Emergency Medical Treatment and Active Labor Act (EMTALA)

June 2007

History
The Emergency Medical Treatment and Active Labor Act (“EMTALA”) was passed by the United States Congress as part of the Consolidated Omnibus Budget Reconciliation Act of 1985.

The law is a response to “patient dumping” where a hospital refuses admission to persons lacking health insurance. Hospital administrators denied that EMTALA was necessary, arguing that current hospital policies and procedures could ensure patient access to needed emergency care. Nevertheless, the Congress passed the law in light of studies and public concern over patient dumping by hospitals.

Basic Provisions of the Law and Regulations
True to its purpose, the Act and regulations primarily focus upon the duties and activities of hospitals. EMTALA requires hospitals to provide an appropriate medical screening examination and stabilizing treatment for emergency medical conditions and labor.

Medical Screening Requirement
In the case of a hospital that receives Medicare reimbursement and maintains an emergency department, if an individual comes to the emergency department and requests examination or treatment for a medical condition the hospital must

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2 See generally Id. See also, Brian Kamoie, EMTALA: Dedicating an Emergency Department Near You, Journal of Health Law, 37 J. Health L. 41, 43 (2004).
3 42 USCA §1395dd (a) & (b).
provide an *appropriate medical screening examination* to determine whether an 
*emergency medical condition* exists.4

Each of the italicized phrases above has a specific meaning under the law.

An *emergency department* has been defined by regulation to be any department or 
facility of the hospital, regardless of whether it is located on or off the main 
campus that meets at least one of the following elements:

- It is licensed by the State as an emergency room (Texas does not license 
enemy rooms);
- It is held out to the public as a place that provides care for emergency 
conditions on an urgent basis without appointment; or
- It provides at least one-third of all out-patient visits for the treatment of 
emergency medical conditions on an urgent basis.5

In comments associated with the adoption of EMTALA regulations CMS stated 
“we believe that most provider-based urgent care centers that are held out to the 
public as such will meet the revised definition of dedicated emergency department 
for purposes of EMTALA.”6 Thus, an urgent care or “free-standing” emergency 
room associated with a hospital (as EMTALA only applies to hospitals) that is off 
campus will likely meet the definition of a dedicated emergency department for 
purposes of EMTALA enforcement.

An individual *comes to the emergency department* if the individual has presented 
at the hospital’s emergency department, has presented on hospital property, or is 
in a ground or air ambulance owned and operated by the hospital even if the 
ambulance is not on the *hospital property.*7

An individual *requests* examination or treatment if the patient (or someone on the 
patient’s behalf) actually requests treatment or if a prudent layperson observer 
would believe, based on the individual’s appearance or behavior, that the 
individual needs examination or treatment for a medical condition.8 The prudent 
layperson standard was placed into regulation because the government was 
“concerned about the circumstance where hospital staff observe the appearance or 
behavior of an individual who clearly has an emergency medical condition, but do 
nothing to provide treatment for that individual.”9 It is important to note that the 
government expressly stated that, “. . . for presentments inside the dedicated 
emergency department, the proposed standard is that the prudent layperson 
observer would believe, based on the individual’s appearance or behavior, that the 
individual needs examination or treatment for a medical condition. . . ” and is not 
limited to only *emergency medical conditions.*10

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4 42 USCA §1395dd (a)  
5 42 CFR §489.24(b)  
7 Id.  
8 Id.  
An appropriate medical screening examination is an examination within the capability of the hospital’s emergency department, including ancillary services routinely available through the emergency department, sufficient to determine whether an emergency medical condition exists. The examination must be conducted by an individual or individuals who are qualified by rules or bylaws to make such determinations. An appropriate medical screening examination is not triage, but is the process of determining whether an emergency medical condition exists. An appropriate medical screening examination is a process that can range from a simple history and physical examination to the utilization of very complex techniques and ancillary studies and procedures.

An emergency medical condition is a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be reasonably be expected to result in:

- Placing the health of the individual (or unborn child of a pregnant woman) in serious jeopardy;
- Serious impairment to bodily functions: or
- Serious dysfunction of any bodily organ or part.

Where the individual is a pregnant woman an emergency medical condition exists if the woman is having contractions and there is inadequate time to effect a safe transfer to another hospital prior to delivery or the transfer may pose a threat to the health or safety of the woman or unborn child.

However, a pregnant woman in false labor does not have an emergency medical condition. Prior to 2006 modifications to the regulations, a physician’s written certification of false labor was necessary.

The American College of Obstetricians and Gynecologists recommended that the federal government amend the EMTALA regulations to allow certified nurse midwives and other qualified medical persons to determine whether a woman is in false labor. The government accepted the College’s recommendation and now non-physicians may certify false labor.

The regulations make clear that the emergency department is not the only place within a hospital where the EMTALA duty to provide an appropriate medical screening examination may spring. A person who presents on hospital property is considered to have “come to the emergency department” for the purposes of EMTALA. However it is important to note that for “presentments on hospital property outside the dedicated emergency department, the prudent layperson

11 42 CFR §489.24(a)(i).
14 42 USCA §1395dd(e)(1).
16 42 CFR §489.24(b).
would believe the individual needs examination or treatment for an emergency medical condition” and not merely a medical condition.\textsuperscript{17}

The government has defined hospital property to be the entire main campus of the hospital including the parking lot, sidewalk, and driveway, but excludes other areas or structures that are not part of the hospital, such as leased physician offices, rural health centers, or skilled nursing facilities.\textsuperscript{18}

\textbf{Stabilizing Treatment}

If the individual suffers from an emergency medical condition, then EMTALA dictates that the hospital must provide care to stabilize the emergency medical condition without delay.\textsuperscript{19}

Under EMTALA to stabilize means that medical treatment of the condition is provided as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer or, with respect to a pregnant woman, to deliver (including the placenta).\textsuperscript{20}

Until the patient’s emergency medical condition is stabilized, transfers to other facilities are restricted by the law.\textsuperscript{21} Interestingly, some courts have held that EMTALA does not require a hospital to completely alleviate the patient’s medical condition, merely stabilize it.\textsuperscript{22}

\textbf{Prohibited Transfers and Appropriate Transfers}

Once it is determined a patient has an emergency medical condition, as defined by the law, transfers are restricted unless:

1. The individual, or a person acting on behalf of the individual as a proxy decision maker, after being informed of the hospital’s duties under EMTALA and the risk of transfer, requests a transfer to another facility. The request must be in writing.

2. A physician has signed a certification that, based upon the information available, the medical benefits reasonably expected from the provision of care at another facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child, from effecting a transfer; or

3. If a physician is not present, a signed certification from a qualified medical person after consultation with a physician and the physician makes a determination that the medical benefits reasonably expected from the provision of care at another facility outweigh the increased risks to the

\textsuperscript{17} 68 Fed. Reg. 53242.
\textsuperscript{18} 42 CFR §489.24.
\textsuperscript{19} 42 USCA §1395dd (b) & (h).
\textsuperscript{20} 42 USCA §1395dd(e)(3).
\textsuperscript{21} 42 USCA §1395dd(c).
\textsuperscript{22} Ercan Iscan, EMTALA’s Oft-Overlooked “Reverse Dumping” Provision and the Implications for Transferee Hospital Liability Following St. Anthony Hospital, 82 Wash. U.L.Q. 1201, 1209 (citing, Brooker v. Desert Hospital Corp., 947 F2d 412 (9th Cir. 1991)).
individual and, in the case of labor, to the unborn child, from effecting a transfer, and the physician subsequently counter-signs the certification.23

A transfer made under the three exceptions above must also meet the elements for an appropriate transfer. An appropriate transfer is a transfer:

- In which the transferring hospital provides medical treatment within its capacity which minimizes the risks to the individual’s health, including the unborn child, and sends all medical records associated with the emergency;
- Where the transfer is effected through qualified personnel and transport equipment;
- Where the transferring hospital is required to provide the name and address of any on-call physician who has refused to appear within a reasonable time to provide treatment to the receiving hospital; and
- Where the receiving facility has space and qualified personnel for the treatment of the individual and has agreed to accept the transfer.24

The capacity of a hospital to provide care encompasses such things as the availability of qualified staff, availability of beds and equipment, as well as the hospital’s past practices of accommodating additional patients.25

Reverse Dumping

“Reverse Dumping” occurs when a receiving hospital refuses an appropriate EMTALA transfer despite the fact that the receiving hospital has the capacity to treat the patient. Or, more simply stated, “reverse dumping occurs when a capable hospital refuses to accept the [appropriate] transfer of an unstable patient.”26

Receiving hospitals have a mere “modicum of discretionary authority based on their capacity and specialized capability to treat patients.”27 EMTALA prohibits reverse dumping.

Hospital Maintenance of a Call List

Each hospital must maintain an on-call list of physicians in a manner that best meets the needs of the hospital’s patients.28 Of the many EMTALA hospital requirements, this duty often leads to confusion and friction between the hospital administration and medical staff.29 However, it should be noted that the

23 42 USCA §1395dd(c)(1).
24 42 USCA §1395dd(c)(2).
25 42 CFR §489.24(b).
27 Iscan, supra note 22, at 1217.
28 42 USCA §1395dd(j).
regulation expressly states that a hospital does not have to develop or create *additional* resources for patients in that the duty is limited to “the resources available to the hospital, including the availability of on-call physicians.”

**EMTALA Duties Discharged**

EMTALA duties are discharged when the patient is admitted, a screening examination has been provided with a determination that an emergency medical condition does not exist, when the emergency medical condition is stabilized, or when an appropriate transfer is made.

The discharge of EMTALA duties upon admission is a result of court decisions and the subsequent modification of the regulations in 2003. When adopting those regulations the government stated that, in regard to admission of a patient fulfilling EMTALA duties, that the government believes state liability laws on abandonment and negligence offer patients protection where EMTALA protections end and that the government will closely scrutinize hospital behavior to ensure “subterfuge” admissions do not occur. However, the restriction on transfers until stabilization remains even upon admission.

**Physician EMTALA Duties**

An on-call physician who fails or refuses to appear within a reasonable period of time when requested may be subject to sanctions under EMTALA. According to the law a physician determines whether the patient needs the services of the on-call physician and makes the request for the on-call physician’s appearance.

Disputes sometimes arise as to the need to appear and can be avoided, to some extent, through the use of protocols developed and approved by the medical staff. However, on-call physicians should note the absolute nature of the statute’s language in regard to sanctions when a physician at the hospital requests the on-call physician’s appearance.

Finally, a physician responsible for the examination, treatment, or transfer of patients must not sign a certification for transfer that the physician knows or should know is not for an appropriate transfer or misrepresent the patient’s condition or other information (including a hospital’s EMTALA obligations) in general.

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30 42 USCA §1395dd(j).
32 42 USCA §1395dd(d)(1)(C).
33 Id.
34 “If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians . . . and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty . . . . However, the previous sentence *shall not apply* . . . to the on-call physician who failed or refused to appear.” (emphasis added).
35 42 USCA §1395dd(d)(1)(B).
A physician who executes a certificate authorizing transfer certifying that the risks of transfer are outweighed by the benefits without actually engaging in any meaningful analysis of the risks and benefits of treatment versus transfer may find himself or herself subject to the statutorily authorized penalties.\textsuperscript{36}

**Physician Concerns and Questions**

*Are subspecialties required to be on-call at all times? Or There are three physicians of my specialty at the hospital. Must we arrange ER call coverage for care at all times?*

“Physicians, including specialists and subspecialists (for example, neurologists), are not required to be on call at all times.”\textsuperscript{37} The hospital must merely have procedures and protocols in place that are to be followed when a specialist is not on-call or the physician can not respond because of circumstances beyond his control.\textsuperscript{38}

Simply, “CMS does not require that a hospital’s medical staff provide on-call coverage 24 hours/day, 365 days/year. If there comes a particular time that a hospital does not have on-call coverage for a particular specialty, that hospital lacks capacity to treat patient needing that specialty service and it is therefore appropriate to transfer the patient because the medical benefits of transfer outweigh the risks.”\textsuperscript{39}

The government has specifically stated that, “Medicare does not set requirements on how frequently a hospital’s staff of on-call physicians are expected to be available to provide on-call coverage; that is a determination to be made between the hospital and the physicians on its on-call roster.”\textsuperscript{40}

Furthermore, “. . . [t]here is no predetermined ‘ratio’ that CMS uses to determine how many days a hospital must provide . . . on-call coverage based on the number of physicians on staff for that particular specialty.”\textsuperscript{41}

*I am a senior staff member, yet the medical staff bylaws are being modified because, I am told, EMTALA does not permit call exceptions for senior staff. Is that true?*

No, it is not true. EMTALA does not prohibit such exceptions. The government has stated that call exceptions for senior staff recognizing years of practice or age are acceptable.\textsuperscript{42}

\textsuperscript{36} Burditt v. U.S. Dept. of Health and Human Services, 934 F2d 1362 (5th Cir. 1991).
\textsuperscript{37} 68 Fed. Reg. 53250.
\textsuperscript{38} Id.
\textsuperscript{39} Memorandum from Steven A. Pelovitz, Director of Survey and Certification Group Center for Medicaid and State Operations to Associate Regional Administrators, DMSO and State Survey Agency Directors entitled On-Call Requirements – EMTALA (June 13, 2002).
\textsuperscript{40} Id.
\textsuperscript{41} 68 Fed. Reg. 53250.
I am being told EMTALA requires that I accept in my office a patient referred to me by the hospital for follow-up care even though I was not called into the ER to examine or treat the patient. Is this true?

EMTALA places no burden on any hospital to provide follow-up care. As discussed above, EMTALA requires a screening examination, stabilizing treatment for emergency medical conditions, and physicians to appear when they are on the call schedule – as well as prohibits inappropriate transfers. In addition, EMTALA applies only to hospitals and not physician offices.

“...A participating hospital may not delay providing . . . further medical examination and treatment. . . .” The use of referrals for follow-up care may be seen as a delay of stabilizing care and it is risky for the hospital to engage in this activity. Also, consider the following scenario:

For instance, if the patient has a displaced fracture and the orthopaedist instructs the ED physician to send the patient to his office, it might be considered a violation if the fracture was not reduced first, since the office care was not truly follow-up in nature but stabilizing.

However, to emphasize the government position stated previously, follow-up outside of the hospital is not an EMTALA issue, but is instead a hospital by-law/protocol issue. The failure to provide follow-up care may be a violation of the terms of hospital privileges and the hospital may take adverse action against the physician.

Merely being on the “on-call” panel, absent any contractual relationships, under Texas law does not itself establish a patient-physician relationship with hospital patients. Contractual relationships may create a patient-physician relationship (even where you don’t treat the patient). So, there is risk to the physician in regard to staff privileges and general medical liability for refusing to treat a person referred by emergency room physicians, but those risks are not a result of EMTALA obligations.

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43 U.S. Gen. Acct. Off., Rep. No. GAO-01-747, supra note 29, at 16, Table 1 (“Hospitals are not required to ensure that follow-up care is obtained. CMS is not currently developing additional guidance.”) (June 2001).
44 42 CFR §489.24(d)(4).
EMTALA prevents me from contacting the patient’s primary care physician, how can I best deliver care to my patient?

Actually, EMTALA does not prohibit such interactions. “An emergency physician . . . is not precluded from contacting the individual’s physician at any time to seek advice regarding the individual’s medical history and needs that may be relevant to the medical treatment . . . of the patient so long as this consultation does not delay services. . . .” 48

**Physician Penalties**

A physician who violates an EMTALA duty or who is on-call and refuses to come to the emergency department to provide stabilizing treatment is subject to civil monetary penalties of not more than $50,000 and may be subject to exclusion from the Medicare and Medicaid programs. 49

A physician is not subject to civil liability as a result of litigation by a patient. The text of the law limits such recovery to “a participating hospital’s violation” of EMTALA. Courts have interpreted this to mean that a hospital may be sued for an EMTALA violation, but that a cause of action does not lie against a physician for a violation. 50

**TMA Policy**

Board of Councilors Ethics Opinion

**EMERGENCY ROOM.** When a patient seeking services at a hospital emergency room indicates he has a private physician, that physician should be notified as soon as is practical that his patient is being treated in the emergency room.

TMA House of Delegate Policy

**100.003 Patient Transfers:** The Texas Medical Association believes that to ensure continuity of care, physician-to-physician communication should occur prior to actual transfer of patients from one hospital to another. It should be clear that the receiving institution has available the anticipated services and space, and that the receiving physician and institution will accept the patient.

The physician requesting transfer should make direct contact with the receiving physician; this task should not be delegated to nurses, other hospital personnel or the family of the patient.

The physician-to-physician communication should include planning for and implementation of pretransfer and intratransfer medical care of the transferee.

All transfers should be to facilities appropriate to the needs of the patient, and socioeconomic considerations should be secondary.

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49 42 USCA §1395dd(d)(1).
If the patient or those responsible for the patient requests transfer which seems medically inappropriate, the medical risks involved must be carefully explained to the patient or those responsible for the patient. The physician should provide the explanation, and if the patient or family insists on transfer, the decision should be documented in writing and signed by the patient or those responsible, as well as by the physician.

All necessary and pertinent medical information and instructions to transfer personnel and other records should accompany the patient.

Proper medical care should be provided before and during transfer, including monitoring and charting the status of the patient.

Nonemergency (elective) patient transfers are beyond the scope of this guideline, and such transfers should follow traditional referral patterns and practices (Physician-Patient Advocacy Committee, pp 133-134, A91; reaffirmed CSE Rep. 5-I01).

130.016 Compensation for Emergency Department Care: Physicians who are required by hospitals to cover hospital emergency departments have the right to compensation from hospitals for such coverage (Res. 405-A-03).

**AMA Policy**

CEJA Ethics Opinion
E-10.05 Potential Patients

(1) Physicians must keep their professional obligations to provide care to patients in accord with their prerogative to choose whether to enter into a patient-physician relationship. (2) The following instances identify the limits on physicians’ prerogative: (a) Physicians should respond to the best of their ability in cases of medical emergency (Opinion 8.11, "Neglect of Patient"). (b) Physicians cannot refuse to care for patients based on race, gender, sexual orientation, or any other criteria that would constitute invidious discrimination (Opinion 9.12, "Patient-Physician Relationship: Respect for Law and Human Rights"), nor can they discriminate against patients with infectious diseases (Opinion 2.23, "HIV Testing"). (c) Physicians may not refuse to care for patients when operating under a contractual arrangement that requires them to treat (Opinion 10.015, "The Patient-Physician Relationship"). Exceptions to this requirement may exist when patient care is ultimately compromised by the contractual arrangement. (3) In situations not covered above, it may be ethically permissible for physicians to decline a potential patient when: (a) The treatment request is beyond the physician’s current competence. (b) The treatment request is known to be scientifically invalid, has no medical indication, and offers no possible benefit to the patient (Opinion 8.20, "Invalid Medical Treatment"). (c) A specific treatment sought by an individual is incompatible with the physician’s personal, religious, or moral beliefs. (4) Physicians, as professionals and members of society, should work to assure access to adequate health care (Opinion 10.01, "Fundamental Elements of the Patient-Physician Relationship").* Accordingly, physicians have an obligation to share in providing charity care (Opinion 9.065, "Caring for the Poor") but not to the degree that would seriously compromise the
care provided to existing patients. When deciding whether to take on a new patient, physicians should consider the individual’s need for medical service along with the needs of their current patients. Greater medical necessity of a service engenders a stronger obligation to treat. (I, VI, VIII, IX) Issued December 2000 based on the report "Potential Patients, Ethical Considerations," adopted June 2000. Updated December 2003. * Considerations in determining an adequate level of health care are outlined in Opinion 2.095, “The Provision of Adequate Health Care.”

AMA House of Delegates

H-130.950 Emergency Medical Treatment and Active Labor Act (EMTALA)
Our AMA: (1) will seek revisions to the Emergency Medical Treatment and Active Labor Act (EMTALA) and its implementing regulations that will provide increased due process protections to physicians before sanctions are imposed under EMTALA; (2) expeditiously identify solutions to the patient care and legal problems created by current Emergency Medical Treatment and Active Labor Act (EMTALA) rules and regulations; (3) urgently seeks return to the original congressional intent of EMTALA to prevent hospitals with emergency departments from turning away or transferring patients without health insurance; and. (4) strongly opposes any regulatory or legislative changes that would further increase liability for failure to comply with ambiguous EMTALA requirements. (Sub. Res. 214, A-97; Reaffirmation I-98; Reaffirmation A-99; Appended: Sub. Res. 235 and Reaffirmation A-00)

H-320.953 Definitions of "Screening" and "Medical Necessity"
(1) Our AMA defines screening as: Health care services or products provided to an individual without apparent signs or symptoms of an illness, injury or disease for the purpose of identifying or excluding an undiagnosed illness, disease, or condition.

(2) Our AMA recognizes that federal law (EMTALA) includes the distinct use of the word screening in the term "medical screening examination"; "The process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist."

(3) Our AMA defines medical necessity as: Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) Clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.

(4) Our AMA incorporates its definition of "medical necessity" in relevant AMA advocacy documents, including its "Model Managed Care Services Agreement." Usage of the term "medical necessity" must be consistent between the medical profession and the insurance industry. Carrier denials for non-covered services
should state so explicitly and not confound this with a determination of lack of "medical necessity".

(5) Our AMA encourages physicians to carefully review their health plan medical services agreements to ensure that they do not contain definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.

(6) Our AMA urges private sector health care accreditation organizations to develop and incorporate standards that prohibit the use of definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.

(7) Our AMA advocates that determinations of medical necessity shall be based only on information that is available at the time that health care products or services are provided.

(8) Our AMA continues to advocate its policies on medical necessity determinations to government agencies, managed care organizations, third party payers, and private sector health care accreditation organizations. (CMS Rep. 13, I-98; Reaffirmed: BOT Action in response to referred for decision Res. 724, A-99; Modified: Res. 703, A-03; Reaffirmation I-06)

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