NAVIGATING THE MAZE

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EMTALA: Requirements, Challenges, and Penalties

The Emergency Medical Treatment & Labor Act (EMTALA) was enacted in 1986 to make sure that individuals have access to emergency services regardless of their ability to pay. The Act requires that Medicare-participating hospitals who offer emergency services provide a medical screening examination for the treatment of an emergency medical condition regardless of an individuals' ability to pay.[1] If an emergency medical condition is identified during the screening, the hospital must stabilize the patient or if the hospital does not have the capacity to provide stabilizing treatment, or if the patient requests, arrange for an appropriate transfer.[2] Hospitals who have specialized capabilities to treat the emergency patient must accept the transfer.

EMTALA applies to hospitals who have "dedicated" emergency departments.

This includes,

> ...a licensed emergency room or department; a department that is held out to the public as a place that provides emergency care without requiring a prescheduled appointment (e.g., an Urgent Care center, labor or delivery unit, or mental health unit); or a department in which at least one-third of its outpatient visits for emergency care during the prior year were provided without pre-scheduled appointments."[3]

Unique Challenges

Recent Compliance Today articles point out unique challenges with EMTALA compliance related to two types of populations; the homeless and behavioral health patients in crisis. Both of these characteristics could exist in the same population. Be sure that all employees, clinical and non-clinical understand EMTALA rules. They may encounter patients who are outside of the emergency room but within 250 yards of the main building. Patients must be seen and provided a medical screening exam each time they present even if they were just discharged a couple of hours before or if they are experiencing an unmanaged mental health crisis within 250 yards of the hospital.[4]

According to McCullough and Morgan, statistics reveal that homeless individuals are more likely to use the emergency room, which may cause a perception that they are "super-utilizers", well known to hospital staff and may lead to a relaxation of EMTALA policies especially if they were seen recently.[5] Some additional steps that may be helpful to consider when working with the homeless population might include developing an enhanced discharge planning process to improve the coordination with post-acute providers, pharmacies, homeless shelters, social services and community resources along with weather-specific policies for post-discharge transportation to promote safety when it is very cold outside or other dangerous weather conditions exist.[6]

Individuals with behavior health concerns can be challenging to transfer due to "...a lack of inpatient and community services, insufficient insurance coverage, and a shortage of qualified providers to treat behavioral health patients."[7] Developing policies and procedures to appropriately treat these types of patients is important. These policies and procedures should include screening and stabilization, providing care and treatment to those boarded in the emergency department, and outlining when and how to transfer patients.[8]

Penalties

Both hospitals and physicians are at risk for fines related to non-compliance with EMTALA rules. Hospitals can be fined $50,000 per violation, may be sued by an individual who feels they have been damaged by the violation including patients and other medical facilities, and the hospital could be at risk of losing their Medicare provider agreement.[9] Physicians can also be at risk. Those who violate EMTALA may be fined up to $50,000 for each violation.[10]

The Office of Inspector's (OIG) website summarizes nine cases that resulted in fines in 2018. Below is a summary of five of those cases. Additional information related to each of the cases below can be found at https://oig.hhs.gov/fraud/enforcement/cmp/cmp-ae.asp.

A hospital in Tennessee paid $25,000 to settle allegations that it failed to provide an appropriate medical screening examination within its capability, including ancillary services that were routinely available to determine if the patient had an emergency medical condition. This occurred when a nurse directed the patient to a local eye doctor after the patient complained of blurred vision and dizziness when it was later determined that the patient had a cerebral infarction.

In Iowa, a medical center paid $90,000 after it was alleged they did not provide an adequate medical screening exam or stabilizing treatment and inappropriately transferred the patient to another hospital. In this case, an on-call cardiologist directed an ED physician to begin transcutaneous pacing. The ED physician then requested that the patient be transferred to another facility for placement of a transvenous pacemaker. The on-call cardiologist did not come in nor was he requested to see the patient even though it was alleged that the on-call cardiologist was capable of providing the transvenous pacemaker instead of transferring the patient.

After directing an ambulance that had already arrived on hospital property to take a patient to another hospital, a North Carolina hospital entered into a $52,414 settlement to resolve allegations that it failed to provide an appropriate medical screening exam and stabilizing treatment.

Another facility in North Carolina experienced a $200,000 penalty after it was determined that they did not provide an appropriate medical screening exam, stabilizing treatment or appropriate transfers for four patients. In two of the cases, the decision to transfer had been made but the actual transfers did not happen until several hours later and neither patient was re-evaluated to determine if the medical benefits outweighed the risk of transfer even though their conditions had deteriorated.

A Florida hospital refused to accept a transfer of a 17-year-old female who was 6 weeks pregnant with abdominal pain and an ultrasound that confirmed an intrauterine fetus with a heartbeat and a left ectopic ruptured mass. The potential accepting doctor discovered during his conversation with the transferring hospital that the patient was "out of county" and refused the transfer, a decision that led to a $42,500 settlement.

Conclusion

Take some time out of your busy schedule to check the OIG website and read the summaries of recent enforcement actions. This is a great resource to gain insight into how the Centers for Medicare and Medicaid interpret the rules and how the OIG enforces them. In the Compliance Today article, *Keys to EMTALA compliance*, Stanger outlines additional tips to avoid or minimize EMTALA liability.

Those include:

- Knowing when EMTALA applies
- Understand how EMTALA applies to ambulances
- Conduct and document an appropriate medical screening exam
- Use qualified personnel to conduct the examination
- Provide and document stabilizing treatment
- Obtain patient consent or physician certification to transfer or discharge an unstable patient
- Provide and document an appropriate transfer
- Document a patient's refusal of care
- Do not delay or discourage care
- Maintain required signs, logs, lists, and policies
- Receive transfers if you have specialized capabilities
- Respond promptly to potential violations and most importantly;
- Do what is best for the patient[11]

[1] Emergency Medical Treatment & Labor Act (EMTALA). Available from https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/

[2] Indem

[3] Stranger, K.C. (2015 May). Keys to EMTALA compliance. *Compliance Today*

[4] McCullough, A. & Morgan, R. (2018 December) EMTALA: Shelter from the storm. *Compliance Today*

[5] Indem

[6] Indem

[7] Greaves, C. & Roshelli, K. (2018, February). EMTALA and the challenges of treating behavioral health patients in crisis.

[8] Indem

[9] Ibid #3

[10] Ibid #3

[11] Ibid #3

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