage the most trivial complaint yet later turns out to be an EMC. In the opinion of this author this section should simply be ignored.

Qualified Medical Person (QMP) Performing the MSE (see also Transfer)
A hospital must formally determine who is qualified to perform the initial medical screening examinations, i.e., qualified medical person. While it is permissible for a hospital to designate a non-physician practitioner as the qualified medical person, the designated non-physician practitioners must be set forth in a document that is approved by the governing body of the hospital. Those health practitioners designated to perform medical screening examinations are to be identified in the hospital by-laws or in the rules and regulations governing the medical staff following governing body approval. It is not acceptable for the hospital to allow the medical director of the emergency department to make what may be informal personnel appointments that could frequently change.

Duty to Stabilize
[42CFR§489.24(a)(1)(ii)]
"If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment . . or an appropriate transfer . . If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends . . ."

[42CFR§489.24(d)]
Necessary stabilizing treatment for emergency medical conditions.—
(1) . . . if . . . the hospital determines that the individual has an emergency medical condition, the hospital must provide either-- (i) Within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition. (ii) For transfer of the individual to another medical facility . . ."

If the MSE determines an emergency medical condition (EMC) exists then additional EMTALA duties apply. However, note that the statutory definition of “emergency” medical condition is quite restrictive, in that it requires that the “absence of immediate medical attention” will result in bad things happening. This fact is useful from a legal defense perspective, but from a practical standpoint almost any acute medical condition should be treated to an appropriate conclusion in the ED prior to discharge. While not required by EMTALA, this approach is prudent in light of aggressive CMS EMTALA enforcement, the impact of an EMTALA investigation, the potential severity of penalties, and the current medial-legal climate. It should also be noted that other Medicare Certificates of Participation, state regulations and general medical liability may apply even if EMTALA does not.

Further, a failure to follow hospital policy is often considered a per se EMTALA violation, even if not otherwise required by the EMTALA statute. Therefore, hospitals should construct their policies and procedures with extraordinary care to assure universal compliance. For example, an ED triage policy that requires every patient to be triaged within 5 minutes of arrival may be unrealistic in the current overcrowded ED environment. A requirement for on-call physicians to arrive within 30 minutes is unrealistic for most communities. Nevertheless, 6 minutes to triage or 31 minutes for the specialist to arrive could both be potential violations for failing to comply with hospital policy.

As with the MSE requirement, the duty to stabilize is all encompassing including necessary on-call specialists. If the EMC can be resolved in the ED and is documented as such, then EMTALA no longer applies. If the EMC cannot be resolved in the ED and the hospital has inpatient services appropriate to do so then the patient must be admitted. At the point of admission the EMTALA obligation ends and is superseded by other Medicare Certificate of Participation requirements79.
If the hospital does not have inpatient or emergency services (i.e. capacity &/or capability) necessary to stabilize the EMC then an appropriate formal EMTALA transfer must be accomplished unless refused by the patient.

**Duty to Transfer**

[42CFR§489.24 (e)]

"Restricting transfer until the individual is stabilized—
(1) . . . If an individual . . . has an emergency medical condition that has not been stabilized . . . the hospital may not transfer the individual unless--
(i) The transfer is an appropriate transfer; and (ii)
(A) The individual (or a legally responsible person . . .) requests the transfer, after being informed of the hospital's obligations under this section and of the risk of transfer . . . in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer;
(B) A physician . . . has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or
(C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person . . . has signed a certification . . . after a physician . . . in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification . . .

There are only three circumstances under which a patient may be transferred:

1) **The patient is “stable” under the statutory EMTALA definition, in which case theoretically EMTALA does not apply.**

This is theoretical because transferring a “stable” patient for admission or for further ED workup begs the question as to why they are being transferred instead of simply being discharged home. Again, this makes for an excellent legal argument when a transfer “goes bad”, but in practice can be risky. While not required by EMTALA, it is prudent to document a legal “appropriate” transfer on all patients not otherwise being routinely discharged from the ED. While in many instances transferred patients will be declared “stable”, if in retrospect the patient deteriorates, the transfer documentation will help protect the transferring hospital. In addition, some states require similar documentation on all transfers regardless of stability.

In an ill-conceived ploy, some have tried to circumvent EMTALA by “discharging” a patient with instructions to “go to the ‘county’ hospital”. For EMTALA purposes a “discharge” is a transfer and such behavior invariably raises suspicion and results in an investigation.

2) **The individual (or legal representative) requests to be transferred and accepts, in writing, the documented risks.**

EMTALA does not empower hospitals to force involuntary treatment, admission, or transfer. However it does require specific documentation and informed risk should a patient request to be transferred or refuse transfer, examination, or treatment. While this may seem relatively straight forward, an EMTALA conundrum can be created when a patient requests to be transferred to a hospital that then refuses to accept based on the premise that the sending facility has the ability to treat. If the patient cannot be dissuaded, the best course of action is to have them sign out “against medical advice”, complete as much of the transfer documentation as is possible including sending medical records, and notify the receiving facility of the situation. 42CFR§489.24(e)(1)(ii)(A) theoretically alleviates the sending facility of the
obligation to obtain acceptance by the receiving facility, although other aspects of the transfer (i.e. appropriate ambulance personnel, etc.) may still apply.

3) The transfer is medically indicated (i.e. the risk of transfer is outweighed by the benefits) as certified by a physician (or qualified medical person in consultation with a off-site physician).

If the ED does not have the ability (capacity or capability) to determine if an EMC exists or to stabilize an identified EMC, then the patient should be consider unstable and an “appropriate” formal EMTALA transfer to a hospital that has the necessary ability accomplished unless refused by the patient.

“Appropriate” Formal EMTALA Transfer

[42CFR§489.24 (e)(2)

“A transfer to another medical facility will be appropriate only in those cases in which--
(i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;
(ii) The receiving facility--(A) Has available space and qualified personnel for the treatment of the individual; and (B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment;
(iii) The transferring hospital sends to the receiving facility all medical records . . . related to the emergency condition . . . that are available . . . and the name and address of any on-call physician . . . who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records . . . not . . . available . . . must be sent as soon as practicable after transfer; and
(iv) The transfer is effected through qualified personnel and transportation equipment . . .”

This section lists the four required elements of an “appropriate transfer”:
1) Ongoing medical treatment until transfer.
2) Confirmation of capability, capacity and acceptance at the receiving facility.
3) Sending of all available pertinent medical records.
4) Assure the transfer is effected with qualified personnel and equipment.

Once the decision to transfer has been made, ongoing treatment and monitoring is required within the ability of the transferring facility until the transfer can be effected. This includes all available services including on-call specialists even if they will not ultimately admit the patient. If the on-site physician requests the presence of an on-call specialist to help care for a patient while awaiting for transfer, the specialist is required by EMTALA to come in within a “reasonable” time. Note the requirement to provide the name of any on-call physician that failed to appear whether or not that is the inciting reason for the transfer.

Documentation that the receiving facility has the ability and has acknowledge acceptance is required. While perhaps good medical practice under many circumstances, there is no specific requirement that a physician be contacted or accept the patient in transfer at the receiving facility. Anyone authorized at the receiving facility to accept the patient may do so, even a clerk in the admitting office.

As with all medical encounters documentation is important. For example, failure to document medical records were sent is a per se EMTALA violation whether they were actually sent or not.

The method of transport will depend upon the situation, but in most cases an ambulance is required. If for some reason an “unstabilized” patient is not being sent by ambulance (such as an eye injury sent with family to an ophthalmologist’s office with better equipment), careful documentation as to the reason and safety of such method of transfer should be done.
Documenting the required elements of an “appropriate transfer” in the medical record is sufficient, but difficult to consistently accomplish. While an EMTALA “Transfer Form” is not required, it is perhaps the best method to ensure technical compliance in documenting these three elements of a transfer: 1) Request for Transfer; 2) Consent to Transfer; 3) Certification of Stability &/or Risk/Benefits of Transfer.

**Special Circumstances Related to Transfers**

**Refusal to consent to transfer**
[42CFR§489.24(e)(2)(5)]
A hospital meets the requirements... if the hospital offers to transfer the individual to another medical facility... and informs the individual (or a person acting on his or her behalf) of the risks and benefits... of the transfer, but the individual... does not consent to the transfer. The hospital must take all reasonable steps to secure the individual's written informed refusal... The written document must indicate the person has been informed of the risks and benefits of the transfer and state the reasons for the individual's refusal. The medical record must contain a description of the proposed transfer that was refused...

**Duty to Accept Transfers - Recipient hospital responsibilities**
[42CFR§489.24(f)]
A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

The “duty to accept” is an often misunderstood and perhaps poorly defined requirement. The operative words are “including, but not limited to” and “if the receiving hospital has the capacity”. As put by one former CMS EMTALA official, “if you have, they need it, you give it, or else you ‘get’ it”. Pediatric hospitals, hospitals with pediatric emergency departments, and community hospitals that provide inpatient pediatric services should all be consider “hospitals with specialized services”.

With increasing hospital ED and inpatient capacity issues, it is not uncommon for hospitals with “specialized services” to lack “capacity”. The issue becomes how to document such transfer refusals for individuals that never become patients. Another issue is who does this documentation if private on-call specialists screen these calls. There is no accepted standard and, in fact, most hospitals rely upon the good will of the calling facility to do this documentation for them. Nevertheless, some facilities have established “transfer coordinators” that document these calls and file a non-accepted patient form by date of call for retrieval if necessary.

**Transfers Between the Same Hospital's Departments or Facilities**
The movement of the individual between hospital departments is not considered an EMTALA transfer under this section, since the individual is simply being moved from one department of a hospital to another department or facility of the same hospital.

**Transfer Agreements**

Although transfer agreements are not required by EMTALA, they are mentioned in the “State Operations Manual – Interpretive Guidelines”. They have been suggested as a way for specialized hospitals, such as pediatric hospitals, to expedite appropriate transfers of adults when necessary. They are useful because they allow for an established well thought-out process before it is needed in the “heat of the moment”. However, transfer agreements are not the panacea that some may hope. First, there may be little incentive, and perhaps a disincentive, for a receiving hospital to cooperate without payment issues being addressed. Second, having a transfer agreement does not guarantee acceptance of a patient, because EMTALA
requires services (i.e. inpatient beds) to be granted on a “first come – first served basis”. It is fundamentally discriminatory to give preference to one hospital over another in accepting transfers and “holding beds” for this purpose will likely be construed as a violation of the section on “recipient hospital responsibilities”. For these and other reasons transfer agreements are rarely executed.

Other EMTALA Duties for Medicare Participating Hospitals

Duty to Report
[42CFR§489.20(m)]
... a hospital ... [must] report to CMS or the State survey agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of ... [EMTALA]

Whistle Bower Protection
[42CFR§489.24(e)(3)]
A participating hospital may not penalize or take adverse action against a physician or a qualified medical person ... because ... [they] refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized, or against any hospital employee because the employee reports a violation of a requirement of this section.

Only hospitals have the duty to report suspect violations and then only for patients transferred to them (i.e. not for a refusal to accept an outgoing transfer). Although permissive to do so, physicians and hospital employees do not have a duty to report under EMTALA. However, they may have an obligation to report to hospital administration under hospital policy. Regardless, a hospital cannot take an adverse action against a physician or employee for complying with EMTALA or voluntarily reporting.

Over the years certain hospitals have used EMTALA reporting, or the threat thereof, for a variety of purposes such as retaliation for legally, but preferentially transferring uninsured patients to them. However, frivolous reporting is a precarious strategy as often times the receiving-reporting hospital ultimately is investigated along with the sending facility. The duty to report should be taken as seriously and with as much due diligence as any other “disruptive behavior” incident.

In an ill-conceived desire to curry favor with CMS when an EMTALA incident occurs, some hospitals have “self-reported”. There is no requirement to self-report and in reality most EMTALA incidents never come to the attention of CMS. Further, there is no evidence that CMS is more lenient on a hospital who has done so. When an EMTALA incident occurs, the best course of action is to document the issues and take aggressive steps to correct and assure it does not reoccur. Should the incident subsequently be investigated, the hospital will have a head start on a “corrective plan of action” and CMS may indeed over look the incident altogether. On the other hand, repeated failures to address ongoing EMTALA issues are a prescription for immediate Medicare Provider Termination and serious civil monetary penalties.

Signage Requirement
[42CFR§489.20(q)(1)]
... [Hospitals must] post conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than traditional emergency departments (that is, entrance, admitting area, waiting room, treatment area), a sign (in a form specified by the Secretary) specifying rights of individuals under ... [EMTALA] with respect to examination and treatment for emergency medical conditions and women in labor; and (2) ... post conspicuously ... information indicating whether or not the hospital or rural primary care hospital participates in the Medicaid program under a State plan approved under title XIX.

Maintenance of Information
[42CFR§489.20(r)(1)]
Maintain -- Medical and other records related to individuals transferred to or from the hospital for a period of 5 years from the date of the transfer; (2) A list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition; and (3) A central log on each individual who comes to the emergency department . . . seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged.

Although perhaps not intuitively obvious, the “list of physicians on-call” must identify specific physicians’ names (i.e. not the group name and not a mid-level provider taking “first-call”).

Although most hospitals keep medical records indefinitely, the “statute of limitations” for an EMTALA violation is 2 years \(^3\), although penalties may be assessed up to 6 years \(^3\) after the incident.

**EXCEPTIONS TO EMTALA**

**Nonapplicability of EMTALA**

[42CFR§489.24(a)(2)]
Sanctions . . . for inappropriate transfer during a national emergency do not apply to a hospital with a dedicated emergency department located in an emergency area . . .”

Although this section provides an EMTALA exemption during a declared national emergency, it is unclear how this would apply during other disaster situations that do not rise to that level.

**Refusal to consent to treatment.**

[42CFR§489.24(d)(2)]
A hospital meets the requirements . . . if the hospital offers the individual . . . examination and treatment . . . and informs the individual . . . of the risks and benefits . . . but the individual . . . does not consent . . . The medical record must contain a description of the examination, treatment . . . that was refused . . . The hospital must take all reasonable steps to secure the individual's written informed refusal . . . The written document should indicate that the person has been informed of the risks and benefits . . .

While this section appears straightforward, there are varying degrees of “treatment refusal” or what CMS refers to as “voluntary withdrawal” of a request for examination and treatment. It is unclear if a low risk patient who refuses a spinal tap or even someone who declines pain medication should be offered a written refusal.

**Exception: Application to inpatients.**

42CFR§489.24(d)(2)
(i) If a hospital has screened an individual . . . and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual.
(ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment.
(iii) A hospital is required by the conditions of participation for hospitals . . . to provide care to its inpatients in accordance with those conditions of participation.

**STATE OPERATIONS MANUAL – INTERPRETIVE GUIDELINES – May 2004**

“The interpretive guidelines serve to interpret and clarify the responsibilities of Medicare participating hospitals in emergency cases. They contain authoritative interpretations and clarifications of statutory and regulatory requirements and are to be used to assist in making consistent determinations about a provider’s compliance with the requirements. These interpretive guidelines merely define or explain the relevant statutes and regulations and do not impose any requirements that are not otherwise set forth in the statutes or regulations. The revised guidelines clarify and provide detailed interpretation of the EMTALA provisions located at 42CFR§489.24 and parts
The Interpretative Guidelines assist state surveyors (those who investigate potential EMTALA violations) and providers better understand how CMS will enforce EMTALA and conduct investigations. The Guidelines do not carry the force of law and are ignored by the courts. Nevertheless, they are an important resource in avoiding an EMTALA citation. To follow are a few areas in which the Guidelines appear to overreach the EMTALA statutes.

**Adequate Staff**
If it appears that a hospital with an dedicated ED does not have adequate staff and equipment to meet the needs of patients, consult the RO to determine whether or not to expand the survey for compliance with the requirements of 42CFR§482.55 (Condition of Participation: Emergency Services).

While within CMS’s authority, this passage puts hospitals on notice that CMS intends to aggressively pursue any and all deficiencies discovered during an investigation. It is unknown how such efforts will impact hospitals with respect to the current shortage of resources that exits at many hospitals.

**In-Service EMTALA Training**
Ask . . . the staff provide you with the following information (as appropriate): In-service training program records, schedules, reports, etc.

While EMTALA education for all hospital employees and medical staff is prudent and often included as part of a “corrective plan of action”, there is no statutory requirement to do so.

**Quality Assessment and Performance Improvement**
. . . review documents pertaining to QAPI [Quality Assessment and Performance Improvement] activities in the emergency department and remedial actions taken in response to a violation of these regulations. Document hospital corrective actions taken prior to the survey and take such corrective action into account when developing your recommendation to the RO [Review Officer].

While not required by statute, CMS often looks favorably toward hospitals who actively pursue remedial actions and sanctions for employees and medical staff who have violated EMTALA.

**“Selective” On-Call**
[State Operations Manual: Appendix V – Interpretive Guidelines, Page 22]
Physicians that refuse to be included on a hospital’s on call list but take calls selectively for patients with whom they or a colleague at the hospital have established a doctor-patient relationship while at the same time refusing to see other patients (including those individuals whose ability to pay is questionable) may violate EMTALA. If a hospital permits physicians to selectively take call while the hospital’s coverage for that particular service is not adequate, the hospital would be in violation of its EMTALA obligation by encouraging disparate treatment.

While hospitals are required to “maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients”\(^{33}\), it is unclear how the notion expressed above could result in a physician being found in violation of EMTALA. On the one hand CMS clearly states that they will not tell hospitals how to structure their on-call coverage (an admission that they do not have the statutory authority to do so), but on the other hand statements like this seem to indicate otherwise. In fact, case law\(^ {34}\) and the plain language of the statute\(^ {35}\) clearly indicate that a physician is only liable under EMTALA if they have “voluntarily” agreed to be on-call and there is no requirement that any medical
staff member involuntarily do so. Each hospital must structure their on-call coverage in a reasonable manner, but there are absolutely no statutory guidelines as to what constitutes reasonable.

**Response Time for On-Call Specialists**  
Surveyors are to review the hospital policies or medical staff bylaws with respect to response time of the on call physician. If a physician on the list is called by the hospital to provide emergency screening or treatment and either refuses or fails to arrive within the response time established by hospital policies or medical staff bylaws, the hospital and that physician may be in violation of EMTALA. Hospitals are responsible for ensuring that on call physicians respond within a reasonable period of time. The expected response time should be stated in minutes in the hospitals policies. Terms such as “reasonable” or “prompt” are not enforceable by the hospital and therefore inappropriate in defining physician’s response time.

Both the statute and CFRs explicitly use the term “reasonable time” in referring to when the on-call specialist must respond. There is no requirement that this statement or any particular minute time limit be included in hospital policies or medical staff bylaws. In fact, the appropriate amount of time will depend entirely upon the clinical situation and may vary widely from patient to patient. If forced into stating a time limit, it is recommended that hospitals list a liberal amount of time for a return phone call and then state that the appropriate time to arrival of the specialist will depend upon the clinical situation as discussed with the on-site physician.

**Stability & Emergency Medical Condition**  
“An individual will be deemed stabilized if the treating physician or QMP attending to the individual in the emergency department/hospital has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.”

These and other similar statements in the Interpretive Guidelines are contrary to the plain language of the EMTALA statute and not authorized by the Code of Federal Regulations. The statutory of definition of “stability” is clearly stated and does not require that the EMC be resolved. It is unclear how such statements will ultimately affect the expansion and enforcement of EMTALA by CMS.

**Outpatient Follow Up**  
[State Operations Manual: Appendix V – Interpretive Guidelines, Page 37]
“An individual is considered stable and ready for discharge when, within reasonable clinical confidence, it is determined that the individual has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow-up care as part of the discharge instructions. The EMC that caused the individual to present to the dedicated ED must be resolved, but the underlying medical condition may persist. Hospitals are expected within reason to assist/provide discharged individuals the necessary information to secure the necessary follow-up care to prevent relapse or worsening of the medical condition upon release from the hospital;”

While community standards and prudent medical practice may agree with the underlined statements above, there is no basis for them under EMTALA. In fact, this is contrary to case law and EMTALA simply does not reach into the private physician’s office even if the patient was referred by virtue of that physician being on-call. Nevertheless, the hospital may still be liable under EMTALA if such patients are not ultimately managed appropriately.

**Definition of Transfer**  
42CFR§489.24 (b) defines transfer to mean:
“... the movement (including the discharge) of an individual outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who has been declared dead or leaves the facility without the permission of any such person. If discharge would result in the reasonable medical probability of material deterioration of the patient, the emergency medical condition should not be considered to have been stabilized.”

While the last sentence of this “citation” may make perfect clinical sense, in fact, it is not part of statute or CFRs. It appears to be a partial combination of the “stability” and “transfers” definitions. While the statute clearly includes “discharge” in the definition of “transfer”, the new CRFs published November 10, 2003 failed to clarify how “stability” of an EMC applies to a patient being discharged. Nevertheless, this error continues a theme in these particular Interpretive Guidelines of overreaching on the issues of stability and emergency medical condition.

**Timing of Transfer with Respect to Transfer Certification**  
The date and time of the physician certification should closely match the date and time of the transfer.

There is no basis for this statement in the statute or CFRs, although CMS has cited hospitals on this basis in the past. Considering the current climate of hospital crowding at times it can take hours to effect a transfer. Regardless, it is difficult to imagine how several minutes or even a few hours would change the risks and benefits involved in such a transfer.

**EMTALA as a Standard of Care Statute**  
[State Operations Manual: Appendix V – Interpretive Guidelines]  
Page 10: If the complaint case did not involve an inappropriate transfer (e.g., the complaint was for failure to provide an adequate screening examination . . .  
Page 46: If the patient requires treatment, it must be sufficient to minimize the risk likely to occur or result from the transfer.

Throughout the Interpretive Guidelines CMS attempts to expand EMTALA by creating references to “adequate MSE” and “sufficient” treatment (neither of these words are used in the statute or CFRs in this context), in addition to more than 100 references to “appropriate”. In fact, the sole purpose of the MSE under EMTALA is to determine whether or not an EMC exists and the sole purpose of “stabilizing treatment” is to allow a safe transfer, if contemplated, in which no deterioration is likely. Neither of these requirements was ever intended to represent a standard of care with regard to emergency services. Unfortunately, Quality Improvement Organization (QIO) EMTALA physician reviewers, charged with preventing such overreaching, have all too often been unwittingly complicit with CMS in this regard.

**EMTALA ENFORCEMENT**

An EMTALA investigation and the resulting citation process can be quite complicated and is beyond the scope of this chapter. However, it should be noted, that defending oneself in an EMTALA action can be expensive, often exceeding the amount of the potential civil monetary penalty. Further, Medicare Participation Termination is a reality for both hospitals and physicians and a potential financial “death sentence”.

EMTALA enforcement is fundamentally a complaint-driven process, so the principle objective in managing EMTALA risk should be to avoid being investigated. This requires that hospitals take an aggressive, yet very conservative approach to EMTALA compliance and at times implement policies more restrictive than technically required by the statute. Also, because of its complexity, the challenge for
EMTALA is to achieve unfailing compliance, but not interrupt the usual and reasonable ED process (Table 2).

EMTALA turns the legal system “on its head” as we know it. Because hospitals voluntarily agree to be investigated and sanctioned under EMTALA, there is no due process and no medical peer review required prior to citing a facility. Subsequent due process and peer review may apply, but often only after the “damage has been done” and thousands of dollars spent trying to prove a negative, i.e. that you did nothing wrong. Ergo, under EMTALA, you are “guilty unless you can prove yourself innocent”.

As a result, once they are cited most hospitals simply seek absolution and compliance by quickly submitting a "corrective plan of action". In part due to recognition that an EMTALA investigation has no due process, CMS has acknowledged that submission of a "corrective plan of action" equate to an admission of guilt. For most hospitals, the only real option after being cited for an EMTALA violation is to present an acceptable compliance plan and seek removal of the Medicare Notice of Termination.

To date, almost 35% of hospitals have been investigated at one time or another and several hospitals more than once. Not unexpectedly, EMTALA complaints increase dramatically after the 1994 CRFs added the requirement to report suspected violations. Failure to properly provide an MSE remains the number one cause for EMTALA investigations although medical staff on-call issues continue to increase.

### Potential EMTALA Sanctions & Fines: [42CFR§1003.102]

<table>
<thead>
<tr>
<th>Action</th>
<th>Amount/Duration</th>
<th>Comment</th>
<th>Regulation</th>
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<tbody>
<tr>
<td>Medicare &amp; Medicaid Program Termination</td>
<td>Up to 2 years</td>
<td>This can be a financial “death sentence” for any hospital or physician.</td>
<td>[42CFR§489.24(g)] &amp; [42CFR§1003.105]</td>
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<tr>
<td>Civil Monetary Penalties</td>
<td>Up to $50,000 for each violation (not each patient)</td>
<td>A malpractice insurance carrier may cover defense of the action, but fines are almost never covered without an EMTALA rider.</td>
<td>[42CFR§1003.103(e)] &amp; [42CFR§1003.106]</td>
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<td>Hospital vs. Hospital</td>
<td>A hospital “dumped on” can recover all costs for the patient’s care.</td>
<td></td>
<td>[42USC§1395dd(d)(2)(B)]</td>
</tr>
<tr>
<td>Private Cause of Action</td>
<td>Depends on proven damages</td>
<td>Allows a civil case to be brought in federal court under “strict compliance with the law”. Strict liability is less open to “expert” defense &amp; easier to prove liability.</td>
<td>[42USC§1395dd(d)(2)(A)]</td>
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<td>Injunctions</td>
<td></td>
<td>The court may impose an injunction requiring certain remedies to correct future violations or public notice of non-discrimination policies.</td>
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<tr>
<td>Hill-Burton Act Funds</td>
<td>Varies</td>
<td>EMTALA violations may result in government action to recover loans and grants made to the facility.</td>
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<tr>
<td>Civil Rights</td>
<td>Fines &amp;/or incarceration</td>
<td>EMTALA violation based on discrimination may result in referral to the Civil Rights Division of DHHS resulting in criminal prosecution under the Civil Rights Act.</td>
<td>[State Operations Manual: Appendix V – Interpretive Guidelines, Page 4]</td>
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Regulating Entities

1) Centers for Medicare & Medicaid Services (CMS)

CMS is authorized to investigate, cite, and terminate Medicare contracts for hospitals it believes violated EMTALA. The on-site investigations are most frequently done by the respective State Department of Health Licensing Division. This often creates double jeopardy for hospitals when these same state regulators uncover potential state violations during the EMTALA investigation.

Once cited a hospital receives a 23-day “Notice of Termination” if the EMTALA violation(s) “poses immediate jeopardy to the health or safety of individuals”. To avoid Medicare termination hospitals must file a “corrective plan of action” by this deadline and if accepted by CMS the termination is typically extended to the less severe 60 day “notice” to allow time for full compliance. Regardless, the hospital may still dispute the citation or challenge a CMS rejection of a “corrective plan of action” in Federal Administrative Court. This is rarely done since a settlement and compliance is nearly always the easiest and least costly option. However, without an acceptable “corrective plan of action”, CMS will follow through with termination of the hospital’s Medicare contract while the case winds its way through the courts under the auspices of the Office of Inspector General.

2) Office of Inspector General (OIG)

The OIG has EMTALA enforcement authority over physicians including investigation, prosecution, civil monetary penalties, and termination of the physician’s Medicare contract. The OIG also prosecutes and has authority to fine hospitals should the hospital dispute the citation &/or the “corrective plan of action” is rejected by CMS. The OIG is in essence the “prosecuting attorney” for the US Department of Health and Human Services (DHHS).

3) The Courts

A) Federal Administrative Courts

Unlike most other legal actions, EMTALA cases are heard before a Magistrate in the Federal Administrative Courts without a jury. Because only the most defendable cases ever make it to this level, the OIG’s success in prosecuting such cases is almost zero.

B) Civil State or Federal Courts

Malpractice actions may lead to or result from EMTALA situations with or without a substantiated citation. Also, the threat of reporting EMTALA may be used to bolster a weak malpractice case or bully hospitals into settling. The ability to sue in federal court allows preemption of most state tort reform and “peer review” protection. All of the information obtained during an EMTALA investigation, including opinions of physician experts, can be freely obtained through the “Freedom of Information Act” and used in a civil malpractice action. EMTALA investigations often become a “ready-made” malpractice case for the plaintiff. Finally, the statute creates a “Private Cause of Action” against hospitals for damages sustained due to an EMTALA violation creating direct liability as opposed to vivacious liability.37
SUMMARY\textsuperscript{38}: Ten Strategies for Successful EMTALA Compliance

EMTALA continues to represent an ever-changing paradigm shift in how hospitals and physicians deliver emergency care and requires new ways of thinking, planning, and documentation.

Regardless of its complexities, solutions are relatively straightforward:

1) Hospitals and physicians must acknowledge EMTALA’s existence and pervasiveness.

2) Area hospitals and medical staffs must act cooperatively because EMTALA compliance is impossible without cooperation from the medical staff leadership and hospital administration.

3) Hospital EMTALA compliance policies and procedures, including forms, medical staff on-call responsibilities, and acceptance of patients in transfer must be developed with extreme care.

4) Hospitals should require EMTALA education for anyone who may come into contact with individuals seeking medical care, including all hospital employees (nursing, ancillary, security, cafeteria, and administrative) and all medical staff.

5) Hospitals and physicians must document using the EMTALA paradigm including appropriate legal terminology, new definitions of medical terms, and required norms and practices.

6) Define hospital capabilities, including on-call services, and review on a regular basis.

7) Create an in-house EMTALA compliance program as part of the regular Quality Improvement Process and establish an EMTALA “hot-line”.

8) Address EMTALA issues aggressively as they occur. It is not if, but when, so prepare for an EMTALA investigation BEFORE it occurs by identifying resources. Preparing a model “corrective plan of action” may be worthwhile.

9) The emergency physicians are the hospital’s first, best, and final defense against an EMTALA violation. Empower them to do whatever is necessary to mitigate a developing EMTALA situation at the time it occurs.

10) Always “take care of the patient” first.
TABLE #2A
EMTALA KISS PRINCIPLES
For the Hospital Staff & Emergency Physicians

Inquiries about any medical condition on hospital property:
- Ask, “Do you want to see a doctor?”
- If “Yes”, take them to the ED.

In the ED:
- Log ALL patients.
- MSE for ALL patients by a physician or a “qualified medical provider”.
  - If not, document why? i.e. Left Without Treatment, Refused MSE &/or Treatment
- Treat ALL patients to a reasonable disposition in the ED.

Transfers:
- Obtain acceptance from the receiving facility & complete a transfer form on ALL patients not otherwise being routinely discharged.
- Accept ALL transfers if the hospital has the capacity *(bed available & ever done it before)* to treat the presenting problem. If not, document why.

Reporting:
- Set up a system for reporting suspicious transfers.
- Report ALL suspicious transfers to you.
- Document ALL incoming & outgoing transfers.

TABLE #2B
EMTALA KISS PRINCIPLES
For the Medical Staff Physician

*[The following only applies when the physician is on-call for the hospital emergency department.]*

If you are called – you are chosen:
- Respond appropriately.
- The emergency physician dictates appropriateness unless or until you assume care of the patient.

Transfers:
- Accept ALL incoming transfers if the hospital has the capacity *(bed available & ever done it before)* to treat the presenting problem. If not, document why.

ED Patient Outpatient Follow-Up:
- Do what you agreed to do in your office or risk being required to always come to the ED.
- Do not demand payment up front or refer back to the ED if patient unable to pay or a non-contracted health plan. Do what the patient needs that day and make definitive arrangements for further care if necessary.

The best response to any inquiry from a hospital emergency department is:
*How can I help you with this patient?*

**NOTE:** These principles are intentionally conservative and go well beyond what EMTALA actually requires. They are designed more to keep everyone out of EMTALA trouble than they are a legal explanation.
Additional Reading:

Taylor TB. EMTALA Q&A: Outpatients vs. ED Patients. Emergency Physicians’ Monthly. 2/00;7:2
Taylor TB. EMTALA On-Call: Duties and Responsibilities. Emergency Physicians’ Monthly. 4/00;7:4
Taylor TB. EMTALA Q&A: ED Follow-Up Care by On-Call Specialists. Emergency Physicians’ Monthly. 2/01;8:2

1 EMTALA Fact Sheet. American College of Emergency Physicians, Dallas, TX. March 2005
2 EMTALA Study. American Medical Association 2003. Chicago, IL
5 Community hospital transfers to a VA medical center. JAMA. 1989;262:70-3
9 Centers for Medicare & Medicaid Services Central Office Investigation Logs, June 2001
11 42CFR§489.24(d)(2)
12 42CFR§482.55
18 MMA Sec. 1011- Payment for EMTALA Services for Undocumented Aliens
19 American Hospital Association Annual Survey of Hospitals, 2003. Chicago, IL
20 Fact Sheet: Costs of Emergency Care. ACEP June 2003. Dallas, TX
21 Burditt v US Dept of HHS, 934 F2d 1362 (5th Cir 1991)
23 42USC§1395dd(f)
24 Vanlandingham B. On-Call Specialist Coverage In US Emergency Departments – ED Director Survey. ACEP Sept 2004. Dallas, TX
27 42USC§1395cc(a)(1)(I)(i) & (iii)
28 Burditt v US Dept of HHS, 934 F2d 1362 (5th Cir 1991)
29 42CFR§489.24 (a)(1)(ii) & (d)(2)
30 42CFR§489.24(f)
31 42 USC§1395dd(d)(2)(C)
32 42 USC§1320a-7(a)(c)(1).
33 42CFR§489.24(j)
34 Burditt v US Dept of HHS, 934 F2d 1362 (5th Cir 1991)
35 42USC§1395dd(d)(1)(C)
36 Phipps v Bristol Regional Medical Center , 1997 U.S. App. LEXIS 17919 (6th Cir. 1997)
37 42USC§1395dd(d)(2)