



EMTALA COMPLIANCE HIGH RISK AREA

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The Emergency Medical Treatment & Labor Act (EMTALA) grew from the 1946 Hill-Burton Free Care Program to provide Federal grants to hospitals for modernization in return for providing uncompensated services without consideration as to race, color, creed, national origin, or ability to pay. EMTALA continues with the same basic non-discrimination principles that protects against “Patient Dumping.” It imposes legal obligation on hospitals penalties to ensure that:

- All patients who come to the hospital with an emergency medical condition or in active labor receive an appropriate Medical Screening Examination.
- Patients with an emergency medical condition are stabilized.
- Patients requiring or requesting a transfer are transferred appropriately.
- The Emergency Department tracks those physicians that are on call to provide necessary treatment.
- Through adequate signage, ensure that all patients have the opportunity to review their right to medical screening examination and stabilization for an emergency medical condition.

The monetary penalty assessed for violating the law is up to \$50,000, or no more than \$25,000 for hospitals with less than 100 beds, per violation.¹ It is one of the enumerated high-risk areas identified by the Department of Health and Human Services Office of Inspector General (OIG) in their compliance guidance documents.

There are a number of EMTALA enforcement and regulatory actions taking place on a regular basis; however, there are only a relatively few that become court cases. Those resolved through the courts have resulted in inconsistent interpretation of the statute’s major provisions on appropriate standard of care with respect to the duty to perform a medical screening. This lack of uniformity has limited EMTALA’s effectiveness and in inhibiting enforcement efforts. The Centers for Medicare & Medicaid Services has attempted to clarify some parts of the provisions that caused confusion with a final rule for the Inpatient Prospective Payment System (IPPS).² In spite of this, case law continues to evidence significant problems with interpreting the scope of EMTALA’s core provisions, such as medical screening, stabilization and transfer requirements. However, there is no question that once an emergency medical condition is confirmed through medical screening, the hospital must treat that condition until the patient is stable. After the hospital provides appropriate examination and stabilizing treatment, anything else that happens to the patient as an inpatient or after discharge becomes a medical malpractice, not an EMTALA issue.

Most EMTALA cases continue to be resolved through a settlement agreement with the OIG and involve refusal to accept in their Emergency Department appropriate transfer of patients or failing to provide adequate medical screening and stabilization of patients. In the last year, there have been a number of

¹ 42 U.S.C. §1395dd. Congress enacted EMTALA under section 9121 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law No. 99-272, 100 Stat. 164-167. Medicare-participating hospitals treating individuals with emergency medical conditions, 68 Fed. Reg. 174, 53221, 53243 (Sept.9, 2003).

² Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009, 73 Fed. Reg. 161, 48434-49084 (Aug. 19, 2008). Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009, 73 Fed. Reg. 161, 48434-49084 (Aug. 19, 2008).

cases resolved this way with settlement amounts ranging from \$20,000-180,000 per case. These involved both highly prestigious hospitals, as well as others that are not, including Emory University Hospital; Donalsonville Hospital; Sacred Heart Hospital; University of Chicago Medical Center; Hackley Hospital; Southcoast Hospital Group; Duke University Hospital; Hendricks Community Hospital; Texas County Memorial Hospital; and Northside Hospital.³ Although the penalties under EMTALA are significant, many hospitals have found that private tort litigation by patients and reputational damage often creates a greater risk.

TIPS FOR COMPLIANCE OFFICERS

EMTALA cases suggest the areas of regulatory and enforcement of most interest to the federal government. Based on what is known from the past court cases, compliance officers should consider:

1. Ensure that the departments affected by EMTALA regulations have ongoing monitoring and ensure they keep current with changing rules in their operating policies, have proper training of their staff and verify everyone is adhering to them.
2. As part of ongoing auditing, ensure periodic review of all EMTALA-related policies and procedures that they adequately address legal/regulatory requirements; verify policies are followed; validate they are achieving the desired outcome and identify gaps that create a risk of noncompliance. It is critical for hospitals to adopt solid compliance policy and procedures.⁴
3. Ensure appropriate medical screening procedures are applied uniformly to all people presenting themselves in the emergency department with similar symptoms. In other words, hospitals would have to be able to demonstrate that all patients were treated uniformly.
4. Verify the hospital actually provides appropriate medical screening and follows their standards and policies; and validate that the written guidance is effective in ensuring compliance with EMTALA.

When assisting hospitals and their Compliance Officers in addressing this high-risk area, we found that each hospital organization, structure, and management varies considerably in how they address EMTALA requirements. This adds to the complexity and difficulties in proper auditing and monitoring and it will involve a number of different departments. The issue areas are also varied in that it includes hospital emergency department capabilities and capacity, central log management, qualifications of medical personnel, physician on-call list, processes for addressing signage and stabilization, admissions and transfer procedures, addressing patient walkouts, claims submissions, etc. As such, when planning to undertake oversight of this high-risk area, it is important to bring together expert resources to ensure proper coverage.

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³ See Patient Dumping on OIG Website at https://oig.hhs.gov/fraud/enforcement/cmp/patient_dumping.asp

⁴ There are many EMTALA policies that vary in number according to the hospital organization and management. See the Policy Resource Center at <https://www.complianceresource.com/products/policy-resource-center/>