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EMTALA and Patient Transfers

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Introduction

The United States Congress passed the Emergency Medicine Treatment and Active Labor Act (EMTALA) in 1986. EMTALA was part of the Consolidated Omnibus Reconciliation Act (COBRA), which Congress enacted to address Medicare issues. The original intent of the EMTALA law was to attempt to prevent discrimination against patients in the form of "patient dumping." Patient dumping is the practice of involuntarily transferring uninsured patients from one hospital to another strictly for financial reasons.[1][2]

This forced moving of uninsured patients was a common practice as private hospitals routinely transferred such patients to public hospitals without adequately considering their emergency medical condition or even if they were medically stable enough for safe discharge.[1]

This situation occurred in most large cities, such as Chicago, New York, and Dallas, where public hospitals received more transfers of uninsured and underinsured patients strictly for financial reasons.[1] Several scathing reports by medical professionals and the lay press described the problem of patient dumping at the time. The growing attention from these reports, the outrage they produced, and the increasing presence of the federal government in healthcare delivery led to the development of the EMTALA law.[1]

In any given year, between 4% and 5% of hospitals in the US are cited for an EMTALA violation. Large, urban, for-profit hospitals with a significant Medicaid population and high emergency department (ED) volumes are the most likely to have such violations. Not surprisingly, for-profit hospitals have more than twice as many violations per one million ED visits as nonprofit facilities.[3]

Issues of Concern

EMTALA applies only to hospitals that accept payment from The Department of Health and Human Services (HHS) and The Centers for Medicare and Medicaid Services (CMS) under the Medicare program.[2][4] However, this is nearly 98% of all United States hospitals.[1] Three legal responsibilities are required of participating hospitals by EMTALA.[1][2]

1. The first of the 3 legal requirements enacted by EMTALA is that the hospital must provide a medical screening examination (MSE) on any person who presents to the Emergency Department and requests treatment to determine if an emergency medical condition exists. EMTALA defines an emergency medical condition as:

"A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health (or the health of the unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or concerning a pregnant woman

who is having contractions, that there is adequate time to effect a safe transfer to another hospital before delivery, or that the transfer may pose a threat to the health or safety of the woman or the unborn child."[5]

The hospital's emergency department completes the screening examination requirement by not altering its standardized screening procedure.[4] This medical screening examination cannot be delayed by obtaining information regarding the patient's ability to pay or insurance coverage. All patients presenting to the emergency department with a potential emergency medical condition are covered under EMTALA; this does not apply solely to Medicare patients.[2]

A medical screening examination must be performed and documented on every patient presenting to the emergency department for medical care. [1] [2]

This rule applies to the emergency department's physical space and the hospital's entire property. It is inclusive of the whole hospital campus within 250 yards.[1][2] EMTALA may not cover patients in an outpatient clinic as such facilities cannot stabilize patients for most acute emergencies. EMTALA protections would start when the patient arrives at an emergency department.[6] Ambulances which are hospital-owned and operated are also subject to EMTALA rules.

There are no legal requirements regarding who exactly performs the medical screening examination other than it should be "qualified medical personnel." The rule also does not describe what specifically constitutes the medical screening exam. On-call specialists may be needed to assist with the medical screening examination or required to help stabilize a patient. On-call physicians also may not refuse to treat and stabilize a patient with an emergency medical condition without regard to their ability to pay, legal status, insurance status, or usual treating physician.

Under EMTALA, hospitals must have an on-call list representative of the typical services provided at that hospital and maintain that list for five years.[1][2]

2. The second legal requirement of EMTALA deals with patient stabilization and treatment. **If the patient has been found to have an emergency medical condition, the hospital must treat and stabilize the patient**. Hospitals cannot refuse emergency care to patients based on their inability to pay, age, color, disability, ethnicity, immigration status, lack of insurance coverage, lack of pre-authorization, or national origin.[1][2]

The same applies to any on-call physicians needed to provide emergency care to stabilize the patient. Most individual physician EMTALA violations and penalties were directed against on-call specialists who declined to evaluate or treat emergency department patients with urgent medical conditions.[7] Possible acceptable reasons to delay or decline treatment would be an inability of the on-call physician to reach the hospital for some legitimate reason (such as severe weather), being involved in the treatment of another patient at the time of notification (such as being in the middle of a surgical operation), or not treating that particular emergency condition in their usual practice.

The same medical screening procedures and stabilizing treatments must be used for all patients with comparable signs and symptoms regardless of their ability to pay, insurance coverage, or legal status.[8] Clinical management decisions are not covered under EMTALA, but good clinical judgment and nationally recognized standards of care would still apply. Also, the same medical screening procedures and stabilizing treatments must be used for all patients with comparable signs and symptoms regardless of their ability to pay, insurance coverage, or legal status.[8]

The hospital can alternatively transfer the patient when stabilized to another medical facility under certain conditions. **The transfer of the patient to another hospital must follow detailed guidelines set by EMTALA.**[1] [2]

An appropriate transfer, as stated by Smith in "EMTALA Basics: What Medical Professionals Need to Know," is defined as:[4]

1. The transferring hospital provides medical treatment to minimize the risks to the individual's or unborn child's health.
2. The receiving hospital has space available, qualified personnel to treat the patient, and agreed to accept the individual and provide treatment.
3. The transferring hospital sends all available documents related to the patient's emergency condition to the receiving facility.
4. The transfer takes place with qualified personnel using appropriate transportation equipment and services.
5. A medically unstable patient cannot be transferred unless the patient requests the transfer and a physician certifies that the benefits outweigh the risks.
6. The transfer meets any other CMS requirements necessary in the interest of the individuals transferred.

3. The final legal requirement **requires hospitals with specialized services, such as a burn unit, to accept patients needing those services.** This prevents specialized hospitals from refusing transfers based on the patient's ability to pay or insurance status. When an emergency department contacts a hospital with specialized services, they can ask no questions regarding insurance.[1][2] If a specialized facility has the capacity (ie, available beds and the ability to care for the patient), they cannot refuse an otherwise appropriate transfer.[1][2]

"Clinically stable for transfer" is not defined in the EMTALA law or rules. The mere statement that the patient is "clinically stable" in the medical record is insufficient. The determination of a patient being "clinically stable for transfer" is based on the medical record documentation of the patient's condition. This will typically include the medical screening examination, history and physical, vital signs, diagnostic test results, symptoms, progress in the emergency department, and other clinical indicators.[1][2]

For purposes of the EMTALA law, the term "clinically stable for transfer" only means that the patient is ready to be moved. In some cases, the patient may actually be medically unstable, but the sending hospital has provided as much stabilizing care as they can, and without an expeditious transfer to another hospital, the patient's health or survival is jeopardized.

A physician must certify that the benefits of a transfer outweigh the risks when transferring a patient to another hospital for stabilization.[1][2] This EMTALA requirement is separate and distinct from any other certification required by the hospital, state licensure, medical board, or patient transportation service policies, rules, or regulations.

The EMTALA law defines *"stabilized"* concerning a medical emergency as "no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual." *Unstabilized* would, therefore, mean that a material deterioration of the patient with the medical emergency is likely, within reasonable medical probability, to result from or occur during a transfer. In practical terms, this means the patient requires ongoing or additional supportive care (medical, obstetric, psychiatric, surgical, etc), and the patient's health will deteriorate without such ongoing treatment.[1][2]

The determination of *"stabilized"* versus *"unstabilized"* is based on the documentation in the medical record and nationally accepted standards. As long as the patient is *"unstabilized,"* full EMTALA protections apply. Remember that reviewers and surveyors have the advantage of a retrospective look back at the documentation and of knowing how the clinical situation eventually ended.[1][2]

For purposes of a patient transfer, it is the physician at the sending hospital that is primarily responsible for the determination of patient stability and clinical appropriateness for a transfer.

When the patient becomes stabilized, the EMTALA law technically ends even though the patient may need ongoing treatment, observation services, discharge, referral for follow-up care, to be transferred, or to be admitted as an

inpatient. If a transfer is still being considered, the receiving hospital can ask about insurance coverage or pre-authorization before accepting the patient.

There are several reasons for EMTALA non-compliance.[8]

- Economic Issues: Hospitals are under tremendous financial pressure to reduce costs and see EMTALA obligations as an unfunded mandate and loss leader. Even when patients are covered by insurance or Medicaid, EMTALA rules may require expensive testing, which some state Medicaid programs and insurance companies refuse to cover as "unnecessary."

- Ignorance of the Rules: While most ED physicians know the EMTALA law, many specialists are unfamiliar with the details, especially their absolute obligation to treat emergency cases when on-call. Specialists who take calls may not know they can be fined up to $50,000 per individual violation! Some smaller, rural EDs may be staffed with family physicians who are not as knowledgeable about EMTALA. There are knowledge gaps, such as the required obligations for psychiatric patients under EMTALA and legal complexities regarding pregnancy-related emergencies usually treated by abortions in states with newer, stricter anti-abortion laws.

- Recipient Hospital Burden: EMTALA has burdened recipient hospitals, which must now accept more uninsured patients in transfer. Many smaller hospitals are closing emergency rooms or handling only general medical problems. Some specialty physician groups are demanding high fees for taking calls, which smaller hospitals can no longer afford. This leaves those facilities with little choice but to transfer those patients to the already over-burdened receiving hospitals.

- Some EMTALA transfer patients are sicker than the receiving hospital was told, making them even more reluctant to accept inpatient transfers. As ED-to-ED transfers become preferred, the patients get stuck in the ED while waiting for an EMTALA-appropriate transfer.

- Inter-Hospital Relationships: Hospitals may not wish to file an EMTALA complaint due to reluctance to damage the relationship with the referring facility or lose them as a transfer partner. This is especially true if they are part of the same hospital network. Physicians are sometimes told by their hospital that the problem will be "handled internally" and that there is no need to report the violation to CMS. The reality is that physicians and hospitals have a legal obligation to report even suspected EMTALA violations to CMS.

- Different priorities: Hospitals are generally much more aware of following EMTALA rules because of the risk of substantial fines and losing their Medicare certification, even though termination is rare. Many specialist physicians are unaware of their obligations and potential liability under EMTALA when on-call, so they may refuse to accept or treat patients inappropriately.

Clinical Significance

EMTALA enforcement is through the Centers for Medicare and Medicaid Services (CMS) and the Office of the Inspector General of the Department of Health and Human Services. If a violation is reported, it is reviewed by a regional CMS analyst. Further investigation, including an on-site visit, may be conducted by surveyors from the state health department and occasional federal reviewers.[5] Surveyors are usually healthcare professionals and not lawyers.

Such investigations will review compliance with all EMTALA rules and requirements, not just the ones targeted as possible violations. This includes reviewing documentation and logs for the presence and appropriateness of medical screening examinations, delivery of stabilizing treatment, compliance with EMTALA transfer rules, on-call physician responses, signage, and published policies and procedures.

The on-site survey will also review the medical record documentation of other emergency department patients, particularly those that resulted in transfers or involved any refusal of care by the hospital or its on-call physicians. Additional unrelated violations may also be identified, and a separate fine can be levied for each infraction.

Physicians and hospitals that violate EMTALA can be liable for a fine of $50,000 for each individual violation, which is not covered by malpractice insurance.[9] A more substantial penalty would be the possibility of losing Medicare and Medicaid hospital funding for repeated or blatant violations.[5] Maximum hospital penalties are reviewed annually and are currently set at over $119,000 for hospitals with 100 beds or more and over $60,000 for smaller facilities.

Questions regarding the quality of medical care provided will be reviewed by a physician from a contracted Beneficiary and Family Centered Care Quality Improvement Organization and are based on the capabilities and capacity of the hospital.

Receiving hospitals that face significant financial losses due to an EMTALA violation by another facility can file suit and seek damages to recover those losses. Patients who suffer injury or personal harm due to breaches of EMTALA rules may file civil lawsuits against hospitals and individual physicians. Civil suits that allege hospital EMTALA violations must be filed within 2 years of the infraction.

A study by Zuabi et al looked at EMTALA investigations by the Office of the Inspector General of the Department of Health and Human Services from 2002 through 2015.[5] They determined that 40% of the investigations found EMTALA violations, but fines were levied in only 3% of cases.[5] There were a total of 192 settlements. The fines totaled $6,357,000. Most of the EMTALA violations were for a failure to provide a medical screening examination (75%), failure to stabilize patients found to have an emergency medical condition (42%), and consideration of the patient's financial or insurance status (15%.)[5] The same study found that the average fine against hospitals was $33,435 and $25,625 against individual physicians. Hospitals received the most penalties and were responsible for 95% of the cases.[5]

Other common causes of EMTALA violations include on-call specialist refusal to treat, inadequate or improper documentation, wrong diagnosis, communication problems, incorrect triage, failure to get needed imaging or laboratory testing, and nursing issues.[10]

The enactment of the EMTALA law has certainly protected uninsured patients and given them access to emergency services that were previously denied. But it has also been associated with unexpected, excessive out-of-network medical bills for some of the insured population. The passage of the No Surprises Act to end excessive out-of-network emergency medical bills may negatively affect reimbursement by on-call physician specialists in emergency settings. Some specialized physicians at tertiary care centers can become overburdened with uncompensated care. Increasing on-call reimbursement and implementing telemedicine services in the emergency department have been proposed to address these concerns.[11]

The issue of a pregnancy-related medical emergency that would require abortion for resolution and patient "stabilization" under EMTALA rules, which conflicts with some strict state anti-abortion laws, has yet to be fully resolved. It was public outrage at pregnancy-related care refusals by a number of private hospitals that originally caused the creation of the EMTALA law.

Hospitals and physicians need to be familiar with the details of EMTALA to avoid potential violations and ensure all patients receive equal and appropriate emergency services. Significant healthcare funding cuts from private and public sectors continue to pressure emergency care and EMTALA's safety net providers. Access to emergency care for the uninsured and underinsured was the driving force for the enactment of EMTALA in 1986 and continues to remain just as important today. This is compounded by the growing problem of undocumented migrants, who are also covered by the EMTALA rules and regulations.

EMTALA Summary

- A medical screening examination must be performed and documented on every patient presenting to the emergency department for medical care.
- If the patient has been found to have an emergency medical condition, the hospital must treat and stabilize the patient without regard for their ability to pay, insurance coverage, or immigration status.
- On-call specialists may be needed to assist with the MSE or to help stabilize a patient. They also must treat and stabilize the patient without regard for their ability to pay, insurance coverage, or immigration status.
- A hospital cannot transfer an unstable patient unless the patient requests the transfer and a physician certifies that the benefits outweigh the risks.
- EMTALA protections apply if the patient's medical emergency remains "unstabilized."
- The key terms for EMTALA compliance are "stabilized" and "unstabilized."
- The transfer of a patient to another hospital must follow detailed guidelines set by EMTALA.
- Hospitals with specialized services and facilities must accept patients who need those specialized services if they have available beds and personnel.
- EMTALA protection covers all patients and provides for examinations, treatment, and transfers without regard for their ability to pay, insurance coverage, or immigration status.

Review Questions

- Access free multiple choice questions on this topic.
- Comment on this article.

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