



RE: EMTALA: DIVING INTO THE MURKY ABYSS¹

DATE: September 15, 2011

An ambulance radios an emergency room from the other side of town saying the ambulance is on the way to the emergency department with a woman in active labor about to deliver. The emergency room physician takes the call and tells the driver the hospital does not have an obstetrical program and that the patient should go to the other hospital two blocks away because they have a fantastic obstetrical program and can better handle the delivery. The EMS driver proceeds to take the woman to the other hospital where the baby is delivered in good health without any adverse medical effects from the transfer. As an aside the woman has fantastic private insurance and it pays all of her medical bills. Has an EMTALA violation occurred? If you live in Maine, Massachusetts, Rhode Island, New Hampshire, Puerto Rico, Hawaii, California, Washington, Oregon, Montana, Idaho, Arizona, Nevada, or Alaska the answer is probably yes. If you live in any other state, the question is still open to interpretation.

The Emergency Medical Treatment and Active Labor Act (EMTALA) was enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as a reaction to scenarios similar to that described above (except where the results were suboptimal and in some highly publicized cases devastating). EMTALA requires hospitals that accept Medicare (which is almost all hospitals except federal military hospitals) to provide emergency medical screening and stabilization care to anyone needing emergency health care without regard to the patient's race, religion, ethnicity, citizenship, legal status, or ability to pay.

¹ Susan C. Smith is a partner with Smith & Associates. She was admitted to the Florida Bar in 1999, after graduating as Valedictorian from Stetson University, College of Law. She served as a Law Clerk for Justice Peggy A. Quince at the Florida Supreme Court before entering the private practice of law. She has over ten years of attorney experience in administrative law, health care law, and civil litigation. Susan is currently an "AV" rated attorney by Martindale-Hubbell. Her key practice areas include: Administrative Law; Health Care Law; Hospital and Facility Licensing and Regulation; Medicare and Medicaid Certification and Regulation; Professional Licensing and Disciplinary Proceedings; Bid Protests; Complex Litigation; Appeals and Appellate Law; Stark Law; Medicaid/Medicare Fraud and Abuse Law; Federal EMTALA; Florida Access to Emergency Medicine; Mergers and Acquisitions; Change in Ownership (CHOW) proceedings.

What does it mean to provide an emergency screening examination? EMTALA provides that any patient who comes to the emergency department requesting examination or treatment for a medical condition must be provided with an appropriate medical screening examination to determine if he is suffering from an emergency medical condition. On its face, the plain language of EMTALA seems clear; however, the legal meaning of the terms highlighted above has spawned decades of litigation that make predictability of liability in scenarios like that described above less than certain.

For example, what does it actually mean to “come to the emergency department”? A literalist might think that it means the patient has to come into the emergency department of the hospital. But, what if the patient is an obstetrical patient that presents to the labor and delivery department of the hospital, does EMTALA still apply even though she did not “come to the emergency department”? After much scholarly debate and legal wrangling, at least for now, this question has been answered. Coming to the labor and delivery department is adequate to invoke EMTALA.

In fact, it is pretty well settled now that coming within 250 feet of the main hospital campus (exclusive of nonhospital owned attached businesses such as gift shops or physician offices) is close enough to invoke EMTALA. Interestingly, even hospitals that do not have an emergency department (a psychiatric hospital for example) can still have EMTALA obligations invoked if the psychiatric facility typically handles psychiatric emergencies or Baker Act patients.

Likewise, “requesting examination or treatment” is not limited to its literal meaning either. If a patient’s condition is such that it would appear that the patient needs medical attention to a reasonably prudent person, then there does not have to be a request at all.

So what is an appropriate medical screening examination? Essentially it needs to be sufficient to determine if the patient has an emergency medical condition. CMS defines emergency medical condition as a condition of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (1) serious jeopardy to the patient’s health; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

So the obvious question is what if a patient comes to the emergency department and requests examination and treatment for an emergency medical condition, but while the patient is waiting for care decides it is taking too long and leaves the emergency department without treatment? Has an EMTALA violation occurred? If there has been an appropriate medical screening examination and the patient was told not to leave and to wait for treatment and the patient is not leaving based upon a suggestion of the hospital staff, then there is not an EMTALA violation. It would be best to get the patient to sign an informed refusal of care if possible to avoid a factual dispute should there be future litigation.

But, what if the medical screening examination was never performed before the patient left and the patient dies in the hospital parking lot? Well, then the issues becomes was the

patient properly triaged, how long had the patient had to wait before s/he left, was the hospital operating above its capacity and if so, was there an offer to transfer the patient; did the patient leave at the suggestion of hospital staff, and most importantly, was there any disparity in the treatment of this patient based upon the patient's race, religion, ethnicity, citizenship, legal status, or ability to pay? Obviously, the best practice is to get the medical screening done quickly because not providing the screening can lead to significant liability.

Some of the key issues to remember when planning for EMTALA are that EMTALA does not by its terms or by any that have been extended to it by judicial interpretation apply to stable patients. EMTALA relates to accepting, treating and transferring unstable patients.

Also, a hospital can only perform that which is within its capability and capacity. However, it is worth noting a hospital is not at capacity just because it is exceeding its licensed bed capacity – the hospital would be expected to move stable patients, bring in additional staff, and borrow equipment before it would likely be found to be at capacity. That said, if the needed service is truly beyond the hospital's capability or capacity, courts have tended to not find EMTALA violations.

Given the lack of clarity regarding EMTALA, it's not surprising so many physicians and hospital administrators struggle with its application. To assist in clarifying this murky abyss, here are a few of the most common questions about EMTALA:

Q. If our hospital does not have an obstetrical department do we have to treat a woman in active labor?

A. Yes, if: (1) there is inadequate time to affect a safe transfer to another hospital before delivery; or (2) transfer may pose a threat to the health or safety of the woman or her unborn child.

Q. If our hospital does not have a psychiatric department and a patient presents with signs of an unstable psychiatric emergency medical condition what are the hospital's obligations?

A. Note: a key word here is unstable. EMTALA does not apply to stable patients. But note there have been some controversial court decisions such as the recent 9th Circuit Moses case, where a court held a hospital that admitted a psychiatric patient and kept the patient for several days before releasing the patient violated EMTALA because the hospital failed to "stabilize the patient" before discharging the patient. On the other side of the coin, a hospital only has to treat the patient within the hospital's capacity and capability. At least one court has held that a hospital that had no psychologist or mental health counselors on staff did not have the capacity to treat a psychiatric patient and therefore had satisfied its

EMTALA obligations by performing a medical screening to determine if there was an organic cause for the psychiatric symptoms.

- Q. Do EMTALA obligations end once a patient is admitted to the hospital?
- A. Until 2009 most authorities on this subject were in agreement that EMTALA obligations ended when the patient was admitted into the hospital. However, in 2009, the Moses court shook up that commonly accepted wisdom with a decision that the key element for ending EMTALA responsibilities was not admitting the patient, but was “stabilizing” the patient. The court reasoned that a patient could be admitted as an inpatient and still remain unstable and thus EMTALA could apply after a patient was admitted to the hospital. No other cases have followed or disagreed with this opinion to date and there has not been any further definitive CMS guidance on this issue.
- Q. Can a patient be asked for their insurance information before the medical screening examination is performed?
- A. Surprisingly yes, so long as taking the information does not delay the medical screening examination or treatment and there is no disparity in screening or treatment of the patient based upon the information collected.
- Q. As a hospital on the receiving end of a transfer can I refuse to accept a transfer if there is a closer appropriate hospital with capacity to accept the patient?
- A. No, you must accept the patient. The hospital can seek reimbursement for unfunded care for improperly transferred patients.
- Q. If a physician knows of an EMTALA violation, is there any duty to report the violation?
- A. Yes, violations must be reported to CMS within 72 hours of the violation.
- Q. What if a patient presents that needs a specialist that is not available under the on-call schedule for the hospital, is transferring the patient an EMTALA violation?

- A. EMTALA is vague on exactly what types of specialist must be on-call 24/7 at a hospital. Clearly, EMTALA accepts transfer agreements between hospitals as a means of covering on-call for specialists.²
- Q. Does EMTALA apply to physicians?
- A. EMTALA is primarily geared towards hospitals, not physicians. EMTALA only imposes a penalty on a physician in the following circumstances: (1) the on-call physician fails to respond to an emergency situation; (2) a physician signs a certification to transfer where the physician knew or should have known that the certification was false; or (3) there can be direct liability for physicians working at specialty hospitals. However, lawyers being lawyers there are other ways to be sued that skirt around EMTALA either through retribution under a contract with a hospital that received a fine based upon the physician's actions, or in a medical malpractice case where the claim is the failure to comply with EMTALA demonstrates failure to observe the usual and customary standard of care.

While it's beyond the scope of this article, it's worth pointing out that Florida has its own version of EMTALA called the Florida Access to Care and Emergency Treatment Act. Much of what is stated here about EMTALA is also true of the Florida Act. One unique provision to the Florida Act worth mentioning, however, is that Florida offers some immunity to physicians as an incentive to put patient quality first in making transfer decisions.

If you have any questions about EMTALA, please feel free to speak with an attorney at Smith & Associates.

² Florida law is much more specific on which specialist must be on call and requires either specific exceptions or specific transfer agreements by medical specialty if there is not 24/7 on-call coverage for almost every specialty service provided at the hospitals.