

EMTALA: Testing the Good Faith Admission Requirement

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ABSTRACT

The Fourth Circuit Court of Appeals' March 13, 2020 decision in *Williams v. Dimension Health Corporation* reintroduced scrutiny on the lesser-known mandate of The Emergency Medical Treatment and Active Labor Act (EMTALA) concerning good faith admission to the hospital. EMTALA was enacted by Congress in 1986 to prevent patient dumping by prohibiting hospitals with emergency departments from refusing to provide emergency medical treatment to patients unable to pay for treatment, and prohibiting the transfer of those patients before their emergency medical conditions are stabilized. The reach of EMTALA ends when a patient is admitted and consequently becomes an inpatient, because then the hospital believes the patient would benefit from admission, and discharge and transfer would not occur as outlined in EMTALA. This paper examines the analysis of this mandate in *Williams v. Dimension Health Corporation*, and closely investigates one particular aspect of it: that admission must be made in good faith; otherwise, application of EMTALA's screening and stabilization requirements has not yet terminated, and hospitals can still be found culpable.

KEYWORDS: EMTALA, Emergency Medicine, Admission, Legal Liability

The Emergency Medical Treatment and Active Labor Act (EMTALA) is colloquially seen as the stipulation of emergency departments to treat all patients with emergency conditions, irrespective of the patient's ability to pay. However, a recent decision of the Fourth Circuit Court of Appeals, *Williams v. Dimension Health Corporation*, rekindled scrutiny under EMTALA, principally reviewing if there was culpability under EMTALA that extended beyond a categorical obligation of treating a patient with emergency medical conditions.¹ The

case specifically analyzed the authority of good faith admissions under EMTALA, and discerned the boundaries of what was required to both constitute and prove an admission was not made in good faith, which is a conscious admission of a patient with the intent of providing the patient with subpar care. The application of EMTALA terminates when a patient is admitted for care and becomes an inpatient; however, this litigation highlights that not only does a patient need to be admitted, but that admission must also be made in good faith and not for the purpose of avoiding liability under EMTALA.¹

In 1986, Congress enacted EMTALA to preclude hospitals with emergency departments from rejecting patients with emergency medical conditions due to their inability to pay. This unfunded mandate empowered Congress to delineate two irrefutable responsibilities of hospitals with emergency departments. One obligation is adequate medical screening, within the capacities of the emergency department and available ancillary services, to determine if a patient has an emergency medical condition.² An emergency medical condition is defined as a medical condition presenting with acute symptoms of sufficient severity, such that absence of immediate medical care would place an individual's health in serious jeopardy, serious impairment to bodily function, or serious dysfunctions of any bodily organ.² The other responsibility of hospitals with emergency departments is the stabilization of an individual's emergency medical condition before transferring the patient to another facility. Notably, EMTALA does not require treating a patient's emergency medical condition in full.³ The legislation specifically states if any individual, whether or not eligible for benefits, comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either further medical examination and treatment required to stabilize the medical condition, within the facilities available at the hospital, or transfer the individual to another facility.⁴ The statute underscores an aim of ensuring medical treatment necessary to assure, within reasonable medical probability,

that no material deterioration of the condition is likely to result from or occur during the transfer of the individual.⁵

In *Williams v. Dimensions Health Corporation*, Williams was involved in a single-vehicle accident, where his vehicle rolled over, in 2014.¹ He was transported to George's Hospital Center, a Level II trauma center in Maryland, where he presented with severe hypovolemic shock, massive bleeding from arteries and extremities, massive soft-tissue injury, vascular injury to the left extremity, multiple open fractures, and pulseless extremities.¹ He was intubated and had a right antecubital cut-down performed by the on-call trauma surgeon within twenty minutes.¹ Throughout the night, Williams received CT scans on his head, chest, and spine, received X-rays, underwent his first surgery after the accident and was formally admitted.¹ Over the next eleven days, Williams underwent more surgeries and interventions, until he was transferred to the University of Maryland Medical Center.¹ Ultimately, Williams's injuries to the lower body necessitated a double-leg amputation. Williams later sued George's Hospital Center, claiming he received improper screening and that they did not satisfy the EMTALA stabilization requirement. These claims were argued and decided in favor of the hospital in 2018, by the District Court for the District of Maryland.⁶ In 2020, Williams appealed the District Court decision to the Fourth Circuit Court of Appeals, and the crux of his argument on appeal was that his admission was not made in good faith, thereby allowing the application of EMTALA to the care he received during his inpatient stay.

The good faith admission requirement is not contained within the EMTALA statute itself, but rather was imposed under regulations promulgated under EMTALA by the Congressional authority of the Centers for Medicare and Medicaid Services (CMS), as part of the Department of Health and Human Services. CMS's regulations, passed in 2003, provide:

"If a hospital has screened an individual and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual."⁷

Under the regulation, an emergency department cannot escape liability under EMTALA by admitting a patient it has no intention of treating and transferring the patient without satisfying the stabilization threshold.⁸ This is because if a hospital believes that a patient would benefit from being admitted as an inpatient, then a transfer or discharge would

not occur, so the hospital would not have to satisfy the stabilization threshold under EMTALA. The ruling in *Bryan v. Rectors and Visitors of University of Virginia* similarly reinforces that EMTALA's obligations terminate when the patient is admitted; however, that admission must be made in good faith.⁹ If a party can prove that a hospital did not admit the patient in "good faith," then the hospital is liable under EMTALA. This is to discourage hospitals from using inpatient admission to avoid liability under EMTALA.⁸

In the *Williams* case, Williams specifically argues that the hospital did not admit him in good faith because the hospital did not involve a sufficient number of on-call physicians, the on-call trauma surgeon refused to perform surgery, and that the hospital was focused on reaping his premium insurance benefits. The judge relied on the 2003 CMS regulations' interpretation of good faith admission to identify whether there was a tenable defense to the liability under EMTALA in this litigation, and ruled that the hospital did admit Williams in good faith.^{1,8} The Fourth Circuit specifically held in this case that:

"[A] party claiming an admission was not in good faith must present evidence that the hospital admitted the patient solely to satisfy its EMTALA standards with no intent to treat the patient once admitted and then immediately transferred the patient. In other words, the standard requires evidence that the admission was a subterfuge or a ruse. The standard is not satisfied by simply alleging or showing deficiencies in treatment following admission."¹⁰

Because he could not meet this burden of proof, Williams was denied the appeal, and the District Court's judgment was affirmed.¹ However, this ruling reinforced the claimant's responsibility to prove an admission was not made in good faith, with substantial evidence and not merely unfavorable health outcomes. The judge noted that Williams was provided treatment for eleven days after his admission, which encompassed resuscitation, surgeries, and several diagnoses.¹ This dispels the claim that Williams was admitted as a subterfuge because it exemplifies the level of care that Williams received. Williams's claim that the hospital admitted him in bad faith to collect his insurance benefits was also dismissed because the court believed it contradicted what the hospital would have done if there was a genuine desire to collect insurance benefits, which is admit him because of his exceptional insurance coverage and profit off that insurance coverage.¹

Williams's inability to provide substantial evidence that his admission was not made in good faith and the documentation of the interventions he received over eleven days allowed the court to rule that the hospital was not liable under EMTALA.¹

Another lesson from this case is the demarcation of appropriate screening. A violation of appropriate screening occurs when a patient does not receive screening or if a patient receives screening that is disparate from screening provided to other patients.⁹ Therefore, to dismiss claims under EMTALA for improper screening, a court must verify the hospital abided uniformly by its own screening policies. Williams claimed the maximum acceptable response times for on-call trauma surgeons and specialty surgeons were 15 minutes and 30 minutes respectively, by state law.¹ Although the surgeons did not satisfy the time constraint, this is irrelevant to the ruling because state law does not affect EMTALA claims. EMTALA imposes a specific responsibility to abide by a hospital's own procedures, which was followed in this case. Additionally, this case exemplifies that subpar treatment alone does not prove an admission was not made in good faith.¹

It is important to note that EMTALA does not serve as a conduit for claims that are intrinsically malpractice claims. In *Power v. Arlington Hospital Association* and *Brooks v. Maryland General Hospital Inc*, the judges stated EMTALA is not intended to guarantee proper diagnosis or provide a federal remedy for medical negligence.¹⁰⁻¹¹ EMTALA does not enforce a standard of treatment that must be upheld; rather it imposes an obligation of hospitals with emergency departments to provide treatment that is not disparate or inadequate. This litigation accentuates the significance of the lesser-known EMTALA good faith admission requirement because it could expand EMTALA's protections to the inpatient care setting, which can result in increased liability for physicians and hospitals. EMTALA extends beyond solely ensuring that patients are not rejected on their inability to pay for medical treatment; it standardizes a practice of ensuring admissions are made in good faith, patients receive uniform treatment in accordance to hospital policies, and conscientious attempts have been made to stabilize emergency medical conditions. ❖

References

1. *Williams v Dimensions Health Corporation*, 952 F.3d 531 (4th Cir. 2020)
2. 42 U.S.C.A. § 1395dd(e)(1)(A) (West)
3. *Bergwall v MGH Health Services, Inc.*, 243 F. Supp. 2d 364 (D. Md. 2002)
4. 42 U.S.C.A. § 1395dd (b)(1) (West)
5. 42 U.S.C.A. § 1395dd (e)(3) (West)
6. *Williams v Dimensions Health Corporation, Inc.*, No. PWG-16-4123, 2018 WL 2445571 (D. Md. May 30, 2018), aff'd sub nom. *Williams v Dimensions Health Corporation*, 952 F.3d 531 (4th Cir. 2020)
7. 42 C.F.R. § 489.24(d)(2)(i).
8. Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 FR 53222-01
9. *Bryan v Rectors & Visitors of University of Virginia*, 95 F.3d 349 (4th Cir. 1996)
10. *Power v Arlington Hospital Association*, 42 F.3d 851 (4th Cir. 1994)
11. *Brooks v Maryland General Hospital, Inc.*, 996 F.2d 708 (4th Cir. 1993)

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