A Practical Guide to EMTALA Compliance

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Introduction to EMTALA

The Emergency Medical Treatment and Labor Act of 1986 (EMTALA) is a set of federal laws and regulations designed to protect individuals seeking emergency medical treatment from being treatment denied due to their inability to pay. Congress enacted EMTALA as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Congress enacted EMTALA following a series of well-publicized incidents in which hospital policy prevented patients in desperate need of emergency medical care from getting it. The Medicare program continues to modify the law based on cases like these. In one recent case, personnel at a Chicago hospital saw a boy with a bullet wound in an alley 35 feet away, but did not bring the individual into the hospital emergency department (ED) for treatment. The victim bled to death, and the Centers for Medicare & Medicaid Services (CMS) subsequently drafted new rules stating that hospitals had to treat anyone with an emergency medical condition who was within 250 feet of hospital grounds. The hospital settled this case for more than $12 million.
Lawmakers designed EMTALA to do several things. First, it ensures that every patient (not just Medicare or Medicaid patients) who presents at an appropriate location at the hospital receives a medical screening examination to determine whether he or she is suffering from an emergency medical condition. Next, it prohibits hospitals from transferring to another hospital—“dumping”—emergency room patients who are either uninsured or unable to pay.

### What a violation means for your facility

Originally, EMTALA provided for a maximum civil monetary penalty (CMP) of $25,000. However, the statute now provides for a CMP of up to $50,000 for physicians and for hospitals with 100 or more beds. Thus, if both a physician and a hospital are implicated in a patient dumping incident, the penalty can be as much as $100,000 per incident—$50,000 for the physician, and $50,000 for the hospital.

Hospitals with fewer than 100 beds can be fined no more than $25,000 for EMTALA violations. All EMTALA penalties carry the serious threat of potential Medicare exclusion (for physicians) or termination (for hospitals).

In fiscal year 1999, the Office of Inspector General (OIG) obtained 61 settlements and judgments under EMTALA, with combined penalties and settlement amounts of more than $1.7 million. A review of available data indicates that roughly 90% of hospital citations for EMTALA violations involved failures to screen, stabilize, or properly transfer patients.
**How EMTALA protects facilities**

EMTALA also protects facilities that provide EMTALA-compliant emergency medical care from potential private civil actions and enforcement actions by CMS and the OIG. Hospitals that implement procedures to follow EMTALA requirements are much more likely to successfully defend themselves against private civil actions filed by patients who feel they were injured while in the care of the hospital.

Further, those patients who receive care in EMTALA-compliant EDs are less likely to report complaints to CMS. This minimizes legitimate complaints, resulting in fewer investigations and penalties.

**How EMTALA has changed**

In September 2003, CMS released a final rule that clarified hospital obligations to patients who request treatment for emergency medical conditions under EMTALA. The final rule does the following:

- Clarifies that outpatient clinics that do not routinely provide emergency care are not obligated by EMTALA
- Clarifies that hospitals aren’t required to provide around-the-clock coverage in every specialty—they can develop their on-call list to best meet the needs of their communities
- Permits physicians to be on call simultaneously at more than one hospital and to schedule elective surgery and other medical procedures during on-call times
- Permits hospital-owned ambulances to comply with citywide and local community protocols for responding to medical emergencies, instead of
Chapter One

only bringing patients to the hospital that owns the ambulance
• Clarifies that a hospital’s obligation under EMTALA ends after the patient has been seen, screened, or admitted as an inpatient
• Requires hospitals to wait until the patient has been screened and stabilized before requesting insurance authorization from the patient’s insurer

What hasn’t changed

EMTALA has undergone many changes since 1986. Since its inception, however, it has remained steadfast in seeking penalties for any of the following negligent violations:

• Failing to provide an appropriate medical screening examination to a patient seeking emergency medical care
• Failing to provide stabilizing treatment to an individual who has an emergency medical condition
• Transferring a patient in an inappropriate manner

Purpose of this book

This book is intended to summarize, clarify, and provide practical applications to the “anti-dumping” statute, its interpretive guidelines, and the final changes released by CMS in September 2003.

It will assist hospitals and physicians in complying with EMTALA’s requirements and pose questions for each of you regarding your own programs and how they can be improved.
November 10, 2003, was the deadline for hospitals’ compliance with the changes to EMTALA. Use this analysis of the major changes and potential enforcement issues to get started:

1. **Presentations at off-campus outpatient clinics and facilities that don’t routinely provide emergency medical services.** The new regulations permit facilities to transfer patients to appropriately equipped facilities, even if those facilities are not on the hospital’s main campus and if another facility is closer or more appropriate.

   **TIP:** You cannot simply transfer a patient to another facility. It is best to have prior arrangements with nearby facilities or internal protocols that mandate transfer procedures to your main campus. CMS surveyors may question transfers to another facility without authorization, even when the transfer was medically necessary. Repeated transfers from one facility to another may raise surveyor scrutiny.

2. **EMTALA no longer applies to inpatients.** New regulations mandate, with two exceptions, that EMTALA no longer applies when patients are admitted as inpatients.

   **TIP:** CMS will be looking for hospitals that perform “sham” admissions: any time the hospital admits a patient for a minimal length of time just to avoid EMTALA, but then transfers them. Be prepared for extensive surveyor questioning regarding any patient who has spent minimal time as an inpatient. Make sure you document very carefully the length of stay, reason for discharge, and resolution of complaint. Surveyors will look for instances in which patients left the hospital or were discharged before the hospital could admit them.
3. Hospitals can use concurrent authorization. The new regulation lets hospitals seek concurrent authorization while administering stabilizing treatment, provided the hospital does not delay treatment while seeking the authorization.

**TIP:** Make sure clinical staff members do not delay appropriate screening and stabilizing treatment while the hospital seeks concurrent authorization. CMS also allows hospitals to contact the patient’s physician, but hospitals must still not delay screening and stabilization to do this.

4. Prudent layperson standard. EMTALA covers every patient who presents to the ED, provided that the individual or someone on his or her behalf makes a request for treatment. EMTALA now includes a prudent layperson standard. This standard is explained in the following scenarios:

- When someone comes to a hospital ED and does not make a verbal request for medical screening examination
- When someone presents on the hospital campus and his or her appearance or behavior indicates, to the prudent layperson, that the individual is in need of an emergency medical examination or treatment

Caution: Rely on this standard as a last resort. Don’t get into a factual dispute over whether an individual behaved in such a way or appeared “to the prudent layperson” to need a medical screening or emergency care. It’s a losing battle. In retrospect, these situations could easily appear more dramatic than they may have been at the time. Patients can easily claim to have made a request for medical screening examination to a staff member, even if they can’t remember to whom.
TIP: Use the following guidelines when considering the prudent layperson standard:

- According to CMS, hospitals only need to provide the screening services necessary to determine whether the patient has an emergency medical condition. It is easier to do this than to guess whether someone is requesting screening/treatment under the nebulous prudent layperson standard.

- Don’t use this standard so broadly as to mandate screening exams for people who are capable of making a verbal request for examination and treatment. Ask them.

- Pharmaceutical services provided in a dedicated ED may be for medical conditions and are therefore subject to EMTALA.

- Hospital personnel must be aware of each individual’s presence, appearance, and behavior. Be on the lookout for any EMTALA violations.

- Language barriers can make requests for treatment impossible and trigger the prudent layperson standard.

- Hospitals can follow reasonable registration processes, as long as the processes don’t delay screening or treatment or unduly discourage the individual from remaining for further evaluation.

- Prior authorization policies apply to services furnished by nonphysician practitioners as well as hospitals. ED personnel may contact a patient’s physician at any time to seek advice, as long as the consultation does not delay screening or treatment.
• Screenings must be commensurate with the condition of the presenting patient.

5. EMTALA is not applicable to outpatients. This is not as straightforward as it appears; however, since CMS has delineated confusing criteria to determine when an individual becomes an outpatient, EMTALA does not apply to outpatients who have “begun an encounter with a health professional at the outpatient department.” However, CMS states that the Medicare Conditions of Participation will govern how hospitals should respond when a patient develops an emergency medical condition during an outpatient encounter.

Caution: The new regulation is unclear on when an “encounter” begins. It seems to indicate that the encounter does not begin until the patient starts to undergo the scheduled procedure.

TIP: Patients in outpatient waiting rooms can still be subject to EMTALA. It’s not uncommon for patients to faint or experience heart palpitations while waiting for medical testing or other outpatient services. Also, EMTALA does not apply when an individual presents to the hospital for examination or treatment for an emergency medical condition and subsequently begins outpatient treatment, provided that the hospital has discharged its EMTALA obligations prior to the outpatient procedure.

6. CMS delayed Medicare+Choice revisions. CMS delayed revisions relating to communications with Medicare+Choice organizations regarding post-stabilization services.

Source: Joseph T. Gatewood, an attorney with extensive experience in the field of health law. He advises clients on regulatory and litigation matters related to health care fraud and compliance.
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