

# EMTALA – Are you prepared?



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# Background and History

1. Emergency Medical Treatment and Labor Act (EMTALA)
  - a) Anti-dumping law
  - b) First Enacted in 1986  
– under COBRA of 1985 passed by Ronald Reagan



# Background and History

1. Over the years EMTALA has changed through various revisions of the original law passed in 1986. These revisions include:
  - a) Phase I – 1994 applied the law’s basic screening and stabilization requirements to patients anywhere on hospital property and required hospitals to report inappropriate transfers.
  - b) Phase II – 1998 – HCFA published guidelines on its interpretation of EMTALA:
    - i. Distinct responsibilities for on-call docs
    - ii. Create an obligation to screen and treat patients with psych emergencies
    - iii. Medical screening is a dynamic process
    - iv. Create distinction for patients who are stable, stable for transfer, and stable for discharge.

# Background and History

1. Over the years EMTALA has changed through various revisions of the original law passed in 1986. These revisions include (cont.):
  - c) Phase III – 1999 – OIG special advisory bulletin providing guidelines on handling patients who require authorization for care by Managed Care Comp. Bottom line is that EMTALA covers all patients including managed care.
  - d) Phase IV – 2000 - CMS OPPS – CMS expands on its interpretation of EMTALA to include:
    - a) Inpatient areas
    - b) Hospital buildings within 250 yards of main campus
    - c) Off-campus facilities considered part of the hospital in terms of Medicare cost reimbursement purposes.
      - a) The Off-campus facilities must also follow EMTALA rules on signage and patient care standards as well.

# Background and History



1. Over the years EMTALA has changed through various revisions of the original law passed in 1986. These revisions include (cont.):
  - e) Phase V – 2002 – OIG publishes regulatory clarifications to EMTALA expanding OIG’s reach regarding administrative penalties for violations, “any other instances” of such conduct. Prior rules limited OIG to “prior history.”

# Background and History

1. Over the years EMTALA has changed through various revisions of the original law passed in 1986. These revisions include (cont.):
  - f) Phase VI – 2003 – CMS issues final rules for EMTALA addressing:
    - a) Prior Authorizations
    - b) Clarification of “comes to the emergency department (ED)” by identifying new term “dedicated ED (DED)”
    - c) Allowing exception to EMTALA for non-emergency services in DED
    - d) Defined EMTALA applications for non-DED presentations on Hospital campus
    - e) Placing limits on EMTALA governance to emergency patients rather than inpatients or scheduled outpatients
    - f) EMTALA’s application to off-campus hospital depts.
    - g) Clarification of hospital’s on-call responsibilities
    - h) EMTALA’s requirements toward hospital-owned ambulances (focus on disaster protocols and bioterrorism emergencies).

# Background and History

1. Over the years EMTALA has changed through various revisions of the original law passed in 1986. These revisions include (cont.):
  - g) EMTALA Technical Advisory Group (TAG) – 2009 – TAG created by Congress to recommend EMTALA improvements to CMS. CMS revised State Operations Manual to reflect TAG changes including:
    - a) Nonphysician practitioners and their role in on-call services
    - b) Use of telemedicine
    - c) Newborn protection under EMTALA
    - d) “Parking” patients who arrive via ambulance
    - e) False labor determination by qualified medical personnel
    - f) Specialty hospital transfers
    - g) Community call for on-call specialists
    - h) Inpatient transfers of unstable patients
    - i) On-call coverage rules/obligations



*"Unfortunately, you have what we call 'no insurance.'"*

# EMTALA Requirements

## 1. General Rule

- a) If an individual Comes to the Emergency Department and a Request is made (or if no request is made applying the reasonable person test as an observer) for examination or treatment of a Medical Condition, then a Hospital must:
  - i. Provide a Medical Screening Exam to determine whether or not an Emergency Medical Condition exists
    - a. If no emergency medical condition exists – EMTALA obligation is finished.
    - b. If there is an emergency medical condition, hospital must Stabilize and/or Appropriately Transfer patient.

# ER Statistics (2007 data)

1. Number of visits: 116.8 million
2. Number of injury-related visits: 39.4 million
3. Number of visits per 100 persons: 39.4
4. Percent of visits with patient seen in fewer than 15 minutes: 18%
5. Percent of visits resulting in hospital admission: 12.5%
6. Percent of visits resulting in transfer to a different hospital: 1.8%
7. **Source: [www.cdc.gov/nchs/fastats/ervisits.htm](http://www.cdc.gov/nchs/fastats/ervisits.htm)**

# ER Statistics (2007 data)

1. Key findings (Who used ER?):
  - a) Older adults (aged 75 and over), non-Hispanic black persons, poor persons, and persons with Medicaid coverage were more likely to have had at least one emergency department (ED) visit in a 12-month period than those in other age, race, income, and insurance groups.
  - b) Among the under-65 population, the uninsured were no more likely than the insured to have had at least one ED visit in a 12-month period.
  - c) Persons with Medicaid coverage were more likely to have had multiple visits to the ED in a 12-month period than those with private insurance and the uninsured.
  - d) ED visits by the uninsured were no more likely to be triaged as nonurgent than visits by those with private insurance or Medicaid coverage.
  - e) Persons with and without a usual source of medical care were equally likely to have had one or more ED visits in a 12-month period.
  - f) **Source: <http://www.cdc.gov/nchs/data/databriefs/db38.htm>**

# Breakdown of EMTALA Requirements

1. Comes to the Emergency Department
2. Medical Screening Examination
3. Stabilizing Treatment
4. Transfer Requirements
5. What are Hospital's responsibilities under EMTALA
6. Enforcement
7. 2009 – TAG and CMS changes
8. Current Caselaw

# Comes to the Emergency Department

## 1. Comes to the Emergency Department

- a) An individual, who is not a patient, comes to the emergency department when he or she:
  - i. Presents at the hospital's DED and requests examination or treatment (in the absence of a specific request, apply the prudent layperson observer test)
  - ii. Presents on other hospital property (main campus, including sidewalks, parking lots, driveway within 250 yards of the hospital) and requests examination or treatment for what may be an emergency medical condition (in the absence of a specific request, apply the prudent layperson observer test)
  - iii. Presents in a hospital owned and operated ambulance for purposes of examination or treatment of a medical condition even if the ambulance is not on hospital property or
  - iv. Or presents to hospital (on hospital property) in an ambulance for examination and treatment of a medical condition at hospital's DED.

# Comes to the Emergency Department

1. Comes to the Emergency Department
  - a) An individual, who is not a patient, comes to the emergency department when he or she (cont.):
    - iii. Ambulances – “Parking” – patients who arrive via EMS and are deliberately not moved from an EMS stretcher onto an emergency department stretcher in belief that EMTALA obligations can be delayed.
      - i. TAG/CMS 2009 – “parking” is non-compliant and could violate not only EMTALA but also hospital Conditions of Participation for emergency services (COPS).
      - ii. “Parking” was distinguished from situations where hospitals did not have capacity or capability to admit when patient arrives.
      - iii. EMS can be asked to stay with patient
      - iv. Hospital must triage patient appropriately

# Emergency Medical Condition

1. Definition:
  - a) When absence of immediate medical attention could reasonably be expected to result in:
    - i. Placing the health of an individual or unborn child in serious jeopardy or
    - ii. Serious impairment to bodily function or
    - iii. Serious dysfunction of any bodily organ or part
  - b) As to pregnant women who are having contractions:
    - i. That there is inadequate time to effect a safe transfer to another hospital before delivery, or
    - ii. That the transfer may pose a threat to the health or safety of the woman or the unborn child.

# Medical Screening Examination

1. Medical Screening Examination – what are hospital obligations?
  - a) Provide for an appropriate Medical Screening Examination (MSE) by a qualified medical personnel (QMP)
    - i. Triage does not equal MSE
    - ii. Ongoing process that begins but does not end with triage.
    - iii. Subjective standard that is dependent on patient's condition
  - b) If Emergency Medical Condition exists:
    - i. Hospital must stabilize and/or appropriately transfer



# Medical Screening Examination

1. Medical Screening Examination – what are hospital obligations (cont.)?
  - a) What are the elements of MSE?
    - i. Log entry with disposition
    - ii. Triage record
    - iii. Ongoing recording of vitals
    - iv. Oral history
    - v. Physical Examination
    - vi. Use of all necessary available testing resources to check for an emergency medical condition
    - vii. Use of on-call physicians as needed; discharge or transfer of vital signs and
    - viii. Adequate documentation of all the above

# NEWS ITEM: AVERAGE EMERGENCY ROOM WAIT NEARS ONE HOUR, C.D.C SAYS.



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# Medical Screening Examination

1. Medical Screening Examination – what are hospital obligations (cont.)?
  - a) Ongoing Monitoring:
    - i. If the MSE requires continued monitoring of the patient over time, the medical record must reflect this continued monitoring.
    - ii. If there is no evidence of this ongoing monitoring prior to discharge or transfer, possible EMTALA violation.
  - b) False Labor:
    - i. Can be determined by a physician and potentially by a certified nurse-midwife, an obstetric nurse, or other QMP.
    - ii. NOTE – nonphysician practitioner who can do MSE must be approved by the Board and can only function within scope of practice dictated by Hospital/state law.

# What is Stabilizing Treatment?

1. Stabilizing Treatment – What is it under EMTALA?
  - a) Necessary stabilizing treatment for emergency medical conditions and labor
    - i. In general
      - a. If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital determines that the individual has an emergency medical condition, the hospital must provide either:
        - 1) Within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
        - 2) For transfer of the individual to another medical facility in accordance with subsection (c) of this section.

# What is Stabilizing Treatment?

1. Stabilizing Treatment – What does it mean to “Stabilize?”
  - a) The term stabilized means:
    - i. With respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within a reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).
    - ii. For Psych patients that are suicidal/homicidal – they must no longer be a threat to self or others.

# What is Stabilizing Treatment?

1. Stabilizing Treatment – What is the definition of obstetric “labor” for EMTALA?



Labor is defined in CFR as:

- i. The process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other QMP acting within his or her scope of practice as defined by the hospital medical staff bylaws or State law, certifies that, after a reasonable time of observation, the woman is in false labor.

# What is Stabilizing Treatment?

1. Stabilizing Treatment – False labor – what happens?
  - a) Once patient is determined to be in false labor, she is stable – EMTALA no longer applies.
  - b) What is “reasonable time of observation?”
    - i. Not defined but considered on case by case basis
  - c) Hospital should be specific when drafting policies and procedures to guide the QMP on how to meet this requirement. The policy should clearly define the clinical standards that define false labor. If there is a dispute between QMP and OB, then OB must come to the hospital and personally attend to patient. All discussions between QMP and OB should be documented in the record.

# Transfer Requirements

1. Transfer Requirement – what is definition?
  - a) The movement (including discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated directly or indirectly, with) the hospital, but does not include such a movement of an individual who
    - i. Has been declared dead or
    - ii. Leaves the facility without the permission of any such person
    - iii. Signs out against medical advise (AMA)
  - b) Once on hospital property
    - i. Any movement of patient to leave property – by formal ambulance, discharge from hospital, referral to HMO office, or simply encouraging patient to leave – “transfer” under EMTALA.

# Transfer Requirements

1. What do surveyors look for to determine possible transfer violations?
  - a) Transfers to off-site testing facilities and return
  - b) Death or significant adverse outcomes
  - c) Refusals of examination, treatment or transfer
  - d) Patients leaving AMA
  - e) Returns to ED within 48 hours; and
  - f) ED visits where the individual is logged in for an unreasonable amount of time before the time indicated for commencement of medical screening examination.

# Transfer Requirements

1. What are EMTALA transfer requirements?
  - a) A hospital may not transfer an individual with an unstable emergency medical condition except:
    - i. It is an “appropriate transfer”
    - ii. The patient/legal guardian requests the transfer in writing, after being informed of the hospital’s obligations and the risk of transfer
    - iii. A physician certifies, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or unborn child, from being transferred. The certification must contain a list of risks/benefit as basis for physician’s certification.
    - iv. A QMP may also sign a certification if physician is not present in ED. But physician must have consulted with QMP and agree with the certification. Physician must countersign certification. A summary of risks/benefits must accompany certification.

# Transfer Requirements

1. What is an “appropriate transfer?” (Of unstable patient with EMC)
  - a) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual’s health and in the case of a woman in labor, the health of an unborn child
  - b) The receiving facility –
    - i. Has available space and qualified personnel for the treatment of the individual; and
    - ii. Has agreed to accept the transfer of the individual and to provide the appropriate medical treatment;
    - iii. The transferring hospital sends to receiving facility all medical records (or copies) related to the emergency condition which the individual has presented that are available at the time of transfer, and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records not available should be sent ASAP.

# Transfer Requirements

1. What is an “appropriate transfer?” (Of unstable patient with EMC) cont.:
  - iv. The transfer is effected through QMP and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.



# Transfer Requirements

1. Who must accept a transfer?
  - a) A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or, in rural areas, regional referral centers) may not refuse to accept from a referring hospital within the US an “appropriate transfer” of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

# Transfer Requirements

1. Who must accept a transfer?
  - a) Hospitals should be in place specific policies and procedures for receiving patients to avoid complications. They should include:
    - i. Who can or cannot accept transfers on hospital's behalf
    - ii. Distinct procedures guiding acceptance of transfer
    - iii. Specific guidelines on refusal of transfer
    - iv. Acceptance and rejection certificates
    - v. Education sessions on EMTALA responsibilities for all personnel who would have input or contact with transfer procedures – including secretaries/telephone operators/staff

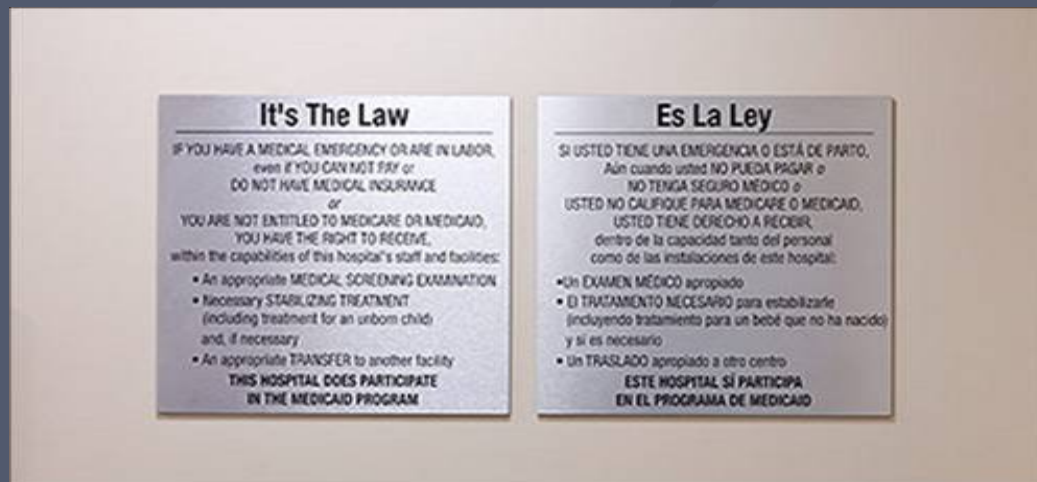
# What should hospitals do?

1. What are Hospital's responsibilities under EMTALA – checklist:
  - a) Entrances and Signage
  - b) Triage
  - c) Registration
  - d) MSE
  - e) Stabilizing
  - f) Transfers Out
  - g) Transfers In
  - h) Documentation

# What should hospitals do?

## 1. Entrances and Signage

- a) Identify and review all entrances to ED that have potential to be used by patients
- b) Are signs posted about right to MSE regardless of ability to pay
- c) Are signs posted in entrances, waiting areas, triage or treatment areas?
- d) Clearly visible?
- e) Multiple languages?
- f) Is waiting area visible to triage staff so patients can be monitored



# What should hospitals do?

## 1. Triage

- a) Where is triage performed and how are patients directed there?
- b) When is triage performed? (Prior to registration?)
- c) What happens if an individual leaves before or after triage?
- d) Are patients notified to inform staff if condition worsens or if they choose to leave? (Need to have in place in case of Informed refusal of care can be completed)
- e) Confirm Informed Refusal of Care forms are near waiting areas

# What should hospitals do?

## 1. Registration

- a) What information is obtained?
- b) Where is it documented?
- c) When is the central log time initiated?
- d) Confirm that MSE and treatment are not being delayed for registration; however, if patient is triaged as non-emergent, reasonable registration is ok.
- e) Does registration have scripts to use in the event patient wants to discuss insurance coverage prior to MSE?
- f) Confirm pre-auths from carriers are not occurring prior to MSE.

# What should hospitals do?

## 1. MSE

- a) Do physicians or QMP document when MSE is completed?
- b) Are ancillary services used as needed to evaluate the presenting complaint and determine if an emergency medical condition exists?



# What should hospitals do?

1. Stabilizing
  - a) Is it performed within capability of the facility and staff?
  - b) Confirm that all physicians are presenting to the facility when called and in compliance with the timeframe set forth in hospital's policy.
  - c) Is there a communication process between the clinical staff and registration staff so that any required pre-auth can be sought once stabilization is initiated?



# What should hospitals do?

## 1. Transfers Out

- a) Audit transfer paperwork to confirm that all transfers of individuals with un-stabilized emergency medical conditions are initiated either by
  - i. A written request for transfer
  - ii. A physician certification regarding medical necessity for transfer (copy of necessity and medical record to accompany patient to receiving hospital).
    - a. If the transfer is requested – do forms allow clear documentation of request – including risk/benefits discussed with patient?
    - b. How does the physician certify that benefits outweigh the risks?

# What should hospitals do?

## 1. Transfers Out

- b) Do facility policies and procedures define documentation standards and persons responsible for:
  - i. Identifying a receiving physician at receiving hospital?
  - ii. Obtaining acceptance of patient by receiving hospital?
  - iii. Sending pertinent medical records with patient?



# What should hospitals do?

## 1. Transfers Out

- c) Do available forms provide a place for physician to write an order for the transfer and describe transportation staffing and equipment requirements?
- d) If a transfer occurs due to an on-call physician's failure to appear, are the name and address of the physician included in the records sent to the receiving hospital?

# What should hospitals do?

## 1. Transfers In

- a) Has the facility established a transfer request log to capture the following information regarding transfers in:
  - i. Date and time of request
  - ii. Facility requesting transfer
  - iii. Services requested/reason for transfer
  - iv. Service availability at receiving hospital
  - v. Whether transfer was accepted or denied
  - vi. Reason for denial

# What should hospitals do?

## 1. Documentation

- a) Audit central log for disposition and compliance with additional state law requirements
- b) Review Bylaws to confirm indication of who may perform an MSE. If non-physician is authorized to perform MSE, confirm that the required credentials, competencies and practice protocols are identified
- c) Review Physician on-call list to verify that it reflects coverage of service available to inpatients. Physicians must be listed by name.
- d) Review triage and re-assessment policy
- e) Confirm that EMTALA policy has been updated to reflect most current regulatory changes

# EMTALA Enforcement

1. What are penalties for EMTALA violation?
  - a) Hospital fines of \$25k - \$50k per violation (hospitals with <100 beds \$25k)
  - b) Physicians - \$50k fine per violation
  - c) Hospital may be terminated from Medicare provider status
  - d) Physician may be excluded from Medicare or Medicaid
  - e) Civil suit
  - f) Receiving hospital, having suffered a financial loss, may sue transfer hospital if there was an EMTALA violation to recover
  - g) Loss of TJC Deemed status

# 2009 changes/clarifications

1. 2009 – TAG and CMS changes (State Operations Manual changes revised May 29, 2009 and CFR revised Oct 1, 2008)
  - a) Definition of triage v. MSE
  - b) On-call requirements and telemedicine
  - c) Labor and Infant requirements
    - i. Interaction of EMTALA and the Born-Alive Infants Protection Act of 2002
  - d) “Parking” of EMS patients
  - e) Recipient Hospital Obligations: Specialized Capacities
  - f) Waiver of EMTALA in areas covered by Public Health Emergency

# 2009 changes/clarifications

## 1. Definition of triage v. MSE

### a) MSE

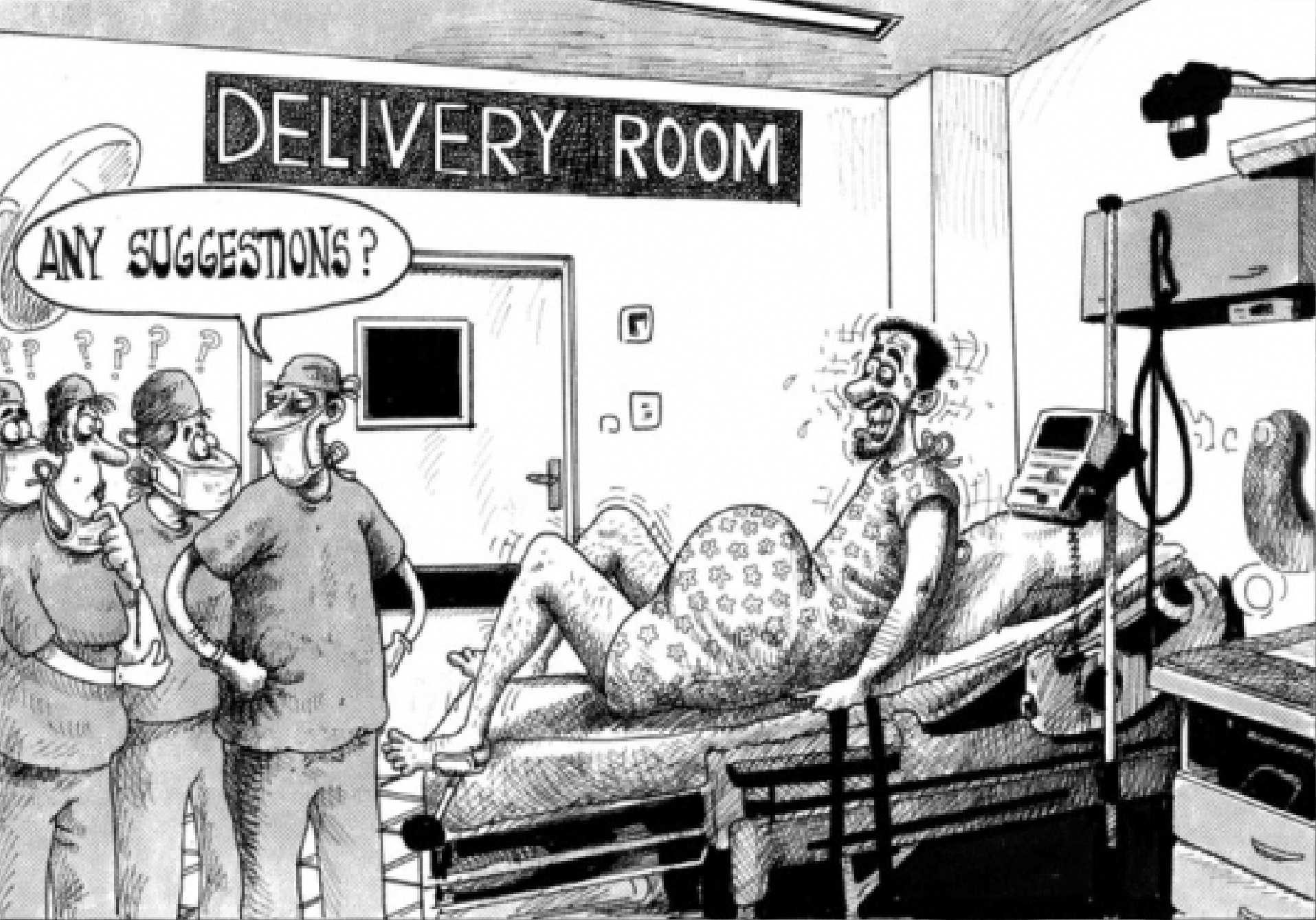
- i. Process required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an EMC or not
- ii. Must be appropriate to presenting signs and symptoms within capability and capacity of the hospital
- iii. Not an isolated event
- iv. Ongoing process that begins but does not end with triage
- v. On-going monitoring required

### b) Triage (is not considered MSE)

- i. Clinical assessment of individual's presenting signs/symptoms upon arrival in order to prioritize when patient will be seen by Physician or QMP

# 2009 changes/clarifications

1. On-call requirements: Physician/telemedicine
  - a) 2008 – telemedicine consults are allowed with physician who may or may not be on the on-call list.
  - b) If on-call physician is requested by on-site physician to come in physically to the hospital, the on-call physician must come. If the physician on the on-call list fails to appear, hospital and physician might be have EMTALA violation.



# 2009 changes/clarifications

1. Labor and Infant requirements
  - a) Interaction of EMTALA and the Born-Alive Infants Protection Act of 2002
  - b) If an infant is born alive in a hospital's ED or related unit, such as OB, or elsewhere on hospital's campus, EMTALA applies to the infant.
  - c) So if request is made on infant's behalf for an MSE or if prudent layperson would think that such an MSE should be done, EMTALA rules for MSE and stabilization apply

# 2009 changes/clarifications

1. “Parking” of EMS patients
  - a) Hospitals that deliberately delay moving an individual from an EMS stretcher to an ED bed do not thereby delay the point in time at which their EMTALA obligation begins
  - b) “Parking” patients arriving by EMS, refusing to release EMS equipment or personnel, jeopardizes patient health and adversely impacts the ability of EMS personnel to provide emergency response services to the community
  - c) Hospitals could be in violation of COPS
  - d) Does not mean that hospital will have violated COPS/EMTALA if it does not, in every instance, immediately assume from EMS all responsibility for individual regardless of other circumstances in ED.  
(capacity or capability issues)

# 2009 changes/clarifications

1. Recipient Hospital Obligations: Specialized Capacities
  - a) A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or, in rural areas, regional referral centers) may not refuse to accept from a referring hospital within the US an “appropriate transfer” of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.
  - b) Applies whether or not hospital has DED

# 2009 changes/clarifications

1. Recipient Hospital Obligations: Specialized Capacities (cont.)
  - c) Assumes that recipient hospital has capacity/capability and transferring hospital lacks capacity or capability
  - d) A hospital with specialized capabilities that has necessary capacity to treat an individual with EMC may not condition, or attempt to condition, its acceptance of an appropriate transfer on the use by the sending hospital of a particular transport services instead of the transport arrangements made by the attending physician at the sending hospital.

# 2009 changes/clarifications

1. Waiver of EMTALA in areas covered by Public Health Emergency
  - a) Waiver of certain sanctions for inappropriate transfer in national emergency
  - b) A waiver of these sanctions is limited to a 72 hour period beginning on the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease, the waiver will continue until the termination of the applicable declaration of a public health emergency
  - c) Need to update disaster plan with guidance material

# Current caselaw

## 1. Current Case-law

- a) Woman wins \$200K for hospital EMTALA violation –
  - i. Lorraine MORIN v. EASTERN MAINE MEDICAL CENTER, Defendant. No. CV-09-258-B-W - United States District Court, D. Maine
  - ii. Plaintiff brought action EMTALA when she was discharged from hospital against her wishes after tests determined that her 16-week old fetus was dead. One issue was whether nurse could testify as an expert as to whether patient was having contractions when discharged and as to potential complications patient may have faced related to a nurse's view of signs, symptoms and processes denoting patient's health needs or reaction to an actual or potential health problem, but nurse could not opine as to correctness of physicians' diagnosis or as to whether hospital complied with EMTALA; nurse was not licensed to arrive at a medical diagnosis under Maine law, and she was not an expert in EMTALA.

# Current caselaw

## 1. Current Case-law

- a) St. Joseph's Hospital and Medical Center in Phoenix.
- b) Admit of a young mother – hospital ethics committee decided that the fetus must be aborted to save mother's life.
- c) Church – excommunicated nun and issued statement against the hospital condemning the action
- d) ACLU got involved to discuss issues with religious hospitals and whether or not EMTALA applies –
- e) ACLU - EMTALA applies to all patients – even in religious hospitals

# Questions or Comments Please contact:

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