EMTALA: Advanced Cases

No law enacted before, or since, EMTALA has had a bigger impact on the way we must examine and treat ED patients. While the new rules maintain basic patient protections and clarify certain obligations, they also limit the responsibilities of medical staff to provide ED on-call services. As for HIPAA, the legislation has led to dramatic changes in our procedures, and some are improvements. These regulations are often misunderstood and interpreted inconsistently. The presenter will provide the latest information and cases. Plenty of time will be left for questions.

Objectives:
- Analyze the current CMS interpretive guidelines and the associated ED obligations.
- Explain medical screening and stabilization, including by whom it can be performed.
- Define obligations related to medical staff, on-call physician, and transfer.
- Describe HIPAA guidelines and the various local interpretations.
- Cite cases that clarify these regulatory mandates.
- Recommend methods to enhance compliance.

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DISCLOSURES:
(+No significant financial relationships to disclose
Emergency Medical Treatment & Labor Act (EMTALA)
Presented By Todd B. Taylor, MD, FACEP

PRESENTATION ABSTRACT
The Emergency Medical Treatment and Labor Act (EMTALA) was part of the very large Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 and was in response to a perceived crisis in patient “dumping” by hospitals denying emergency medical care to patients with inadequate or no insurance. Financial pressures brought about by managed care and Medicare Diagnostic Related Groups (DRGs) in the late 70’s & early 80’s led to fundamental changes in healthcare funding. As a result, some hospitals began to divert indigent patients to public (county) hospitals and to comply with managed care demands for transfer of patients to “contracted” facilities. This practice led to the inevitable disparity in hospital care and emergency care in particular. Several examples of untoward outcomes and even deaths from these practices soon emerged. EMTALA was enacted to eliminate financial and other types of discrimination with respect to hospital emergency care. General funding has never been appropriated for EMTALA despite its obvious and escalating cost to healthcare providers. Instead, Congress made EMTALA part of the Medicare Conditions of Participation Agreement such that hospitals “voluntarily” agree to comply with and bear the cost of EMTALA by virtue of their participation in Medicare.

In subsequent years, the toward and untoward effects of EMTALA have permeated the entire healthcare system. This “solution” has now become the “symptom” of an ill and dying healthcare system. Nevertheless, EMTALA is alive and well and has become the de facto national healthcare policy with regard to treatment of all emergency department patients and the uninsured.

For a PDF of this handout or more information about this topic contact: ttaylor@acep.org

LEARNING OBJECTIVES - Participants Will:
1. Review the history and development of EMTALA.
2. Learn their responsibility regarding EMTALA.
3. Learn the possible penalties for not complying with EMTALA.
4. Review case examples illustrating the nuances of EMTALA.
5. Learn a simple method for compliance with EMTALA.

ABOUT THE PRESENTER
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He practiced emergency medicine for nearly 20 years at Banner Good Samaritan Medical Center in Phoenix, Arizona, a 700-bed, level one trauma, and tertiary referral center. He currently serves as Council Speaker for the American College of Emergency Physicians.

While in Arizona, he served as CMS’s QIO reviewer for EMTALA quality of care issues and now travels the country speaking about EMTALA and other related emergency medicine issues. He is editor of “EMTALA Q & A” for Emergency Physicians’ Monthly and has several other EMTALA publications to his credit. He authored the chapter, “Medical Staff and On-Call Physician Obligations” for the ACEP book, Providing Emergency Care under Federal Law: EMTALA.
History of EMTALA

1) A Rose by Any Other Name (United States Code Section 1867)
   - COBRA: “Consolidated Omnibus Budget Reconciliation Act of 1985”
     (EMTALA was part of this very large bill)
   - “Anti-Patient Dumping Law” or “Patient Anti-Dumping Law”
   - EMTALA: “Emergency Medical Treatment And Active Labor Act”

2) The first 10 years (U of A article) vs. The last 12 months

3) Are these guys serious?
   - Original Bill
   - Current Penalties

4) What is EMTALA?
   - General Principle: “Access to care and non-discriminatory treatment.”
   - It seems reasonable and many hospitals/physicians have assumed they follow “reasonable” procedures.

5) “Trinity”: Statutes: 1) Law 2) Regulations 3) Guidance to Surveyors
   Agencies: 1) CMS (HCFA) 2) OIG 3) Federal Courts (Civil Courts)

   - Medical vs. Legal Definitions
   - Duty to accept transfers
   - Duty to report potential violations
   - Emergency Medical Condition [42USC1395dd (e)(1) (A) & (B)]
     EMTALA: Everything is an emergency until you prove it is not an emergency.
     Managed Care: Nothing is an emergency until you prove it is an emergency.

   - Documentation: EMTALA is a technical law that requires technical compliance. Practicing good medicine may not be enough if that care is not appropriately documented in the manner and form that indicate good medicine was practiced and that technical compliance with the law was accomplished. No adverse outcome is required for CMS (HCFA) to identify a violation; the mere fact that a technical violation exists is enough.

7) Managed Care and EMTALA
   - “We also believe that hospitals should not attempt to coerce individuals into making judgments against their best interest by informing them that they will have to pay for their care if they remain, but that their care will be free or at a lower cost if they transfer to a charity hospital.” *Fed. Register, June 22, 1994.*
**Basic EMTALA Requirements**

The statute imposes 3 basic requirements regarding “individuals” who “come to the hospital” and request medical care:

1) The hospital must conduct an appropriate medical screening examination to determine if an emergency medical condition exists.

2) If the hospital determines that an emergency medical condition exists, it must either provide the treatment necessary to stabilize the emergency medical condition or comply with the statute’s requirements to affect a proper transfer of a patient whose condition has not been stabilized. A hospital is considered to have met this second requirement if an individual refuses the hospital's offer of additional examination or treatment, or refuses to consent to a transfer, after having been informed of the risks and benefits.

3) If an individual's emergency medical condition has not been stabilized, the hospital may not transfer the individual unless (a) the individual or his or her representative makes a written request for transfer to another medical facility after being informed of the risk of transfer and the transferring hospital's obligation under the statute to provide additional examination or treatment; or (b) a physician signed a certification summarizing the medical risks and benefits of a transfer and certifying that, based upon the information available, the medical benefits reasonably expected from the transfer outweigh the increased risk.

If a physician is not physically present when the transfer decision is made, a qualified medical person may sign the certification after the physician, in consultation with the qualified medical person, has made the determination that the benefits of transfer outweigh the increased risks. However, the physician must later countersign the certification.

**Transfers**

EMTALA sets forth requirements as to what constitutes an appropriate transfer defined as “the movement of an unstable patient with an emergency medical condition”. Under the statute (42 U.S.C. § 1395dd(c)(2)), an appropriate transfer has five elements that must be accomplished and documented:

1) Pending transferring, the hospital must provide medical treatment within its capability (including on-call specialists) to minimize the health risks to the patient; and for a woman in active labor, the treatment must address both the health of the woman and her unborn child.

2) The hospital receiving the transfer must have available space and qualified personnel to accept the transfer.

3) The hospital receiving the transfer must have agreed to accept the transfer and to provide appropriate medical treatment.

4) The transfer is accomplished with qualified personnel and transportation equipment, including appropriate life-support measures during the transfer.

5) The transferring hospital must send and document all relevant medical records, radiographs, etc. were sent with the patient.

NOTE: EMTALA does not apply if the patient is “stable” as defined in 42USC1395dd (e)(3)(B) Definitions: The term “stabilized” means, with respect to an emergency medical condition described in paragraph (1)(A), 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, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).
The Penalties:

1. **Medicare & Medicaid**: Program termination for a specified period of time.
2. **Per Violation**: Up to $50,000 for each “violation” (not each patient encounter). A malpractice insurance carrier may cover defense of the action, but fines are almost never covered without an EMTALA rider.
3. **Hospital vs. Hospital**: A hospital that has been “dumped on” can recover all costs for the patient care.
4. **Requirement to Report**: A hospital that believes a violation may have occurred must report it within 72 hours or face possible Notice of Termination.
5. **Private Cause of Action**: Allows the case to be brought to federal court using “strict compliance with the law”. Strict liability is less open to “expert” defense and easier for the plaintiff to prove.
6. **Injunctions**: Once a violation has been proven the court may impose an injunction requiring certain remedies to correct future violations or public notice of non-discrimination policies.
7. **Hill-Burton Act**: EMTALA violations may result in government action to recover loans and grants made to the facility.
8. **Civil Rights**: AN EMTALA violation based on discrimination may result in referral to the Civil Rights Division of the Dept. of DHHS resulting in criminal prosecution under the civil rights act.

**EMTALA Compliance Principles**

- Applies to all Medicare participating hospitals
- Anyone who presents in any way to any where on hospital property and in any way requests medical attention should be taken to the appropriate area of the hospital (i.e. ED, OB triage, psychiatric triage etc.) for a medical screening examination and necessary stabilizing treatment.
- Routine collection of demographic and insurance information is allowed as long as it does not impede the patient receiving a medical screening examination and any necessary stabilizing treatment.
- Patients may not be coerced into being transferred (i.e. “your insurance will not pay for your visit”) or seeking medical care elsewhere even if required by their insurance.
- **EMTALA is an “Anti-discriminatory Law”:**
  
  *Patient must be treated the same regardless of socioeconomic status*
  
  1) With or without insurance
  2) Regardless of nationality
  3) Regardless of complaint

- Hospitals that have the capacity must accept appropriate transfers from facilities that do not have the capacity to provide necessary care for patients:
  1) Without consideration of insurance status
  2) Regardless of nationality or state/county of residence
  3) Regardless of complaint
  4) Regardless of closer appropriate hospital

- **Certification For Transfer/Request For Transfer/Consent To Transfer** form should be completed on any patient not otherwise being discharged home with care completed.
EMTALA KISS PRINCIPLES
For the Hospital Staff & Emergency Physicians

Inquiries about any medical condition on hospital property:
- Do you want to see a doctor?
- I’ll take you to the ER (if not already there)

ED:
- Log ALL patients.
- MSE for ALL patients by a physician or physician extender who has been approved as a “qualified medical provider”. If not, document why?
  LWOT
  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. (There is no requirement to report a refusal to accept outgoing transfers).
- Document ALL incoming & outgoing transfers.
EMTALA KISS PRINCIPLES
For the Medical Staff Physician
Prepared by Todd B. Taylor, MD, FACEP

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

If you are called – you are chosen if on-call for the emergency department (ED):

- Respond appropriately: No excuses, no complaints.
- The emergency physician dictates appropriateness unless or until you assume care of the patient. In doing so, be careful not to get yourself & your hospital into EMTALA trouble.

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.
- Obtain acceptance from the receiving facility & complete transfer documentation (form) on ALL patients not otherwise being routinely discharged.

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 they need done that day and make definitive arrangements for further care if necessary.

Reporting Suspicious Transfers (“Dumps”):

- Only hospitals have a statuary duty to report suspicious transfers coming to them.
- Set up a hospital system for reporting ALL suspicious incoming transfers.
- There is no requirement to report suspicious refusals to accept outgoing transfers.
- Document ALL incoming & outgoing transfers.

The best response to any inquiry from a hospital emergency department is:

How can I help you with this patient?

NOTE: Not all of the above “KISS Principles” are strictly required under the EMTALA statute, but application of this statute varies widely among CMS/HCFA regions and even more so in civil malpractice courts. These principles are intentionally conservative and go beyond what EMTALA actually requires. They are designed more to help keep on-call physicians out of EMTALA trouble than they are a legal explanation. Caveat Emptor!
**EMTALA/COBRA Algorithm**

**Person arrives on hospital property AND requests emergency medical care?**

- **No EMTALA Obligation**
  - Carefully inquire as to what it is they want. If routine outpatient procedure (e.g. blood test), consider having them sign a special consent form.

- **Triage, Log, & ^Register^ Patient**
  - Emergency Medical Condition? (EMC)
    - **Yes**
      - **EMC Resolved or "Stable for D/C"**
        - **Yes**
          - **Stable for D/C**
            - Requires definitive arrangements for follow-up to prevent de-stabilization or provide further stabilization.
            - Formal transfer & documentation of informed "risk vs. benefits" is necessary if sending to another facility for immediate treatment.
            - This may also be necessary for delayed treatment as an outpatient (e.g. ortho follow-up for a fracture).

    - **No**
      - **EMC still within hospital's capability & capacity to treat?**
        - **Yes**
          - **Patient requests to be transferred?**
            - **Yes**
              - **Patient requests to leave AMA?**
                - **No**
                  - **Admit**
                    - Until EMC stabilized or resolved; patient dies or requests transfer.
                - **Yes**
                  - **Treatment Refusal Form**
                    - May be a Combined Form: "AMA/Treatment/Transfer Refusal"

        - **No**
          - **Patient Consents to Transfer?**
            - **Yes**
              - **Transfer Refusal Form**
                - May be a Combined Form: "AMA/Treatment/Transfer Refusal"

    - **No**
      - **Capacity & Capability to Stabilize?**
        - **Yes**
          - **Provide necessary stabilizing treatment**
        - **No**
          - **COMPETE FORMS**
            "Request for Transfer" "Consent to Transfer" "Certification of Transfer"

- **Yes**
  - **Medical Screening Examination (MSE)**
    - **Emergency Medical Condition? (EMC)**
      - **Yes**
        - **EMC Resolved or "Stable for D/C"**
          - **Yes**
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                    - **Admit**
                      - Until EMC stabilized or resolved; patient dies or requests transfer.
                  - **Yes**
                    - **Treatment Refusal Form**
                      - May be a Combined Form: "AMA/Treatment/Transfer Refusal"

  - **No**
    - **TRANSFER**
      - Continue stabilizing Rx within capability until transfer completed.
      - *All transfers should be considered potentially "UNSTABLE"*

  - **Yes**
    - **Patient Consents to Transfer?**
      - **Yes**
        - **Medical Screening Examination (MSE)**
          - **Emergency Medical Condition? (EMC)**
            - **Yes**
              - **EMC Resolved or "Stable for D/C"**
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                    - This may also be necessary for delayed treatment as an outpatient (e.g. ortho follow-up for a fracture).

  - **No**
    - **COMPETE FORMS**
      "Request for Transfer" "Consent to Transfer" "Certification of Transfer"

- **Document**
  - Transfer Acceptance Nursing Report Called Records & X-rays Sent

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^"Registration"^ Registration may begin at any logical time in the ED course as long as it does not delay or impede the patient receiving an MSE &/or stabilizing treatment. Be careful not to dissuade the patient from receiving the MSE. Prior authorization for services is prohibited until the patient is deemed to be medically stable or determined not to have an EMC.
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 Conditions of 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 results 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 annually.3,4,5,6

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 years. 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§489.xx]. By 1999 there had been more than 2000 EMTALA investigations and more than 1000 confirmed violations.

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 ends.11 Once a patient is admitted, other Medicare Certificate of Participation (CoP) requirements apply making EMTALA superfluous for hospital inpatients.12

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 [47 million in 2005] 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 extending 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 ensuring 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 exits – 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)]

Increasingly, 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”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>
</tr>
</tbody>
</table>

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. 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)]

(i) 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.

(ii) 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 . . .

(iii) 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 . . .

(iv) 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 often a 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 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 if 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 the 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 of an emergency nature, 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

"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 . . ."

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 medical-legal climate. It should also be noted that other Medicare Conditions 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 under EMTALA, 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 requirements.

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)(iii)(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 acknowledged 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 the three elements of an appropriate 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(d)(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”30. 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 overlook 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 489.20 (l), (m), (q), and (r).” [Revised Appendix V, Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases – Introductory Letter, May 13, 2004].

The Interpretative Guidelines assistant 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,” 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 and the plain language of the statute 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


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

“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 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 failsafe 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>
</tr>
</thead>
<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>
</tr>
<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>
</tr>
<tr>
<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>
</tr>
<tr>
<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>
<td></td>
</tr>
<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>
<td></td>
</tr>
<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>
</tr>
</tbody>
</table>
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

SUMMARY38: Ten Strategies for Successful EMTALA Compliance

EMTALA continues to represents 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)(i) & (d)(2)
30 42CFR§489.24(f)
31 42 USC§1395dd(d)(2)(C)
32 42 USC§1320a-7(a)(c)(I).
33 42CFR§489.24(i)
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)
INTRODUCTION

The Emergency Medical Treatment & Labor Act of 1986\(^1\) (a.k.a. EMTALA) is a federal legislative solution to problems created by the financial pressures initially brought about by managed care and Medicare Diagnostic Related Groups (DRGs) in the late 1970’s and early 1980’s. Hospitals responded to this fundamental change in healthcare funding by attempting to divert indigent patients to public (county) hospitals and through strict compliance with managed care demands for transfer of patients to “contracted” facilities. Unfortunately, this practice led to inevitable disparity in hospital care and emergency care in particular. Several examples of untoward outcomes and even deaths from this practice soon emerged. As a result, EMTALA was enacted to eliminate financial and other types of discrimination with respect to hospital emergency care. No funding has ever been appropriated for EMTALA despite its obvious and escalating cost to healthcare providers. Instead, to implement this provision, Congress made EMTALA part of the Medicare Certificate of Participation Agreement such that hospitals “voluntarily” agree to comply with and bear the cost of EMTALA by virtue of their participation in Medicare.

WHAT IS EMTALA?

EMTALA has two principle requirements for Medicare participating hospitals:

1) Any individual requesting, must receive a “medical screening examination” to determine if an “emergency medical condition” exists.

\textbf{CFR 42 - Sec. 489.24} Special responsibilities of Medicare hospitals in emergency cases.
\textbf{(a) General.}
In the case of a hospital that has an emergency department, if any individual (whether or not eligible for Medicare benefits and regardless of ability to pay) comes by him or herself or with another person to the emergency department and a request is made on the individual’s behalf for examination or treatment of a medical condition by qualified medical personnel (as determined by the hospital in its rules and regulations), the hospital must provide for 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 examinations must be conducted by individuals determined qualified by hospital by-laws or rules and regulations and who meet the requirements of Sec. 482.55 concerning emergency services personnel and direction.

\(^1\) Emergency Medical Treatment and Active Labor Act, as established under the consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended by the Omnibus Budget Reconciliation Acts (OBRA) of 1987, 1989, and 1990, 59 Federal Register 32086.32127 (1994) (42 USC 1395 dd §012).
2) If an “emergency medical condition” is identified, a hospital must provide stabilizing treatment within its capability or accomplish an “appropriate” transfer with the consent of the patient and a physician certification that the benefits of the transfer are outweighed by the risks.

CFR 42 - Sec. 489.24 Special responsibilities of Medicare hospitals in emergency cases.

(c) Necessary stabilizing treatment for emergency medical conditions —

(1) General. If any individual (whether or not eligible for Medicare benefits) comes to a hospital and 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; or

(ii) For transfer of the individual to another medical facility in accordance with paragraph (d) of this section.

(d) Restricting transfer until the individual is stabilized—

(1) General. If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless—

(i) The transfer is an appropriate transfer (within the meaning of paragraph (d)(2) of this section); and

(ii)(A) The individual (or a legally responsible person acting on the individual’s behalf) requests the transfer, after being informed of the hospital’s obligations under this section and of the risk of transfer. The request must be 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 (within the meaning of section 1861(r)(1) of the Act) 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

EMTALA’s original intent allowed the continued practice of transferring indigent and managed care patients to other facilities, but only after the patient had been evaluated and determined to be “safe” for such transfer. However, in practice (in large part due to aggressive CMS enforcement) this practice has been virtually eliminated due to the inherent increased regulatory and civil liability that EMTALA has created. Furthermore, public hospitals and hospitals contracted with managed care (often capitated such that they receive no additional compensation), soon began refusing to accept these “financially” motivated transfers. Eventually in many states, public hospitals and clinics (with the mission to provide indigent care) were closed or “privatized” because EMTALA removed the principle reason for their existence (i.e. patients would otherwise have no resource for medical care). In effect, EMTALA made every Medicare participating hospital into a “public” hospital with an unfunded federal mandate to provide comprehensive healthcare irrespective of the patient’s ability to pay or intent of the patient or their healthcare plan to pay for services rendered. Despite this significant financial burden, Medicare reimbursements decreased throughout the 1990’s, disproportionate share funding was eliminated or not readjusted to account for the shift in where indigent care was being delivered, and local/county governments exited the healthcare business. In essence, EMTALA allowed America to avoid dealing with the issue of uncompensated healthcare and the uninsured for more than 15 years by transferring that responsibility to healthcare providers. We are now paying the price for that “policy” as evidenced by shortages throughout the healthcare industry including nurses, physician specialists, hospital beds, EMS, certain medications, emergency department (ED) crowding, etc.
IMPACT of EMTALA

It has taken more than a decade for the full impact of EMTALA to be realized and it is only now being documented\(^\text{10}\). By default, EMTALA became America’s national healthcare policy and thrust the financial burden for indigent care upon hospital providers (including for-profit and non-profit hospitals, emergency physicians, and on-call physician specialists). EMTALA has severely limited provider’s ability to obtain appropriate compensation for services even from insured patients due interference with the collection of copays/deductibles and fostering managed care payment denials due to prohibition of prior-authorization and the functional elimination of “financial” transfers. Despite record economic expansion during the 1990’s, this, among other issues, has created what amounts to a “healthcare recession” (contraction of the healthcare market and declining revenues in the face of increases costs of labor and despite an increasing need). The result today is a lack of essential healthcare services (such as inpatient hospital beds, emergency services including EMS, on-call specialists, and severe ED crowding) in many regions of the country\(^\text{11}\).

As currently enforced by CMS, EMTALA prohibits inquiring or requesting payment for hospital emergency services until care is essentially completed. Functionally, this has removed the principle motivation for people to obtain/maintain health insurance (i.e. without it you might be sent to the “county” hospital) and for patients to seek primary care in alternative settings (i.e. family doctor’s office) where they must pay upfront for care. EMTALA has simply changed the healthcare financing equation.

Specific EMTALA Implications:

The GAO EMTALA Study [Part I – published June 2001] commissioned by Congress illustrated many issues. Specific issues are discussed in detail in a document the Arizona College of Emergency Physicians provided to the GAO for that report. These items are summarized below and the full document attached.

EMTALA EXPANSION\(^\text{12}\)

EMTALA is now so complex that textbooks have been written and EMTALA seminars are being held on a regular basis. The worst expansion has occurred through administrative case law & now more frequently through civil malpractice actions. EMTALA has become a functional “national malpractice act” and serves to bolster even the weakest malpractice case by invoking a statute with such dire consequences that many hospitals and physicians settle simply because of the threat of an EMTALA action.

CMS, in over aggressive enforcement, has also been using EMTALA as “quality of care” regulation. Complicating this fact is that there is no requirement for peer review prior to citation even if the allegation is based upon a quality of care concern. The statute also creates a “private cause of action” that has led to an explosion of civil malpractice lawsuits even though CMS may determine that there was no EMTALA violation (eg. Coleman v. Deno, Louisiana Court of Appeals, 2001 & Arrington v. Wong, 2001 U.S. App. LEXIS 783 - 9th Cir. Jan. 22, 2001)

Finally, just the fear of an investigation and citation due to a “guilty unless you can prove yourself innocent” approach in EMTALA tends to cause so much fear that “over-compliance” is often practiced a way to assure staying out of trouble.

\(^{10}\) Taylor TB. Threats to the Health Care Safety Net. Academic Emergency Medicine November 2001; Vol. 8, #11, pp.1080-87
\(^{11}\) Taylor TB. Emergency Services Crisis of 2000—The Arizona Experience. Academic Emergency Medicine November 2001; Vol. 8, #11, pp.1107-08
INCREASED COST OF EMERGENCY CARE

Regulatory compliance; staff time necessary to complete EMTALA documentation requirements (i.e. detailed ED logs, multiple types of forms); managed care payment denials (for treat & release and for admitted patients not transferred to a contracted hospital); lost opportunity to obtain demographic information (thought by some to be prohibited by EMTALA until completion of the MSE); increase regulatory and malpractice liability exposure; EMTALA education; and defense of EMTALA allegations all cost money and the list goes on and on. But even more poignant, is that EMTALA has turned a 2 minute question at triage “does this need stitches”, into a 4 hour wait to see a doctor and a $200 charge to hear, “no it doesn’t”. The aggressive way EMTALA has been enforced by CMS has disrupted tried & true standards in medical care to the point of, at times, being counterproductive.

REDUCED AVAILABLE SERVICES

EMTALA has changed the very purpose of the ED, by making it the healthcare resource of last resort by an unfunded federal mandate for anyone and everyone, including non-citizens. In my opinion, it is largely responsible for the ED crowding crisis we now face.

Hospitals that continue to provide a full range of specialized services are at increasing risk as other hospitals eliminate services or specialize due to budgetary constraints or a lack of available medical staff. Some hospitals have eliminated certain diagnostic test either entirely or made them available only during “business hours”. Since the ED is the biggest user of such services after hours and weekends, these hospitals can no longer afford to provide certain services for the level of reimbursement received.

EMTALA has also had a dramatic effect on the medical staff. Virtually every hospital now has some difficulty obtaining willing specialists (e.g. hand surgeons, ENT, ophthalmologists, etc.) to take ED call. Doctors are now doing everything possible to avoid ED call even to the point of resigning hospital privileges altogether and EMTALA is often cited as the final “straw” in such decisions. In today’s healthcare market, doctors no longer need the ED “business” and, increasingly, do not even need the hospital due the availability of enhanced outpatient services.

PUBLIC PERCEPTION

EMTALA has changed the public perception of the ED: Many patients now know they cannot be refused care and choose the ED instead of seeking routine care in a doctor’s office. Even insured patients come to the ED to avoid paying a co-pay at their doctor’s office (or urgent care) or because they tend to get free medication and “immediate results” in the ED. Local physicians now use the ED as their “admitting office” because once patients are in the ED managed care plans have a difficult time denying the admission and there is much less paper work for the doctor’s office personnel. The word is out that “free” care is available in American EDs and many border hospitals routinely provide uncompensated healthcare for foreign nationals. Even primary care doctors have learned to send their uninsured patients to the ED instead of trying to provide care from a variety of other sources. Local urgent cares often send uninsured patients because, “if they stay here it’s going to cost them a lot of money”.

EMTALA HISTORY & IMPACT SUMMARY

The federal government recognized the need for an “emergency care” safety net in the mid 1980’s when hospitals, due to increasing financial pressures, began refusing to provide emergency care to even unstable indigent and managed care patients. This unfortunate situation led to the enactment of the Emergency Medical Treatment and Labor Act (EMTALA) in 1986, which to this day is the only federally mandated safety net healthcare in America and an unfunded mandate at that.

Mandates aside, America chose the free-enterprise system to fund healthcare, but government intrusion continues to alter the fundamental principles of this “free enterprise”. EMTALA is perhaps the most glaring example of this intrusion and has had serious effects on emergency services directly and indirectly on virtually every other aspects of healthcare. Fully implemented in 1994 by federal regulation, EMTALA has taken more than a decade for its full impact to be realized. EMTALA allowed local county governments to abdicate their responsibility for indigent healthcare and instead thrust this responsibility upon an often woefully inadequate Medicaid system. In effect, EMTALA has become a federal mandate for hospitals and physicians to provide healthcare to everyone (even if not an American citizen) irrespective of ability to pay (or intention of paying even if they have the ability) and thereby alleviating local government and insurance plans of that responsibility. With the ensuing closure or “privatization” of public hospitals and clinics, this left the private sector to grapple with the indigent, infirm, and undocumented. At the same time, through managed care and other funding mechanisms such as Medicare Diagnostic Related Groups (DRGs) and now the Ambulatory Payment Classification System (APCs), America allowed the insurance industry to eliminate the traditional insurance-based “cost shifting” funding for indigent care. Capital for expansion vanished in the 1990’s and dramatic cost cutting made hospitals very difficult places to work and at times more perilous for patients. The federally mandated “EMTALA care” has inadvertently encouraged reliance upon hospital EDs as the principle and perhaps sole remaining safety net resource in America and for bordering countries.

Ultimately EMTALA and associated factors created a “healthcare recession” in many parts of the country throughout the 1990s and into this decade. If these are the problems, then what are the solutions?

SOLUTIONS

Clearly EMTALA has served a useful purpose over its 15-year reign. It has prevented people from indiscriminately being turned away from hospital EDs and suffering as a result. It has allowed America to ignore the plight of the uninsured and foreign national healthcare issues. For a time it assured that the full services of a hospital, including on-call specialty physicians, would be available to care for anyone and everyone. But EMTALA is now beginning to fail and economic pressures have steered healthcare markets in new directions. EMTALA is no longer as effective and in some ways even counterproductive.

Hospitals (particularly “specialty” hospitals) have limited their services by “specializing” or concentrating only on profitable services to the exclusion of general hospital and emergency care. Specialty physicians have limited their practices or opened outpatient centers in an overt attempt to avoid EMTALA. Specialty physicians who cannot practice without the hospital (e.g. general surgeons, neurosurgeons, etc.) are demanding payment to be on-call &/or guaranteed billings. Emergency physicians are struggling to keep up with increasing demand for ED services in the face of declining resources and shortages of even essential services. Experienced ED nurses are leaving in unprecedented numbers. Lawsuits based on the increase liability created by EMTALA promises to perhaps bankrupt the remaining providers.

To follow are regulatory and legislative solutions to help mitigate the untoward effects of EMTALA. 

It must be clearly understood that until the issue of funding and coordination of care is resolved, EMTALA, in some form or another, must be maintained. To do otherwise could potentially result in patients suffering or even dieing in the street.
SUGGESTION #1: Funding Mechanism for EMTALA (and all other healthcare):

While this may seem a daunting, if not an impossible task, the Arizona College of Emergency Physicians in the document, “Proposed Solution for Healthcare Funding in America”, proposes three innovative mechanisms to accomplish EMTALA funding with only an incremental cost.

1) A “low cost government healthcare loan program” to address periodic healthcare for anyone without other means to afford the care necessary. (See full explanation in the above named document)

2) A national standard for Medicaid eligibility similar to the SCHIP program (currently at 200% FPL).

3) “Deemed eligibility” (similar to the SCHIP program) so that those eligible can be assured of first day coverage when needed.

Implementing these three concepts could achieve virtual universal healthcare coverage at an incremental cost; yet hold individuals responsible for their healthcare expenses and averting yet another entitlement. This plan would also go a long way toward resolving the abuse of the ED for primary care since people would be held responsible for the bill and the program would also apply to outpatient care. Family doctors would be able to see uninsured patients in their office without worrying about payment issues.

SUGGESTION #2: EMTALA & Managed Care:
If a patient has insurance, the receiving facility (not necessarily a hospital or higher level of care) agrees to accept the patient in transfer, the patient signs an informed consent for transfer, and is willing to take whatever risks are associated with the transfer whether they are “stable” or not, then the EMTALA obligation should be considered to have been met. Many of the basic tenants of managed care are in direct conflict with EMTALA. Yet, discussing how one can obtain coverage for healthcare has become a necessity under managed care. EMTALA tends to subvert these discussions leading to increased cost for patients, hospitals, and health plans.

SUGGESTION #3: The EMTALA Mandatory Reporting Requirement:
The mandatory reporting provision should be eliminated and be voluntary under all circumstances. This provision was added in the 1994 CFRs and has had a profound effect on EMTALA. It essentially prohibits the discretion of hospitals in reporting EMTALA violations and forces them to report everything, even if only a suspicion. This has lead to a significant number of frivolous reports and bogged down the system to the point that the true EMTALA cases cannot be dealt with expeditiously. It has also created a major cost for hospitals that now must constantly investigate and defend themselves in cases that turn out to be trivial or simple misunderstandings. This has also created a culture of mistrust among hospitals that might otherwise be able to work together to serve the community and solve these problems together. EMTALA should primarily be “complaint” driven.

SUGGESTION #4: Clear Definitions:
The examining physician should have the ultimate authority to determine (based on available information) which patient has an “Emergency Medical Condition” (EMC) and for those who do have an EMC which ones are “stable” for transfer or discharge. An EMTALA citation should only be allowed if it can be shown by a preponderance of the evidence that the physician/hospital was below the community standard of care in arriving at those conclusions. Final outcome or subsequent information should have no bearing on the case. There have been many articles and book chapters written on what “Emergency Medical Condition (EMC)”, “Stable”, and “Medical Screening Examination (MSE)” mean in the context of EMTALA. Nevertheless, these definitions remain elusive because each individual case is decided after the fact (when all subsequent information is known) and are often reviewed by PEER physicians who have limited knowledge of EMTALA.
SUGGESTION #5: EMTALA is Not a Quality of Care Regulation:
EMTALA should only be used as an anti-discrimination regulation and thus returned to its original intent. There are many examples of this “abuse” of EMTALA. In modern healthcare, quality of care is dealt with in many other ways and in a constructive rather than destructive manner. EMTALA by its very nature is destructive and tends to subvert the openness necessary to improve quality.

SUGGESTION #6: Limit the Use of EMTALA in Civil Malpractice
The provision [42-Sec. 1395dd.(d)(2)(A)] that creates a private cause of action should be eliminated and a prohibition against EMTALA as a private cause of action should be added.

Title 42- Sec. 1395dd. Examination and treatment for emergency medical conditions and women in labor
(d) Enforcement
(2) Civil enforcement
(A) Personal harm
Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

As currently written, EMTALA has the potential to bring emergency care to its knees in civil liability. This serves no purpose except to further burden hospitals and physicians with legal wrangling. Medical malpractice should be restricted to state courts where local communities can decide what is right. EMTALA opens up a whole new realm of malpractice in already over burdened federal courts. There are many examples of how “EMTALA malpractice” has led to peculiar outcomes in federal court.

SUGGESTION #7: Safe Harbors
Clear safe harbors need to be established so that hospitals do not find themselves constantly readjusting based on the latest CMS proposed rule or court case. “Fear” of an investigation is perhaps one of the most damaging untoward consequences of EMTALA and has significantly added to the “defensive medicine” problem by encouraging excessive ordering of tests/consults, admitting questionable patients, and in transfer avoidance even when it might be appropriate. Clear regulation that cannot be misconstrued or repurposed by administrative or civil courts is imperative. There are several examples of this in case law. For example we currently do not know when EMTALA begins and when it ends, due to court cases extending EMTALA to ambulances en route and to inpatients.

SUGGESTION #8: Reasonable Procedures in Consideration of Common Medical Practice
EMTALA should conform to common medical practice, rather than forcing medicine to change to EMTALA’s “way of doing things”. There are numerous examples of how EMTALA has not only changed, but uprooted medical care. In many settings it has relegated nurses to mere technicians and stripped them of any medical decision making. For example, many patients can be determined not to have an EMC by a nurse at ED triage. EMTALA has expressly prohibited this decades long practice and resulted in longer ED waits and increased cost for no demonstrable benefit. Somewhere in the EMTALA formulation, it was determined that only a physician could definitively determine if someone was sick or not. Nurses perform this function in virtually every other medical setting (e.g. nurse advice phone lines) and to say that somehow they are not capable of doing so in the ED at triage is ludicrous.

SUGGESTION #9: Service Availability
Only require that hospitals participate in a community-wide service rather than being all things to all patients at all times. One of the tenets of EMTALA has been that whatever is available to inpatients must also be available to ED patients 24 hours per day. While noble in its pronouncement, in many instances it is impractical and at times creates perverse situations. A plan to deal with such situations should be sufficient and would encourage cooperation within communities for coordination of services that might otherwise be impractical for every hospital to have available 24/7.
SUGGESTION #10: EMTALA Administrative Cost
Additional reimbursement must be added to Medicare &/or other funding mechanism to account for the cost of EMTALA. EMTALA education and compliance are expensive and do not translate into better patient care. Nevertheless, hospitals are forced to do this and to divert funds that might otherwise be available to improve or enhance medical services.

SUGGESTION #11: Innocent Unless Proven Guilty
Unless there is compelling evidence of immediate impending harm to patients, CMS should be required to prove their case before citing hospitals for a violation. Investigations should be limited in scope and not become “fishing expeditions”. Increasingly, there are “Roseanne Roseanadana” moments where after a lengthy investigation and multiple citations, information is discovered that exonerates the hospital, and CMS says, “never mind”. Allegations should be made, proof given and a judge should decide upon whether to impose a citation unless the parties enter into a consent decree. Also, the investigation should be limited in scope and only broadened under strict criteria, such as evidence of fraud.

SUGGESTION #12: Clear Guidance on Providing Information to Patients
There must be clear guidance, based in reality, as to what patients may be told prior to the MSE. Patients are often alienated because there is no clear guidance as to what can be said and when. Telling a patient the wait is 5 hours to see a doctor or how much they can expect to pay for the visit have been interpreted as possible EMTALA violations. Obviously this important information anyone might want to know and refusing to provide this information sometimes makes patients indignant.

SUGGESTION #13: Conflict with State Law or Community-Wide Programs
As a federal statute, EMTALA may supercede state law, but reasonable adjustments must be made to accommodate local variances. There are a variety of examples where EMTALA conflicts with state law. Many involve behavioral health and involuntary commitment procedures. Others involve established community-wide plans to deal with specialized care such as sexual assault or behavioral health. It has even been suggested that allowing a police officer to remove a patient under arrest from the ED prior to completing the MSE could be a violation. The untoward situations are numerous and there must be some protection for providers often caught in the middle.

SUGGESTION #14: Abuse of the ED Due to EMTALA:
Providers must have some protection from patients who show a pattern of abuse by “gaming the system” or who refuse to provide accurate basic demographic information. This is a burgeoning untoward consequence of EMTALA. Increasingly foreign nationals are using EMTALA as a way to access healthcare in America. While this has also been true of American citizens, providers do not have the same legal options available to deal with the undocumented. It seem ludicrous for hospitals to be forced to extend services (including narcotic pain medications and invasive procedures) to people who have no requirement to provide even a single form of identification, a legal social security number, or accurate contact information. Strict interpretation of EMTALA prohibits a hospital from refusing care to someone even if they refuse to provide their name.

SUGGESTION #14: On-call Specialists
Liability protection, compensation, and safe harbors are necessary as a minimum to rebuild our specialty rosters at most hospitals. This area may be perhaps the most difficult challenge and it does not entirely revolve around EMTALA. Perhaps without EMTALA we would have lost most of our on-call coverage several years ago. Specialists are now being forced to take call as a condition of medical staff membership. Other issues involve being on call at one hospital, but being scheduled to do procedures all day at another. How can this be balanced? More and more doctors are simply resigning privileges at smaller hospitals to avoid this conflict and leaving these hospitals without any coverage. Solutions for the on-call crisis require a coordinated effort and EMTALA is a big piece of that effort.
SUGGESTION #15: Physician EMTALA Liability Exposure
*It is not reasonable for individual physicians to assume equal, if not more, liability than hospitals with regard to EMTALA.* Physicians have equal fines ($50k/violation) and consequences (Medicare decertification, malpractice risk, etc.) as hospital with regard to EMTALA. At the same time, physicians clearly do not have the same resources as hospitals. Additional liability coverage must be obtained to cover an EMTALA action against a physician. It is any wonder doctors want to avoid being involved with anything (i.e. on-call duty) associated with EMTALA?

SUGGESTION #16: Complexity
*As EMTALA is reorganized we should keep simplicity in mind.* Human nature dictates that people, especially on-call specialists, will avoid things they cannot understand. Although many of the suggestions above could resolve much of the confusion and complexity surrounding EMTALA, a concerted effort must be made to ground the law in reality and with consideration of common practices. If it does not make sense at 3am on the weekend, perhaps it should be revised.

SUGGESTION #17: Managed Care
*Require managed care to provide coverage for EMTALA services using an “EMTALA-Based Standard”.* Perhaps one of the greatest failings of the original EMTALA statute was the lack of attention paid to the realities of managed care. This fact has led to contentious fighting and abuses by managed care for many years. At least one partial solution has been forwarded in several states and at the federal level in the form of the “Prudent Layperson Standard” for an emergency. Unfortunately this concept does not address the real issue. EMTALA requires certain services irrespective of prudence and prohibits providers from insisting upon payment or in seeking prior-authorization from managed care until after the fact. Using an “EMTALA-Based Standard” is more practical. Such a law was passed in Arizona in 1996 (SB1286–Access to Emergency Health Care, available at www.azcep.org) with the cooperation of the state’s managed care industry. Although other issue remain, with respect to EMTALA, this law has been very effective.

SUGGESTION #18: Foreign Nationals
*Provide a basic funding mechanism for foreign nationals that access healthcare under the guise of EMTALA.* In 1997, immigrants made up about 10% of the US population; however they accounted for 20% of the uninsured. This special group of healthcare users includes foreign nationals that enter the American healthcare system by misfortune or by a covert attempt to receive healthcare is the U.S. rather than in their native country. The reasons for this phenomenon are many, but the fact remains that this special group remains the responsibility of the federal government and requires a separate system to manage and provide appropriate compensation to providers. Border issues and international relations will often dictate how such patients are managed. We should not turn our backs on those in need, but at the same time we must find ways to deliver such care without overburdening our healthcare system and making services unavailable to our own citizens. Our border hospitals can no longer afford for this issue to be ignored.

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The New York Times

Health Care Trade-Off: Fewer Choices, Lower Bills.

By REED ABELSON
April 14, 2015, Page B1

Dr. Emily Rubenstein, right, with Sandra Guaccio during a dermatology consultation at Swedish Covenant Hospital, which recently teamed with an insurer to offer a so-called limited network health plan. Credit Taylor Glascock for The New York Times.

In all the turmoil in health care, one surprising truth is emerging: Consumers seem increasingly comfortable trading a greater choice of hospitals or doctors for a health plan that costs significantly less money.

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<th>LARGEST CITY</th>
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Insurance Status and the Transfer of Hospitalized Patients: An Observational Study

Janel Hanmer, MD, PhD; Xin Lu, MS; Gary E. Rosenthal, MD; and Peter Cram, MD, MBA


Background: There is little objective evidence to support concerns that patients are transferred between hospitals based on insurance status.

Objective: To examine the relationship between patients’ insurance coverage and interhospital transfer.

Design: Data analyzed from the 2010 Nationwide Inpatient Sample.

Patients: All patients aged 18 to 64 years discharged alive from U.S. acute care hospitals with 1 of 5 common diagnoses (biliary tract disease, chest pain, pneumonia, septicemia, and skin or subcutaneous infection).

Measurements: For each diagnosis, the proportion of hospitalized patients who were transferred to another acute care hospital based on insurance coverage (private, Medicare, Medicaid, or uninsured) was compared. Logistic regression was used to estimate the odds of transfer for uninsured patients (reference category, privately insured) while patient- and hospital-level factors were adjusted for. All analyses incorporated sampling and poststratification weights.

Results: Among 315,748 patients discharged from 1051 hospitals with any of the 5 diagnoses, the percentage of patients transferred to another acute care hospital varied from 1.3% (skin infection) to 5.1% (septicemia). In unadjusted analyses, uninsured patients were significantly less likely to be transferred for 3 diagnoses (<0.05). In adjusted analyses, uninsured patients were significantly less likely to be transferred for 3 diagnoses: biliary tract disease (odds ratio, 0.73 [95% CI, 0.55 to 0.96]), chest pain (odds ratio, 0.63 [CI, 0.44 to 0.89]), septicemia (odds ratio, 0.76 [CI, 0.64 to 0.91]), and skin infections (odds ratio, 0.64 [CI, 0.46 to 0.90]). Women were significantly less likely to be transferred than men for all diagnoses.

Limitation: This analysis relied on administrative data and lacked clinical detail.

Conclusion: Uninsured patients (and women) were significantly less likely to undergo interhospital transfer. Differences in transfer rates may contribute to health care disparities.

Primary Funding Source: National Institutes of Health.

Perspective

30 Years of EMTALA
Burgeoning EMTALA Issues

- Health plan (ACA) network transfers (CMS proviso)
  - Posting of Signs
- Deferral of Care (“Screen & Street”)
- Narcotic pain medication policy
- ED “Appointments”
- Continued on-call issues exacerbated by ACA
- Psych boarding & lack of inpatient services
- EMTALA training requirement
- Observation services (when does EMTALA end?)
- Telemedicine
- Documentation of declined transfers
- Stand alone EDs & hospital owned urgent care
- Regionalization of services

What’s New (since 1985)?

- 1989 Statutory Amendments
  - Obligation to accept transfers
  - On-call physicians included
  - 1st real enforcement, regional variation
- Not much 1989-2003
  - Codified CMS guidance to date in CFRs
- 2008 CFRs
  - Pandemic waiver
  - Duty to accept regardless of (dedicated) ED
  - Community on-call plan delineations
- Hospitals & on-call specialists creative
- Lots of opinions & folklore
New EMTALA Regulations
Effective November 10, 2003

- What did not change?
  - The EMTALA statute
  - EMTALA-Related Regs §489.20
    - Requirement to comply
    - On-call list
    - Reporting (tattle-tale”) requirement
    - Central log
    - Records
    - Signage

- Only change is how CMS interprets the statute via these new regs
  - Civil courts often ignore CFRs & rely on statute, i.e. make up their own “rules”

“Guidance to Surveyors”

Surprise

“A patient will be deemed stabilized if the treating physician or QMP attending to the patient in the ED/hospital has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.”

“To be considered stable, a patient’s emergency medical condition must be resolved, even though the underlying medical condition may persist.”

EMTALA Definitions-Sec. 489.24 (b)

1. Capacity
2. Comes to the emergency department
3. Dedicated emergency department
4. Emergency medical condition
5. Hospital
6. Hospital property
7. Hospital with an emergency department
8. Inpatient
9. Labor
10. Participating hospital
11. Patient
12. Stabilized
13. To stabilize
14. Transfer
15. Outpatient (Sec. 410.2 Definitions)

Rule by Exceptions

- Dedicated ED (DED)

The law no longer applies to:

- Non-emergency services
  - “nature of request” – No real change
- In-patients (what you think it is)
- Direct admits (in-patient)
- Outpatients (once encounter begun)
- “National” emergencies
  - Not necessarily local disaster
New EMTALA Regs Overview

- EMTALA applicable only in “dedicated” ED & not the inpatient setting
- Depends on which “door” you enter
- Formalizes more flexible language for on-call specialists
  - Specialists can be on-call at more than one hospital simultaneously
  - Can schedule elective procedures while on-call.
- Basic requirements unchanged
  - MSE w/o delay
  - Stabilization
  - “Appropriate” transfers

Dedicated ED (DED)

Any dept. or facility of the hosp., 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 in which it is located under applicable State law as an emergency room or ED;

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; or

3. During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, 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.
**Dedicated ED (DED)**

What is included?
- EDs
- OB/L&D Units
- Psychiatric Intake Unit
- Urgent Care & FSED (?)

What is not? (anything that doesn't meet the definition)
- Primary Care Clinics
- Rehabilitation Centers
- Diagnostic Centers (MRI)
- Hospital-based renal dialysis center

Still must have polices as to how to handle any emergency that occurs

**EMTALA Obligation Begins?**

1. An “individual” (not a “patient”) that comes to the DED; **and**
2. Request Rx for a medical condition
   - Implied Request = *Prudent layperson* would believe they need Rx for *emergency* medical condition
   - Unclear if you actually need to be aware they have arrived
Hospital Property?

- The entire main hospital campus
  - Within 250 yards from main building
  - Parking lot, sidewalk, & driveway
  - Common areas (hallways)
- Excluding:
  - Areas or structures of the main building that are not part of the hospital
  - Physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare
  - Restaurants, shops, other nonmedical facilities

Ambulances

- Hospital Owned
  - = Hospital property
  - No real change = codified
  - If operating within community protocols not required to go to home hospital
  - Express purpose for EMC
  - Independent medical control can designate destination
- Non-Hospital Owned Ambulances
  - Applies only on hospital property
  - Request still applies (prudent layperson)
  - Telemetry contact request does not apply, but if not on diversion cannot discriminate
- May pre-empts EMS tort reform
No Delay Clause

- Codifies prior guidance
- Cannot delay MSE/stabilization
- Authorization
  - Cannot seek before MSE *
  - Allowed concurrent with stabilization
- Cannot delay MSE to call a doctor *
- Reasonable registration process allowed
  - Cannot unduly discourage
  - Previous had to encourage to stay
- Nothing about timeliness of MSE (crowding)
  * (contrary to statute)
On-Call Physicians

- Old vs. New
  - If offered to the public must provide to ED patients: “too high of an expectation”
  - Old: Within your capabilities, resources & availability of on-call staff
  - New: “Best meets the needs of the patients & community served”

- Qualified flexibility
  - Simultaneous coverage
  - Exempt (e.g. senior medical staff)
  - Ad hoc call allowable if not discriminatory

On-Call Physicians

- Coverage:
  - No predetermined ratio: medical staff to days
  - Advance policy/plan for gaps in coverage
  - Physician (not a group, PA, etc) listed
  - May use NP/PA for initial MSE/ Rx if medically appropriate

- CMS will not say how to structure on-call
  - Lack of statutory authority
  - Political reality
  - Post hoc determination of compliance
What about inpatients?

- New regulations – Nov 10, 2003
  - Explicitly does not apply to inpatient (unless patient was admitted to skirt EMTALA)
  - “Enhance” existing COPs
  - Some civil & federal administrative courts have held is does (“comes to the hospital”)
- Hospitals must assess this risk
Notice:

IF YOU HAVE A MEDICAL EMERGENCY OR ARE IN LABOR, YOU HAVE THE RIGHT TO RECEIVE, within the capabilities of William Beaumont Hospital’s staff and facilities:

• an appropriate medical SCREENING EXAMINATION
• necessary STABILIZING TREATMENT, including treatment for an unborn child, and if necessary,
• an appropriate TRANSFER to another facility even if YOU ARE UNABLE TO PAY or DO NOT HAVE MEDICAL INSURANCE or YOU ARE ENTITLED TO MEDICARE OR MEDICAID.

William Beaumont Hospital does participate in the Medicaid program.

William Beaumont Hospital in accordance with state law, will test your blood to detect the presence of serious communicable diseases such as hepatitis, or AIDS, if a health care worker is exposed to your blood or body fluids.
Enforcement - The real issue

- Does not matter what we think it means
- Only matters what CMS\OIG says it means & how they enforce it
- Often a disconnect between what central CMS says & how it is enforced in the field (Regions)
American College of Emergency Physicians®
Supplement to
Providing Emergency Care Under Federal Law: EMTALA
April 2004

Download free at:

EMTALA FAQ
Frontline Compliance Answers
By Stephen A. Fraw JD

270+ Pages Of The Most Frequently Asked Questions From The Medlaw.com Website

www.medlaw.com/faq.htm
"Bible of Practical EMTALA Compliance"
(newly updated)
Highlights of legal developments & regulatory changes, along with accumulated enforcement information since the 1986 inception of EMTALA.
Narrative summary & most recent version of federal site review guidelines for EMTALA compliance.
“Flash card” reviews of individual EMTALA compliance topics, the real world application, necessary compliance documentation, & cautions on common compliance issues.

www.medlaw.com

CALL COVERAGE STRATEGIES
Securing Physician On-Call Cooperation

- Drivers of the Emergency Department Call Crisis
- Best Practices for Ensuring Adequate Specialty
  - ED Call Coverage
  - Instituting Hospital Policies
  - Providing Monetary Compensation
  - Relieving Call Burden

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EMTALA and On-call Responsibility for Emergency Department Patients

Revised & approved by ACEP Board of Directors April 2006

ACEP believes that:

Hospitals, medical staff, and payers share an ethical responsibility for the provision of emergency care.

American College of Emergency Physicians

ADVANCING EMERGENCY CARE

For millions of Americans, emergency medicine & emergency physicians are the only thing between health & no healthcare at all.”

Rick Blum, MD, FACEP
Past ACEP President
Additional Information

Send e-mail request to:

ttaylor@acep.org

Specify what you want:

- PDF of lecture slides
- PDF of handout
- Anything else, please be specific

Who Am I?

- Former ACEP Council Speaker
- Board Certified Emergency Physician
- EMTALA Compliance Consultant
- Former Vice-President for Public Affairs
  Arizona College of Emergency Physicians
  Medical Staff & On-Call Physician Obligations
- 18 Years Attending Emergency Physician – Phoenix, Arizona
  Banner Good Samaritan Regional Medical Center
- 8 Years as EMTALA Consultant Arizona QIO
  Health Services Advisory Group
- Emergency Physicians’ Monthly
  Contributing Editor & Editorial Advisory Board
  EMTALA Q & A Editor
Who Am I - NOT?

- Not a lawyer!
- Not a hospital administrator.
- Not a government official.
- Not here to tell anyone how to practice medicine.

Disclaimer

- I’m an ER doctor
- By federal law (EMTALA)
- My services are “free”
- “You get what you pay for.”
- Nothing I say should be construed as legal or personal advice and should be taken in the context in which it is rendered, thereby being no implicit or explicit warrantee, guarantee or assurance of accurately, timeliness, usefulness, or applicability to real world Investing, except as stated, is stated, and only if explicitly stated in the context in which it is intended to mean, otherwise, it does not mean anything other than what I meant to say, unless it gets me into trouble then I did not mean to say it in the...
The Role of Government

I’m here from the government
Choose one:
1. I’m here to help you.
2. I’m here to protect you.
3. I’m here to spy on you.
4. I’m here to drown you in paperwork.
5. I’m here to take your money.
6. I’m here to throw you in jail.
Public Policy Does Not Supercede Natural Laws

Laws of Nature

- The average cost of rehabilitating a seal after the Exxon Valdez oil spill in Alaska was $80,000.

- At a special ceremony, two of the most expensively saved animals were released back into the wild amid cheers & applause.

- A minute later, in full view, a killer whale ate them both.

Are these guys serious?

- Original Bill

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S. 1615

To amend the Public Health Service Act to permit continuation of health benefits coverage for certain uninsured individuals, to provide subsidies for the establishment of reimbursement, insurance, and inpatient hospitalization costs for eligible patients in medical emergencies, and for other purposes.

IN THE SENATE OF THE UNITED STATES

September 5, 1995

Mr. KENNEDY introduced the following bill, which was read twice and referred to the Committee on Labor and Human Resources.

... (Text of the bill follows) ...
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Waiting Room Homicide

➢ A patient presented with chest pain &
died of a heart attack after waiting
nearly 2 hours in the waiting area.

➢ Lake County coroner’s jury ruled
September 14, 2006 that the death of
was a homicide.
Los Angeles may make patient dumping by health facilities a misdemeanor.

"A new [Los Angeles] city ordinance, believed to be the first of its kind in the nation, makes it a misdemeanor for health facilities to transport a patient to a place other than his or her residence without written consent."

The Wall Street Journal (8/2/08, A2, Rundle)
AAEM Writes Amicus Brief in the
$4+ Million “Patient Dumping” Case

BY LAUREN D. WEISS, MD, JD, FAAEM

AAEM came to the defense of a beleaguered EP held personally liable for $4+ million for the now intentional tort of “patient dumping” by a Louisiana appellate court. In addition to being held liable for negligence in the amount of $500,000, the court determined that the physician intentionally “dumped” the patient by transferring him to a public hospital, even though the court admitted that the physician did not violate EMTALA. In this case, the EP transferred a patient with sepsis and secondary to intravenous drug use to a public hospital located 10 minutes away. He transferred the patient in a stable condition, and the patient’s condition did not deteriorate en route.

The brief, filed on behalf of Van Meter & Associates, a large provider of emergency medical services in the New Orleans area, AAEM, and AAEM Law, argued that the physician could not possibly have “dumped” the patient if he did not violate EMTALA or the analogous state law. The brief also argued about the dangerous precedent this case would create. Malpractice insurance policies ordinarily do not cover intentional torts. The defendant physician in this case will face personal ruin unless the Louisiana Supreme Court reverses the decision. Unless reversed, this decision will not only drive emergency physicians out of Louisiana, but will compel physicians not to transfer patients to a higher level of care.

Robert McNamara, MD, President of AAEM, was involved in every aspect of the preparation and submission of the brief. Among EM organizations, only AAEM and AAEM Law wrote and submitted their own brief. This case serves as a typical example of how AAEM can quickly put its Mission into action, coming to the support of an EP victimized by unfortunate circumstances. Very few medical societies have a president willing to immediately commit his time and expend considerable effort on behalf of a physician in need. This case serves as yet another example of the value of AAEM membership, and how the AAEM Mission directly benefits the interests of individual emergency physicians and patient care.

From AAEM's website: AAEM.org, Article posted Oct 1, 2003. Reproduced by permission.)

THE INTENTIONAL TORT OF PATIENT DUMPING: A NEW STATE CAUSE OF ACTION TO ADDRESS THE SHORTCOMINGS OF THE FEDERAL EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

THOMAS A. GIONIS
CARLOS A. CAMARGO, JR.
ANTHONY S. ZITO, JR.

AMERICAN UNIVERSITY LAW REVIEW Vol. 52:173
EMTALA costs physicians billions in unreimbursed care

Doctors seek better compensation to make up for the bad debt they incur caring for patients in emergency settings.

Markian Hawryluck
AMNEWS STAFF

JUNE 2/9, 2003 AMERICAN MEDICAL NEWS

Source: American Medical Association
Let's delve into this a bit more
Basic EMTALA Requirements

- Three basic statutory requirements regarding “individuals” who “come to the hospital” & request medical care:

1) The hospital must conduct an appropriate medical screening examination (MSE) to determine if an emergency medical condition (EMC) exists.

What is an “Appropriate” Medical Screening Examination Under COBRA?

By ROBERT A. BITTERMAN, MD, JD, FACEP, DIRECTOR OF RISK MANAGEMENT AND MANAGED CARE, DEPARTMENT OF EMERGENCY MEDICINE, CAROLINAS MEDICAL CENTER, CHARLOTTE, NC.

Appropriateness, like nature, is “a mutable cloud which is always and never the same.” Correa v. Hospital of San Francisco, 63 F.3d 1184 (1st Cir. 1995) quoting, in part, Ralph Waldo Emerson in Essays: First Series (1841).
Emergency Medical Condition

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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;

42 USC 1395dd (e)(1)(A)

Managed Care:
Nothing is an emergency until you prove it is an emergency.

EMTALA:
Everything is an emergency until you prove it is not an emergency.

YOU
Basic EMTALA Requirements

2) If the hospital determines that an emergency medical condition exists, it must either -
   a) provide the treatment necessary to stabilize the emergency medical condition or
   b) comply with the statute’s requirements to affect a proper transfer of a patient whose condition has not been stabilized.
   A hospital is considered to have met this second requirement if an individual refuses the hospital’s offer of additional examination or treatment, or refuses to consent to a transfer, after having been informed of the risks and benefits.

Basic EMTALA Requirements

3) If an individual's emergency medical condition has not been stabilized, the hospital may not transfer the individual unless
   (a) the individual or his or her representative makes a written request for transfer to another medical facility after being informed of the risk of transfer and the transferring hospital’s obligation under the statute to provide additional examination or treatment; or
   (b) a physician signed a certification summarizing the medical risks and benefits of a transfer and certifying that, based upon the information available, the medical benefits reasonably expected from the transfer outweigh the increased risk.
Basic EMTALA Requirements

- Non-physician certification requirements:
  If a physician is not physically present when the transfer decision is made, a qualified medical person may sign the certification after the physician, in consultation with the qualified medical person, has made the determination that the benefits of transfer outweigh the increased risks. However, the physician must later countersign the certification.

Transfers

- Appropriate transfer
  - “the movement of an unstable patient with an emergency medical condition”.
  - Five elements must be documented:
    1) Provide treatment within its capability (including on-call specialists) to minimize the health risks to the patient until transfer.
    2) The receiving hospital must have space & qualified personnel to accept the transfer.
    3) The receiving hospital must agree to accept the transfer & to provide appropriate treatment.
    4) Qualified personnel/equipment are used during the transfer.
    5) Send & document all relevant medical records, radiographs, etc. were sent with the patient.
Transfer of “Stable” Patients

- EMTALA does not apply to “stable” patients as defined in 42USC1395dd (e)(3)(B)

Definitions:

The term “stabilized” means, with respect to an emergency medical condition described in paragraph (1)(A), 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, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).
Transfer by POV

Is it ever acceptable to send a patient by private car?
- Yes, if patient is “stable” or “stable for discharge”
- No, if “unstable” &/or requires monitoring
- “Safest” is to always send “transfers” by ambulance

EMTALA Compliance Principles

- Applies to Medicare participating hospitals
- Anyone who presents in any way to any where on hospital property & in any way requests medical attention should be taken to the appropriate area of the hospital (i.e. ED, OB triage, psychiatric triage etc.) for a MSE & necessary stabilizing treatment.
- Routine collection of demographic & insurance information is allowed as long as it does not impede the patient receiving a MSE & stabilizing treatment.
EMTALA Compliance Principles

- Hospitals that have the capacity must accept appropriate transfers from facilities that do not have the capacity to provide necessary care for patients:
  1) Without consideration of insurance status
  2) Regardless of nationality or state/county of residence
  3) Regardless of complaint
  4) Regardless of closer appropriate hospital
  5) Regardless of the sending facility’s non-compliance with EMTALA

EMTALA Compliance Principles

- Patients may not be coerced into being transferred (i.e. “your insurance will not pay for your visit”) or seeking medical care elsewhere even if required by their insurance.

- EMTALA is an “Anti-Discrimination Law”:
  Patient must be treated the same regardless of socioeconomic status
  1) With or without insurance
  2) Regardless of nationality, race, creed, religion
  3) Regardless of complaint
EMTALA Compliance Principles

- EMTALA documentation should be completed on any patient not otherwise being routinely discharged with care completed:
  1) Certification For Transfer
  2) Request For Transfer
  3) Consent To Transfer

EMTALA Compliance Is:
Simple

Official Florida Presidential Ballot
Follow the arrow and Punch the appropriate dot.

- Bush
- Buchanan
- Gore
- Nader
Thorny EMTALA Issues

EMTALA/COBRA Algorithm

Person arrives on hospital property AND requests emergency medical care?

No EMTALA Obligation

Registration** Registration must begin at any time, 24 hours a day, 7 days a week. The registration must include the patient's name and, if known, the name of the admitting facility. The registration must be updated no later than 30 minutes after the patient arrives at the hospital or the hospital still has not admitted the patient from the registration (if not admitted).

Prior authorization for services is required until the patient is determined not to have an EMC.

Triage, Log, & Register Patient

Emergency Medical Condition? (EMC)

Yes

No

Capacity & Capability to Stabilities?

No

Yes

TRANSFER

Continue stabilizing Rx within capability until transfer completed.

*All transfers should be considered potentially "UNSTABLE"*

Patient Consents to Transfer?

No

Yes

COMPETE FORMS

"Request for Transfer"

"Consent to Transfer"

"Certification of Transfer"

Document

Transfer Acceptance

Nursing Report Called

Records & X-rays Sent

Transfer Refusal Form

May be a Combined Form

"AMA/Treatment/Transfer Refusal"

Treatment Refusal Form

A Discharge AMA

Make available best possible outpatient Rx & follow-up.

Admit

Until EMC stabilized or resolved; patient dies or requests transfer.

EMC Resolved or

***"Stable for D/C" with EMC***

Yes

No

EMC still within hospital’s capability & capacity to treat?

No

Yes

No

Yes

No

Yes

No

No

Yes

No

No
Sent: Thursday, January 26, 2012
To: ED Directors Academy Class 1
Subject: Medical screening exam

I have just been told that I have a week to put together a system that medically screens self pay patients and then asks them for money or refers them elsewhere.

Does anyone have a protocol or guideline that they are using to do this that they are willing to share?

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Deferral of Care Programs

Are “triage out”, “deferral of care”, & similar programs:
- EMTALA permissible?
- A good idea?
- Are there better alternatives?
ACEP Policy:
Medical Screening of ED Patients

The American College of Emergency Physicians (ACEP) believes that:
• emergency departments (EDs) should have a standardized process to ensure that patients presenting for medical care receive an appropriate medical screening examination by a qualified medical person; and
• the examiner should be designated by hospital bylaws, rules, and regulations; &
• appropriate medical treatment should be provided for emergency medical conditions, as is required by the Emergency Medical Treatment and Labor Act (EMTALA).

ACEP strongly opposes deferral of care for patients presenting to the ED.
ACEP believes that deferring medical care for patients presenting to the emergency department reflects a void in the healthcare system.
In situations in which it is required that patients be deferred, very specific and concrete standards must be adopted by the hospital to ensure patient access to an alternative setting and timely, appropriate treatment. Deferral of care from the ED can have significant risks. Emergency departments participating in deferral of care processes should have active emergency physician involvement in the development of the processes. Emergency physicians should always have the opportunity to further evaluate and treat any patient presenting to the ED and should not be compelled to participate in deferral of care strategies.

Approved ACEP Board of Directors January 2007

Sent: Thursday, April 25, 2013
To: ED Directors Academy Class 1
Subject: InQuicker?
I just heard a presentation from a company called InQuicker. They offer online appointments for Emergency Department patients. No added staff or other cost to the hospital, the charge is passed on to the patient. They are currently in 150 ERs in 22 States...so I am hoping to hear from anyone who uses InQuicker. They claim to improve throughput, Press Ganey's, and commercially insured market share. Is this true? Do they really add value? Any unintended consequences? Is the juice worth the squeeze?
Have you heard this one?

A nearby hospital had no inpatient beds, nor orthopedic surgeon on-call. My hospital had both. Their ED doc attempted to get our ortho to accept a patient that had fallen ~10' fracturing/dislocating his elbow. He was told "I'm not on #$%^ call for your hospital".

Later the same hospital had an open tib/fib fracture & this time call our ED. We accepted & called our ortho doc (as a courtesy) to let him know.

He went ballistic, but we held our ground citing EMTALA. He continued to fuss & last I heard was going to get administration involved.

Sent: Monday, April 1, 2013

Advanced EMTALA Case #1

Suppose an orthopedic surgeon was on-call for Hospital A and is called to see a patient with a femur fracture that requires surgery. Due to an administrative issue (for example maybe he had not completed his medical records and was unable to complete them before the patient would need surgery due to so many uncompleted charts) Hospital A would not let him operate because his staff privileges had been temporarily suspended. No one else was either available or would take over care of the patient.

The orthopedic surgeon then decides to transfer the patient to Hospital B where his privileges are in good standing and do the surgery there. The transfer goes uneventfully except for obvious extra delay and pain/suffering incurred by the patient due to the transfer. For argument sake let's say the patient consented to the transfer but was not necessarily apprised of the reason behind it.

Let's say Hospital B finds out about the reason for the transfer and reports Hospital A because the patient had no insurance. What, in your opinion, would be the likely decision regarding whether this would be an EMTALA violation based on these facts and are there any mitigating issues?
Advanced EMTALA Case #2

I have heard it said that once a patient is “stable” EMTALA no longer applies. Can "stable" be defined in clinically useful way?
I have seen many examples where one doctor says the patient is stable and another will disagree
(i.e. The patient was somewhere between going home and being admitted to the ICU. Now there’s a range of stable!)

Advanced EMTALA Case #3

What obligations does the receiving hospital have if:
1. the patient requests the transfer?
2. it is a "lateral" transfer between hospital with equal capacity?

There may be a non-established patient at another ED who will say, "I want to go to XXXX." What obligation do we have to accept these patients if it is a patient request and the transfer is to our facility that has the same capabilities as does the other hospitals that are in our vicinity.
Advanced EMTALA Case #4

If a specialist on-call for the ED refuses to see a hospitalized patient in consultation, is this covered by EMTALA?

Does EMTALA apply to inpatients?

Advanced EMTALA Case #5

Three year old taken to the ER at hospital with a deep cut on her foot. She gets triaged by the nurse and registration asks for insurance info/verification. Parents wait with the toddler for two hours in the waiting room while the toddler cries and screams in pain. The toddler never receives a medical screening exam. The parents leave the ER and take the toddler to an urgent care because they cannot wait any longer with their child in pain and bleeding. The UC doctor starts to stitch the wound, but stops because the cut had gone through her Achilles tendon. He says that she needs surgery right away and to take her back to the hospital. Parents take her back to the hospital. The ER doc calls every surgeon on list, but cannot get any surgeon to come in to perform the surgery. The nurse tells the parents, “Your child is not getting surgery tonight because every surgeon on our call list refuses to come in. You can blame HMOs for this.” The toddler is sent to a third hospital the next day for surgery. Due to lack of a physician, the child does not have surgery for 36 hours.
Advanced EMTALA Case #6

A small town with one hospital and at least one family doctor (FP) with a particularly keen interest in his patients. The ED sees only about 800 patients per month. The FP has requested that any time one of his patients present to the ED that he be called and given the option of seeing the patient himself rather than by the ED physician (EP). The hospital is concerned that such an arrangement might be an EMTALA violation because:

1) Patients may have to wait to be seen by the FP instead of being seen immediately by the EP.
2) Although all of the FP's patients would be treated the same, other patients presenting will not follow this procedure.

The FP insists because:

1) These are his patients and he can provide more continuity than the "rotating EP" and provide better care that may be even more efficient because he knows his patients.
2) He has committed to arriving to the ED in 30 minutes from the time of notification, otherwise the EP can see the patient.

As long as critical patients care is not delayed would CMS have a problem with this arrangement?

Advanced EMTALA Case #7

We need to place into our Medical Staff Rules and Regulations a statement regarding responsibilities of follow-up for the on-call physician.

In reviewing the EMTALA rules it is pretty clear that if an ER doctor talks directly with the on-call physician and follow-up arrangements are made that doctor is responsible to see that patient in follow-up.

The gray areas and the questions arise when the ER doctor does not actually make phone contact with the on-call doctor but instructs the patient to follow-up with Dr. X (on call for that day) in x number of days. Is the on-call doctor bound by EMTALA law to follow-up with that patient?
Advanced EMTALA Case #8

Under current CMS policy, are “lateral” transfers (hospitals of equal capacity and capability) for admission after ED work up done strictly for managed care (economic) reasons permissible? (i.e. there is no benefit to the patient other than the fact the sending facility &/or needed specialty physician is not contracted with the patient’s manage care plan.)

INTERPRETIVE GUIDELINES: §489.24(e)
Lateral transfers, that is, transfers between facilities of comparable resources, are not sanctioned by §489.24 because they would not offer enhanced care benefits to the patient except where there is a mechanical failure of equipment, no ICU beds available, or similar situations. However, if the sending hospital has the capability but not the capacity, the individual would most likely benefit from the transfer.

Advanced EMTALA Case #9

A 10YO female presents with multiple facial dog bites: a large stellate laceration to the forehead and the right pinna of the ear is nearly bisected. Plastic surgery consultation is clearly required. The hospital has 3 plastic surgeons on staff but no one on call. The EP contacts each of them they all refuse. The EP then contacts several plastic surgeons at other area hospitals but they also refuse.

If there are plastic surgeons on the staff of the hospital, who has the responsibility under EMTALA to mandate ED coverage by these surgeons? The hospital governing board? The medical staff? The hospital administrator?

Assuming the EP cannot obtain a plastic surgery consultation, what should he do? Attempt to repair the wounds to the best of his/her ability? Transfer to a nearby hospital that has plastic surgeon on call? What if they refuse? Can the patient be transferred to a hospital that has the capability of handling the patient but refuses the case?
Advanced EMTALA Case #10

Doctor A is the assigned internist on-call for the ED, but is out of town. The doctor covering for doctor A in not on staff at this hospital.

Who is in violation of EMTALA? Doctor A, the covering doctor, the hospital, or all of these?

What should the EP do? Who to admit patients to? Should the EP report this violation?

What action should be taken against doctor A by the medical staff?

Advanced EMTALA Case #11

In a rural hospital, Dr. A was on call for OB-GYN. Dr. A went out of town leaving no local coverage for OB-GYN emergencies. The hospital has only one other OB-GYN, Dr. B, who is on the hospital's on-call roster, but not scheduled to take call during Dr. A's absence.

During Dr. A's absence, a five-month OB patient came to the ED with an emergency medical condition. The nurse evaluated the patient, then called Dr. B. Dr. B, without examining the patient, told the nurse to transfer the patient to another hospital, which she did.

Is Dr. A liable under EMTALA?

Is Dr. B liable under EMTALA? Do physicians who are on the hospital's on-call list but not on-call for a particular day have a duty under EMTALA to attend to the patient if called?

Is the hospital liable under EMTALA?

Must the OB nurse (who normally evaluates these patients since there is no in house doctor) contact a physician about every patient they decide to discharge or transfer? Can a nurse or physician's assistance medically screen patients without direct contact (via telephone or other means) with a physician?
Advanced EMTALA Case #12

Hospitals are having difficulty securing specialty physicians who are available to provide emergency department coverage. Hospital A is unable to secure coverage during certain times and for various specialties, including ENT. There is only one ENT on staff at the hospital and she will not (and cannot) take call every night. One night, when the ENT is not on-call, Hospital A transfers a patient with an emergency condition who needs ENT stabilizing services to Hospital B.

Does Hospital B have a duty to accept the patient when Hospital A lacks adequate specialist physician coverage?

What is Hospital A's responsibility to ensure on-call coverage for patients who require specialty treatment to stabilize their emergency medical condition?

Does Hospital A have an obligation to provide ENT coverage 24 hours a day if not required by its medical staff bylaws?

If Hospital A places physicians on its call schedule without their consent, are the physicians liable under EMTALA if they refuse to respond to call?

Advanced EMTALA Case #13

Wednesday, January 16, 2013

Well I wish I could say, “Now I have heard everything (EMTALA)”, but I am sure there are more ridiculous scenarios to come.

In this case, it appears there were no inpatient mental health services available at your hospital nor in the region.

Whether it was reasonable to send the patient 3 hours away vs hold in the ED until a local bed was available could be debated. But under EMTALA that is not a factor. The referral center had an available bed (capacity). The issue then would be one of “capability”. It appears the patient was “voluntary”, but I have never heard the term “voluntary commitment”. Did you mean “INvoluntary commitment”? Anyway, I am not sure that would matter.

The question is: Did the receiving facility have the capability to treat the patient? It seems so since on the initial request they accepted and I am not sure how having a history of a felony would change that unless there is some regulation in Michigan to that effect. It would seem this was just a preference by the physician. But even if it were a hospital policy, I am not sure that would stand up under EMTALA.

The point being, even if they had refused to accept based on that
Regional Saturation

A hospital has an ED patient with a leaking thoracic aortic aneurysm. All hospitals in the region with cardiothoracic capability are without ICU beds & closed to outside transfers.

What to do?
Reporting

- When is mandatory reporting required?
  - Only when “dumped” upon
  - Does not apply to “reverse dumping”

- Who has this duty to report?
  - Only hospitals are required to report

- If you know you erred, will “self-reporting” engender leniency?

Transfer by POV

Is it ever acceptable to send a patient by private car?

- Yes, if patient is “stable” or “stable for discharge”
- No, if “unstable” &/or requires monitoring
- “Safest” is to always send “transfers” by ambulance
Direct Admits

Does a patient who is a direct admission, but stops at the ED desk to ask for assistance need an MSE?
No, unless they request to be seen in the ED for whatever reason.

“Non-Emergency” Services

Do blood pressure checks, etc. need to have an MSE?
- It depends.
- Anyone presenting to the ED should be “offered an MSE and that should be documented somewhere (eg. in the ED log).
- If their query is medical & they receive any type of service they should sign a waiver of MSE.
Waiting Room Monitoring

- Follow your policy.
- Many hospitals have not relooked at policies in light of ED crowding.
- Make sure they are reasonable.

On-Call Trap

Does ortho have to see hand injuries?

- It depends.
- If there are sufficient specialists credentialed in hand surgery then the hospital has a duty to make those services available to ED patients.
- A specialist without proper credentials should not be called to care for such patients.
- But, if called & asked to do so they must respond “appropriately”.
EMTALA Avoidance Award

A specialist, who maintains medical staff privileges only at Hospital A (a tertiary referral hospital), is weary of receiving referrals from other hospitals around the state when on-call. He informs his answering service to ONLY page him with calls from Hospital A when he is on call. He does not inform the medical staff of this decision.

New EMTALA Regs – Q&A

Q: Does EMTALA apply to inpatients?
A: No, but CoPs enforced (duty)

Q: Is authorization to treat allowed?
A: No
Q: What does "Comes to the ED" mean?
A: Individual presents (or appears elsewhere on the hospital grounds requesting emergency care) to "dedicated" ED used a "significant" portion of time for evaluation & treatment of EMC

"Dedicated" ED = 1/3 of annual visits for Rx of unscheduled emergency conditions

"Hospital property" = entire main campus (parking lot, sidewalk, driveway, etc.), but excludes other areas/buildings on campus (physician offices, clinics, restaurants)

Q: Who is entitled to a screening?
A: 1) Non-emergency (e.g. suture removal) EMTALA is triggered, but after brief MSE & no EMC, patient may be directed to more appropriate setting.

2) "Prudent layperson" would consider a potentially emergent condition

3) Patient comes for scheduled OP service on campus & experiences unexpected EMC, no EMTALA obligation.
New EMTALA Regs – Q&A

Q: On-call requirements for specialists?
A: Hospitals must maintain ED on-call lists reflecting the medical staff capability “to best meet the needs of patients” (formerly “for services the hospital provides”).
Written policies/procedures to assure coverage, but no formula
Contingency plans for coverage gaps
Must respond in a “reasonable” time
Selective response prohibited
Simultaneous call, coordinated call, elective procedures allowed

New EMTALA Regs – Q&A

Q: Hospital owned ambulances
A: EMTALA does not apply to hospital-owned ambulances operating under community EMS protocols.
Questions

1. Can the sending hospital bypass closer hospitals for insurance reasons?

Questions

2. Can we require the sending hospital to disclose or document what other hospitals they have tried to send the patient prior to contacting the receiving hospital? (This is out of a feeling that we are first call for dumping patients)
Questions

3. What is the receiving hospital's recourse when the sending hospital provides incomplete or false information regarding the patient's medical condition to the receiving on-call physician? Is this an EMTALA violation for the sending hospital?

Questions

4. Curbside Consults?
Questions

5. What about provider-based clinics that are on its campus. Are they therefore part of the hospital for EMTALA purposes?

Questions

6. If a physician is on-call for a hospital’s ED & an EP from another hospital is directly connected to that physician and requests a patient with an EMC be transferred because they do not have the specialty care needed to stabilize the condition:

   a. Can the on-call physician have EMTALA liability if he/she refuses to accept the patient?
   b. Does the physician have to be notified by his own ED and refuse to come in to have liability?
   c. Would this be considered a hospital transfer rather than an emergency transfer?
Questions

7. If a patient with an EMC is stabilized (i.e. a splint is placed), but needs follow-up care, what can an ED do to best insure that care?
What obligations does an on-call physician have to render that care?
Is this at all covered under EMTALA?

For more information: ttaylor@acep.org