

SPECIALTY HOSPITAL RESPONSIBILITIES UNDER EMTALA

IF YOU HAVE QUESTIONS REGARDING THIS MATTER, PLEASE CONTACT:

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The Emergency Medical Treatment and Active Labor Act ("EMTALA") was enacted in 1986 because of concern over the issue of patient "dumping" and, more specifically, to ensure the provision of emergency medical treatment for the poor and uninsured. In general, EMTALA is fairly straightforward in its application to women in labor and patients with other emergency conditions (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) who present at "full service" hospitals with dedicated emergency rooms. To the extent the statute is ambiguous with respect to full service hospitals, there are numerous federal court opinions providing interpretation. In contrast, the obligations of specialty facilities called upon to receive a transfer patient have received considerably less attention and commentary. Nonetheless, all transferee facilities, including specialty facilities without dedicated emergency rooms¹ have significant obligations under EMTALA.

RECIPIENT HOSPITAL RESPONSIBILITIES:

Specialty hospitals without dedicated emergency rooms have obligations as "recipient" hospitals under EMTALA based upon their Medicare provider status. Specifically, a "participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual." A participating hospital for purposes of EMTALA is a hospital that has entered into a Medicare provider agreement with the federal government. See 42 CFR § 489.24 (2006).

The obligation to accept a transfer patient under EMTALA is predicated upon the recipient hospital having the capacity to treat the patient. The issue of capacity should be addressed in the dialogue between the transferring hospital and the recipient hospital, and an appropriate transfer requires that the recipient hospital agree to the transfer.

EMTALA defines capacity as "the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual." The regulations further explain that capacity encompasses such things as the number and availability of qualified staff, beds and equipment and the hospital's past practices of accommodating additional patients in excess of its occupancy limits. See 42 CFR § 489.24 (b). In other words, if a legitimate request for transfer is made, it would not be permissible under EMTALA to deny the request based upon the fact that the hospital has a full census if, in the past, arrangements were made to accommodate insured or paying "overflow" patients. In light of the myriad factors impacting a facility's capacity, requests for transfer must be considered on a case-by-case basis.

In the case of a transfer acceptance, once the recipient facility provides the patient with an appropriate medical screening and the treating physician or other qualified medical personnel determine that the emergency medical condition has been resolved, the recipient facility has no further EMTALA obligation to provide other treatment. EMTALA does not require full treatment and resolution of the

underlying medical condition, only stabilization of the emergency condition.

OIG REPORTED EMTALA FINES FOR TRANSFER REFUSAL:

The HHS Office of Inspector General listing of EMTALA civil monetary penalties (January 2002 through June 2005) reflects over 80 facility payments, a handful of which were related to allegations of transfer refusal. These reports, which are listed below, provide insight into CMS' willingness to compromise in the settlement of various EMTALA claims. In addition to civil monetary penalties, however, CMS may terminate the hospital's provider agreement in accordance with 42 CFR § 489.53 if a hospital fails to meet its EMTALA obligations.

6-21-05: Behavioral Hospital of Litcher, f/d/b/a St. James Psychiatric Hospital (Louisiana), paid a \$30,000 penalty for allegedly failing to accept the appropriate transfer of two patients with psychiatric emergencies.

2-19-2004: Jackson Memorial Hospital (Jackson, Florida) paid a \$50,000 penalty for allegedly failing to accept the appropriate transfer of a patient to its burn unit. The referring hospital did not have a burn unit, and the patient was subsequently airlifted to another hospital with a burn center.

1-13-04: University of Colorado Hospital authority paid a \$35,000 penalty for allegedly refusing transfer of patient who attempted suicide with an overdose of medication and alcohol.

4-15-03: Kaiser Foundation Hospital (Sunset, Los Angeles) agreed to pay a \$20,000 penalty to resolve CMS liability for allegedly refusing to accept transfer of a patient who required bypass surgery.

8-08-02: Tenth Circuit Court of Appeals upheld CMS' imposition of a \$35,000 fine against St. Anthony Hospital (Oklahoma) for allegedly refusing to accept an appropriate transfer of a critically ill patient who required surgery. Of note, the hospital refused to accept the transfer because the on-call surgeon refused to come to the hospital and perform the surgery.

TATTLING REQUIRED:

If a facility believes it has received an improperly transferred patient, EMTALA requires this be reported to CMS or the State survey agency promptly (normally within 72 hours). The potential penalties for failure to report an inappropriate transfer include termination of the Medicare provider agreement.

The OIG includes both Stark Law and Anti-Kickback violations in CMP settlements in an Open Letter to Health Care Providers issued April 24, 2006

The Office of Inspector General ("OIG") for the U.S. Department of Health and Human Services ("HHS") published an Open Letter to Health Care Providers on April 24, 2006. The OIG is initiating a process which supplements the Self-Disclosure Protocol ("SDP") whereby certain matters, particularly hospital/physician arrangements, can be handled more efficiently when entities

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uncover arrangements that may involve potential physician self-referral (e.g., Stark Law) or anti-kickback violations. The new procedure is available principally for entities that have robust corporate compliance programs in place, that uncover a problematic relationship, and that self-disclose the relationship to the OIG. The OIG initiative will provide guidance on how these types of disclosures will be resolved. The Open Letter encourages providers to self-disclose using SDP and suggests that in the majority of instances the existence of an active compliance program, proper self-disclosure, and working with the OIG may result in lower penalties being assessed.

And Next Week--
BRIAN FLOOD

Brian Flood, Texas Inspector General, will be our guest author discussing Medicaid fraud issues relevant to health care providers, including hospitals and physicians.

ⁱ As opposed to the commonly understood sense of the term "emergency room," EMTALA casts a fairly wide net. Clarifying language found in the September 9, 2003, Federal Register, Part II, and the 2004 CMS EMTALA Interpretive Guidelines includes the following definition:

The entity: (1) is licensed by the state in which it is located under applicable State law as an emergency room or emergency department; or (2) is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions (EMC) on an urgent basis without requiring a previously scheduled appointment; or (3) during the preceding calendar year, (i.e., the 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 the calendar year, it provides at least one-third of all its visits for the treatment of EMC's without requiring a previously scheduled appointment. This includes individuals who may present as unscheduled ambulatory patients to units (such as labor and delivery or psychiatric units of hospitals) where patients are routinely evaluated and treated for emergency medical conditions.