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Complete Healthcare Compliance Manual
Emergency Medical Treatment and Labor Act (EMTALA)

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What Is the Emergency Medical Treatment and Labor Act (EMTALA)?

The Emergency Medical Treatment and Labor Act (EMTALA), known as the "anti-dumping law," was part of the Consolidated Omnibus Budget Reconciliation Act of 1986, resulting from hospitals "dumping" indigent emergency patients.[2] The statute was amended in 1988, 1989, 2003, and 2011.

The law, signed by President Ronald Reagan, was in response to public outrage over a surge in community hospitals transferring unstable emergency patients to public hospitals for financial purposes. EMTALA was the first law that guaranteed individuals a right to healthcare, though it was and continues to be limited to healthcare treating emergency conditions. EMTALA continues to be an unfunded mandate, and hospitals often absorb the cost of treating these uninsured patients needing emergency care.

EMTALA requires that any Medicare-participating hospital that has a dedicated emergency department (DED) must provide a medical screening examination (MSE) to any individual who presents to the hospital (or anywhere within 250 yards of the hospital's main buildings) requesting treatment. A DED is defined as "any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

1. "It is licensed by the State in which it is located under applicable state law as an emergency room or emergency department;
2. "It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
3. "During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year,...at least one-third of all of its outpatient visits [are] for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment."[3]

An MSE is defined as an "appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists."[4]

Treatment must be provided in a nondiscriminatory way, regardless of the individual's actual or perceived ability to pay for the services, and regardless of diagnosis, race, national origin, or disability. The statute also prohibits "reverse dumping," where a hospital would refuse to receive the transfer of a patient based on the same criteria.

If an individual presents to the emergency department but is unable to, or fails to, request treatment for themselves, the requirement still stands if a prudent layperson would reasonably believe that the individual needs emergency examination or treatment. If an emergency medical condition (EMC) is determined to exist, the

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patient must then be stabilized prior to being transferred or discharged.[5] 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… (i) 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, (ii) serious impairment to bodily [organs]…; or…with respect to a pregnant woman who is having contractions,… (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child." Psychiatric disturbances as well as symptoms of substance abuse are also considered under the definition of an EMC.[6]

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.

Risk Area Governance

The Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Health & Human Services Office of Inspector General (OIG) have ultimate oversight responsibility for EMTALA, including conducting investigations and issuing enforcement actions, although violations of EMTALA are also reported to the Department of Justice (for evaluation of possible Hill–Burton Act violations), the Office for Civil Rights (for evaluation of discrimination allegations), the Internal Revenue Service (for evaluation of implications for tax-exempt status), and The Joint Commission (for accreditation review).[7][8]

CMS has adopted and published interpretive guidelines as part of the *Medicare State Operations Manual*, which provides guidance to state and federal surveyors in their investigation and enforcement of EMTALA. While not considered regulations, the interpretive guidelines are considered the official interpretation of EMTALA and are used to evaluate compliance. CMS published revisions to the interpretive guidelines in 2019.[9] Occasionally, CMS also publishes program memoranda and frequently asked questions regarding EMTALA.[10] The most recent memorandum was published in March 2020 and provides guidance regarding complying with EMTALA during the COVID-19 pandemic.[11] Details of these memoranda are often incorporated into updates of the interpretive guidelines, keeping the these guidelines the most comprehensive source of EMTALA guidance for hospitals and regulators alike.

The enforcement of EMTALA is mainly a complaint-driven process. The interpretive guidelines require a hospital that has received an improper transfer from another hospital to report the violation within 72 hours, or face potential sanctions, including possible misdemeanor charges or termination of its Medicare provider agreement. There is no legal obligation to self-report; however, if a hospital believes that the receiving hospital is likely to report to CMS, there may be some benefit to self-reporting a violation. Hospitals should consider the risks and benefits of self-reporting, which are determined by the specific circumstances and must be evaluated on a case-by-case basis.

If CMS receives a complaint, or otherwise becomes aware of a possible EMTALA violation, CMS most often will direct the state survey agency to conduct a complaint survey of the hospital. CMS may also choose to conduct the survey itself. The surveys are unannounced, and the scope typically expands beyond the violation that was reported. Results of the survey are forwarded to CMS, which then determines whether an EMTALA violation occurred and, if so, determines appropriate penalties. There is sometimes a discrepancy between the state survey agency and CMS due to the depth of EMTALA knowledge of the state survey agency or the interpretation of the

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regulation. While state survey decisions are important, decision-making authority regarding an EMTALA violation lies solely with CMS. If CMS decides that an EMTALA violation has occurred, it will initiate an investigation that can result in Medicare program exclusion, substantial civil monetary penalties, and corrective actions.

Oftentimes an incident investigated by CMS may lead to the discovery of more than one violation, resulting in significant penalties to a hospital. The physician(s) involved may also face disciplinary actions by state licensing boards' Quality Improvement Organization hearings and disciplinary actions by the hospital's medical staff leadership committee.

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