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# Compliance Today - December 2019
# EMTALA: What hospitals and physicians need to know

By Jennifer McAleer, MBA, MSPPM, CHC, CHPC, CCEP, CHRC

**Jennifer McAleer** (jennifer.mcaleer@swedish.org) is Chief Compliance & Privacy Officer, Research Integrity Officer, Office of Compliance & Privacy, Swedish Health Services, Seattle, WA.

The Emergency Medical Treatment and Labor Act (EMTALA),[1] passed by Congress in 1986 as a result of high-profile patient dumping, has morphed into a complex regulation with implications many hospitals might not fully comprehend.

In short, if an individual presents at a Medicare-participating hospital's emergency department (or anywhere within 250 yards of the hospital's property) requesting treatment, EMTALA requires that the hospital provide a medical screening examination (MSE) to the individual, regardless of the individual's actual or perceived ability to pay for the services.[2] An MSE is defined as an appropriate medical screening examination within the capability of the hospital's emergency department, including tests routinely available to the emergency department, to determine whether or not an emergency medical condition exists. If the individual presents to the emergency department but is unable to request treatment for themselves, the requirement still stands if a prudent layperson/observer would reasonably believe that the individual needs examination or treatment.

If an emergency medical condition (EMC)[3] is determined to exist, the patient must then be *stabilized* prior to transferring or discharging them. An EMC is defined as 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. If a pregnant woman is having contractions, there must be adequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.

In some cases, patients can be transferred to another hospital if the EMC that caused the patient to seek care is stabilized (even if an underlying medical condition persists), if the patient requests the transfer, or if the patient requires specialized treatment that cannot be provided at the initial facility, as long as the medical benefits of the transfer outweigh the risks. In all circumstances, a transfer form must be completed prior to the transfer taking place.

## Clinically stable vs. EMTALA stable

Clinicians point out that there is a discrepancy between standard medical terminology referring to "stabilization" and the EMTALA definition of stabilization, and they are correct. Under EMTALA, "stabilized" means that no material deterioration of the patient's condition is likely, with reasonable medical probability, to result from or occur during the transfer or discharge of the patient from the facility. In the case of a woman in labor, stabilized means that she has delivered her child, along with the placenta.

To be stabilized does not mean that the underlying medical condition has been resolved, but instead refers to the

resolution of the EMC determined to be present at the time of the MSE. Sometimes it will be necessary for those patients classified as unstable under EMTALA to be transferred, if the hospital does not have access to the services or equipment needed to evaluate or treat the patient. Patients transferred to higher levels of care are usually not considered stable under EMTALA. This means that unless the comprehensively documented benefits outweigh the risks, transferring the pregnant woman to another hospital *may* be an EMTALA violation, even if the hospital does not have a designated obstetrics service.