

Frequently Asked Questions about the Emergency Medical Treatment and Active Labor Act (EMTALA)

NOTE: Updated to incorporate the 2003
regulations

CONTENTS

1. What is EMTALA?
2. What are the provisions of EMTALA?
3. What is an "emergency medical condition"?
4. What are the provisions for pregnant women in active labor?
5. When can a patient be transferred to another facility?
6. What is meant by "stabilized"?
7. What is an appropriate transfer?
8. What if the patient refuses examination and/or treatment?
9. What if the patient requests transfer?
10. Who is covered?
11. What obligations apply to physicians?
12. What if an emergency medical condition is not properly diagnosed at the transferring hospital?
13. Can the hospital inquire about the patient's ability to pay?
14. Does EMTALA apply only to E.R. patients?
15. Does EMTALA apply only to people without insurance?
16. What obligations are imposed on receiving hospitals?
17. What obligations are imposed on ambulance services?
18. What about the transferring hospital's responsibility regarding ambulance services?
19. What rules apply to patients who are being transported to a hospital via ambulance?
20. What penalties are imposed for violations?
21. Does civil liability attach for claims under EMTALA?
22. How does this statute affect malpractice claims?
23. Doesn't EMTALA simply restate in a different way the general obligation to provide appropriate treatment when it is needed?
24. What other resources are available on this subject?

SPECIAL SITUATIONS

1. What are the requirements of EMTALA for ER staffing and call lists?
2. What if the patient leaves the E.R. before he undergoes a triage assessment?
3. Does the initial assessment need to be done by a physician?
4. What about specialty care hospitals such as pediatric hospitals and the like?
5. Does EMTALA require that patients be seen for follow-up visits without consideration of

ability to pay? 6. This is what happened at our facility. [Facts and events are recounted.] Is this a violation of EMTALA?

SPECIAL NOTE

[What is the 250-yard rule](#) and how does it affect these issues?

A preliminary note:

As is the case with any legal inquiry, the interpretation of this statute and its provisions as applied to a particular situation is subject to varying conclusions depending on the facts of the case and is also subject to judicial interpretation, with all of its inherent fallibility and unpredictability. The law is not a discipline which provides its guidance in sharply-defined areas of black and white. Most legal areas present multiple shades of gray, and this applies to EMTALA just as strongly as (and in some respects more strongly than) any other area. A lawyer often cannot tell a client "what the law is"; he can do no more than offer a prediction of what a court will find the law to be.

The field of medicine, likewise, has many uncertainties and gray areas, and decisions made in its sphere are based on subjective assessments and conclusions based on clinical judgments, rather than on objectively deduced truths. An area in which clinical medical decisions must be made, often within a short period of time, is also subject to being critically reviewed under the microscope of expert opinion testimony in the event of later litigation.

An area of inquiry in which legal considerations and medical principles overlap, then, is one where very little can be clearly defined and demarcated in general terms in advance and in a vacuum, without regard to a particular factual situation.

The following is intended to provide some general guidance on the statute, the regulations which implement it, and the reported cases which interpret it. It is not a substitute for sound legal advice from a knowledgeable attorney familiar with the law, the facts of a specific case, the hospitals and physicians involved, the nature of the medical problem at issue, and the jurisdiction in which a lawsuit is pending or may be filed.

The author of this FAQ does not intend to create an attorney-client relationship by distributing it, and does not invite or expect any person to rely on it as legal advice or a substitute for legal advice. What is contained herein is no more than general information and guidance about a controversial and developing area of medicine and law. Reliable legal advice must come from your own attorney.

TERMINOLOGY USED

EMTALA - The Emergency Medical Treatment and Active Labor Act

COBRA - The Consolidated Omnibus Budget Reconciliation Act of 1986 (See Section 1 below)

HCFA - The Health Care Financing Administration - previous name for CMS

CMS - Centers for Medicare and Medicaid Services, a division of the Department of Health and Human Services. Responsible for the Medicare program and the development and enforcement

of regulations on EMTALA.

Transferring hospital - A facility at which a patient is seen initially and whose personnel determine that transfer to another facility is warranted

Receiving hospital - A facility to which a patient is transferred; it may or may not constitute a "regional referral center" as that term is used elsewhere in the Medicare statute and (at one point) in EMTALA.

METHODOLOGY

The primary focus of this FAQ is on the statute, found at 42 USC 1395dd et seq. (This notation style means that the statute is found in volume 42 of the United States Code, section 1395dd and the following sections.)

Several of the sections below include a subsection which identifies additional requirements imposed under the regulations adopted by CMS. The regulations were enacted in June 1994, some eight years after EMTALA was first passed and required that the regulations be drafted. Significant updates were enacted in 2000 and 2003. The regulations are found at 42 CFR 489.24, except as may be noted below. They were published at 59 Fed Reg 32120 et seq, dated June 22, 1994.

Several sections include references to cases which have been decided by courts. No attempt is made to be comprehensive.

1. What is EMTALA?

The Emergency Medical Treatment and Active Labor Act is a statute which governs when and how a patient may be (1) refused treatment or (2) transferred from one hospital to another when he is in an unstable medical condition.

EMTALA was passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1986, and it is sometimes referred to as "the COBRA law". In fact, a number of different laws come under that general name. Another very familiar provision, also referred to under the COBRA name, is the statute governing continuation of medical insurance benefits after termination of employment.

Reportedly, a 1989 amendment to the statute removed the word "active" from the official name of the statute. The amendment, however, cannot be found in the report of the official public law.

EMTALA is also known as Section 1867(a) of the Social Security Act. It is included as part of the section of the U.S. Code which governs Medicare.

EMTALA applies only to "participating hospitals" -- i.e., to hospitals which have entered into "provider agreements" under which they will accept payment from the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) under the Medicare program for services provided to beneficiaries of that program. In practical terms, this means that it applies to virtually all hospitals in the U.S., with the exception of the Shriners' Hospital for

Crippled Children and many military hospitals. Its provisions apply to all patients, and not just to Medicare patients. (See Section 15 below.)

The avowed purpose of the statute is to prevent hospitals from rejecting patients, refusing to treat them, or transferring them to "charity hospitals" or "county hospitals" because they are unable to pay or are covered under the Medicare or Medicaid programs. This purpose, however, does not limit the coverage of its provisions -- see Sections 15 and 16 below.

EMTALA is primarily but not exclusively a non-discrimination statute. One would cover most of its purpose and effect by characterizing it as providing that no patient who presents with an emergency medical condition and who is unable to pay may be treated differently than patients who are covered by health insurance. That is not the entire scope of EMTALA, however; it imposes affirmative obligations which go beyond non-discrimination. See Section 16 below.

2. What are the provisions of EMTALA?

The essential provisions of the statute are as follows:

Any patient who "comes to the emergency department" requesting "examination or treatment for a medical condition" must be provided with "an appropriate medical screening examination" to determine if he is suffering from an "emergency medical condition". If he is, then the hospital is obligated to either provide him with treatment until he is stable or to transfer him to another hospital in conformance with the statute's directives.

What constitutes "coming to the emergency department"? See our [special note on the 250 yard rule and its discussion of presentations to locations other than the emergency room, as well as the further discussion below.](#)

If the patient does not have an "emergency medical condition", the statute imposes no further obligation on the hospital.

A pregnant woman who presents in active labor must, for all practical purposes, be admitted and treated until delivery is completed, unless a transfer under the statute is appropriate. The statute explicitly provides that this must include delivery of the placenta.

In essence, then, the statute:

- imposes an affirmative obligation on the part of the hospital to provide a medical screening examination to determine whether an "emergency medical condition" exists;
- imposes restrictions on transfers of persons who exhibit an "emergency medical condition" or are in active labor, which restrictions may or may not be limited to transfers made for economic reasons;
- imposes an affirmative duty to institute treatment if an "emergency medical condition" does exist.

Additional regulatory provisions

The regulation [42 CFR 489.24(a)] adds the following:

The person who does the examination must be specifically determined to be a "qualified medical person" by the hospital bylaws. The hospital must make the designation in its bylaws or rules and regulations. The regulation also provides that the person must "meet the requirements of 42 CFR 482.55", although that rule really has no substantive requirements.

Another section [42 CFR 489.20(q)(1)] requires that the hospital post a conspicuous sign which notifies patients and visitors of the right to be examined and to receive treatment. The sign must be in a form approved by the Secretary of Health and Human Services.

The 2003 regulations define a "dedicated emergency department" as a state-licensed ER or a place where medical services are provided on an urgent basis, without the need for an appointment, including (significantly) hospital-based ambulatory care centers. At a DED, any request for medical treatment triggers EMTALA obligations. See paragraph 14 below for a discussion of presentations elsewhere.

The 2003 regulations permit an abbreviated assessment by a qualified medical person for patients not presenting for examination or treatment, whose presentation is not likely to involve an emergency medical condition.

Under the 2003 regulations, a person presenting for the dispensation of medications at his physician's direction **does** trigger EMTALA obligations, because he may have a medical condition which needs evaluation. A person being brought in by law enforcement personnel for blood alcohol testing may or may not trigger the obligation, depending on the circumstances.

3. What is an "emergency medical condition"?

An attempt is made by the statute to provide a definition, but as usually happens, the legal definition leaves much to be desired. The determination is ultimately a medical one rather than a legal one. That is not to say that it is sheltered from review. As is the case with any medical decision, it must often be made quickly, with such information as is available, and is subject to critical retrospective review by physicians testifying as expert witnesses in the alien setting of the courtroom, in the event of litigation.

The definition provided under the statute is:

"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 --
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,

serious impairment to bodily functions, or
serious dysfunction of any bodily organ or part, or

"With respect to a pregnant woman who is having contractions --
that there is inadequate time to effect a safe transfer to another hospital before delivery, or
that the transfer may pose a threat to the health or safety of the woman or her unborn child."

4. What are the provisions for pregnant women in active labor?

Note that the determination of whether a woman in labor falls under the definition of "emergency medical condition" is determined by consideration of time factors -- whether there is adequate time to effect a "safe transfer" to another hospital before delivery. (If the woman is not in labor, that is, is not having contractions, then she does not fall under the terms of the statute unless her condition fits the general definition of "emergency medical condition" under the first paragraph for some other medical reason.)

Do all patients in active labor need to be admitted? It is common for patients to present with "false labor" or in the very early stages of true active labor, and certainly it is not necessary to admit all such patients. EMTALA clearly requires an examination ("medical screening examination") to determine the stage of labor, in order to make the determination of whether the patient has reached the level at which a safe transfer cannot be effectuated. If the patient is at the stage at which a safe transfer could be arranged, she can be discharged without a violation of EMTALA.

This can be one of the most problematic areas of application of the language of EMTALA. Since a seemingly safe and normal course of labor can suddenly take a turn for the worse, it can often be very difficult to determine precisely where the line for "safe transfer" is crossed. As with the application of the other key language of the statute, the determination of where the line is located is ultimately a medical decision.

5. When can a patient be transferred to another facility?

Under EMTALA, unless the patient requests transfer [see Section 13 below], this depends on whether the patient has become stable -- i.e., whether his emergency medical condition has resolved. See Sections 10 and 11 below.

A transfer to another facility before the patient has become stable can only take place if it is an "appropriate transfer" under the statute.

A transfer after the patient has become stable is permitted and is not restricted by the statute in any way. The statute's restrictions apply only to transfers before the patient has become stable, either on his own or as a result of medical treatment. Of course, the question of whether the

patient has become stable is sure to generate factual and medical issues when litigation ensues, so the prudent hospital is cautioned to tread carefully here.

A transfer of a patient who is not experiencing an "emergency medical condition" is permitted and is not restricted by the statute in any way. In other words, and speaking a bit loosely, a patient may be freely transferred either before the emergency condition arises or after it has been resolved, and may only be transferred under a defined set of circumstances while the condition exists.

6. What is meant by "stabilized"?

As is the case with the term "emergency medical condition", the statute offers a definition, but this determination is ultimately a matter of clinical judgment on the part of the medical professional assessing the patient. By contrast, the definition for a pregnant woman is clear and has little need for interpretation.

The definition is:

- (for emergency medical conditions) that no material deterioration of the patient's condition is likely to result from the transfer or is likely to occur during the transfer;
- (for patients in active labor) the infant and the placenta have been delivered.

7. What is an appropriate transfer?

An "appropriate transfer" (a transfer before stabilization which is legal under EMTALA) is one in which all of the following occur:

- The patient has been treated at the transferring hospital, and stabilized as far as possible within the limits of its capabilities;
- The patient needs treatment at the receiving facility, and the medical risks of transferring him are outweighed by the medical benefits of the transfer;
- the weighing process as described above is certified in writing by a physician;
- the receiving hospital has been contacted and agrees to accept the transfer, and has the facilities to provide the necessary treatment to him;
- the patient is accompanied by copies of his medical records from the transferring hospital;
- the transfer is effected with the use of qualified personnel and transportation equipment, as required by the circumstances, including the use of necessary and medically appropriate life support measures during the transfer.

The statute provides that, if a physician is not physically present in the emergency room, the written certification in support of transfer may be signed by a "qualified medical person" in

consultation with the physician, provided that the physician agrees with the certification and subsequently countersigns it. [42 USC 1395dd(c)(1)(iii)]

Additional regulatory provisions

The regulations add a requirement that the written certification contain an express summary of the risks and benefits upon which it is based [42 CFR 489.24(e)(1)(ii)(C)] and that the transferring hospital forward copies of test results which become available after the transfer. [42 CFR 489.24(e)(2)(iii)]

The regulations also require that, if a physician has violated the EMTALA provision requiring that he respond if he is on call, the information conveyed by the transferring hospital to the receiving hospital must include his name and address. [42 CFR 289.24(e)(2)(iii)]

8. What if the patient refuses examination and/or treatment?

Section 1395dd(b)(2) provides that a hospital has met the requirement of a medical screening if it

- offers the patient the further medical examination and treatment required under Section 1395dd(a);
- informs the patient or another on his behalf "of the risks and benefits of the offered examination and treatment";
- and the patient or another acting on his behalf refuses to consent to the examination and treatment.

Additional regulatory provisions

The regulations additionally provide that:

- the medical record must contain a description of the examination and/or treatment which was refused;
- the hospital must take all reasonable steps to secure the refusal in writing;
- the document to be signed by the patient should include a recitation of the fact that the patient or other acting on his behalf has been informed "of the risks and benefits of examination or treatment". 42 CFR 489.24(d)(3)

A court would undoubtedly conclude that the requirement of a discussion of the risks and benefits "of the examination and treatment", in both quoted sections above, includes a discussion of the risks of refusing the examination and treatment.

9. What if the patient requests transfer?

A patient may request a transfer to another institution, and it appears from the wording of the statute that this request takes the place of the physician's certification mentioned in section 11 above. The transfer must still be an "appropriate transfer", however.

Additional regulatory provisions

The regulations require that the request for the transfer must be made in writing, after being advised of the hospital's EMTALA obligations and of the risk of transfer, and the written request must include a statement of the risks and benefits of transfer, and the reasons for the requested transfer. 42 CFR 489.24(e)(1)(ii)(A)

10. Who is covered?

Most of the provisions of EMTALA apply by their terms to hospitals only. There are numerous court cases which have held that its principal provisions do not give rise to a claim against a physician. There are some situations in which physicians may be subject to liability, as noted below.

Hospitals, of course, are not persons. A hospital is an institution which can operate only through the people who work within its walls. A hospital is typically a corporation, and a corporation is a legally-recognized entity which can be sued and which can have its Medicare provider agreement revoked by CMS. In truth, then, the requirements of EMTALA are imposed on the people who work within and on behalf of the hospital, but the hospital is the entity which must bear the loss if it is found that they have violated the statute. A hospital may seek to assert a claim for reimbursement (indemnity or contribution) in the event that a decision by one of its employees or staff physicians makes a decision for which it becomes legally liable; these claims have been recognized by some courts.

The person who will usually have to make the sometimes difficult decisions which are governed by EMTALA is the emergency physician.

11. What obligations apply to physicians?

There are a few provisions which do, by their terms, apply to physicians:

- Section 1395dd(d)(1)(C) imposes a penalty on a physician who fails to respond to an emergency situation when he is assigned as the on-call physician. (See also item 1 under "Special Questions" below.)
- A physician who signs a certification in support of an appropriate transfer, as detailed in Section 11 below, is liable if he knew or should have known that the certification was false.

- The Balanced Budget Act of 1997 amended section 1395dd(d)(1)(B) to provide directly for liability of physicians working at specialty hospitals (not just assigned on-call physicians) which violate the special obligations imposed on those hospitals. Presumably this section applies only to the physician involved in the violation.

The penalty imposed on physicians adds exclusion from the Medicare program in repeated cases or in a "gross and flagrant" violation.

12. What if an emergency medical condition is not properly diagnosed at the transferring hospital?

If the patient is erroneously diagnosed, and the physician mistakenly believes that he does not have an "emergency medical condition", when in fact he does, several courts have held that the statute does not apply to that case. *Urban v. King*, 834 F Supp 1328 (1993). There could, of course, be a claim for professional negligence for failure to make a diagnosis under State malpractice law in this situation.

The court in *Jones v. Wake County Hospital System, Inc.*, 786 F.Supp. 538 (E.D.N.C. 1991) stated that EMTALA requires only that a medical screening procedure be established and that it be followed in every case, without regard to ability to pay, and that EMTALA is not violated even if the screening procedure is insufficient under state malpractice law.

Some of the cases have suggested otherwise, however. There was a brief mention in *Deberry v. Sherman Hospital Association*, 741 F. Supp. 1302 (N.D. Ill.1990), to the effect that a hospital could be found to be in violation of EMTALA for failure to diagnose an emergency medical condition through an inadequate screening procedure. This principle is at least implicitly recognized in other cases as well. See, for example, *Power v. Arlington Hospital*, 42 F3d 851 (4th Cir 1994) (failure to order CBC, leading to missed diagnosis of sepsis).

The most prominent case on this point is *Summers v. Baptist Medical Center of Arkadelphia*, 69 F.3d 902 (8th Cir. 1995), *rev on reh en banc* 91 F.3d 1132 (1996). In that case, an examination of a patient who had fallen from a tree stand while hunting was allegedly incomplete because a chest x-ray had not been included when a set of spinal x-rays was ordered. The physician did not believe that the patient had any fractures, and discharged him home, with instructions. There was no transfer to another facility involved. The patient presented at another hospital two days later, and he was diagnosed with an acute comminuted vertebral fracture, a sternal fracture, and bilateral hemopneumothoraces secondary to untreated rib fractures.

The original decision of the three-judge Court of Appeals was that the Complaint did state a claim on which relief may be granted, and that the failure of a doctor to follow what he admitted was a standard screening diagnostic protocol supported a claim for a violation of EMTALA. When the case was decided on rehearing by the full Eighth Circuit, sitting en banc, this decision was reversed and it was held that providing a screening examination, even if it is negligent under state-created malpractice law, is sufficient to provide full compliance with EMTALA, and that

only disparate treatment in the screening process would support a claim. Further information on this case is found at the EMTALA.COM site, <http://www.emtala.com/summers.htm>.

13. Can the hospital inquire about the patient's ability to pay?

Yes, but timing is everything. The statute does not prohibit an inquiry into availability of medical insurance; it does provide that neither examination nor treatment may be delayed to make the inquiry.

Some knowledgeable commentators have suggested that no discussion of any payment issues should take place before the medical screening examination and any needed stabilizing treatment are provided. Others have found no reason for an outright prohibition on asking about insurance coverage while the patient is waiting for the examination so long as it is made clear that financial considerations will not affect decisions regarding examination and treatment. This is obviously an area with some dangers, and one benefit of absolute rules is that no one has to wonder where the line may be drawn. CMS has even recommended that hospital personnel not answer any questions initiated by the patient, apparently on the theory that some patients may be dissuaded from staying if they learn that they will be financially responsible for the treatment, even if they are assured that they will be seen without consideration of payment issues. Such recommendations, however, do not arise to the level of a definitive statement of what is required.

It should go without saying, but it unfortunately doesn't, that there should be no sign on the wall declaring any policy regarding prepayment of fees or payment of co-pays and deductibles.

A pre-authorization requirement imposed by a managed care organization or a health insurer may not be allowed to prevent or delay the performance of a medical screening evaluation or the institution of necessary stabilizing treatment once it is determined that an emergency medical condition exists. There is nothing which prohibits concurrent contact with an MCO or an insurer, so long as that contact or the answer received is not permitted to interfere with the course of evaluation and (if there is an emergency medical condition) treatment. The requirements of EMTALA are mandatory and are unaffected by payment considerations. A hospital may not permit a denial of payment or uncertainty about payment to interfere with its obligations under EMTALA. The issue of payment or authorization for payment must not be allowed to influence the physician's decision as to (1) whether an emergency medical condition exists or (2) the nature or timing of the treatment needed. In February 1996, the Medical Services Administration changed its policies to provide for payment to providers for EMTALA-mandated medical screening examinations for patients receiving services through its MCOs. A prohibition against pre-authorization in Medicare and Medicaid managed care plans was then enacted into law by Congress in 1997 with the Balanced Budget Act.

In 1998, CMS issued a Special Advisory Bulletin -- reproduced at <http://www.emtala.com/oblig.txt> -- to underscore its position on this issue, in view of the fact that this is one of the most common sources of noncompliance. Its recommendations should be carefully reviewed. They offer some comments on common situations, including dual staffing

arrangements, when calls to the MCO or carrier should be made, and how to respond when the patient inquires about payment issues.

14. Does EMTALA apply only to E.R. patients?

At locations on the hospital campus and within the 250-yard sphere (see paragraph 2 above and the special note) but not at a Dedicated Emergency Department, the obligation under EMTALA arises only if (1) a request for emergency services is made, or if (2) a reasonably prudent layperson would conclude, based on the person's appearance or behavior, that he is in need of emergency treatment. This will include new conditions which arise for visitors or employees.

Once the patient is admitted and stabilized, the EMTALA obligations end, under the 2003 regulations. A new emergency medical condition which arises thereafter does not invoke EMTALA. 42 CFR 489.24(d)(2)

15. Does EMTALA apply only to people without insurance?

No. Despite the fact that the purpose of the statute is to prevent "patient dumping", several Courts have held that there is no requirement that the patient in fact be unable to pay his bills or that there be an economic motivation behind the decision to transfer the patient. *Cooper v. Gulf Breeze Hospital*, 839 F. Supp. 1538 (1993).

The statute expressly provides that the Act's provisions apply to all patients "whether or not eligible for Medicare benefits". [42 USC 1395dd(a)]

Some courts have held that there must be disparate treatment of patients who cannot pay for treatment, for liability to be imposed under EMTALA. *Holcomb v. Monahan*, 30 F.3d 116 (11th Cir. 1994); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037 (D.C.Cir. 1991) Others have held that that is not an essential requirement. *Deberry v. Sherman Hospital Association*, 741 F. Supp. 1302 (N.D. Ill.1990).

16. What obligations are imposed on receiving hospitals?

Most of the obligations under EMTALA are imposed on the transferring hospital. There are a couple of significant obligations imposed on the receiving hospital as well.

The statute and the regulations provide that any participating hospital which has "specialized capabilities or facilities" such as burn units, shock-trauma units, or neonatal intensive care units, or which is a "regional referral center" in a rural area, may not refuse to accept a patient in transfer, if it has the capacity to treat the individual. [42 USC 1395dd(g); 42 CFR 489.24(f)] The

receiving hospital will be obligated to accept the transfer in most cases, so long as it has the ability to treat the patient and its capabilities exceed those of the referring hospital, even if only because of overcrowding or temporary unavailability of personnel. The receiving hospital will be obligated to accept the transfer in most cases, so long as it has the ability to treat the patient and its capabilities exceed those of the referring hospital, even if only because of overcrowding or temporary unavailability of personnel.

We earlier suggested that it could be argued that the fact that the statute provides specific examples of "specialized capabilities or facilities" would suggest that the obligation exists only where the specified services or similarly-recognized specialty services are involved. The *St. Anthony Hospital* case, decided in August 2002, found otherwise. See the writeup under "EMTALA news" and on the Cases page.

One court has held that the receiving hospital has no obligation to conduct another medical screening examination. *Baber v. Hospital Corporation of America*, 977 F.2d 872 (D.W.Va. 1992). Whether that decision will be accepted by other courts is questionable.

We do not believe, incidentally, that a receiving hospital which meets the standard may refuse to accept a transfer simply because another hospital also has the specialized capabilities, even if the other hospital is geographically closer or has better facilities.

Additional regulatory provisions - the "snitch rule"

The regulations do include a provision which imposes a very significant obligation on receiving hospitals. The regulation, at 42 CFR 489.20(m), obligates a participating hospital "to report to [CMS] or the State survey agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of the requirements of Section 489.24(d)." Like the other "basic commitments" that this section of the regulations imposes on participating hospitals, this section is enforced by the prospect of termination of the provider agreement and thus disqualification from receiving reimbursement for services under the Medicare program. This regulation became effective on September 29, 1995.

17. What obligations are imposed on ambulance services?

The statute imposes no requirements on ambulance services per se. The responsibilities of the ambulance service and its employees are solely a matter of State-created law. See item 19 below, however, for special information relating to hospital-owned ambulances.

18. What about the transferring hospital's responsibility regarding ambulance services?

EMTALA places the responsibility on the transferring hospital to ensure that the statute's requirements are met. The statute requires that the patient be accompanied by "qualified personnel and transportation equipment" [Section 1395dd(c)(2)(D)] In some cases, this may be construed to mean that it must send its own personnel with the patient.

There is already a case on the books which found that it was necessary that a physician accompany a pregnant patient on a transfer to a hospital 170 miles away. *Burditt v. U.S. Department of Health and Human Services*, 934 F2d 1362 (5th Cir 1991). The court in that case decided that sending an OB nurse with the patient during the transfer did not comply with the "qualified personnel" requirement. The Court noted that the nurse was capable of doing an emergency vaginal delivery but not of doing an emergency C-section, although how a physician could in fact carry out an emergency C-section in an ambulance was not explained by the Court.

19. What rules apply to patients who are being transported to a hospital via ambulance?

EMTALA itself does not address the question of whether a patient being transported via ambulance is considered to have "presented" to the hospital. The regulations, however, provide some help.

The regulations specify that a patient in a non-hospital-owned ambulance in transit is not considered to have "come to the emergency department" even if the ambulance is in contact with the hospital by telephone or by radio telemetry. Further, the regulations provide that the hospital may deny access to the patient in transit if it is in "diversionary status" -- that is, if it does not have the staff or facilities to accept additional patients.

Under previous regulations, an ambulance owned by a hospital was obligated to transport the patient to that hospital, even if another or even a more suitable facility was closer. The 2003 regulations have now removed the obligation for hospital-owned ambulances if they are "integrated" with EMS services. The net effect is that these ambulances will now be free to transport patients to a suitable hospital facility and will not be required to automatically transport the patients to the hospitals which own them.

20. What penalties are imposed for violations?

The essential provisions are:

A hospital which negligently violates the statute may be subject to a civil money penalty (i.e., a fine, but without criminal implications) of up to \$50,000 per violation. If the hospital has fewer than 100 beds, the maximum penalty is \$25,000 per violation.

A physician who is responsible for providing an examination or treatment, including but not limited to an on-call physician, may be liable for a civil money penalty for signing the medical

certificate if he knew or should have known that the benefits of transfer did not in fact outweigh the risks of transfer, or if he misrepresents the patient's condition or the hospital's obligations under the statute.

A physician who is on call and who fails or refuses to appear after being called by an E.R. physician (or other physician) may be subject to a penalty under the statute, or may subject his hospital to a penalty. The wording of this section [1395dd(d)(1)(C)] is so garbled as to be virtually indecipherable.

Additional regulatory provisions

The regulations also provide that a hospital found to be in violation may have its provider agreement revoked. This, of course, is likely to be a much more significant potential sanction, and this "Medicare death penalty" provides the biggest incentive to hospitals to accept the positions adopted by CMS in its enforcement activities.

21. Does civil liability attach for claims under EMTALA?

Yes. The following provisions apply:

A hospital may be held liable to an injured person in a civil action for damages under the statute, with no maximum on the liability. Unlike a number of other Federal statutes enabling a civil remedy, there is no provision for an award of attorneys' fees to a successful plaintiff.

A hospital may also be held liable to another hospital in a civil action for any financial loss suffered by the second hospital, to the extent available under State law.

Precisely what that means is uncertain. It is not clear what, if any, remedies were available under common law to a hospital which received a patient in transfer from another facility. Presumably, the receiving hospital could recoup from the transferring hospital any expenses and liabilities which were not reimbursed by Medicaid, Medicare, or third-party medical insurance. Depending on State law and/or the applicable contractual language, a third-party payor, such as a medical insurer, may become subrogated to the claim, meaning that it would be entitled to recover from the transferring hospital the amounts that it paid on behalf of the patient. It would not require much of a stretch for a court to conclude further that the statute would entitle CMS to recover the benefits paid under Medicare or a State to recover benefits paid under Medicaid if a violation is found, even if there is no specific provision for such a recovery elsewhere in the Medicare statute.

22. How does this statute affect malpractice claims?

As noted above, claims for medical malpractice arise under State law, and vary from State to State. EMTALA does not take the place of or limit any malpractice claim under State law. Instead, it offers another way for a plaintiff to make a claim for damages, another avenue in addition to claims under State law, and a way to get his claim heard in Federal court if he wishes to do so. It may also avoid the effect of limitations on damages or other substantive or procedural barriers under State law. The courts have had varying rulings on whether procedural aspects of a State's tort law (caps on damages, presuit notice, etc.) will apply to claims under EMTALA.

23. Doesn't EMTALA simply restate in a different way the general obligation to provide appropriate treatment when it is needed?

No. To some extent, of course, the obligations of EMTALA and of a State's substantive tort law are coextensive. EMTALA does impose an affirmative obligation to conduct an assessment and to provide treatment, even when State law may not have so required.

It would be overly simplistic to assume that compliance with the standard of care will automatically entail compliance with EMTALA. The statute imposes certain limits on a transfer and certain requirements as to treatment which go beyond the ordinary standard of care requirements.

One Court has held that the obligations under EMTALA are absolute, and that the patient must be treated even when that treatment would not be necessary under State law and even when treatment, in fact, may be ethically inappropriate and/or a violation of the standard of care. In *In re Baby K*, 16 F.3d 590 (4th Cir 1994), the Court found that EMTALA imposed an obligation to intubate an infant and to provide mechanical ventilation, in the case of an anencephalic infant who had no hope for conscious awareness or for any form of what most people would think of as human existence. Even though all parties agreed and the Court found that, under the common law of the Commonwealth of Virginia, under generally-accepted principles of medical ethics, and under the standard of care, intervention could and should be withheld, the Court ruled that EMTALA imposes an affirmative (and ongoing) obligation on the hospital to provide such intervention and care to the infant.

24. What other resources are available on this subject?

The American College of Emergency Physicians puts out a newsletter, published quarterly, called Patient Transfer News. Its stated purpose is to "provide accurate information with regard to patient transfers". Subscriptions are \$89 per year for members of ACEP, and \$107 for non-members. Contact ACEP Sales and Services, P.O. Box 619911, Dallas, Texas 75261-9911; (800) 798-1822.

ACEP has published a book entitled "Patient Transfers: How to Comply with the Law". The author is Stephen A. Frew, J.D. The book is available for \$54.00 from ACEP at the number provided above.

Dr. Robert Bitterman has written "Providing Emergency Care Under Federal Law: EMTALA", also offered through ACEP.

In addition, there are a number of law review articles which have been written on EMTALA and the issues it raises. Several have been listed at this site.

SPECIAL SITUATIONS

1. What are the requirements of EMTALA for ER staffing and call lists?

A quick and roughly accurate answer is that there are no official requirements imposed by EMTALA. Rather, the affirmative obligation to maintain a call schedule is imposed on hospitals by another section of the Medicare statute, although it refers back to the EMTALA obligations.

The language of 42 USC ♦ 1395cc(a)(1)(I) is:

[In order to be eligible, a facility must file an agreement]

* * *

(I) in the case of a hospital or critical access hospital -

* * *

(iii) to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. . .

Physicians are often told by hospitals that they are "required by EMTALA" to serve on a call schedule. The truth is that EMTALA does not impose any requirement on physicians that they serve on a call schedule. It is the hospital which imposes an obligation on physicians in order to meet the obligation imposed upon it by the Medicare statute. The obligation of a physician to serve on a call schedule is legally based on state law governing contracts, derived from the agreements attendant to medical staff membership, rather than an obligation placed on the physician by Federal law.

As noted above, Section 1395dd(d)(1)(C) imposes a penalty on a physician who fails to respond to an emergency situation when he is assigned as the on-call physician. This is the only obligation placed on physicians governing the obligation to respond to an emergency situation. This provision does not require that a particular physician or particular specialty provide coverage on a call basis.

With a couple of exceptions, the statute and regulations impose all of their obligations on hospitals. This area is no exception. The expectations of CMS and of the courts in construing

EMTALA are directed at hospitals. Hospitals are left to their own devices as to how to ensure compliance by members of their medical staffs.

How are hospitals expected to structure the coverage requirement? The [Interpretive Guidelines document](#) (PDF format) includes a general statement to the effect that any specialty service that a hospital offers should be available through on-call physicians covering that service. But that general statement is overly broad. It does nothing to distinguish between specialists -- who really cares if a dermatologist is not immediately available to see a patient? -- and to address the particular needs of small rural hospitals and other facilities where the number of available specialists is limited.

Prior to 2003, CMS reportedly used an undocumented informal 3-physician "rule of thumb" which requires a hospital to ensure that it has 24 hour on-call coverage for any specialty for which it has three or more physicians. If fewer than three were on staff, then full-time coverage was not required. Under this rule, a hospital which has only one or two specialists in a given area could have less than full coverage for that specialty without being considered to be in violation of EMTALA requirements.

The 2003 regulations expressly decline to follow a numerical approach, instead stating that CMS will consider "all relevant factors" in determining whether a hospital is in compliance with EMTALA requirements in maintaining its call list. The new regulations do not require 24-hour coverage for under-represented specialties when that is not feasible, they permit physicians to serve on call at more than one hospital simultaneously, and they permit the ER to direct the patient to the specialist, such as to his office or another hospital where he is working, to see and examine the patient. The regulations require that hospitals develop protocols for handling specialty needs when its specialists are not available on call.

For more information on this point, see [CMS Question and Answer Program](#), Memorandum on EMTALA On-Call Responsibilities, June 2002. Note the disclaimer of a "three-specialist rule of thumb", even at that time.

2. What if the patient leaves the E.R. before he undergoes an assessment?

This could be a significant problem. The obligation to do the medical screening examination to determine whether the patient exhibits an emergency medical condition is couched in absolute terms.

Triage is the process by which a quick determination is made as to how quickly and how extensively the emergency department's resources should be used to provide treatment to a patient. By its nature, it needs to be done early. A hospital which regularly keeps its patients waiting for the triage examination or for the medical screening examination runs the risk that the patient will become impatient, leave, and then raise a claim that the initial assessment was not done.

It is important to remember this crucial point: Triage is not the same as a medical screening examination. Triage is a process which determines **when** a patient is seen by a physician, not **whether** he is seen.

3. Does the medical screening examination need to be done by a physician?

The short answer is that any assessment which is done by any person other than a physician has a much higher risk of being found insufficient under EMTALA. As noted in sections 4 and 12 above, the regulations provide that the hospital must make a designation of who is considered to be a qualified medical person for purposes of (1) performing the medical screening examination and (2) the certifying signature in support of transfer in the event that a physician is not available. It is doubtful, however, that CMS or the courts would give hospitals unfettered discretion to specify who can be regarded as a "qualified medical person" as provided in the regulations. It is very unlikely, for example, that an attempt to simply designate all nurses as "qualified medical persons" would be found to comply. On the other hand, tailoring the provisions to particular areas of nursing specialty, such as permitting OB nurses to examine patients who may be in labor, would probably be found reasonable.

Designating appropriate "physician substitutes" such as physicians' assistants or nurse-midwives is often reasonable, but it is recommended that the bylaws provide for phone consultation with the supervising physician and also identify the situations in which the supervising physician must come in to see the patient personally. (Note also the provision in the regulations, buried in the definitions section, requiring that a physician certify, after a reasonable period of observation, a diagnosis of false labor. The amendments to the regulations adopted in August 2006 have relaxed this requirement, declaring that such a certification may properly be made by physician surrogates such as nurse midwives.)

It is possible that a court, faced with a decision in a case in which a person other than a physician has done an emergency room evaluation and has determined that the patient may be sent home rather than being admitted, and a serious complication has arisen, would use this regulation to support a conclusion that a direct consultation with a physician was required in that circumstance. Judges are human, and subject to some of the same prejudices that affect juries, including a tendency to view cases in light of medical hindsight.

4. What about specialty care hospitals such as pediatric hospitals and the like?

What happens if an adult patient comes to a specialty pediatric hospital or a similar specialty care facility and demonstrates an obvious emergency medical condition? It is likely that a court would find that the obligation to provide treatment until a patient is stable is the same, despite the hospital's special status, although a physician may be more willing to provide a written certification that care can and should be provided within a general hospital environment. A physician's determination in this regard may be given some degree of deference by a reviewing court.

5. Does EMTALA require that patients be seen for follow-up visits without consideration of ability to pay?

After the patient is seen in the ER, treated, and sent home, does EMTALA require that the hospital provide follow-up care? If the patient had been seen by a specialist in the emergency room, does the specialist have an obligation to see the patient for follow-up care regardless of ability to pay?

This is an issue which does not have an easy answer. We take the position that a hospital which provides for a medical screening evaluation and provides, with the help of a consulting specialist, medical treatment necessary to stabilize a patient to the point where he can be discharged without violating EMTALA has at that point fully discharged its obligation to the patient, and that the specialist's office followup of the patient thereafter does not implicate EMTALA in any way.

We recognize, however, that other attorneys knowledgeable about EMTALA have suggested that there may arguably be some continuing responsibility, and they have reported that CMS has at times issued citations in situations in which a specialist has declined to see the patient in followup. CMS has cloaked these citations in general terms such as "failure to stabilize", and of course the decision of whether to accept that citation or contest it has to be made by the hospital on a case-by-case basis. In our opinion, such a citation could probably be successfully challenged in many factual situations. Further, if CMS were to properly find a violation, it would be a violation on the part of the specialist, for failure to respond, rather than that of the hospital.

6. This is what happened at our facility. [Facts and events are recounted.] Is this a violation of EMTALA?

Recall our introductory comments about the differences between black and white and shades of gray. Health care providers concerned about EMTALA compliance and litigation exposure will naturally ask "Is this a violation?", and they will want a yes or no answer. The responsible lawyer cannot, in many cases, answer with a yes or a no. A more detailed factual and legal analysis is required.

You may be surprised to learn that the question of whether a violation occurred is perhaps not very important for the institution. The more pertinent questions are:

- What are the chances that somebody going to sue based on this event?
- If he does, what are the chances that he will win?
- If CMS is called to investigate, what are the chances that it will cite the hospital for a violation?

EMTALA compliance is, at base, a risk management endeavor. Thus the questions are best focused on the chances of an adverse finding or result, rather than on the issue of whether a given event "is a violation". As is the case in other areas of the law, the issue is not so much what the law says as whether someone (a judge or an investigator) is likely to conclude that the law was violated.

Very often, the answers to these questions will depend on the particular factual situation and the competing interests that are at work. This would require an in-depth factual, policy, and legal analysis by experienced counsel. Thus the answer is not very amenable to a simple answer.

The author of this FAQ is M. Sean Fosmire, an attorney practicing in Marquette, Michigan with 25 years' experience in defending hospitals and physicians in professional liability litigation, both in Detroit and in Northern Michigan.

emtala.com