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HEALTH CARE LAW

Preventing Patient Dumping

EMTALA regulates hospitals' screening and transfer policies

By Patrick J. Hughes and Megan M. Roberts

The Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, was enacted in 1986 as a part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

Initially, EMTALA may have appeared to be yet another weapon to wield against hospitals and health care providers in malpractice actions. EMTALA was not, however, meant to serve as a supplement to medical malpractice claims, and was truly meant to create a right of action for those who might not have a right from another statute or the common law. Its purpose was to address "patient dumping," or the turning away of patients without health insurance, which was considered a significant issue at the time in some hospital emergency departments. *Bryan v. Rectors and Visitors of the Univ. of Va.*, 95 F.3d 349, 351 (4th Cir. 1996).

A review of reported cases demonstrates that while many actions brought under EMTALA are brought to supplement medical malpractice allegations, in most of these cases, the court has granted the hospital's motion for summary judgment.

EMTALA imposes two requirements on hospitals. First, hospitals with emergency medical departments must provide an "appropriate medical screening examination" to determine if an "emergency medical condition exists" when an individual seeks treatment. An individual has an "emergency medical condition" if his condition manifests itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of the organs or body parts. For a pregnant woman who is having contractions, an emergency medical condition exists if there is not enough time for a safe transfer before delivery, or if such a transfer would pose a threat to the health or safety of the woman or the unborn child.

The second requirement is triggered if there *is* an "emergency medical condition," the hospital must provide "necessary stabilizing treatment" before releasing or transferring the patient. Stabilization is defined in the act as providing medical treatment to assure, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from the facility. For a pregnant woman in labor, stabilization means the delivery of the placenta.

EMTALA also prohibits a hospital from delaying medical screening or treatment "in order to inquire about the individual's method of payment or insurance status," however, the act's regulations do allow for the collection of some insurance information during a "reasonable registration process." The hospital may ask "whether an individual is insured and, if so, what that insurance is, as long as that inquiry does not delay screening or treatment. Reasonable registration processes may not unduly discourage individuals from remaining for further evaluation." 42 C.F.R. § 489.24(d)(4)(iv).

Failure to comply can result in civil monetary penalties of up to $50,000 and the possible loss of Medicare and Medicaid funding. Both the hospital and the doctor can be subject to the fines. 42 U.S.C. § 1395dd(d)(1)(A). Despite the fact that EMTALA was passed to protect those with no insurance or with Medicare or Medicaid, the act is silent as to that purpose, and so EMTALA protects any individual who seeks emergency medical care. *Bryant v. Advent Health Systems/West*, 289 F.3d 1162, 1165 (9th Cir. 2002); *Summers v. Baptist Medical Center Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996).

The act also provides a private right of action for any individual who suffers harm as a direct result of a hospital's violation. 42 U.S.C. § 1395dd(d)(2)(A). This private right of action extends only against the hospital, and not against the health care profes-

Hughes is a partner and Roberts is an associate at Connell Foley of Roseland.

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sional. *Eberhardt v. City of Los Angeles*, 62 F.3d 1253 (9th Cir. 1995). It should not, however, be confused with a malpractice claim. The Eighth Circuit remarked "EMTALA is not a federal malpractice statute, and it does not set a national emergency health care standard; claims of misdiagnosis or inadequate treatment are left to the state malpractice area." *Summers v. Baptist Medical Center of Arkansas*, 69 F.3d 902, 904 (8th Cir. 1995).

EMTALA falls under the purview of the Centers for Medicare and Medicaid Services (CMS), which receives complaints of patient dumping and investigates. If the claims are substantiated, CMS will then typically give the hospital 23 days in serious cases and 90 days in less serious cases to correct the problem. *Government Accounting Office, Emergency Care: EMTALA Implementation and Enforcement Issues*, July 2001, GAO-01-747, Appendix II. Continued failure to correct the problem may lead to termination of the hospital's provider agreement. CMS will then refer the case to the Office of the Inspector General (OIG), who will determine whether any civil monetary penalties are appropriate.

Two typical scenarios trigger EMTALA. First, a patient arrives at a hospital with chest pains and *before* he is examined the hospital calls his physician, who denies insurance coverage for the emergency visit. The hospital then tells the patient that he will be responsible for payment and the patient decides to leave the hospital. This is a failure of the first requirement — screening. Second, a patient is brought in from a nursing facility. He is diagnosed with pneumonia and medicated, but is sent back to the nursing facility without being cleared as stable by a doctor. The patient ultimately returns in worse condition and dies. This is a failure of the second requirement — stabilization. These examples exhibit that so far as enforcement by the government is concerned, the purpose of the act is to focus on the provision of an initial screening and stabilization before transfer, and not to punish the type of screening provided. In fact, as several cases have shown, if a patient is screened, treated and released, and then later deteriorates due to something that the hospital did not discover, no violation of EMTALA has occurred. See *Davis v. Township of Paulsboro*, 424 F. Supp. 2d 773 (D.N.J. 2006).

A simple search of the annotated statute will show that there have been a myriad of cases under EMTALA. The Supreme Court, though, has only weighed in on one of those cases, addressing the limited issue regarding the stabilization requirement. In *Roberts v. Galen*, the Court considered the case of Wanda Johnson, who after a serious car accident in Kentucky, spent six weeks in a Louisville hospital. *Roberts v. Galen of Virginia*, 525 U.S. 249, 251 (1999). While her health was still in a "volatile" state, the hospital transferred her to another facility in Indiana, her condition worsened, she was then transferred again, and spent many months in acute care. The District Court dismissed Johnson's EMTALA claim because she failed to show that the decision to transfer her was based on an improper motive. While the Sixth Circuit affirmed, the Supreme Court reversed, holding that "there is no question that the text of § 1395dd(b) does not require an 'appropriate' stabilization, nor can it reasonably be read to require an improper motive."

Interestingly, the Court opted not to weigh in on whether the screening requirement imposes an improper motive. The Sixth Circuit held in *Cleland v. Bronson Health Care,* 917 F.2d 266 (6th Cir. 1990), that a plaintiff must show that the hospital had an improper reason for giving less than the standard screening. However, the Supreme Court did point out in *Roberts* that the Sixth Circuit's requirement was adverse to rulings in other Circuit Courts of Appeal.

The Third Circuit has not weighed in on EMTALA since its inception. The District Court of New Jersey has entertained a few cases, though the majority were unpublished and resulted in summary judgment in favor of the defendants. And while a plaintiff who has a medical malpractice claim and would also like to bring a claim under EMTALA may proceed before the state court, the New Jersey Appellate Division has only seen one such claim.

The one recent exception to the general rule of thumb that courts grant summary judgment on malpractice claims cloaked as EMTALA violations occurred when the First Circuit Court of Appeals pointed out that screening of patients has not been defined by the statute, but the courts have stepped in to define what is proper. *Cruz-Queipo v. Hospital Espanol Auxilio Mutuo de Puerto Rico*, 417 F.3d 67, 70 (1st Cir. Puerto Rico 2005). "A hospital fulfills its statutory duty to screen patients in its emergency room if it provides for a screening examination reasonably calculated to identify critical medical conditions that may be afflicting symptomatic patients and provides that level of screening uniformly to all those who present substantially similar complaints." When a hospital sets protocols for screening, those internal procedures will be the benchmark for what constitutes an "appropriate screening." In this atypical case, the doctor failed to follow standard hospital procedure for patients experiencing chest pain and, therefore, the court would not grant summary judgment on the EMTALA claim.

While the CMS and the OIG still actively investigate claims, and indeed a recent case out of Los Angeles made news and caused CMS to implement a 23-day time period for the hospital to fix its problems, the case law exhibits that EMTALA has worked in cutting down on improper transfers and lack of screening. A 2001 report from the Government Accounting Office found that CMS conducts about 400 investigations a year and half of those investigations result in violations. Fines tend to be low.

There are still some issues for hospitals, though. Hospital and physician representatives who participated in the GAO survey complained that they have more difficulty obtaining payment since the inception of EMTALA. Prudent layperson laws, which require coverage of emergency services by health care organizations without preauthorization when symptoms are of a certain severity, will continue to help hospitals receive payment. Furthermore, the strict application of the act by the courts will continue to protect hospitals from allegations of malpractice clothed to appear as EMTALA claims. ■