

# PATIENT DUMPING LAW: PHYSICIANS BEWARE: The BITE is bitter

Patient dumping law complaints increased dramatically in recent years.

by Jeanine Freeman, JD

The Emergency Medical Treatment and Active Labor Act of 1986, amended in 1989, was enacted by Congress to guard against patient dumping in hospital emergency rooms. Known as COBRA, EMTALA, PADS or the "patient dumping law," complaints filed under the law have dramatically increased and government enforcement through the OIG is aggressive. And, where once only hospitals were the target, physicians are now being sanctioned.

The basic requirements of the law include: 1) appropriate medical screening for *all* persons coming to the emergency room; 2) necessary sta-

bilizing treatment for emergencies; 3) transfer only if stable or the patient requests or a physician certifies that transfer benefits outweigh the risks; and 4) prohibited initial inquiry about insurance or ability to pay.

Embedded within these simply-stated requirements are a plethora of unresolved issues. The regulators take a broad, literal approach and accept complaints at face value. Hospitals and physicians bear a heavy burden of proof and, in the end, usually settle to be done with the case.

The medical community recently celebrated a well-deserved victory when a federal court threw out a \$100,000 fine levied by the OIG against a surgeon who transferred two critically-injured accident victims from a small rural hospital. The surgeon believed they were stable and needed to be in another facility; eight experts agreed. The court chastised the government for second-guessing physicians who

must make critical on-the-spot medical decisions.

Another note of encouragement is an OIG/HCEFA review currently underway on the regulatory reach of EMTALA; the American College of Emergency Room Physicians is being consulted.

While major changes are not likely, this review could lead to a better enforcement balance.

*What should physicians do?* Be familiar with the law.

Ask questions. Provide a medical screening to all patients coming to the ER. Communicate with the patient to receive and give information. Insist on forms that are clear and concise. Complete all documentation. Comply with ER and specialty on-call protocol. Communicate with receiving facilities. And, as always, remain focused on patient care.

## Enforcement facts

### Fines:

1986-96: Hospitals fined \$1.5 million

1997-April 1999: 108 hospitals/physicians fined \$3.4 million

Iowa fines (Informal report): From \$4,000 to \$43,000; 1 physician fined \$22,500

**Complaints:** (Usually from patients/families or receiving hospitals required to report inappropriate transfers)

1993: 21% of complaints led to citations

1994: 33% of complaints led to citations

1995: 38% of complaints led to citations

1996: 50% of complaints led to citations

1997: 50% of complaints led to citations

### Current Investigations:

Nationwide (OIG report): 140 cases

representing 490 violations

OIG litigating 2 hospital and 4 physician cases

Iowa (Informal report): several pending, 5 initiated in May 1999

**Areas of high sensitivity:** medical screenings for OB and psych

## Penalties

### Hospitals:

Under 100 Beds: Up to \$25,000 per violation

100+ Beds: Up to \$50,000 per violation

**Physicians:** Up to \$50,000 per violation

### Hospitals and Physicians:

Medicare/Medicaid Program Exclusion

Defense Against Exclusion: Corrective Action Program



Jeanine Freeman is vice president of public policy and advocacy for the Iowa Medical Society. Information in this column is not intended to be legal advice. Call your attorney with specific questions or concerns.