

At the Crossroads of Care and Compliance: EMTALA in the ED

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Objectives:

1. Explore current landscape of Texas law regarding EMTALA including physician and hospital obligations.
2. Describe most frequent EMTALA complaints, what to expect, and how to avoid noncompliance.
3. Review EMTALA violations, investigations and fines, identifying ways to reduce potential exposure.

Emergency Medical Treatment and Labor Act (EMTALA)

EMTALA is a U.S. federal law requiring Medicare-participating hospitals with emergency departments to provide a **medical screening and stabilizing treatment** for any patient with an emergency medical condition (EMC), regardless of their insurance or ability to pay, preventing "patient dumping" and ensuring access to care, including **appropriate transfers** if needed.



EMTALA statute, codified at 1867 of the Social Security Act, the accompanying regulations in 42 CFR 489.24, and the related requirements at 42 CFR 489.20.

Scope of EMTALA



EMTALA applies:

- When an individual presents **on hospital property**

AND

- Requests treatment for an EMC

OR

- A prudent layperson believes the individual needs an exam or treatment for an EMC

EMTALA Basics

Key Requirements:

Medical Screening (MSE): Anyone coming to the ED requesting care must receive an MSE to determine if an EMC exists, performed within the ED's capabilities.

Stabilizing Treatment: If an EMC is found, the hospital must provide treatment to stabilize the condition (or deliver the baby and placenta in labor cases).

Appropriate Transfer: If the hospital can't stabilize the patient, it must arrange an appropriate transfer to a facility that can, explaining risks and benefits first.

Enforcement:

Violations can lead to significant fines and potential loss of Medicare participation.

IT'S THE LAW

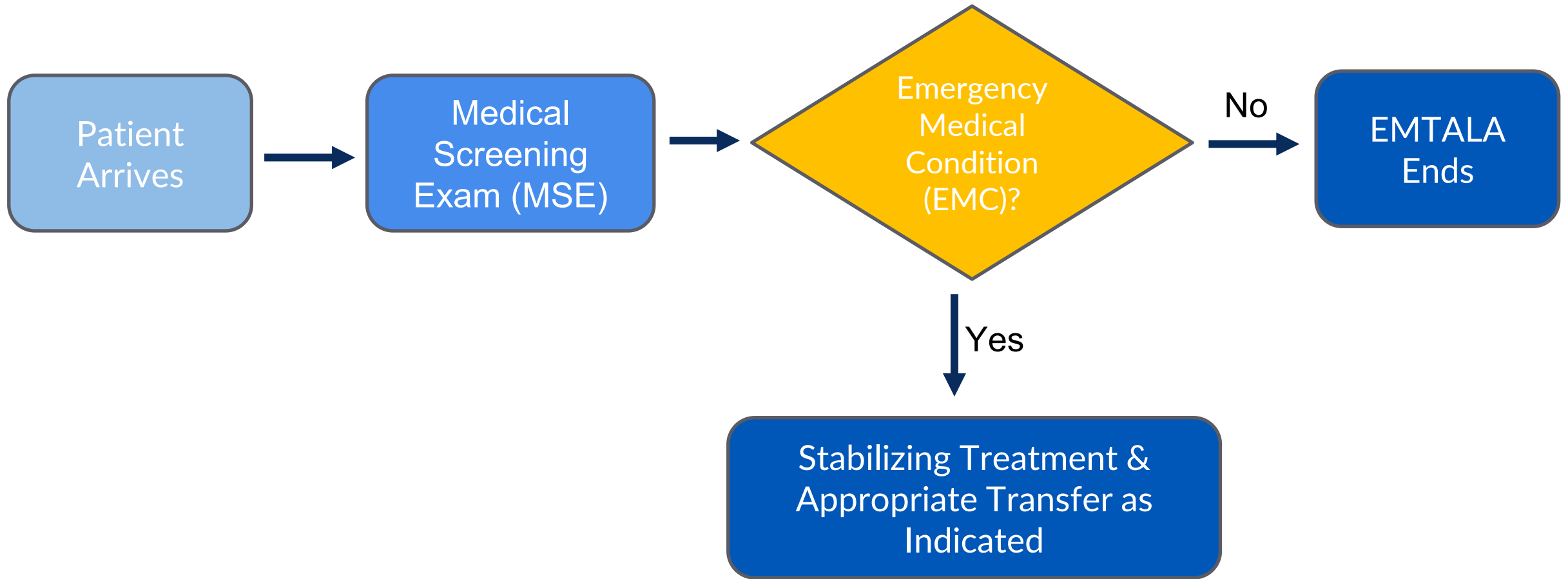
If you have a medical emergency or are in labor, you have the right to receive within the capabilities of this hospital's staff and facilities:

An appropriate medical screening examination and necessary stabilizing treatment

(Including treatment for an unborn child)

- **Provide a medical screening examination (MSE) appropriate to the individuals' signs & symptoms within the capability of the hospital's ED, including ancillary services routinely available to the ED, to determine whether or not an emergency medical condition (EMC) exists**
- **Must be the same MSE that the hospital would perform on any individual coming to the ED with those signs & symptoms.**
- **Examination must be conducted by an individual(s) who are determined qualified by hospital bylaws or rules & regulations & who meet the requirements concerning emergency services personnel & direction**

EMTALA Flow

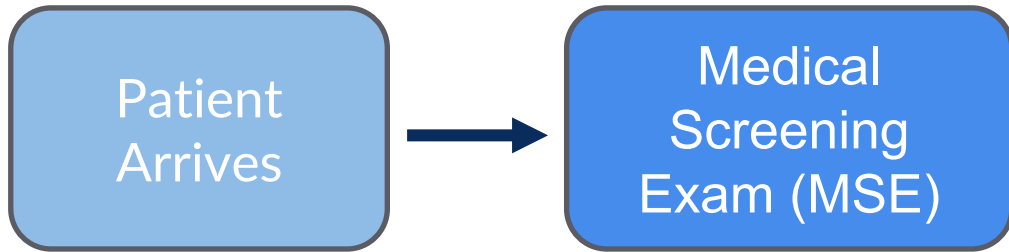


EMTALA

Patient
Arrives



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graph LR; A(Patient Arrives) --> B[ ]
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Appropriate to individuals' signs & symptoms, as well as the capability & capacity of the hospital

Can involve a wide spectrum of actions

- Simple process involving brief history & physical exam
- Complex process that also involves performing ancillary studies & procedures

Per EMTALA, the medical record must reflect continued monitoring according to the individual's needs, until determined whether or not the individual has EMC

- If they do, until they are stabilized or appropriately transferred.
- Should be evidence of ongoing monitoring prior to discharge or transfer in the medical record

Patient Arrives



Medical Screening Exam (MSE)

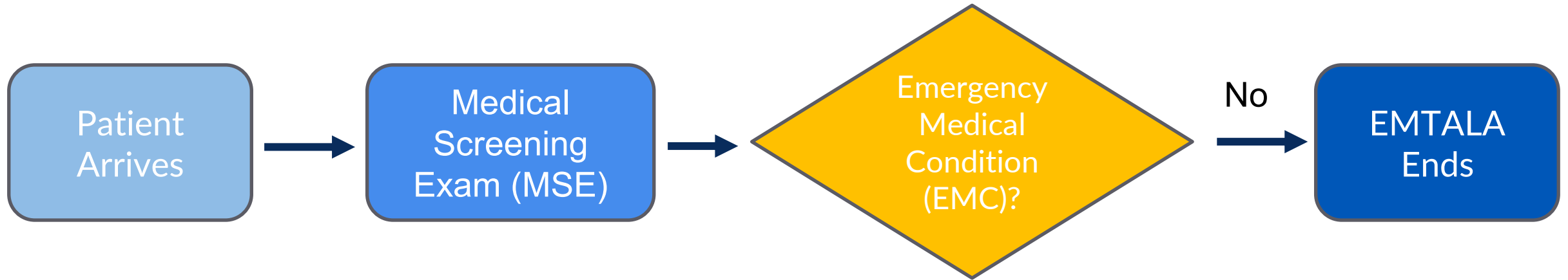


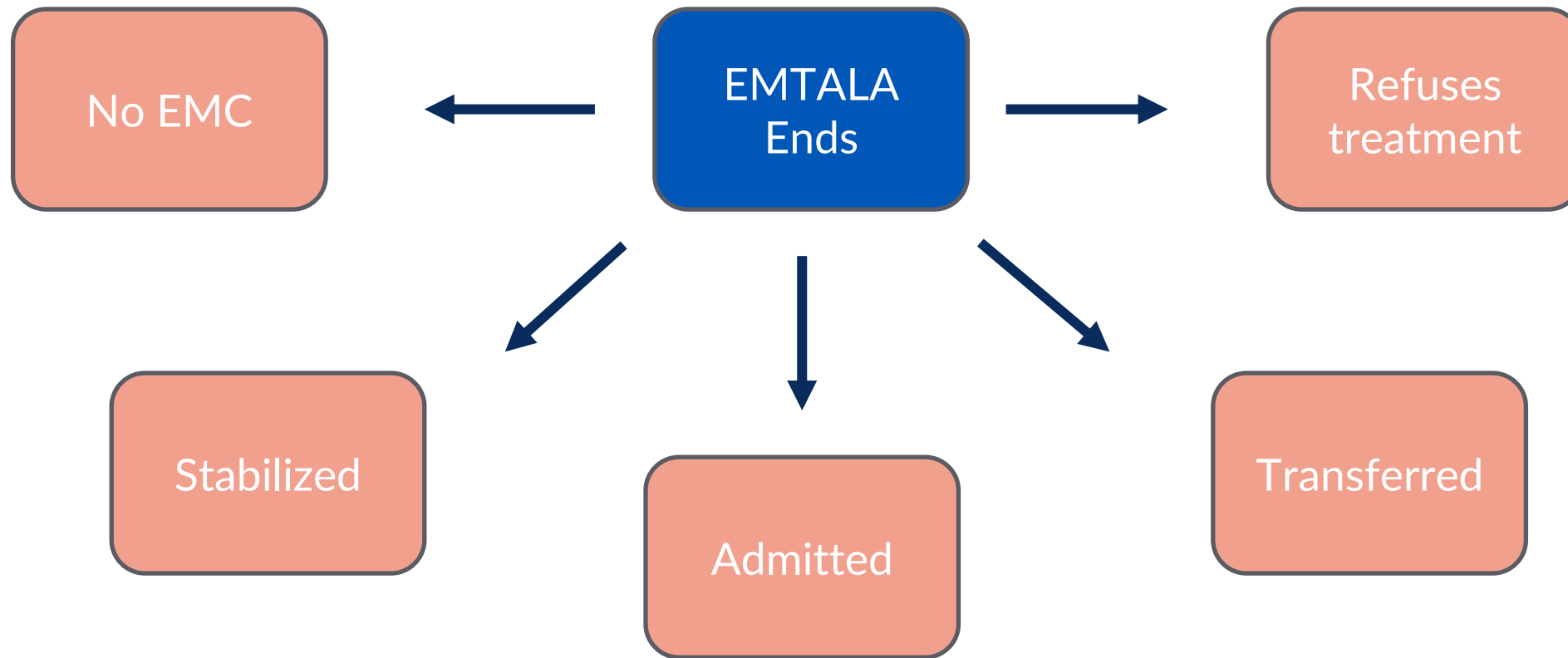
Table 1. EMTALA definition of “emergency medical condition”*

The term “emergency medical condition” means—

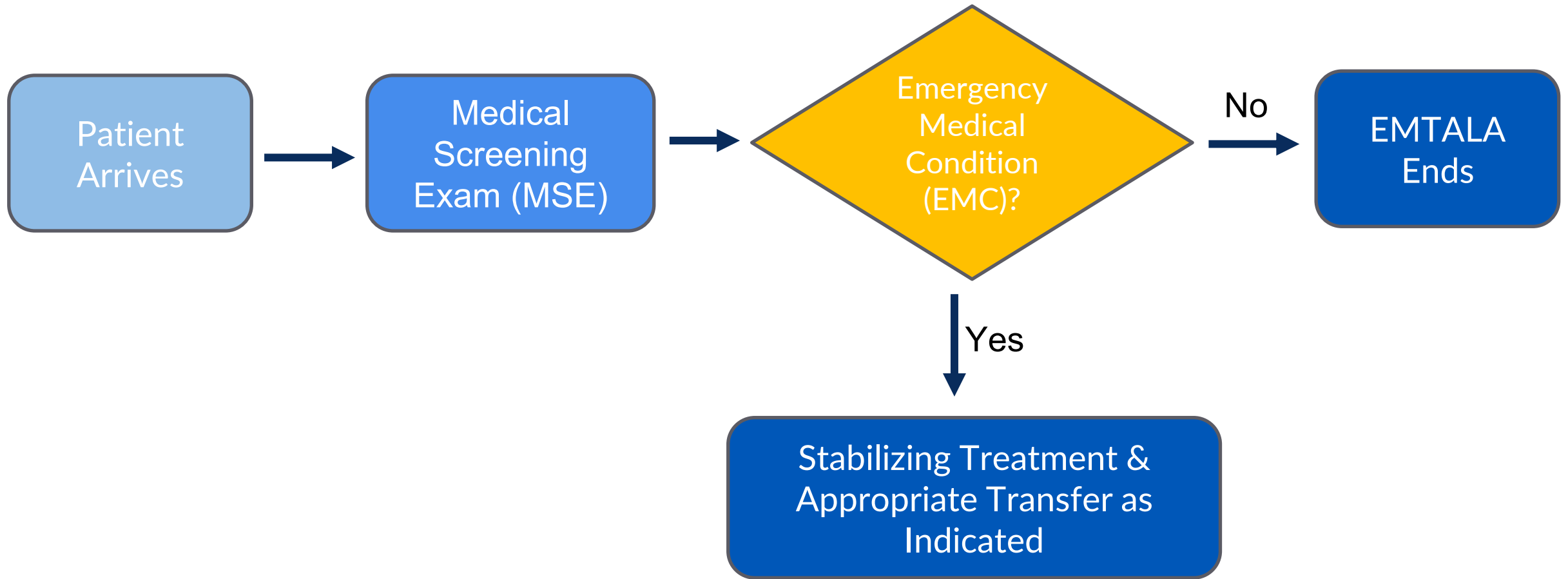
- (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—
 - (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
 - (ii) serious impairment to bodily functions, or
 - (iii) serious dysfunction of any bodily organ or part; or
- (B) 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.

*From reference 5.





EMTALA Flow



Stabilization

- Provide treatment as may be required to stabilize the emergency medical condition within the hospital's capability and capacity.
- Stabilized: No material deterioration of the condition is likely to occur
 - Woman in labor: once the baby and placenta are delivered
 - Psychiatric: patient is protected from harming self or others; risk of imminent deterioration is mitigated

If the patient CANNOT be stabilized:

- 1) Continue treatment
- 2) Arrange an appropriate transfer

Transfer

When a hospital cannot stabilize a patient due to limitations in capacity or capability, transfer may be necessary. EMTALA permits transfer in two main circumstances:

- **Medical necessity**—The benefits of care at the receiving hospital outweigh the risks
- **Patient request**—The patient (or representative) requests transfer in writing after being informed of risks and the hospital's obligations

In both cases, several conditions must be met:

- Medical screening exam & necessary stabilizing interventions within the capacity of the initial facility
- Informed consent
- Confirmation of accepting/receiving facility with the capability & qualified personnel to treat the individual
- Agreement to accept transfer & provide appropriate medical treatment, at the accepting/receiving facility
- Patient report provided to the accepting/receiving facility
 - All available medical records, labs, radiographic, & other related information or copies provided or transferred with the patient
- Appropriate transfer personnel, equipment & transportation must be available

Receiving Hospital Responsibilities



Hospitals capable of specialized care are required to accept transfers of patients with emergency medical conditions who require their services if the receiving hospital has capacity.

Hospital requirements

- Establish written transfer acceptance policies
- Implementation procedures for accepting or declining transfers
- Educating medical staff & others in accepting or declining transfer requests
- Ensure hospitals' transfer policies, in addition to EMTALA, are adhered to

EMTALA Violation Commonalities



Penalties for Violating EMTALA

CMS & OIG Have Enforcement Powers

Penalties may include:

- Medicare provider agreement terminated
- Hospital's Medicare agreement terminated
- Hospital fines up to \$129,233 per violation
- Physician fines up to \$129,233 per violation

Other possible actions:

- Hospital sued for personal injury
- Receiving facility can bring suit to recover damages



Logistics of the investigation



EMTALA Complaint



Case Review: Regional Office of the CMS



“5 day” Review: To determine whether the hospital violated EMTALA and whether it should terminate the hospital from Medicare.



“60 day” Review: QIO affords the affected hospital and providers the opportunity of a hearing to formally present their side of the case.



Disposition

EMTALA Investigation

Key Questions:

- Was an appropriate MSE provided?
- Was the emergency medical condition stabilized?
- Was the transfer appropriate?
- Did the hospital follow its own policies?

What They Review:

- ED logs
- Medical records
- Transfer documentation
- On-call schedules
- Policies and procedures
- Staff interviews
- Security footage (if relevant)

EMTALA Violation: MSE

What Happened:

An 88-year-old man presented to the ED but was not examined by a physician for nearly 3 hours. His family repeatedly asked for care, but no medical screening was provided. During this time, the patient's condition worsened and he eventually went into cardiopulmonary arrest and died without treatment.

Investigation Findings:

OIG found the hospital violated EMTALA because it failed to provide the required medical screening examination and did not stabilize the patient once an emergency medical condition existed.

Penalty/Outcome:

An administrative law judge upheld a \$50,000 civil monetary penalty – the maximum at that time – based on the severity of the violation.



EMTALA Violation: MSE and Stabilizing Treatment

What Happened:

A patient was found lying in a hospital parking lot after being discharged the prior day. Hospital staff and security repeatedly failed to respond to concerns that the person needed help. The patient was later found dead, and autopsy showed acute bacterial pneumonia.

Investigation Findings:

OIG determined the hospital failed to provide appropriate medical screening and stabilizing treatment under EMTALA for someone on its property who appeared in need of medical evaluation.

Penalty/Outcome:

The hospital agreed to settle for \$50,000 (maximum fine at the time).

EMTALA Violation: MSE and Stabilizing Treatment

What Happened:

A hospital received allegations that it failed to provide an appropriate psychiatric screening examination or stabilizing treatment for three patients who presented to the ED when an on-call psychiatrist was available.

Investigation Findings:

- A woman presented to the ED complaining of depression and suicidal thoughts but was later discharged with instructions to follow up with her PCP.
- A child presented to the ED following violent outbursts but was later discharged with instructions to follow up with his primary care physician.
- A man presented to the ED stating his mind was "disturbed," but later eloped from the ED into single-degree weather wearing paper scrubs while his discharge was processed. His body was found about 300 feet from the hospital; the cause of death was attributed to hypothermia.

Penalty/Outcome:

A hospital entered into a \$100,000 settlement agreement with OIG in 2017



EMTALA Violation: MSE and Stabilizing Treatment

What Happened:

Hospital received complaint regarding allegations that the hospital violated the EMTALA in 36 incidents. In these incidents, individuals presented to the hospital's ED with unstable psychiatric EMCs.

Investigation Findings:

Instead of being examined and treated by an on-call psychiatrist, and despite empty beds in its psychiatric unit to which the patients could have been admitted for stabilizing treatment, the patients were involuntarily committed and kept in the ED for between 6 and 38 days each. The following is an example of one such incident.

- A patient presented to the ED via law enforcement with psychosis and homicidal ideation and was involuntarily committed. The patient did not receive psychiatric examination or treatment by available psychiatrists and was not admitted to the psychiatric unit for stabilizing treatment. Instead, the patient was kept in the ED for 38 days; at one point she was seen by a psychiatrist from another facility who was familiar with her condition. The psychiatrist prescribed a variety of medications for agitation. The patient eventually was discharged home.

Penalty/Outcome:

The hospital entered into a \$1,295,000 settlement agreement with OIG in 2017.

EMTALA Violation: Transfer

What Happened:

An 18-month-old toddler ingested Drano. After evaluation, the pediatric GI transfer was initially accepted; later the acceptance was rescinded when physicians believed on-call specialists were unavailable.

Investigation Findings:

OIG alleged that the hospital improperly rescinded acceptance of an appropriate transfer for a child needing specialty care — violating EMTALA's transfer rules.

Penalty/Outcome:

The hospital agreed to a \$50,000 settlement (maximum fine at the time).



EMTALA Violation: On-call

What Happened:

Hospital was investigated by HHS-OIG over an alleged failure to provide an emergency medical screening examination to a patient in February 2022.

Investigation Findings:

The patient presented at the ED with a suspected ectopic pregnancy.

Diagnostic tests revealed a beta HCG of 4049, indicative of intrauterine or ectopic pregnancy. She had an ultrasound, which the radiologist interpreted as a left simple cyst with no uterine pregnancy.

The ED physician discussed the findings with the on-call OB/GYN, who agreed to have the patient discharged. The on-call OB/GYN did not evaluate the patient in the ED.

Penalty/Outcome:

The hospital settles the alleged EMTALA violation and paid an \$80,000 financial penalty.

EMTALA Complaint (Open): Transfer

What Happened:

The patient, a 58-year-old woman, arrived at the ED of Hospital “A” by private vehicle complaining of left-sided pleuritic chest pain and abdominal pain.

- An ED physician examined the patient and noted that her abdomen was diffusely firm. The patient's chest X-ray showed a large amount of intraperitoneal air under the right diaphragm, which suggested bowel perforation.
- The ED physician discussed the patient's condition with the on-call surgeon, who recommended that the patient be **transferred to Hospital “B”** where she had undergone a uterine procedure two days earlier. Hospital “B” agreed to accept the transfer and asked that the patient be air-lifted to its facility.
- **Three hours and forty-seven minutes** after her arrival at Hospital “A,” the patient was transferred to Hospital “B” in critical condition. Upon arrival at Hospital “B,” the patient was in septic shock and on the verge of respiratory collapse. Even after receiving emergency surgery to repair the bowel perforation, the patient's condition continued to worsen, and she died later that day.

Examples of EMTALA complaints

- Pt refused ambulance, allowed to travel by private vehicle
- Transferring pt stable at time of arranged transfer, boards in ED, status changes and still transferred. Decompensates en route.
- Minor presents for care; awaiting guardian consent; minor leaves and presents to another ED. Other ED files complaint. Initial ED did not complete MSE prior to elopement.
- Specialist requests transfer because they do not “do that procedure” (eg: ophtho) despite being on call. Receiving ophthalmologist files complaint.

EMTALA Violation Commonalities

Special High-Risk EMTALA Scenarios

- Psychiatric patients
- Pregnant patients in labor
- On-call physician obligations
- Patients leaving AMA or eloping
- Capacity and refusal of care
- Boarding and lack of inpatient beds



EMTALA Complaints

- **Failure to screen** patients presenting with complaints that could represent an emergency medical condition – often minutes to hours of delay, incomplete evaluation, or no assessment at all – is the most common basis for settlements.
- **Failure to stabilize** before discharge or transfer is another major violation.
- **Inappropriate transfers** or **failure to accept** appropriate transfers occur when specialists refuse or mismanage transfer requests.



Key Takeaways

- EMTALA is about process, not outcomes
- Most EMTALA cases hinge on documentation failures
- Failure to follow hospital policy is often cited
- On-call response cases are high-risk
- Receiving hospitals are frequent complainants
- High-risk populations drive enforcement



Three Main Hospital Obligations Under EMTALA

1

Everyone, regardless of their chief complaint, receives a medical screening exam.

- Examination and treatment cannot be delayed to determine insurance coverage or payment.
- Emergency departments must post signs that notify patients & visitors of their rights

2

Treatment must be provided until the emergency medical condition is resolved or stabilized, or until an appropriate transfer occurs.

3

Hospitals with specialized capabilities (e.g., burn centers, shock-trauma centers, neonatal critical care centers, & regional referral centers) are obligated to accept transfers from hospitals that lack the capability or capacity to treat unstable emergency conditions

Transferring Hospital's Responsibilities for Unstable Patient

Provide treatment within capability of the hospital.



Send appropriate data to the accepting facility or hospital



Arrange for another hospital to accept the patient in transfer



Transfer occurs through qualified personnel and transportation equipment



Hospitals with specialized capabilities (e.g. burn centers, shock trauma centers, neonatal critical care centers, & regional referral centers) are obligated to accept transfers from hospitals that lack the capability or capacity to treat unstable emergency conditions.

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