# EMTALA: The Law That Forever Changed the Practice of EM

September 25, 2018 by **Robert A. Bitterman, MD, JD, FACEP**

> *"The statutory definition renders irrelevant any medical definition."*
> *—Judge, in the case of U.S. Dept. of HHS vs. Dr. Burditt*

In the early 1980's, dreadful stories began to stack up about "patient dumping," the practice of refusing treatment due to a patient's lack of insurance or ability to pay. Some hospital emergency departments and physicians were refusing to treat patients in the throes of an emergency. Some only perfunctorily examined patients before transferring them (in medically unstable conditions) to public hospitals.

Congress responded to patient dumping in 1986 by enacting The Emergency Medical Treatment and Active Labor Act (EMTALA). While EMTALA did not address the causative issue of uncompensated care, it did guarantee universal emergency access for all. Through its financing powers under the Medicare Act, Congress required health care providers to assume fiscal responsibility for the emergency care of the indigent and the uninsured. Refusing treatment based on payment status could result in punitive fines, civil liability, or loss of participation in the Medicare and Medicaid programs. Essentially, the law created a federal right to emergency care for anyone in the United States.

## Background

More than 30 years after its enactment, EMTALA now governs virtually every aspect of hospital-based emergency medicine, including triage, registration, the "medical screening examination" done by the hospital's designated "qualified medical personnel" to determine if the individual has an emergency medical condition, and stabilizing treatment and transfer, which includes ED discharges. Unknown by many, EMTALA even controls the role of advanced practice providers in the emergency department or their participation in the on-call panel, as well as the duties of the nurses and obstetricians in the hospital's labor and delivery department. Hospital owned and operated ground and air ambulances, urgent care centers, psychiatric intake centers, and freestanding emergency departments also may be subject to EMTALA to varying degrees.

Privacy - Terms

But awareness of the law and an appreciation for its potential benefits spread very slowly at first. The Act was a mere four pages tucked into the "miscellaneous" section of the giant 2,200-plus page year-end omnibus bill.

The Centers for Medicare and Medicaid Services (CMS), the agency charged with drafting the EMTALA rules for hospitals and enforcing the law, took nearly 10 years to promulgate the initial regulations. Since that time, it has adjusted these regulations as well as published a number of explanatory EMTALA "Survey & Certification" memos and "Interpretive Guidelines."

The law itself was also amended a few times over the years, most meaningfully in 1989, to require our country's more capable hospitals to accept unstable patients in transfer from the emergency departments of less capable hospitals, if they had the capacity to stabilize the patient's emergency condition. Previously, tertiary hospitals refused to accept ED transfers, even of dying patients, unless payment was assured in advance, branded as "reverse dumping."

The Office of Inspector General (OIG) can impose civil, monetary penalties upon hospitals and physicians for EMTALA violations, or terminate physicians from Medicare. Congress recently more than doubled the amount of potential fines to almost $105,000 per violation and set the amount to increase annually by an inflation factor. Be somewhat grateful; Congress originally wanted physicians to pay $250,000 and spend five years in prison for violating the law.

## The Good

More than anything, EMTALA has changed the culture and the acceptable practice model in our nation's emergency departments. It fortified emergency physicians to remain steadfast in providing emergency care to all regardless of the external forces of the day—anyone, anywhere, any time.

Emergency physicians have also learned how to use the law to advocate for our patients. It was our specialty that, under the force of EMTALA, dismantled the detrimental preauthorization requirements, economic coercion, triage out practices, and other limits on access to emergency care imposed by insurers, managed care companies, and state Medicaid programs in the 1990s and 2000s.

More immediately, EMTALA has also improved the behavior of emergency physicians transferring patients, and those physicians accepting transfers on behalf of higher-level hospitals. Invoking EMTALA to demand appropriate responses from on-call physicians is

another everyday example of the law's usefulness in advocating for patients.

## The Not-So-Good

In enacting EMTALA, Congress used the Medicare Act to define, for the first time, a standard of care for emergency services. A boon for patients, yet it was a standard of care established by law, not by medicine—no less than 15 common emergency medical terms are now legally defined by EMTALA and its regulations. Many of the government's definitions mean something substantially different than what is generally understood by emergency physicians.

There is some frustration about the enforcement of EMTALA as it can be inconsistent across the country (CMS allows each of its 10 regional offices to function autonomously),which can unnecessarily drain hospital and physician time, money, energy, and damage a hospital's reputation. There is often little due process—hospitals must come into compliance as dictated by CMS or risk being terminated from Medicare. But there has been some improvement to this. For example, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 did require CMS to obtain a medical review by a physician from a Medicare Quality Improvement Organization before it could cite or terminate a hospital for violating the law.

The Office of Inspector General recently modified the factors it considers in determining the amount of penalty when it has found an EMTALA violation, adding more aggravating circumstances such as patient harm or even risk of harm resulting from that violation. Moreover, the presence of any single aggravating factor is now sufficient to justify imposing the maximum penalty. Worst of all, the OIG can attempt to impose the penalties for ordinary medical negligence, such as if an emergency physician's medical screening exam fails to diagnose a patient's emergency condition.

Finally, civil enforcement under EMTALA via lawsuits has expanded the liability of hospitals, since the hospital is directly liable for any patient harm caused by violations of the law by the hospital's staff or by the responsible physicians—the emergency physician and/or on-call physician. Furthermore, plaintiff's attorneys have learned how to use EMTALA to circumvent state tort reform protections and even the damages caps in some states.

## The Future

Now, we look to the future of EMTALA and the influence it has on our practice.
Yes, EMTALA contributed to crowding, boarding, lack of specialty coverage, increased

transfers, and governmental insertion into the practice of medicine, and it poses a giant unfunded mandate on emergency providers.

However, it unquestionably saves lives. It affirms the unique and venerable role of the specialty of emergency medicine as the safety net of the U.S. health care system. ACEP should be proud of its 50 years advocating for patient access to emergency care, and EMTALA has profoundly facilitated that mission.

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