The Emergency Medical Treatment and Active Labor Act (EMTALA): what it is and what it means for physicians

JOSEPH ZIBULEWSKY, MD

The Emergency Medical Treatment and Active Labor Act (EMTALA) was passed by the US Congress in 1986 as part of the Consolidated Omnibus Reconciliation Act (COBRA), much of which dealt with Medicare issues. The law's initial intent was to ensure patient access to emergency medical care and to prevent the practice of patient dumping, in which uninsured patients were transferred, solely for financial reasons, from private to public hospitals without consideration of their medical condition or stability for the transfer. Although only 4 pages in length and barely noticed at the time, EMTALA has created a storm of controversy over the ensuing 15 years, and it is now considered one of the most comprehensive laws guaranteeing nondiscriminatory access to emergency medical care and thus to the health care system. Even though its initial language covered the care of emergency medical conditions, through interpretations by the Health Care Financing Administration (HCFA) (now known as the Centers for Medicare and Medicaid Services), the body that oversees EMTALA enforcement, as well as various court decisions, the statute now potentially applies to virtually all aspects of patient care in the hospital setting. Thus, all physicians on the hospital staff, not just emergency physicians, need to be familiar with its general requirements.

This article summarizes the historical context of EMTALA and discusses the requirements of the statute both in the law's original language and in the subsequent interpretations by HCFA and the courts. It includes discussions of on-call physician responsibilities under the statute, penalties, and enforcement procedures. The emphasis is on the impact of the statute—not just on the emergency care of patients but on the hospital and its medical staff.

HISTORICAL PERSPECTIVES

In 1986 and 1987, 2 articles appeared in the literature by physicians from Cook County Hospital in Chicago detailing the extent of patient dumping to that facility (1, 2). The authors defined dumping as "the denial of or limitation in the provision of medical services to a patient for economic reasons and the referral of that patient elsewhere" (1). The majority of such transfers to Cook County Hospital involved patients who were minorities and unemployed. The reason given for the transfer by the sending institution was lack of insurance in 87% of the cases. Only 6% of the patients had given written informed consent for their transfer. Medical service patients who were transferred were twice as likely to die as those treated at the transferring hospital, and 24% of the patients were considered to have been transferred in an unstable condition. It was concluded that this practice was done primarily for financial reasons and that it delayed care and jeopardized the patient's health. This practice was not limited to Chicago but occurred in most large cities with public hospitals. In Dallas, such transfers increased from 70 per month in 1982 to more than 200 per month in 1983 (1).

The ironic twist to this story is that safeguards for indigent patients already existed; however, most were guidelines without the force of law that were being ignored by private hospitals and doctors. The Joint Commission on Accreditation of Hospitals stated that "individuals shall be accorded impartial access to treatment or accommodations that are available or medically indicated, regardless of race, creed, sex, nationality, or sources of payment for care" (3). The American College of Emergency Physicians had similar language in its bylaws (4). The Hospital Survey and Construction Act of 1946 (commonly called the Hill-Burton Act) had established federal guidelines for emergency medical care at certain hospitals, and many state laws were also on the books mandating nondiscriminatory access to emergency care (1).

The combination of reports in the professional and lay press, the obvious impotence of the laws already on the books, and the increasing presence of the federal government in all things health-care related led to the enactment of EMTALA. It is interesting to note that shortly after EMTALA was passed the same physicians who authored the study on patient dumping to Cook County Hospital commented that "monitoring, enforcement and the effectiveness of this federal law will be crippled" by its vague definitions of emergency care and stabilization (1). Although they were correct concerning the law's ambiguities, they could not have been more wrong about the impact of the law over the next decade.

THE LAW IN ITS OWN (AND HCFA'S AND THE COURT'S) WORDS

Although the initial intent of EMTALA was to ensure nondiscriminatory access to emergency medical care, its practical ramifications have broadened significantly over the years and

From the Department of Emergency Medicine, Baylor University Medical Center, Dallas, Texas.

Corresponding author: Joseph Zibulewsky, MD, Department of Emergency Medicine, Baylor University Medical Center, 3500 Gaston Avenue, Dallas, Texas 75246 (e-mail: josephz@baylordallas.edu).

Table 1. EMTALA definition of "emergency medical condition"*

The term "emergency medical condition" means—

(A) a medical 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—
  (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
  (ii) serious impairment to bodily functions, or
  (iii) serious dysfunction of any bodily organ or part; or
(B) with respect to a pregnant woman who is having contractions—
  (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
  (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

*From reference 5.

Table 2. EMTALA definition of "stabilized"*

To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely 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) [a pregnant woman who is having contractions], to deliver (including the placenta).

*From reference 5.

arise from 3 sources: the statute's original language (5); the interpretive guidelines that have been issued by HCFA, which are not merely suggestions but have the force of law; and the various federal court decisions that have resulted from alleged EMTALA violations. Because EMTALA is a federal statute, such cases are usually heard in federal courts. These include the federal district courts, the US Court of Appeals, and finally (in only one EMTALA-related case to date) the US Supreme Court.

EMTALA imposes 3 distinct legal duties on hospitals. According to the statute, only facilities that participate in Medicare are included, but this encompasses almost 98% of all US hospitals. First, hospitals must perform a medical screening examination (MSE) on any person who comes to the hospital and requests care to determine whether an emergency medical condition (EMC) exists. Second, if an EMC exists, hospital staff must either stabilize that condition to the extent of their ability or transfer the patient to another hospital with the appropriate capabilities. Finally, hospitals with specialized capabilities or facilities (e.g., burn units) are required to accept transfers of patients in need of such specialized services if they have the capacity to treat them.

THE MEDICAL SCREENING EXAMINATION

EMTALA states:

> In the case of a hospital that has a hospital emergency department, if any individual . . . comes to the emergency department and a request is made . . . for examination or treatment for a medical condition, the hospital must provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department to determine if an emergency medical condition exists (5).

Furthermore, the law prohibits any participating hospital from delaying such screening examination or further care "in order to inquire about the individual's method of payment or insurance status" (5). Recent HCFA rulings have stated that it is acceptable to obtain basic demographic information on patients prior to the MSE, even information on insurance status; however, calls for insurance verification or authorization for treatment are not included, and such information gathering should not unduly delay the MSE. Thus, requirements of EMTALA conflict with those of many managed care plans, with their emphasis on preauthorization of services, and can create significant challenges for emergency departments (EDs) trying to ensure payment for services while at the same time not wanting to run afoul of federal law. Despite managed care dictums, emergency medical care should never be delayed to wait for authorization—whether authorization for initial evaluation, for advanced tests such as computed tomography (CT) scans, for specialist consultation, or for admission, all of which can be considered part of the MSE in terms of EMTALA.

Which patients are covered by this law? The term "any individual" means just that: any person who presents for care of an EMC, regardless of whether that person is a Medicare patient or even a US citizen. Although the law was initially aimed at the protection of the indigent, it applies even to those with excellent insurance. In fact, the one Supreme Court case heard on EMTALA found that no improper financial motive must be proved to find a hospital in violation of EMTALA (6). The law applies until a qualified medical professional certifies that the person does not have an EMC or until the person's condition is "stabilized," as defined by the statute (*Tables 1* and *2*). As far as EMTALA and the federal courts are concerned, "EMC" and "stabilized" are now legally defined and not terms to be defined by a series of expert witnesses, as in civil malpractice cases. Therefore, virtually any person presenting for care in the ED should have an MSE, along with the appropriate documentation noting whether an EMC exists.

What about the phrase "comes to the emergency department"? It sounds simple enough. Someone walks in to the ED or is brought in by ambulance and has a complaint. What if a woman collapses on the sidewalk in front of the ED or gets chest pain in the hospital's gift shop? Does it matter if she is on public property at the time? What if she is 10 feet away from the ED, or 200 feet? What if the patient is in an ambulance in the parking lot? What if a man is brought to the hospital by ambulance for a radiologic procedure at the orders of his private physician but on the way through the ED is noted to not be breathing well? Which of these patients is considered to have "come to the emergency department" and therefore to be entitled to an MSE?

The answer is all of them. Although the statute states that only hospitals with an ED are subject to its rules, subsequent regulations by HCFA and court rulings have vastly extended the meaning of "emergency department." It is not limited to a designated physical space in the hospital but can refer to any area of the hospital where patients can present for the evaluation and

treatment of EMCs. As was stated by the US Court of Appeals (First Circuit) in 1999: "Patient dumping is not a practice that is limited to emergency rooms. If a hospital determines that a patient on the ward has developed an emergency medical condition, it may fear that the costs of treatment will outstrip the patient's resources, and seek to move the patient elsewhere" (7). Thus, in-hospital wards, labor and delivery, hospital-owned clinics, urgent care facilities, outpatient surgery centers, and psychiatric facilities may be included. Moreover, the HCFA interpretation guidelines expand EMTALA requirements to facilities that provide "emergency services." Thus, a "boutique" hospital (e.g., a women's hospital that has no ED but delivers babies) potentially is subject to EMTALA.

It is crucial to be aware of all the areas of the hospital where a patient can present for care and to have written protocols for when a patient presents for care on hospital property but not necessarily in the ED. Clearly, if a patient presents in the hospital's psychiatric ward for care, sending the patient to the ED for medical clearance does not constitute a formal transfer in terms of paperwork. In fact, the movement of patients between 2 areas of a hospital or facility that have the same Medicare provider number is usually not considered a formal transfer, although the hospital should have written protocols for their movement, especially for nonpatients who suffer problems on hospital property (as with Baylor's "Stat-13s").

If part of the hospital contains a clinic or service that operates under a different Medicare provider number, then movement of the patient from the hospital to that clinic is an EMTALA transfer and can only occur after an MSE is performed by the hospital and the other EMTALA requirements are met. It should be noted, however, that recent HCFA final regulations regarding provider-based status now define the hospital's "campus" to include structures and all areas that are not strictly contiguous with the main building but are located within 250 yards of it (8). In addition, the new regulations have increased the responsibilities of the staff at the hospital's satellite clinics and facilities (e.g., outpatient surgery centers, outpatient laboratories, radiological services) to include knowledge of and compliance with EMTALA requirements. Thus, a patient presenting for care at a clinic a football field away from the hospital's ED could potentially require an MSE, and the staff at that facility need to know what that entails and, if an EMC is suspected, how to formally transfer the patient to the ED for a higher level of care. In addition, as in the ED, action cannot be delayed to guarantee or collect payment. This puts a great burden on large facilities such as Baylor University Medical Center (BUMC) to ensure compliance with the law across all of its on-campus facilities.

Finally, hospital-owned and -operated ambulance services are considered part of the ED as far as EMTALA is concerned. Once a patient is inside such an ambulance, he or she is considered to have "come to the ED." However, a recent federal Court of Appeals ruling in Hawaii has extended this to include virtually any ambulance, even those run by city or county services (9). So now once the paramedics have contacted an ED and have made the staff aware of the patient's condition, a patient in any ambulance can be considered to have come to the ED.

The concept of an "appropriate MSE" also is fraught with interpretive nightmares. What constitutes this screening examination has never been specifically defined by HCFA or the courts, but a few things are clear. It does not include merely a history and physical and clearly is not fulfilled by a brief triage evaluation; it is more an ongoing process that ends only when an EMC has been ruled out or stabilized, regardless of how long it takes to stabilize the patient. Thus, laboratory tests, CT scans, and consults by specialists all can be included in the term "screening exam." For obstetric patients, an MSE includes monitoring of fetal heart tones and cervical dilation, and for psychiatric patients it includes assessment and documentation of suicide attempt or risk. For myriad other patient complaints, the overriding question becomes: Was the screening exam for similar complaints the same for all patients, regardless of their insurance status or ability to pay? Where hospital protocols exist and were followed, the courts have generally found that no EMTALA violation existed, as long as the protocols themselves did not violate EMTALA principles (10).

It sounds appealing to have reams of written protocols for every major presentation, such as chest pain and fever, but beware. Any substantive deviation from a hospital's or ED's written protocol may be considered strong evidence of an EMTALA violation and also may be used in state malpractice cases. Where no specific protocols exist, HCFA and the courts will determine if other patients with the same complaint received more thorough evaluations. If they did, the burden is on the hospital to provide justification. Since it is impossible to have written protocols for all the possible patient presentations to an ED, EMTALA makes it even more critical to document and justify the evaluation of every patient. Despite the complexities of the MSE, the courts have generally found that it does not guarantee a diagnosis but merely establishes a uniform standard of evaluation and care, thus keeping EMTALA from becoming a federal malpractice law (11–15).

The statute also does not designate who can perform the MSE but merely states that it should be "qualified medical personnel." Technically, the hospital, in its bylaws or rules and regulations, can designate personnel other than physicians to conduct MSEs.

ON CALL AND ON THE SPOT

Because on-call physicians can be responsible for patients presenting for emergency care by participating in the MSE or in stabilization, it has been interpreted that essentially all physicians with privileges at a hospital are covered under EMTALA. Before EMTALA, the on-call list was considered a responsibility of medical staff membership at a hospital. It also was a way for young physicians to build their practices. One of the problems today is that physicians in managed care plans get most referrals through their plans and no longer have a need to be on call for the hospital (17). Thus, since EMTALA, there has been a great deal of friction between on-call physicians and EDs. Many on-call physicians do not understand the ramifications of EMTALA and feel that they do not have to come in to see a patient at the "whim" of the emergency physician.

A survey of the >600 members of the medical staff at BUMC conducted in October 2000 found that only about 30% of the 249 respondents had ever heard of EMTALA (18). Of those physicians who took ED call at least monthly, only 50% had ever heard of it. HCFA guidelines require hospital EDs to have on-call lists displayed in the department daily and to maintain the

lists on file for 5 years. Although it usually falls on the individual departments to create their on-call schedules, EMTALA makes the hospital responsible for them. This is usually accomplished through hospital bylaws. What constitutes an "appropriate" call list? Generally, any service that the hospital routinely offers must be represented on the list. Thus, if the hospital does not do orthopaedic surgery or have a psychiatric unit, then these physicians need not be on the call list. Since virtually all services are performed at BUMC, the on-call list is extensive.

What if a smaller hospital offers orthopaedic surgery but has only 1 or 2 orthopaedists? HCFA uses a rule of three. If there are ≥3 specialists on staff, the call list must include them daily. If there are <3, the hospital can have them on call intermittently—for example, every second or third day—as long as its bylaws state this. What if the hospital performs complicated spine surgeries but the particular orthopaedist on call when such surgery is needed states that he does not do backs and requests that the patient be transferred elsewhere? This can be considered a violation, especially if HCFA investigates and finds evidence that spine surgeries are done at the hospital but this patient was refused such care. Since EMTALA makes it the hospital's, and not the individual physician's, responsibility to establish on-call panels, the hospital is ultimately responsible if services it normally provides are not covered on those panels. Thus, to remedy this situation, the hospital might need to establish a separate on-call list for spine problems.

On-call physicians need to realize that when they are on call, they represent not their group or even themselves but the hospital. Thus, if a medical problem for which they have been asked to consult in the ED is beyond their particular scope of practice but is a problem commonly cared for at that hospital, it may be considered their responsibility to find someone to care for the patient.

EMTALA citations have been made because the on-call physician either failed to appear when called or appeared late, which has generally been accepted to be >30 to 60 minutes after being called. Although this time is not a rule according to HCFA, New Jersey and West Virginia have state laws mandating an ED specialty consultation within 30 minutes of being called (19). Should the on-call physician refuse to appear or appear late, the emergency physician is responsible for reporting this to HCFA. In addition, if it is well documented in the chart that all efforts were made to obtain on-call consultation (e.g., calling the head of the department or the hospital administrator), the ED physician should not be subject to sanctions for transferring the patient in unstable condition. If the patient has to be transferred because the on-call physician does not report, EMTALA requires that the name of the physician be placed on the transfer form. The receiving hospital has an obligation to report the physician to HCFA. The physician is subject to civil fines (up to $50,000) and potential malpractice liability, as well as possible exclusion from Medicare.

On some occasions, on-call physicians may request that the ED physician send the patient from the ED to their office for further care. This is a common practice among ophthalmologists, since they have specialized equipment in their offices to examine the eye, and in fact may afford the patient a better evaluation than if it were done in the ED. If the patient's condition has been stabilized, according to the EMTALA definition, and the documentation supports this, then sending the patient elsewhere for further care is not a formal transfer as far as paperwork is concerned. However, if the patient's condition has not been stabilized, then sending him to a private doctor's office does constitute a formal transfer; appropriate paperwork and consents must be obtained, and it must be well documented that the benefits offered in the private doctor's office outweigh the risks of the transfer. For instance, if the patient has a displaced fracture and the orthopaedist instructs the ED physician to send the patient to his office, it might be considered a violation if the fracture was not reduced first, since the office care was not truly follow-up in nature but stabilizing.

Another potential liability issue is the private physician who is called by the ED staff when one of his patients arrives in the ED and requests that the patient be put in a room so he can examine the patient. Unless the patient requests to be examined only by his own physician and this is documented in the chart, a lengthy delay until the private physician arrives could be interpreted as delaying the patient's MSE. This is rarely a good idea, and all attempts should be made to have the patient seen, either by his private physician, or, if there is any delay over 30 minutes, by the ED physician.

STABILIZE OR TRANSFER?

The second EMTALA mandate states that if the patient is found to have an EMC, as defined by the statute, the hospital must provide "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 for transfer of the individual to another medical facility" (5). Furthermore, if the EMC has not been stabilized, the hospital may not transfer the individual unless: 1) "the individual . . . requests transfer to another medical facility" after being informed by the hospital of the risks of transfer and of the hospital's obligation to stabilize; or 2) "a physician . . . has signed a certification based upon the information available at the time of transfer [that] the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child." Finally, the transfer, as defined by the statute, must be "appropriate" *(Table 3)*.

The crucial issue in this duty is the definition of "stabilized." "Stabilized" means that within reasonable medical certainty, "no material deterioration" should occur from or during the transfer (5). Like the MSE, stabilization is a process and could require several days or even weeks of hospitalization. In addition, HCFA and the courts may interpret the term so narrowly that almost any patient could potentially be considered unstable. For instance, a patient with significant pain on discharge from the ED, the cause of which has not been determined from the MSE, could be considered medically unstable, as has been established in at least one Court of Appeals case (20). The courts, however, as with rulings on the MSE, have kept the issue of stabilization from becoming a malpractice issue by generally ruling that hospitals and physicians must first be aware of the presence of an EMC before they are obligated to stabilize it (14, 15, 21–23) and that the hospital is required only to stabilize, and not cure, the EMC

Table 3. EMTALA definition of "appropriate transfer"*

An appropriate transfer to a medical facility is a transfer—

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility—
  (i) has available space and qualified personnel for the treatment of the individual, and
  (ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies), related to the emergency condition for which the individual has presented . . . 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;

(D) in which the transfer is effected through qualified personnel and transportation equipment . . . ; and

(E) which meets such other requirement as the Secretary [of Health and Human Services] may find necessary in the interest of the health and safety of individuals transferred.

*From reference 5.

(24). Again, the overriding issue is not the actual diagnosis, as with state malpractice cases, but the process used to assess the patient and its nondiscriminatory nature.

Under EMTALA no actual injuries need be proven to lose a case in federal court. It is commonly likened to a speeding ticket. No one has to be hurt for a driver to get a ticket for speeding. Thus, all transfers are fraught with potential liability. If it can be shown that deterioration might have occurred during the transfer and the benefits did not outweigh the risks, then the hospital and transferring physician could be found liable.

As a tertiary care facility, BUMC has the capabilities to stabilize most conditions and treat most patients. One of the few exceptions is when a critically ill child is brought to the ED; such patients usually need to be transferred to Children's Medical Center for a higher level of care. Despite the liability risks inherent in transferring a patient, the ED physician must remember that the reason for EMTALA is to prevent patient dumping, not to prevent patients from going to a medically appropriate facility for their EMC. So, for instance, if the only general surgeon in a small rural hospital has a broken hand, a patient with a ruptured appendix will need to be transferred to another facility. The hospital would just need to ensure that 2 hours later, when the next patient with a ruptured appendix came in (and had great insurance), its surgeon had not suddenly made a miraculous recovery.

One usually thinks of transfers in terms of sending the patient to another facility, but any discharge home from the ED (or actually from any part of the hospital) is interpreted as a transfer. It is assumed that the ED physician's evaluation concluded that the patient either had no EMC or that the EMC had been stabilized. It also is assumed that the documentation reflects this. For example, if pneumonia was diagnosed in a patient, the administration of antibiotics prior to discharge would be documented, along with normal vital signs and pulse oximetry findings, indicating that the patient's condition was stable. Instead of a transfer document, discharge instructions would be given. Thus, technically, patients sent home who have bad outcomes may seek legal recourse against the hospital through the EMTALA statute if they can show that they were discharged in an unstable condition. Only hospitals can be sued for EMTALA violation in federal court (although physicians can have civil monetary penalties levied against them by HCFA—see under EMTALA Violations).

Finally, even sending the patient to another facility for testing with the intent to accept the patient back is considered a transfer. For instance, if the ED's CT scanner is down, the patient may be transferred to another hospital for a scan if the benefit of the scan outweighs the risk of the transfer, but appropriate paperwork must be done, consent obtained, and notification made. The same is true of some outside psychiatric facilities, such as Timberlawn, that transfer their patients to an ED for testing for medical clearance before taking them back.

Once the decision is made to transfer the patient, there are yet more EMTALA requirements. First, the physician must obtain the patient's consent for the transfer, explaining the reasons, risks, and benefits. This must be documented on a patient transfer form. If the patient refuses the transfer, this also must be documented. Then, a receiving hospital must be found, be contacted by the physician, and accept the transfer. Sometimes this is an easy task, if prior transfer agreements between hospitals are in effect, but at times, it may be difficult to find a hospital to accept the transfer (see under Reverse Dumping). The medical records and all laboratory tests and radiographs must be copied and sent with the patient. It is permissible to send the patient without all test results if some are still pending, if delaying the transfer to wait for them would jeopardize the patient. Finally, an appropriate transfer team must be called. This may consist of paramedics from a commercial ambulance company in the case of patients in reasonably stable condition, or it might require the services of more specialized transport teams, such as a neonatal or pediatric team or even one with a physician on board for those who are exceptionally ill. The ED physician must also decide if helicopter transport is necessary, as in sending someone with an acute myocardial infarction to another hospital for cardiac catheterization. Any discrepancy or problem with any of these steps may result in EMTALA liability.

REVERSE DUMPING (THE BEST COME TO BAYLOR . . . IF THERE IS A BED)

The third EMTALA mandate states that "a participating [i.e., Medicare] hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, and neonatal intensive care units) . . . shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities . . . if the hospital has the capacity to treat the individual" (5). This section of the statute has come to be known as the reverse-dumping provision, which prevents specialized hospitals, such as BUMC, from accepting in transfer only those patients with the ability to pay for their services. Thus, when an outside ED contacts the BUMC ED to request a transfer, no questions can be asked about insurance status, just as if the patient had arrived at BUMC on his or her own. The only considerations that may be

made before accepting the patient are whether BUMC has the ability to care for the patient's problem and whether it has the capacity (i.e., bed space) to receive the patient. If the answers to both questions are yes, then BUMC cannot refuse the transfer; if it does, it would be subject to a HCFA investigation if the other hospital thinks it is refusing on grounds not related to ability or capacity.

There are 2 interesting caveats. First, the definition of "capacity" is not fixed. Receiving hospitals that claimed they were at capacity were later found in violation of the law because they kept an open bed in the intensive care unit for patients in the ward whose condition deteriorated, and that bed could have been used for the transfer (25). Thus, any hospital must carefully review its policy on capacity. For an ED to justify being at capacity, it should have gone on some form of official ambulance diversion prior to refusing the transfer. Second, if the sending hospital decides to ignore the refusal and send the patient anyway, it is in violation of EMTALA, but once the patient reaches the other hospital's doors, the receiving hospital is obligated to care for the patient as it would any patient coming to the hospital. The receiving hospital is obligated to report the sending hospital to HCFA within 72 hours, but it must care for the patient within its capabilities. If there is some question as to the legitimacy of the transfer (i.e., the receiving hospital thinks it was "dumped on"), it should be addressed by the receiving hospital's administration later.

The statute also includes sections on the ability of patients to refuse treatment and transfers, both of which should be secured in writing by the hospital from the patient. It also specifically states that the statute does not preempt state laws, "except to the extent that the requirement directly conflicts with a requirement of [EMTALA]" (5). It allows patients who have suffered personal injury due to a violation of the statute to obtain damages in civil court in the state where the hospital is located. Thus, the law respects individual states' statutes, but if the state's law requires less of a mandate, the federal law supersedes. It also allows hospitals that have suffered financial losses as a direct result of an EMTALA violation to seek damages in court against the violating hospital. It contains a section on "whistleblower protection" to prevent a participating hospital from taking action against a physician for refusing to carry out an inappropriate transfer or against any hospital employee for reporting violations of the law. Finally, the law establishes a statute of limitations of 2 years after the date of the violation to bring an action. In its 1994 regulations, HCFA also requires hospital EDs and any areas of the hospital where an MSE can be provided, such as labor and delivery, to post a sign, visible from 20 feet away, specifying the rights of individuals with regard to examination and treatment under EMTALA and to state whether the hospital accepts Medicaid.

EMTALA VIOLATIONS: WHAT IF HCFA SHOWS UP AT THE DOOR?

The statute, of course, contains specifics on enforcement and penalties. While investigations of violations are the responsibility of HCFA, enforcement of penalties and citations falls under the Office of the Inspector General of the Department of Health and Human Services. Participating hospitals and physicians who negligently violate the statute are subject to a civil monetary penalty not to exceed $50,000 (or $25,000 for hospitals with <100 beds) for each violation. Because a single patient encounter may result in >1 violation, fines can exceed $50,000 per patient. It is important to note that most physician malpractice policies will not cover such administrative penalties; thus, the physician might have to pay them out of his or her own pocket. The defense costs to the physician might be covered. More importantly, hospitals and physicians are liable to be denied participation in the Medicare program, a rarely instituted but potentially fatal loss for either. Since 1986, HCFA has terminated 13 hospitals from Medicare, and all but one termination occurred prior to 1993 (the single termination since then was voluntary) (26). Since 1994, on average, HCFA has conducted about 400 EMTALA investigations per year. To date, about one third of all US hospitals have been investigated by HCFA for alleged violations of EMTALA law and, of those, one third have been cited by the Office of Inspector General (27).

As the federal government has become more interested in fraud and abuse in health care, the number of EMTALA violations and settlements has risen significantly. In 1987, there were 13 documented violations; in 1997, there were 174 (26). The monetary penalties are also on the rise. During the 10-year period from 1986 to 1996, the government collected $1.45 million. During 1997 to 1998, it collected >$2 million (26). Inappropriate transfers accounted for about half of these penalties, with failure to provide an MSE accounting for another 20%. Another 16% were for not stabilizing a patient's condition prior to transfer, and 12% involved delay or refusal to treat based on financial considerations (27). Thus, enforcement has not been a problem with EMTALA, unlike the laws that preceded it. What happens when a possible EMTALA violation is reported and what a hospital and ED can expect are outlined in this section.

First of all, how is an investigation started? Quite simply, any citizen, physician, or hospital may report a possible EMTALA violation. The complainant may even be a malpractice attorney who sees a potential EMTALA violation and advises a client to file a complaint on that issue prior to proceeding with the state malpractice claim. The interesting thing about this angle is that the malpractice attorney can often use much of the information gathered by HCFA in his or her investigation to pursue a civil malpractice case. All complaints are forwarded to the appropriate HCFA regional office, and the regional office then refers the complaint back to the state's HCFA survey agency if it feels an investigation is warranted. The agency then has 5 working days to initiate an investigation; it usually tries to conclude the investigation within 15 days. Thus, the hospital has little time to prepare. The accused hospital and physician do not get any advance announcement of an investigation until HCFA representatives show up at the door.

There is also little in the way of due process for the accused hospital and/or physician. Complainants do not have to give their names and, if they do, are guaranteed anonymity during the investigation. In addition, the burden is on the hospital either to prove it did not violate the statute or, if it did, to show that it has established a plan of correction to prevent future violations. The investigatory team is first assembled, consisting of officials from the state survey agency and possibly other federal officials such as agents of the Federal Bureau of Investigation or federal marshals, as well as physicians and nurses experienced in both

Table 4. List of documents required by HCFA during an investigation*

1. Emergency department registration log for the past 6 months
2. Emergency department policy and procedure manual
3. Emergency department transfer log
4. Emergency department committee meeting minutes for the past 12 months
5. Emergency department physicians' schedule for the past 3 months
6. Emergency department nurses' schedule for the past 3 months
7. Medical staff bylaws/rules and regulations
8. Current medical staff roster
9. Physicians' on-call staff roster
10. Credentials files
11. Quality assurance plan
12. Quality assurance meeting minutes for the past 6 months
13. List of contracted services
14. Emergency department personnel records
15. Emergency department in-service training records
16. Ambulance trip reports and memoranda of transfer
17. Closed medical records
18. Number of transfers per month for the 6 preceding months
19. Number of patients seen in the ED for the 6 preceding months
20. Incident reports/complaint file summaries
21. Other documents as requested

*From reference 28.

EMTALA law and peer review procedures, usually specific to the specialty being investigated.

The first order of business is the entrance conference, usually held with the chief executive officer/president of the hospital. At that time, the hospital will be asked for records and documents needed for the investigation *(Table 4)* (28). These documents are not limited to the index case but are all encompassing, including ED meeting minutes, personnel records, and incident reports. The investigators are concerned not so much with whether a violation took place in the index case as with whether the hospital is in general compliance with the law. Thus, the information they gather covers just about any issue that could indicate noncompliance.

The investigators will then request that 20 to 50 patient charts be pulled. They (not the hospital or physician) will select these charts based on the index case and will tend to pull high-risk patients, such as those transferred out of the facility, return cases, patients leaving against medical advice, and patients who refuse treatment. They will look for patterns of noncompliance and discrimination in such areas as diagnosis (e.g., AIDS), race, color, insurance type, handicap, or nationality. Interviews with appropriate staff also may be conducted. After the fact-finding is over, an exit interview is conducted with the same principals who were present at the entrance interview.

At no time during this interview is the hospital representative told if a violation occurred. This is because the survey agency still must turn over everything to the regional office for final peer review and disposition, usually in 10 to 15 working days from the conclusion of the investigation.

After the peer review process, the regional office issues its findings, which fall into 4 categories. First, it may find that the complaint was not substantiated and drop the case outright. Again, the regional office's main aim is not in finding out if there was a violation in the index case but in finding areas of general noncompliance with the law. So the hospital may win the battle of the index case and lose the war for compliance if the investigation team finds other evidence during the investigation.

Second, the regional office may find that the hospital was "in compliance, but previously out of compliance." That is, the hospital on its own identified and corrected the problem.

Third, the regional office may recommend termination of the hospital's Medicare provider agreement in a 90-day track. Usually this means that significant noncompliance issues were identified but that they do not pose an immediate threat to patient health and safety. This is not a fatal edict and may be remedied if the hospital takes quick and appropriate actions to correct the problems.

Finally, the hospital may be served notice that it will be terminated from Medicare in 23 days if the deficiencies are deemed an immediate threat to patient safety and health. This usually means that the hospital failed to provide stabilizing treatment, improperly transferred patients, or denied an MSE in some form or that an on-call physician failed to see the patient when called. The hospital CEO will receive a letter from HCFA indicating the date of termination. The hospital is encouraged to provide evidence (in 23 calendar days, not working days) that the findings of the regional office are in error or present an acceptable plan of correction and pass a subsequent survey within the 23-day period. If the evidence is compelling, the regional office will suspend the termination date and hold another survey. If the evidence does not meet regional office approval, the hospital is terminated. If the hospital is terminated from Medicare, it is also required to pay for an announcement in the local newspaper notifying the community of the penalties.

Of course, the hospital has legal recourse: it may file an appeal with the federal district court, but while the appeal is being processed, the hospital's termination from Medicare continues. Thus, it is in the hospital's best interest to satisfy the requirements of the regional office as quickly as possible. In reality, HCFA does not want to shut down hospitals. It only wants to bring them into compliance with the law and, therefore, is inclined to work with the hospitals. The bottom line is that, just as you would prefer not to have the Internal Revenue Service audit your taxes, you would prefer not to have HCFA investigate your hospital.

CONCLUSIONS

Despite its initial intent as a nondiscrimination bill, EMTALA has far-reaching implications for all aspects of emergency care of patients. Although unambiguous in its intent, it is inherently ambiguous in its interpretations and has as many unforeseen ramifications as there are limitless presentations of disease in the ED.

One important consequence is monetary. According to the American Hospital Association (AHA), in 1996 about 16% of ED patients were uninsured (29). The ED is the portal of entry for as many as 3 of every 4 uninsured patients admitted to the nation's hospitals (30). Traditionally, uncompensated care was recouped by charging more for services for the insured. Through such cost-shifting, hospitals were able to provide care for the

indigent and stay financially solvent. However, prospective payment systems, diagnosis-related groups, and health maintenance organizations have hindered hospitals' abilities to continue this practice. The uncompensated costs to emergency physicians for services provided under EMTALA were estimated to be $426 million in 1996, and the costs to hospitals for uncompensated inpatient care is a staggering $10 billion (30).

In addition, the number of uninsured in the country continues to rise, with many more being the "working poor." From 1988 to 1996, the number of working people with employer-sponsored health care coverage dropped from 72% to 58% (31). These people go to the ED for much of their acute care. This helps to explain the 25% increase in ED visits during the same period. In 1998, 3.4% of children under the age of 18 were reported to use the ED as their usual source of health care (32). Add to this the fact that the number of EDs in this country has decreased over the same period, and financial strains on the remaining departments and hospitals to provide indigent care and stay financially afloat become critical. Studies have shown that the bulk of this financial strain falls on urban and rural hospitals, the former becoming overcrowded and the latter unable to financially compete and thus threatened with closure (29).

Recently, HCFA has begun to consider such uncompensated care in its reimbursement formulas for emergency physicians. However, until there is some guarantee of insurance coverage for all Americans, our system of EDs will continue to be the "safety net" that protects people from catastrophic medical problems, and EMTALA will continue to be the government's guarantee that the system will work in the best interest of those people.

A well-versed knowledge of the law is a requirement for anyone who treats hospital patients in an emergency situation. Despite the fear that EMTALA can put in the hearts of health care workers, providers need not be afraid to treat, discharge, or transfer patients if they place the health and welfare of the patient above all other considerations and act accordingly. Those hospitals and physicians who "do the right thing" and practice good medicine that puts the patient's interests first will, generally, not have to worry about being on the wrong side of the law. Certainly, anyone may file a claim, but with good intent (and a lot of good documentation) emergency care providers and departments should prevail if there was no violation.

1. Ansell DA, Schiff RL. Patient dumping. Status, implications, and policy recommendations. *JAMA* 1987;257:1500–1502.
2. Schiff RL, Ansell DA, Schlosser JE, Idris AH, Morrison A, Whitman S. Transfers to a public hospital. A prospective study of 467 patients. *N Engl J Med* 1986;314:552–557.
3. Joint Commission on Accreditation of Hospitals. *Accreditation Manual for Hospitals/85*. Chicago, Ill: Joint Commission on Accreditation of Hospitals, 1984.
4. American College of Emergency Physicians. Emergency care guidelines. *Ann Emerg Med* 1982;11:222–226.
5. Examination and treatment for emergency medical conditions and women in labor. 42 USC 1395dd (1986). Available at http://www.medlaw.com/statute.htm (accessed July 2001).
6. *Roberts v. Galen*, 119 SCt 685 (1999).
7. *Lopez v. Hawayek*, 98 F3d 1594 (1st Cir 1999).
8. 59 *Federal Register* 32120 et seq. (1994) (codified at 42 CFR 489.24).
9. *Arrington v. Wong*, No. 98-17135 (9th Cir 2001).
10. Frew SA. Introduction to patient transfer regulations. In *Patient Transfers: How to Comply with the Law*. Dallas: American College of Emergency Physicians, 1995:1–2.
11. *Gatewood v. Washington Healthcare Corporation*, 933 F2d 1037 (DC Cir 1991).
12. *Baber v. Hospital Corporation of America*, 977 F2d 872 (4th Cir 1992).
13. *Collins v. DePaul Hospital*, 963 F2d 303 (10th Cir 1992).
14. *Brooks v. Maryland General Hospital*, 996 F2d 708 (4th Cir 1993).
15. *Williams v. Birkeness*, 34 F3d 695 (8th Cir 1994).
16. American College of Emergency Physicians. Appropriate interhospital patient transfers. *Ann Emerg Med* 1993;22:766.
17. Groth SJ, Begley D, et al. Emergency department back-up panels: a critical component of the safety net problem. In Fields W, ed. *Defending America's Safety Net*. Dallas: American College of Emergency Physicians, 1999:25–28.
18. Zibulewsky J. Ignorance of the law is no excuse. Knowledge of the statute by the medical staff of a large, tertiary-care hospital. *Ann Emerg Med* (submitted for publication, May 2001).
19. Glauser J. Screening examinations, stabilization, and the law. *Emergency Medicine News* 2000(June):26.
20. *Power v. Arlington Hospital*, 42 F2d, 3d 854 (4th Cir 1994).
21. *Urban v. King*, 43 F3d 523 (10th Cir 1994).
22. *Holcomb v. Monahan*, 30 F3d 116 (11th Cir 1994).
23. *Eberhardt v. The City of Los Angeles*, 62 F3d 1253 (9th Cir 1995).
24. *Green v. Touro Infirmary*, 992 F2d 537 (5th Cir 1993).
25. Frew SA: 78.
26. Department of Health and Human Services, Office of Inspector General. *The Emergency Medical Treatment and Labor Act. The enforcement process* (Pub. no. OEI-09-98-00221). January 2001. Available at http://oig.hhs.gov/oei/summaries/b510.pdf (accessed July 2001).
27. Levine RJ, Guisto JA, Meislin HW, Spaite DW. Analysis of federally imposed penalties for violations of the Consolidated Omnibus Reconciliation Act. *Ann Emerg Med* 1996;28:45–50.
28. Health Care Financing Administration. Appendix V—Interpretive guidelines and investigative procedures for responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual* (Pub. 07). May 1998. Available at http://www.hcfa.gov/pubforms/07_som/somap_v_001_to_012.htm (accessed July 2001).
29. Fields W. Defining America's safety net. In Fields W, ed. *Defending America's Safety Net*. Dallas: American College of Emergency Physicians, 1999:5–14.
30. Fields W. Defending America's safety net. *ACEP News* 2000;19(4):1–6.
31. *ACEP News* 2000;19:3.
32. Hodge D III. Managed care and the pediatric emergency department. *Pediatr Clin North Am* 1999;46:1329–1340.