

# Key EMTALA Concepts for ED Staff

## Background

In the early 1980s, some emergency departments were refusing medical care to uninsured patients. Essentially, unstable patients were being turned away – either transferred or simply told to go to a county facility. In response to this “patient dumping,” Congress enacted the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA). The statute is found in Section 1867 (a) of the Social Security Act and has been periodically amended since.

EMTALA requires Medicare participating hospitals and associated physicians to provide care to anyone needing emergency treatment. The tooth of this policy includes monetary penalties, as well as potential termination from the Medicare program. EMTALA defines the medical screening and patient stabilization process. Although its initial intent was to protect the uninsured, EMTALA protects “any individual” (including undocumented aliens, prisoners, and minors), imposing a legal duty that had not existed under common law.

The Centers for Medicare and Medicaid Services (CMS), a division of the Department of Health and Human Services (DHHS), administrates the Medicare program and enforces EMTALA regulations. CMS officially defines an emergency department (ED) as "a specially equipped and staffed area of the hospital used a significant portion of the time for initial evaluation and treatment of outpatients for emergency medical conditions." Private practices and outpatient clinics simply need to refer patients to the nearby emergency department in order to satisfy EMTALA. However, EMTALA does apply to hospital-owned treatment areas that accept unscheduled visits for over one-third of their visits or where the name implies emergency services, such as "Urgent Care" or when hospital advertising or signage holds the location out to the public as a place to come for emergency services. EMTALA applies to every acute care hospital that accepts Medicare payment, which includes virtually every one of them since participation in Medicare is not a financially viable prospect for hospitals (excepting specialty children's hospitals). EMTALA does not include a provision for payment of care for unreimbursed care required under EMTALA. Thus, the burden of EMTALA falls squarely upon the shoulders of hospitals, emergency physicians, and on-call physicians, as this is an



unfunded federal mandate. EDs have become the dumping ground for unfunded, sick patients presenting anywhere else in the medical system. According to a May 2003 American Medical Association study, the average emergency physician provides \$138,300 of EMTALA-related charity care each year. It is no surprise that about 10% of US EDs have closed over the past decade.

Hospitals have three main obligations under EMTALA. First, everyone requesting emergency care must receive a Medical Screening Examination (by a physician, physician assistant, or advanced practice nurse) in order to determine whether an Emergency Medical Condition (EMC) exists. Second, the ED must treat every patient with an EMC until the condition is stabilized. If the hospital does not have the capability to treat the condition, the patient must be transferred. And third, hospitals with specialized capabilities must accept such transfers.

### **Hospital campus**

The reach of EMTALA is not confined to the ED. CMS requires the hospital staff respond to emergencies anywhere on the campus. The medical center campus includes the main buildings and other structures located within 250 yards of the main buildings (private physicians' offices and retail businesses are exempt). In addition, the hospital must provide emergency response capabilities, beyond merely calling 911 (although paramedics may be summoned in addition to the hospital response).

### **Medical Screening Examination (MSE)**

EMTALA obligations begin after a request for emergency services is made by a patient (or anyone accompanying a patient) or when someone on hospital premises appears or behaves in a manner suggesting that emergency treatment may be necessary. Thus, hospital staff must be vigilant and intervene when there is any concern.

The triage assessment does not satisfy the CMS definition of a medical screening examination (MSE). Instead, the MSE entails a more complete evaluation that includes diagnostic tests and specialist consultation when



indicated. For instance, a patient presenting with a severe headache may require a head CT scan and lumbar puncture to exclude SAH in order to complete the MSE.

The use of non-physicians to provide the MSE must be approved by the Hospital Board in a similar manner as midlevel providers are otherwise credentialed. CMS specifies that the MSE must be the same exam that the hospital performs on any individual coming to the ED with like signs and symptoms in order to determine whether an Emergency Medical Condition (EMC) exists.”

The use of triage nurses to perform MSEs is strongly discouraged by EmEx though not explicitly prohibited by CMS. In recent years, the University of California-Davis Hospital began using specially trained nurses to provide MSEs to patients presenting to the ED. If an EMC was not identified, the patient was referred to a clinic, regardless of payer status. Several subsequent studies criticized this process as demonstrating an unacceptable risk of missing an EMC.

The denial of emergency services to uninsured patients that have no EMC found after a MSE is a high risk practice for hospitals and providers. CMS judges the appropriateness of such practices retrospectively. If a serious problem arises later, the reviewer may not, in hindsight, agree that there was no EMC.

Occasionally medical staff members direct their patients to the ED and then instruct the staff that the emergency physician does not have to see the patient. Complying with such a directive is a high risk practice - EmEx recommends your ED institute a policy prohibiting this practice. If the patient has an EMC and there is a delay in performing the MSE and stabilizing the patient there is a valid claim for violation of EMTALA.

### **Emergency Medical Condition (EMC)**

CMS defines an EMC as a condition manifested by acute, severe symptoms (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health (or that of an unborn child) in serious jeopardy or when serious impairment to bodily functions, or serious dysfunction of bodily organs could occur. If an occult EMC is missed and goes untreated after a good faith MSE, there is



not a violation of EMTALA (although malpractice may be alleged if damages result).

The use by CMS of the word “appropriate” in reference to the MSE relates less to what the exam constitutes and more to the requirement that there must be a uniform evaluation of ED patients (regardless of insurance status). EMTALA requires a customary history and physical be performed and necessary tests ordered. It does not require a correct diagnosis and disposition from the results.

### **Stabilization**

Stabilization involves treatment of the EMC to reasonably ensure that the condition will not further deteriorate upon transfer or discharge. Once a patient stabilizes, the hospital has no further EMTALA obligations.

The key to understanding EMTALA is that the term “stabilized” is determined by a panel of experts examining all the data that was apparent to the healthcare provider. An EMTALA violation is not substantiated simply because a patient's condition deteriorated following ED discharge or transfer. Of course, deterioration after transfer will occur in some discharged patients, even though appropriate criteria were used to make the disposition decision.

The intent of EMTALA is to promote careful medical judgments before patient transfer or discharge that is not biased by insurance status. Moreover, even if a patient's condition is not clearly stabilized, the patient still can be transferred if the medical benefits exceed the risk or upon the patient's request. This is a common occurrence in centers that cannot provide certain services such as neurological surgery or interventional cardiology.

No further EMTALA obligation exists if an MSE does not uncover an EMC or if an EMC is stabilized and appropriate outpatient treatment arranged.

‘Stable’ under EMTALA is much broader than the meaning of ‘stable’ used by medical professionals. For instance, a patient with severe pain is considered ‘unstable’ by EMTALA, until the pain is adequately controlled.

Patients with psychiatric conditions or problems related to chemical dependency are entitled to the same EMTALA protections as those with medical conditions. In this situation, the MSE assesses for capacity of the



patient to care for him/herself as well as suicide/homicide risk. While chemical/physical restraints minimize transfer risk, they do not satisfy the stabilization requirement, which usually requires transfer to a safe setting. Screening of psychiatric and intoxicated patients must include ruling out non-psychiatric EMCs such as occult trauma or illness contributing to the presenting symptoms.

### On-Call Requirements

Hospitals are required to maintain an on-call roster such that usual patient needs are met (the hospital's full capabilities must be fully used to stabilize EMCs). Specialists are not required to be on-call at all times, though the hospital must have reasonable policies that dictate what happens when a physician cannot respond. On-call physicians must respond in a timely manner and come to the ED when their presence is needed to stabilize an EMC.

A specific physician (and not a group or call service) must be listed and held responsible for responding. The call list must be conspicuously posted in the ED. An accurate record of on-call lists must be maintained for 5 years. On-call physicians must respond to the hospital and render evaluation and care in the hospital -- it is not permissible to send patients that have not been stabilized to a specialist's office for definitive care, especially when this is clearly a means of physician convenience. Ultimately, CMS surveyors decide if the on-call system, physician response and patient needs are reasonable.

It is permissible for a midlevel provider to respond for the on-call physician as long as the emergency physician concurs and the on-call physician is fully apprised of the patient's condition and approves a midlevel response.

If it is necessary to transfer a patient because an on-call physician improperly fails or refuses to come in, the emergency physician must list the name and address of the on-call physician on the transfer documentation. If the receiving hospital reports the incident to CMS, both the hospital and on-call physician will be investigated for an EMTALA violation. The emergency physician may also be implicated if the name is not listed.

It is permissible for a specialist to be on-call at more than one hospital on the same day. When this occurs s/he must make the hospitals aware so that



procedures can be developed to determine what should occur when there are simultaneous emergencies. Additionally, the on-call physician may schedule surgeries or appointments while on-call, with the same provision. When the on-call physician is engaged in surgery or actively managing an unstable patient there is a legitimate reason for being unable to respond to the ED. However, attending to stable patients (routine office visits) and scheduling non-urgent surgery are not appropriate excuses for avoiding on-call responsibilities. Furthermore, patients may not be transferred for physician convenience.

Exempting "senior staff" from the on-call roster is permitted as long as it does not impair the hospital's ability to staff call. If this practice does result in uncovered calls, it is viewed as unacceptable practice by CMS and an EMTALA violation.

### **Transfers**

CMS defines 'transfer' as whenever a patient leaves the hospital campus, including discharge, unless the patient makes an informed decision to leave against medical advice.

#### Outgoing Transfers

If a physician on-call cannot be reached or overtly refuses to participate in the patient's care and this action influences the need for transfer, then the on-call physician's name and address must be documented on the medical records provided to the receiving facility. And, the receiving facility can be sanctioned for not reporting the occurrence to CMS. Consultant convenience or practice preferences are not permissible reasons for transfers.

CMS requires the transferring hospital to record the following information on a transfer form:

1. Reason for transfer
  - a) Medically indicated: Emergency physician certification that the risks of transfer are outweighed by the anticipated benefits (list individual risks and benefits separately. Patients with incompletely stabilized emergency medical conditions may be transferred under EMTALA when the emergency physician attests that the medical



- benefits reasonably expected from transfer outweigh the risk to the individual.
- b) Patient insistence: Written request for transfer signed by the patient (or family) making an informed decision that the patient is incompletely stabilized but insists transfer to another facility, even though the hospital is able and willing to provide treatment.
  2. Acknowledge that the destination hospital has been informed about the case, has assured that there is space available (even if in their ED), and that an accepting physician was identified.
  3. Document that the transfer will be facilitated by qualified personnel, with the appropriate medical equipment and transfer vehicle such that stabilizing treatment is maintained. Private passenger vehicles are generally not permitted unless ambulance transport has been refused in writing.
  4. All available medical records, other pertinent documents, radiographs (digital or film), and copies of test results must be sent to the receiving hospital. If a delay to copy or produce the records might jeopardize the patient, the records must be sent to the receiving hospital immediately upon completion.

### Incoming Transfers

Specialized hospitals are obligated by EMTALA to accept transfers from other hospitals unable to care for the patient due to limitations with on-call specialists or ability. Cases must be readily accepted whenever there is space.

Specialty hospitals may decline a patient who can be adequately cared for at the originating facility or when they lack the space or personnel to handle the patient. However, the latter scenario creates risk for an EMTALA violation unless all on-call personnel are working and the acuity/volume exceeds the capacity at which transfers have been accepted in the past. Certainly, patients must be accepted regardless of the ability to pay or the third-party payer. Thus, it is advised that the receiving hospital or accepting physician never ask about insurance status.

Hospitals are required to accept all appropriate transfers and are liable for the decisions made by the delegate that makes transfer acceptance or declination decisions. Commonly this responsibility falls to emergency



physicians, on-call physicians, nursing supervisors, or a transfer team. The designee must have real-time awareness of the hospital's capacity and resources. Hospitals are advised to create a uniform transfer policy and perform EMTALA updates to staff on a regular basis.

### Medical Insurance

Hospitals should not call insurance companies (or have the patient call) to make any verification or pre-authorization calls to payers prior to completion of the MSE and stabilization of any EMC. CMS specifically states that third-party payers do not have the authority to authorize treatment. Medical decisions regarding patients with EMCs may not be based on HMO/PPO “requirements.” In fact, hospitals that alter their usual practice to accommodate insurers are subject to EMTALA violations.

It is permissible to collect insurance information as a routine function of patient registration, though doing so may not interfere with the timing of the MSE and this information must never influence treatment or disposition decisions. Registrars may ask for insurance information and copy the card but may not engage in any financial discussions until after the patient has been stabilized or admitted. If the patient asks about financial issues, registrars should be scripted to respond “we deal with those issues after you are treated.”

Physicians and nurses should never engage in financial discussions with the patients. And, it is prudent to keep the financial face sheet separate from the treatment record.

### Enforcement

EMTALA violations must be reported by the receiving hospital within 72 hours (or they risk sanctions for non-reporting) When there is a credible complaint, the regional CMS office directs state officials to conduct an unannounced survey to gather facts. The state does not disclose the originating case or the findings during the investigation. The investigator relays all discovered information to the regional CMS office for determination.



Congress predicates a hospital's Medicare reimbursement on EMTALA compliance. The loss of Medicare funding poses an enormous financial burden to a hospital. An EMTALA violation results in fines up to \$50,000 each against the hospital and the treating physician for each separate violation committed. In addition, hospitals are required to compensate the patient (or family) for damages. While physicians may incur hefty fines, they are not responsible for damage compensation. Of course, physicians may be sued for malpractice. Physicians with multiple or flagrant violations may also be terminated from Medicare participation.

Violations are found in about one-quarter of investigations. Monetary fines against hospitals have reached \$150,000 (multiple violations) and the ability to bill Medicare has been terminated at about a dozen hospitals.

Violations of EMTALA are also reported to the Department of Justice to consider Hill-Burton Act violations (loss of federal funding to improve the hospital), to the Office of Civil Rights to consider discrimination implications, to the Internal Revenue Service for evaluation of tax-exempt status, and to the Joint Commission for accreditation review. All of these agencies are potential enforcers of the law, but only CMS and the Office of the Inspector General are actively involved in most instances. Because CMS is often understaffed, citations may be delayed for several years.

Private civil action against hospitals can be based on the actions of their employees, policies/procedures, and medical staff. Such actions may be brought in state or federal court, and are separate from medical malpractice claims. In fact, the Plaintiff need not establish deviation from the standard of care, but only prove that their client received different treatment than another similarly situated patient.

Some believe that the risk of EMTALA is overestimated because one-third of U.S. acute care hospitals have received an EMTALA action while only about a dozen have had their Medicare privileges terminated. However, the cost of an EMTALA citation is very high when accounting for the internal time committed to a plan of correction, use of external consultants/lawyers, and additional equipment or FTE to satisfy the remediation. The cost to address a violation can exceed \$1 million in large facilities.

When a violation occurs, CMS issues a notice to the hospital that its Medicare participation will terminate in 23 days, unless a plan of correction is submitted and the breach is immediately rectified. Otherwise, on day 19, a



notice of termination is published in local newspapers. If a suitable plan of correction is put in place, the hospital is resurveyed to validate on-going compliance.

Hundreds of EMTALA civil cases have been filed in the US, with occasional verdicts/settlements exceeding several million dollars. The legal environment is still in flux over EMTALA and conflicting rulings are frequently disputed in federal circuit courts. 80% of private malpractice actions where EMTALA impropriety is alleged are dismissed.

### References

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