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Lessons Learned from EMTALA Enforcement

Steps Compliance Officers Should Be Taking As Part of Ongoing Auditing and Monitoring

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The Emergency Medical Treatment and Active Labor Act (EMTALA) has its origin in the Hill-Burton Free Care Program established in 1946 to provide federal grants to hospitals for modernization in return for providing uncompensated services for 20 years after receiving funds. Facilities that received funding were to provide services without consideration of race, color, creed, national origin, or ability to pay.

Enforcement responsibility ultimately fell to the Office of Civil Rights in the U.S. Department of Health and Human Services (HHS). Over the years, questions were raised about the effectiveness of enforcement, and Congressman "Pete" Stark introduced new legislation passed by Congress under its current title EMTALA that applied to all hospitals participating in Medicare, not just the Hill-Burton hospitals. It also was designed to fortify enforcement actions.

EMTALA continues with the same basic nondiscrimination principles of the Hill-Burton requirements, including making emergency care available to everyone regardless of their ability to pay.[1] The statute imposes a legal obligation on hospitals that participate in Medicare and operate an emergency department to provide appropriate medical screening and stabilization care to persons presenting themselves to the emergency room with an emergency medical condition or in active labor. Violations of EMTALA may result in monetary penalties of not more than $50,000 (or not more than $25,000 for hospitals with less than 100 beds) for each violation.

Nevertheless, notwithstanding few exceptions, EMTALA regulatory and legal enforcement actions continue to be limited. This is due in part to disagreement among the courts interpreting the statute. This lack of uniformity

has limited EMTALA's effectiveness but at the same time has revealed areas of the law that have been causing confusion and are of interest to the government.

Compliance officers should learn about EMTALA court decisions as they identify risk areas that might be the focus of future enforcement actions. Not only are there few court cases, but those that do exist are inconsistent regarding the interpretation of the statute's major provisions.

The Centers for Medicare & Medicaid Services (CMS) has attempted to clarify some parts of the provisions that caused confusion. Recently, the inpatient prospective payment system (IPPS) final rule clarified EMTALA requirements regarding hospital inpatients and proposed a flexible way for hospitals to meet EMTALA physician on-call requirements.[2] Nevertheless, case law continues to evidence significant problems with the interpretation of the scope of EMTALA's core provisions, such as medical screening, stabilization, and transfer requirements. Furthermore, courts disagree on the appropriate standard of care with respect to the duty to perform a medical screening. In some cases, the standard seems to be to provide a uniform screening to everyone; in other cases, even nonuniform treatment cannot be covered under EMTALA. No standard of care required under EMTALA threatens the quality of health care to the extent that the screening provided to a patient might be medically inadequate.

EMTALA Requirements

In 2000, a Departmental Appeals Board (DAB) ruling seemed to limit the scope of EMTALA regarding screening and stabilization requirements in *Inspector General v. Bowen*.[3] The issue in the case was what action a reasonable physician should have taken in light of what he knew or should have known about the patient's condition when he or she came to the emergency department.

The DAB held that the EMTALA stabilization requirements apply only when a hospital determines through a medical screening examination that the individual has an emergency medical condition. Therefore, even if the doctor knew or should have known without conducting a medical screening examination that the patient had an emergency medical condition, the patient left the emergency department before the doctor could take any action consistent with the stabilization and transfer requirements. The court held that the doctor was not able to perform the appropriate screening procedure to detect an emergency medical condition; therefore, without the emergency determination the stabilization requirement of EMTALA does not apply.

The interpretation of the stabilization requirement by the 9th Circuit Court of Appeals in *Bryant v. Adventist Health System* is what most courts are likely to follow today.[4] In *Bryant*, the patient was treated and discharged after being diagnosed with pneumonia. Later that day, the patient was asked to return to the hospital after a second physician's examination. After spending time in the intensive care unit, the patient was transferred to another hospital, where the patient had surgery and was eventually released and subsequently died. In this case, the appellate court decided that the duty to stabilize under EMTALA ended when the patient was admitted for inpatient care.

Based on this decision, EMTALA can now be interpreted in the following way: 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 issue, not an EMTALA issue.

This interpretation was put into regulation in 2003 when, in the standalone final rule on EMTALA, CMS determined that a hospital's obligation under EMTALA ends when that hospital, in good faith, admits an individual with an unstable emergency

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medical condition.[5] Further, the IPPS final rule published in August 2008 clarified that a hospital with specialized capabilities does not have an EMTALA obligation to accept an appropriate transfer of an individual (who presented to the admitting hospital under EMTALA) to stabilize an emergency condition.[6] These provisions clearly narrowed a hospital's duties under EMTALA.

Standard of Care

The medical screening requirement helps increase access to health care but at the same time may lower the quality of care as EMTALA does not establish a national standard of care. The statute only requires hospitals to develop and provide screening procedures to detect emergency medical conditions. In other words, a hospital itself determines what its screening procedures will be for people coming to the emergency room. This does not mean, however, that medical screening provided will be adequate and sufficient.

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The 9th Circuit Court of Appeals ruling in *Jackson v. East Bay Hospital* shows that even medically inadequate screening, as long as the same screening is routinely given to all patients presenting similar symptoms, satisfies EMTALA requirements.[7] The issue in the case was whether a hospital violates EMTALA if it fails to diagnose the cause of a patient's emergency condition but treats the symptoms identified and concludes that the patient has been stabilized. The appellate court ruled that a hospital is not liable for failure to diagnose the physical cause of an emergency medical condition when it provided a screening examination that is comparable to that offered to other patients with similar symptoms, stabilized the symptoms, and concluded that the patient was stable. Therefore, the only standard that has emerged under EMTALA is that patients are entitled to be provided with uniform treatment within the hospital's capabilities; however, the statute does not specify what is medically adequate and sufficient treatment.

In *Summers v. Baptist Medical Center Arkadelphia,* a patient was treated differently from other patients and differently from the treatment prescribed by the hospital's normal screening process.[8] Therefore, the patient requested recovery under EMTALA. The 8th Circuit Court of Appeals ruled that the treatment was simply a physician's negligence that EMTALA does not cover. The appellate court also emphasized that it would almost always be possible to characterize negligence in the screening process as nonuniform treatment because any hospital's screening process presumably will include a nonnegligent response to symptoms or complaints presented by a patient. Therefore, instances of negligence in the screening or diagnostic process are not actionable under EMTALA. This ruling reduced the reach of EMTALA imposing a limited duty on hospitals.

The *Jackson* case shows that the "appropriate medical screening" requirement does not necessarily mean correct diagnosis as long as uniform screening procedures are applied. Therefore, this type of claim is not covered under EMTALA as the statute is not a remedy for federal malpractice actions. On the other hand, the *Summers* case shows that even nonuniform medical screening cannot be covered under EMTALA because it is considered to be a negligence claim.

Suggestions for Compliance Officers

EMTALA's past court rulings suggest the areas of regulatory and enforcement that are of interest to the federal government. Although some of those areas remain unclear, it is beneficial for hospitals to adopt good compliance practices. Based on what is known from the past court cases, compliance officers should do the following as part of ongoing auditing and monitoring:

- Review all EMTALA-related policies and procedures to ensure that the legal and regulatory requirements are addressed adequately.
- Identify any weaknesses in the policy documents that might put a hospital at

risk of noncompliance or make it vulnerable for private cause of action.

- Verify the hospital is following its policies and procedures.
- Ensure appropriate medical screening procedures are applied uniformly to all people with similar symptoms presenting themselves in the emergency department. In other words, hospitals would have to be able to demonstrate that all patients were treated uniformly.
- Ensure the hospital provides an appropriate medical screening and does not compromise its own standards. Most enforcement actions resulting in civil monetary penalties have involved allegations that a hospital failed to provide appropriate medical screening examinations.

Endnotes:

1. 42 U.S.C. §1395dd. Congress enacted EMTALA under Section 9121 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (PubLNo. 99-272), 100 Stat. 164-167, available at www.medlaw.com/statute.htm.
2. Final rule, 73 FR 161, 48434-49084, Aug. 19, 2008.
3. *Inspector General v. Bowen*, HHS Departmental Appeals Board, Doc. No. A-2000-7, CR 618, Dec. No. 1720, March 23, 2000, available at www.hhs.gov/dab/decisions/dab1720.html.
4. *Bryant v. Adventist Health System*, 289 F.3d 1162 (9th Cir. 2002).
5. Final rule, 68 FR 174, 53221, 53243, Sept. 9, 2003.
6. Final rule, *supra* n. 2.
7. *Jackson v. East Bay Hospital*, 246 F.3d 1248 (9th Cir. 2001).
8. *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996).

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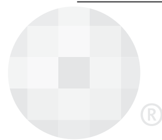

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