Primer: Overview of the Emergency Medical Treatment and Active Labor Act (EMTALA)

Overview:

In 1986, Congress enacted EMTALA as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA). Often referred to as the "anti-dumping" law, its intent was to ensure public access to emergency services regardless of a person's ability to pay. "EMTALA is an unfunded mandate that does not require health insurance companies, government agencies, or individuals to pay " for the requisite services[i].

EMTALA states that all presenting persons must have a medical screening exam to evaluate for an 'emergency medical condition' (EMC) and that the hospital is obligated to 'stabilize' the patient within its ability prior to transfer. EMTALA defines an emergency medical condition as a "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 placing the health of the individual in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part." Pregnant women are specifically addressed: any pregnant patient who is having contractions is defined by EMTALA as unstable. She is considered unfit for transfer until delivery of the fetus and placenta.

What is the Medical Screening Exam (MSE)?

The scope of the medical screening exam must be of sufficient depth as to reasonably intend to determine whether an emergency medical condition exists. This includes all necessary testing and on-call services within the capability of the hospital. Recent judgments have ruled that EMTALA was violated when an inadequate screening exam failed to diagnosis an emergency medical condition. While triage is not considered a medical screening exam, EMTALA does not specify that a physician must perform the exam. If a hospital board and by-laws states so, the exam may be performed by another "qualified medical person" such as a physician assistant or nurse practitioner. If an emergency condition is diagnosed, then the hospital is obliged to provide treatment until it resolves or is stabilized. Most importantly, examination and treatment cannot be delayed to inquire about payment or insurance coverage.

If the hospital does not have the capacity to treat a particular emergency condition, then an "appropriate" transfer of the patient to another hospital must be done in accordance with the EMTALA provisions. Hospitals with specialized capabilities are obligated to accept transfers from hospitals that lack such capacity.

EMTALA defines the Emergency Department as the entire hospital campus, which includes a 250-yard zone around the main building (but does not include non-medical buildings). Any persons presenting with an emergency condition within this zone falls under EMTALA.

What are the penalties for EMTALA violations?

Physicians, including on-call specialists, found in violation of EMTALA are liable to up to $50,000 per citation. Hospitals may also be fined $50,000 ($25,000 for fewer than 100 beds). However, "gross and flagrant", or repeated violations, could result in exclusion from the Medicare program. Exclusion from Medicare often results in bankruptcy and closure of that hospital. Additionally, receiving facilities that have suffered a financial loss as a result of an inappropriate transfer can sue for reimbursement. Furthermore, hospitals may also be sued in civil court for personal injury resulting from EMTALA violations.

Citations are evaluated on a case-by-case basis, and are subject to a great deal of judicial interpretation.

Transfers

Patients may only be transferred under EMTALA for medical necessity, and they must be in "stable" condition. EMTALA defines "stable" as "no material deterioration of the patient's condition is likely to occur during transfer". However, an unstable patient can be transferred if the following criteria are met for an "appropriate transfer":

1) A higher level of care, or specialized services are required and the patient has been stabilized to the extent that the transferring facility is capable;
2) The risks of transfer are outweighed by the presumed benefits, and this is documented;
3) The receiving facility has accepted the transfer and this is charted;
4) Written consent to transfer from the patient;
5) The patient is accompanied by all medical records; and
6) The transfer employs appropriate medical vehicle and qualified personnel and equipment (private passenger vehicles are not permitted unless the ambulance has been refused in writing).

Patients who are potentially unstable, cannot be transferred, if the referring hospital has the capabilities and the physical capacity to treat the patient. In addition, hospitals with the capacity to care for a patient may not decline a transfer if that transfer is appropriate. "Where the hospital has the ability to utilize on-call personnel, it must do so to accommodate the patient. Where the hospital has handled patients in excess of its stated capacity on prior occasion, it is required to accept the patient. Where the hospital could use step-down beds or early discharge to accommodate a patient, it must do so. Patients must be accepted without regard to means or ability to pay, or the third-party payer involved."[ii]

A patient's request for transfer to another institution can supersede the hospital's obligations, but the transfer must still be "appropriate" as stated above, and the reason for the patient's request must be documented.

Who is exempt form EMTALA?

1) Admitted patients;
2) Patients without an emergency condition;
3) Out-patient procedures, labs, radiographic studies ordered the primary care physician;
4) Persons requesting specific tests;
5) Scheduled out-patient visits;
6) Blood tests for law enforcement; or
7) Ambulances on hospital property for the sole purpose of meeting a helicopter (unless the paramedics request assistance in managing the patient).

Who pays for EMTALA?

We do. In May 2003 the AMA stated that emergency physicians on average provided $138,300 of EMTALA-related charity care each year. Physicians in other specialties provide, on average, about six hours a week or EMTALA mandated care, on average incurring $25,000 a year in bad debt.

Pitfalls:

The patient told me she needed pre-authorization from her HMO to be seen in the Emergency Department. She asked if I wouldn't mind giving them a quick call, before we got started. Can I do this for her?

No. While the 2003 revisions makes it possible to obtain pre-authorization in certain circumstances, these are exceedingly complicated so that making such a call is very risky and not worth considering.

My on-call consultant never answered my pages. After several hours of trying, and with the patient deteriorating, I had no choice but to transfer the patient. I couldn't have done anything wrong, as I had no choice.

If it becomes necessary to transfer a patient due to the refusal or failure of an on-call physician to come in, then the Emergency Physician must list the name and address of the of the on-call physician in the transfer documentation. This may result in the hospital and on-call physician being cited for an EMTALA violation. However, not providing this information will likely result in the citation of the Emergency Physician, hospital, and on-call doctor. Hospitals must maintain a well-displayed on-call list by physician name (not just the group). The only excuse for not appearing is being actively engaged in surgery or actively managing a patient who is in crisis (scheduled patients and elective surgeries do not apply).

The patient just seemed intoxicated. So I discharged him to jail. He didn't complain of anything. How was I to know he had a subdural?

While this may have been fine, screening of intoxicated and psychiatric patients must be sufficient to rule out underlying traumatic, toxic, or organic causes that may be contributing to the presenting symptoms or apparent state.

A 19 year old, prima-gravid, dilated 2 centimeters, having contractions 10 minutes apart showed up in my ED in the middle of the night. The family practice doctor told her to go the nearest ED, but our hospital does not have any OB services. I called the nearest hospital, which does have OBs on-call, but they refused the transfer saying it would be an EMTALA violation. They said I could not transfer the patient until the fetus and placenta were both delivered. I hadn't delivered a child in over 10 years, and didn't know what to do.

Transfer in this case is not necessarily an EMTALA violation. The patient should only be delivered in your ED if the risk is not outweighed by the benefits of transfer to more specialized care. In a hospital without OB services, the ACT is clear that the risk/benefit ratio must consider the pregnant patient and the unborn child. In this case there should be adequate time to safely transfer to a nearby facility. This is true of all emergency medical conditions (i.e. trauma, cardiac, neurosurgery, etc), when the patient requires services not within the capability or capability of the referring facility. Depending on the clinical situation, the patient might not ever be stabilized at the current facility. Your medical record should reflect this risk/benefit analysis, and the informed consent of the patient being transferred. Also, appropriate medical transport should be provided.

I just found out the hospital got an EMTALA citation for a patient that I didn't even transfer. They complained I didn't provide translation services, but I speak some Spanish and though I understood him pretty well.

Another provision of the Act required the ED, and the hospital as a whole, to comply with translation services for persons with limited English proficiency. This includes translation services, signs and translated documentation.

Endnotes:

[i] Billingham, Graham. EMTALA. American College of Emergency Physicians Website. http://www.acep.org/Content.aspx.

[ii] Frew, Stephen. *Executive EMTALA Summary*. 2008

Other References:

Booth, Ashley. *The Emergency Medical Treatment and Labor Act*. ACEP News, Vol 27; 8. Aug 2008

U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services Web Site. www.cms.hhs.gov/EMTALA/Downloads/CMS

Social Security Act: Section 1867 – Examination and Treatment for Emergency Conditions and Women in Labor. www.ssa.gov/OP_Home/ssact/title18/1867.htm#t