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Avoiding EMTALA Penalties

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In the aftermath of the Affordable Care Act, providers should not forget the original means for extending care to the uninsured: the Emergency Medical Treatment and Active Labor Act ("EMTALA"). Under EMTALA, if a patient comes to a hospital or hospital-owned urgent care center, the hospital and its on-call physicians must provide an appropriate screening exam and, if the patient has an emergency medical condition, provide stabilizing treatment or an appropriate transfer regardless of the patient's ability to pay. 42 U.S.C. § 1395dd; 42 C.F.R. § 489.24. Participating hospitals with specialized capabilities cannot refuse to accept the transfer of an unstabilized person. 42 C.F.R. § 489.24(f). Physicians—including on-call physicians—who violate EMTALA may be subject to a \$50,000 civil penalty. Hospitals that violate EMTALA are subject to civil penalties of \$25,000 to \$50,000 per violation, lawsuits for damages, and/or exclusion from Medicare. 42 U.S.C. § 1395dd(d).

The following are a few "best practices" to avoid EMTALA liability based on my years of defending EMTALA cases:

1. **Always do what is best for the patient.** In the end, EMTALA is about the patients. So long as you do what is best for the patient, you will not face significant EMTALA liability even if there is an EMTALA violation.
2. **Document, document, document!** In the majority of the actions I have defended, the providers rendered appropriate care consistent with EMTALA, but they failed to adequately document their actions or the bases for their actions. "If it's not in the chart, it didn't happen." Make sure you document your actions and the reasons for your actions. If you discover deficient documentation, correct the record through appropriately designated late entries, supplements, or amendments.
3. **Maintain written policies.** Written policies enable your staff to comply and establish the basis for correction when staff fails to comply. Appropriate policies also help protect you: regulators are less likely to impose penalties against you if a rogue employee violates written policies. Regulators are less sympathetic when you have no written policies. Periodically check your policies against 42 C.F.R. §§ 489.20(r), 489.24, and CMS's corresponding Interpretive Guidelines to ensure the policies track regulatory requirements.
4. **Train and re-train personnel.** The policies matter little unless you periodically train staff and document the training. The training may work: staff may actually comply. Even if they fail to comply, documented training will help insulate you from the actions of a rogue employee who knowingly or negligently violates your policies

after being properly trained.

5. **Post the required EMTALA signs.** The signs must be posted in "dedicated emergency departments" as defined in 42 C.F.R. § 489.24(b) and associated waiting areas. The signs should be posted in English as well as other languages required by HHS's Limited English Proficiency guidance. Ensure your personnel are familiar with the rights guaranteed in the signs.

6. **Know to whom, when, and where EMTALA applies.** EMTALA's screening requirements apply to all Medicare-participating hospitals with dedicated emergency departments. EMTALA's obligation to receive transfers applies to all participating hospitals with specialized capabilities whether or not they have dedicated emergency departments. EMTALA is generally triggered if a potential emergency patient is on hospital property, including hospital-owned facilities within 250 yards of the main campus. It applies to persons in hospital-owned or in-bound ambulances. It generally applies to a hospital's off-campus urgent care, labor and delivery, mental health, and similar centers where persons typically come for emergency-type services without an appointment. EMTALA does not apply to on- or off-campus facilities that are not operated under the hospital's provider number, e.g., private physician offices or rural health centers. EMTALA does not apply to off-campus centers that do not typically provide urgent care or emergency-type services even if owned by a hospital. EMTALA does not apply to requests for preventive care, e.g., immunizations or flu shots. EMTALA does not apply to patients who come for scheduled diagnostic, therapeutic, or outpatient appointments even if an emergency arises after they begin treatment. EMTALA does not apply to police requests to gather evidence unless the situation suggests the patient may have an emergency condition. EMTALA does not apply after a patient is admitted as an inpatient. Of course, malpractice standards and Medicare conditions of participation may still apply even if EMTALA does not.

7. **Maintain and review the emergency department log.** Hospitals are required to maintain a central log of persons who come to the hospital for emergency care, whether the person received treatment, and whether the patient was stabilized, admitted, transferred, or discharged. This is the first document the surveyors will review when they investigate your facility; be sure that it is accurate. Periodically review the log to ensure it contains appropriate information and identify potential EMTALA problems. If there are deficiencies, correct the log or the underlying medical records as appropriate.

8. **Conduct and document an appropriate medical screening exam.** If a person comes to the hospital seeking potential emergency care, provide an appropriate screening exam to determine whether an emergency medical condition exists. The appropriateness of the exam depends on the patient's presenting symptoms and the hospital's capabilities. In some cases, a brief

exam or questioning may be sufficient to rule out an emergency medical condition; other cases may require diagnostic tests and on-call specialists. Triage is not an exam. Depending on the symptoms, an appropriate exam typically includes obtaining vital signs, relevant history, physical exam of the involved area or system, ancillary tests or specialty consults as indicated, and continued monitoring, all of which should be documented in the record. If the exam rules out an emergency medical condition, the hospital's EMTALA obligation ends; the hospital should document the absence of an emergency condition. If the exam identifies an emergency medical condition, then the hospital must provide the stabilizing treatment or appropriate transfer described below. If the patient needs exams or tests beyond the hospital's capability to determine whether an emergency condition exists, the hospital should transfer the patient to an appropriate facility to complete the exam consistent with the transfer requirements described below.

9. **Use qualified medical personnel.** The screening exam must be conducted by qualified medical personnel ("QMP"). QMP may be physicians, midlevels, or even nurses so long as they have the necessary competence and privileges to conduct the exam, the exam is within their scope of practice, and the hospital's governing body has authorized that category of practitioner to perform the exam through its bylaws or policies. Some clinicians may be a QMP for certain exams but not others, e.g., an L&D nurse may be a QMP for labor-related issues, but not other conditions. Check the hospital's bylaws or policies to ensure that the board has appropriately identified and privileged those who may perform screening exams, and that the exams are performed accordingly.
10. **Document a timely response.** Do not delay care. Unduly delayed care is inadequate care. Impatient persons may leave the emergency room due to delays which raise EMTALA suspicions. Triage patients. If you cannot examine them relatively promptly, communicate with the patient. If a person leaves before receiving the exam or stabilizing treatment, document any justifiable delay and your reasonable efforts to convince them to remain.
11. **Do not delay the exam while obtaining payment info.** The key here is "delay". You may start the registration process before the exam so long as you do not condition or delay the exam or treatment based on payment. For example, you may ask the patient about his or her means of payment, but ensure the patient understands that you will provide emergency care regardless of the patient's ability to pay. Do not seek preauthorization from payors before examining the patient or initiating stabilizing treatment. Do not discourage the patient from receiving the required emergency care.
12. **Perform and document stabilizing treatment.** If the screening exam reveals an emergency medical condition, the hospital must provide stabilizing treatment within its capabilities and/or an appropriate transfer. EMTALA ends once a patient is stabilized, i.e.,

the emergency condition has resolved even though the underlying medical condition may persist. A patient is stable for transfer if no material deterioration in the patient's condition is likely to result from or occur during the transfer. A patient is stable for discharge if the patient has reached a point where his or her continued care could be reasonably performed as an outpatient or later as an inpatient, provided the individual is given appropriate discharge instructions. A woman in labor is stable when she has delivered the child and the placenta, and there are no other emergency conditions. A psychiatric patient is stable if the patient is protected and prevented from harming themselves or others. If the patient is stable, you may discharge or transfer the patient without complying with the remaining EMTALA obligations; however, ensure that your documentation confirms that the patient is stable. Regulators will review the records to determine compliance and hindsight is always 20/20. If the patient is not stable, you must continue to provide stabilizing treatment or conduct an appropriate transfer as described below.

13. **For transfers, document patient consent and/or or physician certification.** Movement within the hospital or between the hospital's own facilities generally does not constitute a "transfer" for purposes of EMTALA or trigger EMTALA's transfer requirements; nevertheless, the hospital should ensure that patients who are moved between hospital facilities are accompanied by appropriate personnel. If the patient is not stabilized, transfers or discharges outside the hospital must comply with EMTALA. An unstabilized patient may request transfer or discharge, in which case the hospital should obtain a written request from the patient that documents the reasons for the request, associated risks and benefits, and the patient's EMTALA rights. Absent such a request, a physician must certify in writing that the benefits of the transfer or discharge outweigh the risks. Transfer forms may help document physician certification, but beware forms that simply allow a physician to check a box. The form and/or medical records should document the relevant risks and benefits and demonstrate the physician's considered decision. Only physicians may certify patient transfers. If the physician is not present, a QMP may certify the transfer after consulting with the physician. The physician must countersign the certification. Although physician certification is only required for the transfer of unstable patients, hospitals should consider following the certification and EMTALA transfer process for all patients who are transferred or discharged from the emergency department—even those who are considered stable—for several reasons: (i) physician certification helps confirm EMTALA compliance if the regulators dispute that the patient was stable; (ii) a uniform process helps avoid compliance lapses; and (iii) physician certification helps protect against malpractice in addition to EMTALA claims.
14. **Use appropriate means for transfer.** If an unstable patient is to be transferred, the hospital must contact the receiving facility to

confirm that the receiving facility has the capability and agrees to receive the patient. The transferring hospital should document the contact, including the name and title of the person at the receiving facility who agreed to the transfer. The transferring hospital must do what it can to minimize the risks of transfer, including providing appropriate treatment, personnel and means of transportation. Transfer by private vehicle may be appropriate in some cases, but it will raise suspicions. If a patient is to be transferred by private vehicle, consider and document (i) the patient's request to transfer by private vehicle; (ii) your offer to transfer by ambulance or other means; (iii) factors indicating that transfer by private vehicle is appropriate, or the patient's informed refusal to transfer by other means; (iv) the patient is accompanied by competent person(s); and (v) any instructions appropriate for the transfer, e.g., to proceed directly to the other facility. Finally, the transferring hospital must send relevant records to the receiving facility, either at the time of the transfer or as soon as such records become available. If the transfer resulted from an on-call physician's failure to respond, the transferring hospital must forward the name of the on-call physician to the receiving facility.

15. **Receive appropriate transfers.** Hospitals that participate in Medicare and have specialized capabilities (e.g., specialty hospitals) must accept the transfer of unstabilized patients even if they do not have an emergency department and, therefore, would not otherwise be obligated to provide a screening exam or stabilizing treatment if the patient had come directly to the receiving hospital. The receiving hospital cannot place conditions on their acceptance, or require a certain method of transfer. The receiving hospital must receive the transfer even though there are other hospitals with specialized capabilities closer to the sending hospital. Hospitals are not, however, required to accept transfers if they provide the same level of service as the transferring hospital and, therefore, have no specialized capabilities. Also, the receiving hospital is not required to accept the transfer of inpatients or patients who have been stabilized since EMTALA no longer applies to such patients. If a hospital with specialized capabilities refuses to accept a transfer, document the circumstances of such refusal and warn them of their EMTALA obligations. If you represent a hospital that refuses to accept a transfer, ensure that the refusal is justified and document the basis of the refusal, including any circumstances that confirm the absence of specialized capabilities.
16. **On-call physicians beware.** The hospital is obligated to maintain and utilize a list of physicians who are on call to respond to emergency cases. The list should identify the particular physician(s) by name; assigning physician groups is insufficient. Failure to timely respond in person at the hospital may subject the on-call physician to a \$50,000 penalty. CMS advises hospitals to establish and enforce a set response time in minutes (e.g., within 30 minutes); hospitals that fail to enforce call requirements may be subject to EMTALA penalties along with the delinquent physician.

Physicians may use mid-levels to respond in their place if clinically appropriate; however, the physician must respond in person if requested by the emergency department. Unless there is a compelling patient care need, the physician must report to the hospital where the patient is located; the physician cannot direct that the patient be sent to the physician's office or another hospital merely for the physician's convenience. Hospitals must have written policies in place to cover situations when an on-call physician cannot respond, e.g., backups if the hospital allows on-call physicians to schedule elective surgery while on-call or to provide on-call duties simultaneously at other facilities. Although there is no specific rule, CMS wants hospitals to "strive" to provide call coverage for specialty services offered at the hospital; with that said, CMS acknowledges that circumstances may prevent 24/7 call coverage for all specialties. Hospitals may enter community call plans that allocate call for certain specialties among hospitals if certain conditions are met.

17. **Watch out for in-bound ambulances.** EMTALA is triggered if a patient is in a hospital-owned or in-bound ambulance; hospitals generally cannot divert an in-bound ambulance unless the hospital is on diversion status. If you are on diversion status, document your status, including the time and reason for diversion. If you are not on diversion status, you can still discuss treatment recommendations with the ambulance crew. For example, if you are not on diversion status but the patient needs services you cannot provide, explain that to the ambulance; just make sure they understand that you are not diverting them, and that you document that fact. If the ambulance disregards your advice and comes to your hospital, perform an appropriate screening exam, provide stabilizing treatment, and/or document an appropriate transfer before sending them on.
18. **Document the patient's refusal of treatment or transfer.** Competent patients have the right to consent to or refuse treatment. If a patient refuses the exam, treatment or transfer otherwise required by EMTALA, the hospital should take reasonable steps to obtain the patient's written refusal. The written refusal or medical records should describe the exam or treatment that was offered, the associated risks and benefits, the patient's reasons for refusing the offered care, and the patient's EMTALA rights. If the patient refuses to sign a written refusal, the hospital should document its attempt to obtain the patient's written refusal.
19. **Respond promptly to complaints and investigations.** If you discover a possible EMTALA violation, immediately collect and review the relevant records and confirm the relevant facts. Interview those involved. As appropriate, supplement or correct the record while memories are still relatively fresh and the information is available. The additional information may confirm that no EMTALA violation occurred, or may otherwise justify the actions taken. If there was a violation, take appropriate corrective action, which may include modifying policies, conducting additional

training, and disciplining those involved. Prompt remedial action may mitigate exposure to sanctions.

20. **Reporting violations.** Hospitals that receive improper transfers must report the violation within 72 hours to CMS or the state surveyors, but there is no obligation to self-report your own violation. If you believe you have received an improper transfer, contact the sending facility to confirm the facts before reporting. If you believe you violated EMTALA and that the receiving facility intends to report you, consider self-reporting to obtain whatever credibility you can with the regulators.
21. **Responding to investigations.** If you are investigated, be cooperative. CMS will give you an opportunity to explain and submit a corrective action plan. Use your opportunity to present your reasonable position, e.g., by providing additional facts or statements that may not appear in the record; explain why there was no EMTALA violation; and/or state remedial steps you have taken to avoid any problems in the future. An experienced healthcare attorney who understands EMTALA may help you respond. In most cases, CMS will accept the plan of correction without further action. In some cases, CMS may refer the matter to the Department of Justice to prosecute EMTALA violations. Even in those cases, regulations require that the government consider several factors before imposing penalties. Complying with the foregoing steps should help you avoid the penalties.

For questions regarding this update, please contact

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