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EMTALA confusion: Clinically stable, stable for transfer, and stabilized

by Mary Ellen Palowitch MHA, RN

The terms *clinically stable* and *stable for transfer* are frequently used by and familiar to emergency department and hospital staff. When it comes to compliance with the Emergency Medical Treatment and Labor Act (EMTALA) in hospitals, however, the key term is *stabilized*.

This article will provide clarity on the use of these important terms in everyday clinical practice as well as their impact on EMTALA complaint investigations. This information will be helpful to clinical, compliance, and administrative staff working in Medicare-participating hospitals.

Background

EMTALA was signed into law in 1986. The law was passed to address nationwide outrage against what was then known as "patient dumping."[1] Some hospitals refused to provide care to individuals without insurance, the right type of insurance, or the ability to pay. Hospital staff would send patients to public hospitals, frequently with minimal or no treatment for their emergency medical conditions. This inappropriate "dumping" of patients resulted in harm and even death.

Hospitals, including critical access hospitals, that receive Medicare funding are required to comply with Medicare provider agreement requirements, which include compliance with EMTALA. EMTALA requires hospitals to provide a screening examination of all individuals who "come to the emergency department" for evaluation of possible emergency medical conditions.[2] The hospitals must then provide stabilizing treatment for any emergency medical conditions identified or if unable to stabilize the patient, arrange appropriate transfers to facilities with the capabilities and capacity to provide the necessary treatment. The EMTALA requirements are located in the Medicare provider agreement regulations.[3]

EMTALA applies to all individuals—not just Medicare and Medicaid beneficiaries—regardless of insured status, type of insurance, or ability to pay. Hospitals cannot refuse to provide emergency care to individuals based on race, color, national origin, age, disability, or sex. EMTALA also applies to individuals from outside of the United States who present to hospitals for evaluation of potential emergency medical conditions without regard to country of residency or immigration status.

Compliance and enforcement

Compliance with EMTALA is a complaint-driven process. In contrast to the routine compliance assessment of the

Medicare conditions of participation for recertification or reaccreditation (which typically occurs every three years), EMTALA is not routinely surveyed.

Complaints to the Centers for Medicare & Medicaid Services (CMS) or the state survey agencies in state departments of health come from various sources including patients, family, friends, physicians, nurses, and other healthcare professionals. News reports can also generate complaints. CMS analysts are responsible for determining if an onsite investigation will be performed—even if the complaint is initially submitted to the state survey agency or another state health department division. The CMS Locations (previously known as Regional Offices) review the complaint and may even reinterview the complainant as needed. If the allegations of the complaint are determined to be serious enough to potentially result in an immediate jeopardy or condition-level finding, an on-site survey will be authorized. Complaint processes of Medicare and Medicaid providers and suppliers are described in "Chapter 5—Complaint Procedures" of the *CMS State Operations Manual*.[4]

State and occasionally federal surveyors will present on-site to investigate the complaint's allegations. The investigation will include a thorough assessment of all EMTALA requirements—not only the requirement(s) potentially implicated by the allegations. For example, suppose the complainant says they did not receive a complete medical screening examination (MSE). Then the survey will review medical record documentation of other emergency department patients to determine the presence and appropriateness of their MSEs. In addition, the investigation will also assess compliance with all other EMTALA requirements (e.g., stabilizing treatment, transfers, logs, on-call lists, signage, policies, procedures, etc.).

The on-site surveyors determine if the allegations of the complaint are substantiated and whether the hospital is currently in compliance with all EMTALA requirements. Additional unrelated findings may also be identified. The surveyor(s) complete the statement of deficiencies on Form CMS–2567, but the CMS analyst will make the final determination of compliance for the hospital.[5]

If the provision of clinical care is in question, CMS will send the case to one of the Beneficiary and Family Centered Care Quality Improvement Organizations (QIO) for physician review. The QIO physicians will not weigh in on the compliance determination but will address questions regarding the care provided based on the capabilities and capacity of the hospital. The CMS analyst will review both the state investigation materials and the QIO physician reviewer comments on the CMS Exhibit 138 EMTALA Physician Review Worksheet to make the final determination of compliance.[6]

The hospital will be notified of the survey results. If noncompliance is identified, the notification will include whether the hospital is at risk of termination in 23 days (immediate jeopardy level) or 90 days (condition level). The hospital must then submit a plan of correction within 10 days to address each issue. The CMS analyst will review the plan and, if deemed acceptable, will authorize a revisit survey by the state to ensure compliance has been achieved. The revisit survey must be completed prior to the tentative termination date. The process from initial to final survey can occur over a few weeks but may also last months.