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The Largest EMTALA Settlement Underscores the Difficulty of Treating Behavioral Health Patients in the Emergency Room

By James A. Hoover

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On June 2, 2017, Anderson, S.C.-based AnMed Health and the Department of Health and Human Services Office of Inspector General entered into the largest settlement under the Emergency Medical Treatment and Labor Act ("EMTALA"). AnMed agreed to pay \$1,295,000.00 to settle allegations that AnMed involuntarily held behavioral health patients in its emergency department for multiple days on numerous occasions. Specifically, the allegations were that AnMed kept 35 individuals in its emergency department, pursuant to a longstanding policy of not admitting involuntary patients to its psychiatric unit. AnMed's policies provided that if an individual should be involuntarily committed and did not have financial resources, the attending physician could write an order for the local mental health center to evaluate the patient for commitment to the state mental health system after the patient is medically stable. These individuals were kept in AnMed's emergency department for 6-38 days until they were discharged or transferred to another medical facility. These individuals ranged in age from young adults to elderly adults. Most of them were suicidal and/or homicidal and suffered from depression, schizophrenia, bipolar disorder, drug abuse, psychosis, personality disorders or other serious psychiatric disorders. AnMed strongly denied that it ever considered an individual's ability to pay when providing care.

Under Section 1867(d)(1)(A) of the Social Security Act, "[a] participating hospital that negligently violates a requirement of that section is subject to a civil money penalty of not more than \$50,000 (or not more than \$25,000 in the case of a hospital with less than 100 beds) for each such violation." The fine was calculated based on the OIG's investigation into individuals who presented to AnMed's emergency department with unstable psychiatric emergency medical conditions. Instead of being examined and treated by on-call psychiatrists, patients were involuntarily committed, treated by emergency department physicians and kept in AnMed's emergency department for days or weeks instead of being admitted to AnMed's psychiatric unit for stabilizing treatment.

The settlement is a disturbing development for hospitals and emergency room physicians because of the frequency of how often involuntarily committed behavioral health patients are brought to hospitals' emergency departments. Additionally, there are often shortages of appropriate psychiatric beds or behavioral health facilities to treat the individuals, and a shortage of psychiatrists on-call to determine if the individuals are experiencing a true emergency medical condition as defined by EMTALA.

To compound matters, individuals that present to the emergency room with possible psychiatric emergency conditions are some of the most difficult patients for the emergency room physician and emergency department to properly address under EMTALA. Hospitals are required under EMTALA to screen all patients who show up in their emergency departments and stabilize those patients with an emergency medical condition before either transferring or discharging the patient. This duty extends to behavioral health patients who are involuntarily brought to the emergency department. The difficulty

often arises in determining whether or not a behavioral health individual is experiencing an emergency medical condition as defined by EMTALA and whether an individual is appropriate to transfer.

The EMTALA Regulations and Interpretative Guidelines are better suited and easier to apply to treating individuals experiencing a medical emergency condition and transferring those patients between medical facilities. It is significantly more difficult to apply the EMTALA Regulations and Interpretative Guidelines to transfers involving individuals experiencing a behavioral health condition from a medical facility to a psychiatric facility. For example, the EMTALA Regulations and Interpretative Guidelines generally permit a transferring facility to transfer a patient once the individual is "stable for transfer." The "stable for transfer" language connotes stabilizing the patient long enough to make a medically safe transfer. This is understandable and easier to apply when the receiving facility is another medical facility since the receiving facility can continue treating the patient medically once the patient arrives at the receiving facility.

However, the "stable for transfer" language is significantly more difficult to apply when the transfer is from a medical/surgical facility such as local hospital with medical/surgical capabilities to a psychiatric facility with limited medical capabilities to continue treating the patient's medical condition. This is because the receiving facility with limited medical capabilities often times cannot continue treating the patient's medical condition. Thus, it is important to consider the psychiatric-receiving facilities' capability to continue treating the patient's medical condition when examining the transfer or attempted transfer of a patient that continues to have a medical condition that although may be "stable for transfer" still requires continuing medical attention.

Additionally, the emergency room physician is often times put in a difficult position when deciding whether or not a patient is experiencing an emergency medical condition that also involves a psychiatric condition. Many times a behavioral health individual that presents to a dedicated emergency department is not experiencing an emergency medical condition as defined by EMTALA. They may be exhibiting personality disorders or behavioral health issues that are not commonly encountered by the emergency room physician, but do not meet the definition of emergency medical condition. Notwithstanding this, the emergency room physician is the "captain of the ship" and is the one who determines whether or not the individual is experiencing an emergency medical condition under EMTALA.

With the number of emergency department visits for behavioral health patients continuing to increase and the number of psychiatric or behavioral health beds continuing to decline, the problem will continue to grow. Consequently, it is incumbent on the hospital, emergency room physicians and behavioral health providers to talk often and openly about how to best care for the behavioral health individual that presents to the emergency room.



James A. Hoover

Partner

Birmingham, AL

Phone (205) 458-5111

E-Mail jhoover@burr.com

Jim Hoover is a partner in the Health Care Practice Group at Burr & Forman LLP and exclusively represents health care providers in false claims litigation and regulatory compliance matters.