



## EMTALA Overview for Ophthalmologists

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*This information is intended solely to provide risk management recommendations. It is not intended to constitute legal advice and should not be relied upon as a source for legal advice. If legal advice is desired or needed, an attorney should be consulted. This information is not intended to be a modification of the terms and conditions of your OMIC policy of insurance. Please refer to your OMIC policy for these terms and conditions.*

**Version 10/24/06**

Ever since it was passed by Congress in 1986, EMTALA—the Emergency Medical Treatment and Active Labor Act—has played a major role in determining how hospitals and physicians treat patients in the emergency room (ER).<sup>1</sup> This discussion is designed to provide ophthalmologists with an overview of the aspects of the **current** federal regulations that most impact them. Prior regulations, or aspects of EMTALA that are unlikely to apply to ophthalmologists, such as determining if a woman is in labor, are not addressed. For ease of use, this discussion is organized in a question and answer format and contains legal information from attorneys who have special expertise in this arena. At times, the legal situation is not clear. In those instances, ophthalmologists should exercise their medical judgment and prioritize patient safety.

The EMTALA regulations contain many defined terms. Ophthalmologists should be careful to distinguish between their usual understanding of these terms (e.g., *emergency medical condition*) and the legal definition given in the EMTALA regulations. Words with special legal meaning are placed in *italics* and explained as necessary.

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<sup>1</sup> Published in draft form in 1988, the interim final regulations were filed in 1994. The statute was amended in 2000, but some of those changes were repealed in the 2003 amendments. The Center for Medicare and Medicaid Services (CMS) published Interpretive Guidelines in 1996, which were revised in 1998 and 2004, as well as Special Advisory Bulletins. The EMTALA statute is found in the United States Code Title 42 Section 1395dd, and the regulations are in the Code of Federal Regulations Title 42 Sections 413.65(g), 482.12, 489.20, and 489.24. The Interpretive Guidelines are in the *Medicare State Operations Manual*, Appendix V, Part 2, Column III.

In addition to the federal requirements under EMTALA, there may also be state laws or regulations governing emergency room care, as well as duties imposed by hospital medical staff by-laws or HMO contracts. Ophthalmologists should verify their understanding of these other laws and regulations. Detailed recommendations about obligations ophthalmologists have as consultants to a hospital emergency room are treated in “The Ophthalmologist’s Role in Emergency Care: On-Call and Follow-up Duties under EMTALA,” available at [www.omic.com](http://www.omic.com).

## **HISTORY, ENFORCEMENT, AND CONSEQUENCES OF NONCOMPLIANCE**

### **Why was EMTALA enacted?**

Congress focused attention on access to emergency care after news reports surfaced of uninsured pregnant women being refused care despite being in labor. Studies ensued which confirmed that “indigent emergency patients had been turned away from hospitals for necessary services or transferred (i.e., “dumped”) to public and charity hospitals in an unstabilized condition” (M. Steven Lipton, *A Guide to Patient Anti-Dumping Laws*, California Hospital Association, 2004, page 5; page numbers in parentheses refer to this publication). In response, Congress enacted EMTALA in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA). It was designed to meet two primary objectives: enhance access to emergency care for all patients, and “prohibit discrimination in the provision of emergency services to persons presenting with the same or similar types of conditions” (5).

### **Who must comply with EMTALA?**

The EMTALA obligations are a condition of the Medicare provider agreement with hospitals and physicians. They thus apply to all patients seen at hospitals that participate in Medicare, regardless of the patient’s financial or insurance status (5). Physicians and other providers who see patients in the hospital, or who have agreed to serve on call to the hospital, must also abide by the EMTALA laws and regulations.

### **Who oversees EMTALA and what are the consequences of noncompliance?**

The enforcement of EMTALA is a complaint-driven process; once a complaint is filed, it is investigated. If a violation is confirmed, penalties apply (126). At the federal level, several agencies are involved. The Centers for Medicare and Medicaid Services (CMS) have the authority to conduct complaint and enforcement surveys for compliance, and to terminate a hospital’s Medicare provider agreement if EMTALA violations are confirmed. The Office of Inspector General (OIG) can impose civil money penalties up to \$50,000 against hospitals and physicians (\$25,000 for hospitals with less than 100 beds), and/or exclude a hospital or physician from the Medicare program. There are regional quality improvement organizations—these used to be called provider review

organizations or PROs—which help CMS and OIG evaluate EMTALA issues. The Office for Civil Rights may further evaluate violations confirmed by CMS that have been committed by hospitals with certain community service obligations (5-6).

In addition to federal agencies, private organizations and state agencies also exercise oversight and impose sanctions. The healthcare facility may lose its accreditation from the Joint Commission on the Accreditation of Health Care Organizations (JCAHO). State departments of health services may also impose civil penalties and revoke a hospital's emergency medical service permit. State medical boards may impose civil penalties against physicians and take licensure actions, and district attorneys may bring misdemeanor charges against individuals.

### **Can a patient sue me for an EMTALA violation? What are the differences between my EMTALA obligations and the standard of care?**

Ophthalmologists should be mindful of differences between their duties and liability risks under EMTALA compared to those imposed by the physician-patient relationship. EMTALA mandates a *medical screening examination* and *stabilizing* treatment. Lawsuits for EMTALA obligations—which can only be filed against a hospital—may be brought in state or federal court. They would address, for example, whether under the federal regulations 1) the screening process was applied in a non-discriminatory manner, 2) it was reasonably calculated to determine whether an *emergency medical condition* existed, and 3) if the hospital used all of its resources, including on-call physicians, to screen and stabilize the patient.

Courts have consistently ruled that EMTALA does not address the **quality** of the mandated examination or treatment. In order for a patient to seek redress for a misdiagnosis or negligent treatment, he or she would have to sue the hospital and/or physician(s) under the state's medical malpractice statutes. In this civil proceeding, expert witness testimony would help establish if the provider met or deviated from the standard of care. This standard is often defined as what a reasonably prudent physician/provider would do under the same or similar conditions.

### **Does my OMIC policy cover me for EMTALA violations?**

OMIC's *Professional Liability* policy would respond to medical malpractice lawsuits related to emergency care. EMTALA violations would be covered by the \$25,000 *Broad Regulatory Protection Policy (BRPP)* OMIC policyholders are automatically provided upon purchase or renewal of their malpractice coverage. *BRPP* pertains to many types of regulatory issues, including EMTALA, and covers reimbursement for legal fees, certain audit expenses, and fines and penalties (when allowed by law). Members of the American Academy of Ophthalmology may purchase the *BRPP*.

## **EMTALA OBLIGATIONS**

Under EMTALA, any individual who comes to the *emergency room* and requests an examination for a medical condition must be afforded a *medical screening examination (MSE)* to determine the presence of a *emergency medical condition (EMC)*. If an *EMC* exists, it must be *stabilized*. Once a physician determines that no *EMC* exists, it has been *stabilized*, or the patient is admitted to the hospital, EMTALA no longer applies.

### **Where does EMTALA apply? Does it apply to inpatients and scheduled visits?**

This has been one of the most contentious issues surrounding EMTALA. In 2003, CMS clarified that EMTALA is triggered when an individual *comes to the emergency department* and requests examination for a medical condition. The *emergency department* includes a *dedicated emergency department*,” the hospital *campus*, an air or ground ambulance owned and operated by the hospital, and a non-hospital owned air or ground ambulance that is on hospital property. *Dedicated emergency departments* meet certain criteria, including licensure by the state in which they are located, and “holding themselves out” to the public as a place that provides care for emergency conditions on an urgent basis without a previously scheduled appointment (22-23). The *campus* includes the physical area immediately adjacent to the hospital’s main buildings and other structures within 250 yards of the main building (15). The regulations indicate that the request can be made by someone else on the individual’s behalf, or be assumed if a prudent layperson observer would believe, based upon the individual’s appearance or behavior, that the individual needs examination or treatment for a medical condition (20).

EMTALA now does not apply to inpatients, facilities, or services that are not considered part of the hospital for Medicare purposes (22), or off-campus provider-based departments and facilities of a hospital that are not *dedicated emergency departments* (28). It also does not apply to visitors, guests, vendors, and hospital employees (30). Furthermore, if a patient makes a request for non-emergency services, EMTALA applies only if the individual presents for these services in a *dedicated emergency department*. It is not clear if this restriction applies to patients who have an appointment for hospital-based services, so attorneys advise following EMTALA if the patient with an appointment presents to a *dedicated emergency department* (28-29).

### **What are the obligations of Medicare-participating hospitals with *dedicated emergency departments*?**

The intention of EMTALA is to ensure that all persons who come to the ER with the same or similar types of conditions are evaluated and *stabilized* in similar ways before they are discharged home or transferred to another healthcare facility. To ensure this equal access and treatment, hospitals must:

- provide a *medical screening examination (MSE)* to each individual who “comes to the hospital and requests examination for a medical condition”;

- provide necessary *stabilizing treatment* for *emergency medical conditions* (EMC) and *labor*;
- provide for an *appropriate transfer* of the patient if the hospital does not have the capability or capacity to provide the treatment necessary to *stabilize the emergency medical condition*; and
- accept *appropriate transfers* of patients with *emergency medical conditions* if the hospital has specialized capabilities not available at the transferring hospital and has the capacity to treat those individuals.

Other duties include the maintenance of a central log, an on-call schedule, and signage, and to report suspected EMTALA violations, such as when an on-call physician does not respond, or a hospital does not effect an *appropriate transfer*. The hospital must maintain medical and other records for a period of five years.

### **Financial issues**

EMTALA and the efforts of managed care plans to limit costs have often been in conflict. Current Guidelines emphasize that “a managed care plan may only state the services for which it will pay or decline payment,” and that decisions about coverage do not affect the hospital’s obligation to comply with EMTALA (61). Thus the hospital may not delay providing a *medical screening examination* or other emergency services in order to inquire about an individual’s method of payment. It can follow reasonable registration processes but “cannot seek prior authorization for screening or stabilizing services until the hospital has provided the medical screening and initiated further examination and stabilizing treatment” if indicated (61). Once the stabilizing treatment has begun, the hospital may contact the plan to obtain prior authorization.

The prohibition on contacting a health plan for prior authorization does not apply to consulting with physicians. A Special Advisory Bulletin clarified that the emergency physician may “contact any physician who can provide clinical information that will assist the treating physician in providing emergency services to the patient” as long as the consultation does not “inappropriately delay services” (64). Off-site physicians should not “attempt to limit or deny necessary emergency services for the patient or influence the treating physician to transfer or discharge the patient” (64). Patient questions about his or her financial liability for emergency services should be answered honestly, but the hospital should clearly convey its obligation to provide the *MSE* and *stabilizing* treatment

### **What is a *medical screening examination* and who may perform it?**

The *medical screening examination* (MSE) is the process that determines, with reasonable clinical confidence, whether such an *emergency medical condition* exists. The examination can range from a simple process involving only a brief history and physical, to a complex one that involves performing ancillary studies and procedures routinely available to the emergency department. It should be tailored to the individual’s presenting symptoms and medical history. The Guidelines clearly state that “triaging” the patient is not equivalent to performing a MSE. It is very important to provide the MSE in the same manner to all

individuals presenting with similar signs and symptoms. Finally, medical staff by-laws must state who may perform the MSE (39).

EMTALA entitles patients to screening and stabilizing treatment of *emergency medical conditions*; it does not mandate any care beyond that. Thus, if the patient does not have an “*emergency medical condition*,” or it has been *stabilized*, the hospital’s EMTALA obligations end. Similarly, if the patient’s emergency condition requires hospitalization for further treatment, EMTALA no longer applies.

**What is an emergency medical condition?**

Defined from the perspective of a prudent layperson with an average understanding of medicine, an *emergency medical condition* (EMC) is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse), such that the absence of immediate medical attention could reasonably be expected to result in:

- placing the individual (or, with respect to a pregnant woman, the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part (14).

**When is an emergency medical condition stabilized?**

To *stabilize* an EMC means to provide medical treatment as necessary to ensure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer or discharge of the patient from the facility (79). CMS clarified in November 2003 that an EMC is considered *stabilized* when the treating physician has determined, within reasonable clinical confidence, that the *emergency medical condition*—not the underlying medical condition—has been resolved. Using asthma as an example, CMS stated that if an individual comes to the ER during an asthma attack, the hospital and treating physician must alleviate the acute respiratory symptoms. Once this *EMC* has been resolved, EMTALA no longer applies, and the hospital patient may discharge the patient, admit the patient, or transfer the patient as needed (note that If the EMC is not resolved, then an *appropriate transfer* must be effected).

**What must the hospital do in order to effect an appropriate transfer of a patient who has not been stabilized?**

Patients who have not been *stabilized* can only be transferred if there is a patient request or a physician certification (78). In order for the transfer to be deemed *appropriate*, four conditions must be met.

1. Before transfer, the hospital must provide treatment within its capability and capacity in order to minimize the risks of the transfer.

- This includes the use of on-call physicians.
  - Prior to departure, the hospital must conduct and document a timely reassessment of the patient's condition.
2. The hospital must find another hospital that has available space and qualified personnel to provide treatment to the patient and obtain the receiving hospital's acceptance of the transfer.
  3. The hospital must transfer all medical records related to the emergency condition available at the time of transfer, including informed consent and certification for the transfer, and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment.
    - The transferring physician must obtain the patient's informed consent. To do this, he or she must "certify that the medical benefits reasonably expected from treatment at the receiving facility outweigh the increased risks to the patient from the transfer" (77). The written certification must "include a summary of the risks and benefits upon which it was based" (78).
  4. The transferring hospital must use qualified personnel, equipment, and transportation to effect the transfer.

#### **What are the obligations of receiving hospitals?**

When a hospital is asked to accept the transfer of a patient with an *emergency medical condition* that is not *stabilized*, it must accept the transfer. It can only refuse to accept the transfer if 1) the patient's *EMC* has resolved; 2) it does not have the present capacity or capability to provide the needed emergency services, or 3) the transferring hospital itself has the present capacity and capability to provide the emergency services; i.e., the transferring hospital can provide the same level of services as the receiving hospital and is trying to effect a "lateral" transfer (99). This obligation to accept transferred patients applies to on-call physicians at the receiving hospital as well.

#### **When is an individual with an EMC *stabilized* or *stable for discharge*?**

Once the EMC is resolved, the patient may be discharged. As defined in the CMS Interpretive Guidelines (IG), "an individual is considered stable and ready for discharge when, within reasonable clinical confidence, it is determined that the individual has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an in-patient, provided the individual is given a plan for appropriate follow-up care as part of the discharge instructions" (80).

#### **On-call and follow-up duties**

Detailed recommendations about obligations ophthalmologists have as consultants to a hospital emergency room is treated in "The Ophthalmologist's Role in Emergency Care: On-Call and Follow-up Duties under EMTALA," available at [www.omic.com](http://www.omic.com). OMIC policyholders can earn a 5% risk

management premium discount and CME credits by taking the online EMTALA course.

**OMIC policyholders who have additional questions or concerns about practice changes are invited to call OMIC's confidential Risk Management Hotline at (800) 562-6642, extension 641.**