drafting a proposal to limit EMTALA and prevent expansion of the law to include provider-based facilities. The AMA is advocating for Medicare and private insurers to pay for the EMTALA required screening and stabilizing of patients.

Managed care has been a significant deterrent to EMTALA implementation. Administrative barriers interfere with patients getting the care they need in an emergency. Payment for emergency services is based solely on discharge diagnoses. This "retrospective" denial places a financial burden on emergency departments because a complete evaluation and testing may easily have been justified by the presenting symptoms (e.g., chest pain turns out not to be a heart attack).

Senators Graham (D-Florida) and Chaffee (R-Rhode Island) have introduced the "Access to Emergency Medical Services Act of 2001", which would require insurers to cover screening and stabilization treatment without prior authorization. Several states have enacted legislation in support of these mandates. In California, the Bergeson Bill stipulates that emergency departments provide initial stabilizing treatment without pre-authorization telephone calls and requires that managed care pay for that care.

EMTALA violations

EMTALA violations may bring a civil penalty to both physician and hospital up to $50,000 (or $25,000 for hospitals with under 100 beds) for each violation and can result in exclusion from Medicare and Medicaid provider status. Receiving facilities can also bring suit to recover damages if they’ve suffered financial loss as a result of another hospital’s violation of EMTALA. A civil suit in a federal court may be brought by an individual to recover financial losses resulting from a hospital’s violation of the Act.

Since 1995, about 400 hospitals have been investigated and about half of them have been cited for EMTALA violations. During this period the Office of Inspector General (OIG) has imposed fines totaling over $5.6 million on 194 hospitals and 19 physicians. The majority of hospital fines were $25,000 or less with only four hospital exclusions.

"Questionable Hospitals" the sixth report by the PCHRG outlines violations from 1997-2000. They state that 527 hospitals (about 9% of all hospitals) have been cited for confirmed EMTALA violations. However most were not fined and if fined, fees paid were paltry compared to a hospital’s overall budget, doing nothing to discourage hospitals from turning needy patients into the streets.

When is it not an EMTALA violation?

A negligent screening examination, malpractice issues or cases of a patient’s refusing treatment do not invoke EMTALA violations unless evidence of hospital coercion can be offered. A poor patient outcome does not necessarily signal an EMTALA investigation and an EMTALA violation can be shown without evidence of a poor outcome.

Violations

In Oregon there have been 20 cases of confirmed EMTALA violations. Fines were paid in 10 of the cases to resolve alleged violations, with civil penalties ranging from $7,500 to $175,000.

In 1997 Legacy Good Samaritan Hospital in Portland, Oregon was cited for “failure to provide initial medical screening examinations of sufficient quality to determine if an emergency medical condition existed.” ER staff considered the triage exam equivalent to the EMTALA-required medical screening. Investigators found that ER documentation did not always support a finding that the patient had been evaluated and an emergency medical condition ruled out. To date, a penalty had not been imposed in connection with this HCFA-confirmed violation.

In 1999 Oregon Health Science University in Portland, Oregon was found to have violated EMTALA’s transfer and nondiscrimination policies. The patient presented to the initial hospital with a severe infection and frank necrosis that had exposed the bones of both feet extending to at least the knees. Osteomyelitis, diabetes and kidney dysfunction were also diagnosed. Identified treatment would have been amputation, aggressive treatment of the infection and a lengthy, complex rehabilitation. OHSU refused admission stating it was the “usual Friday afternoon dump.”

Cases of interest

In the Supreme Court’s first EMTALA case, Roberts v. Galen of Va, Inc., 525 US 249 (1999), the high court rejected the ruling of the 6th Circuit that patients had to prove an improper motive for EMTALA violations in order to sue. More importantly, the court allowed suit to proceed based on a transfer of an allegedly unstable patient to a nursing home after weeks of hospitalization, further supporting the argument that EMTALA applies to all in-house patient stability issues. The patient in this case was hospitalized for two months following a motor vehicle accident. Her guardian brought suit under EMTALA, alleging that she was transferred before her condition had been stabilized and that Galen’s administrators expedited her discharge because of her inability to pay for continued care.

The Supreme Court declined to review Baxter v. Holy Cross Hospital of Silver Spring, U.S., No. 98-1169 in 1999. They acknowledged the decision of the Fourth Circuit involving the application of EMTALA to a patient transfer. The Fourth Circuit stated that EMTALA drops from the picture once the hospital stabilizes a patient and subsequent disputes are governed by state
medical malpractice law. The issue in this case was whether a patient should not have been transferred to a nursing home 30 days after he was admitted to a hospital with cardiac and kidney problems.

In a similar case, Reynolds v. Maine General Health 1st Circuit No. 99-2153 July 17, 2000 defined claims governed by state medical malpractice law. The court upheld that a medical condition, which arises after the patient is admitted, does not constitute a current “emergency medical condition” at the time of initial presentation. The case involved a patient involved in a serious automobile accident, with a prolonged hospital course and death due to a massive pulmonary embolism. The court followed the rule in other circuits and found that these claims were for malpractice and did not state a claim under the EMTALA.

A distinction was made regarding inpatient emergencies in Lopez-Soto v. Hawayek First Circuit No. 98-1594 April 1999. The Court held that EMTALA applies to any hospital inpatient with an emergency medical condition regardless of how person enters the hospital or where he is located at the time of onset of the emergency medical condition. The newborn in this case had a severe respiratory distress, was transferred to a neonatal intensive care unit at a different hospital without being stabilized and died the next day. The court held that the stabilization provisions of EMTALA applied under these facts, even though the mother had not come to the emergency room. The court noted that the Congressional intent of EMTALA included protection for inpatients with emergency conditions from being improperly discharged or transferred in order to save costs.

Diversion of non-hospital ambulances was defined with Arrington v. Wong, 237 F.3d 1066 (9th Circuit 2001). The court found that EMTALA applies to non-hospital ambulances still enroute to a facility and that a hospital may not divert an ambulance enroute unless the hospital has declared that it is in diversionary status. The case involved a patient that died in an ambulance enroute to the hospital after being diverted to another facility. For the purposes of the law the patient presented at the emergency department when the paramedics discussed the patient with the emergency physician by radio and was diverted before arriving at the facility.²

**Rulings in favor of defendants**

An important reversal for a physician charged with failing to stabilize a patient prior to transfer was in Cherukuri v. Shalala 6th Circuit No. 97-4464 (May 1999). The Sixth Circuit reversed the ruling of an Administrative Law Judge (ALJ) of violation of EMTALA in this case involving a surgeon handling of two seriously injured patients from a small rural hospital. Using a flexible standard of reasonableness the court found the physician used his best medical judgment and that the hospital is required to stabilize patients within the resources or staff of the hospital. The $100,000 civil monetary penalty was reversed.

The court ruled in Jackson v. East Bay Hospital 9th Circuit No. 98-17152 (December 2000) that the hospital was not liable for failure to diagnose the physical cause of an emergency medical condition (drug toxicity) when it did provide stabilizing treatment of the symptoms (psychiatric manifestations) and concluded that he was stable. Courts state that the weight of authority is that “an examination does not have to be ‘medically adequate’ to satisfy EMTALA’s requirements.”³

Judgment was awarded in favor of defendant hospital in Bloomer v. Norman General Hospital (10th Circuit) No. 99-6074 July 2000. The court stated the fact that the patient received different treatment at different presentations does not raise an inference of differential care, since medical decisions may be justifiably different at each presentation.

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**References**


2. Kusske, J EMTALA: Where We Stand American Association of Neurological Surgeons, Fall 2001; 15(7) 658-70

3. California State Law Administrative, Code Title 22, Section 51056, 1995


7. http://www.uplaw.net/cases.htm

8. Federal Register Vol. 67, No. 90 Thursday, May 9, 2002

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Changes in EMTALA RULES

Many of these court cases were the impetus to re-define and clarify EMTALA regulations. On May 9, 2002 the U.S. Department of Health & Human Services (DHHS) proposed significant, major changes to the EMTALA regulations, which are expected to be adopted in early October 2002. Listed below is a summary of these changes.8

• The concept of "dedicated emergency department" was added. This would include an "emergency room," and other departments such as labor and delivery or psychiatric units, that are perceived by the public as an appropriate place for medical services on an urgent, unscheduled basis.

• Off-campus outpatient clinics that do not provide emergency services would be excluded from EMTALA regulations. If emergency services are provided at an off-campus department, written policies and procedures for appraisal of emergencies and referral when appropriate must be in place. This would be enforced under the Medicare conditions of participation, not EMTALA.

• A clarification was made between emergency services and non-emergency services. If no emergency condition exists after the determination by qualified medical personnel, the hospital's EMTALA obligation would be satisfied.

• Concerning the 250-yard rule, the new regulations exclude physicians' offices, rural health clinics, skilled nursing facilities, and other entities that participate in Medicare separately from the hospital as well as businesses such as restaurants, shops and other non-medical activities.

• EMTALA will apply to inpatients that have been determined to have an emergency medical condition and are not stabilized at the time of his/her inpatient admission to the hospital. If the patient is later stabilized, the EMTALA obligations will terminate. The changes also stipulate that EMTALA will not apply to elective admissions, regardless of the stability of the patient's condition prior to or after admission.

• Clarify that there is no requirement under EMTALA for full-time on-call coverage by a specialty. Hospitals should develop policies and procedures for when a physician in the specialty is not available or the on-call physician is unable to respond.

• Outlines that EMTALA will not apply to hospital-owned ambulances that are integrated with citywide and local community EMS networks for responding to medical emergencies.

• Prohibits hospitals and managed care from seeking prior authorization, or requiring patients to seek prior authorization for emergency services until a patient has received a medical screening examination and treatment has been initiated to stabilize an emergency medical condition.

Conclusion

The changes in EMTALA regulations will most certainly impact legislative actions and future judicial proceedings. It will be imperative for the medical and legal communities to be knowledgeable regarding these changes. Use the expertise of the Legal Nurse Consultants at Century Consulting to assist you in supporting your next case. Call today at 503-465-9796.
Amid growing concern over the availability of emergency health care services to the poor and uninsured, Congress, in 1986, enacted the Emergency Medical Treatment and Labor Act (EMTALA). Commonly known as the federal “anti-dumping law”, EMTALA was designed to address the problem of hospital emergency rooms denying uninsured patients medical care either by refusing care outright or by transferring uninsured patients to other facilities. While the language of the law is quite simple and direct, it establishes broad legal obligations relating to medical care misconduct and failure to provide appropriate treatment.

What EMTALA requires

EMTALA applies to all hospitals participating in the federal Medicare program. When an individual presents for treatment at an emergency department, the hospital is required to provide an appropriate medical screening examination to determine whether or not an emergency medical condition exists. If an emergency medical condition exists, the hospital is required to provide treatment until the patient is stabilized before discharging the patient and/or transferring the patient to another hospital.

Additionally hospitals may not delay treatment to question about methods of payment or insurance coverage. Care must be provided to all patients, not just Medicare beneficiaries, and emergency departments must post signs that notify patients and visitors of their rights to be examined and to receive treatment.

Transferring patients under EMTALA

Under the law hospitals cannot transfer patients unless the transfer is “appropriate”. A patient may request a transfer in writing after being informed of the hospital’s obligations under EMTALA. In that situation, a physician must certify that the medical benefits expected from the transfer outweigh the risks. The transferring hospital must provide the care it can, minimize transfer risks, and provide copies of medical records. Qualified personnel with necessary equipment must make the transfer. The receiving facility must have available space, qualified personnel and agree to accept the transfer.

EMTALA, the controversies

A common complaint is that EMTALA implementation is complicated and confusing, resulting in burdensome costs and reduced efficiency in emergency departments. Health care providers question how EMTALA applies to on-campus versus off-campus hospital departments and whether walk-in patients could supplant scheduled patients by claiming their conditions are emergencies.

Physician groups, such as the American College of Emergency Physicians (ACEP) are critical of the expense required to comply with EMTALA standards. The American Medical Association (AMA) is (continued on next page)