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As a newly licensed attorney, now practicing in health care operations, I have been able to experience how the law plays out in practice. Upon first glance, many Federal health care regulations intend to protect patient interests. However, in practice, those same Federal health care regulations are problematic operationally, and result in processes that are not value added to the patient or the organization. Compliance can become especially burdensome on the revenue cycle of health care organizations. This essay will explore the impact of several federal regulations upon health care operations.

I. EMTALA

The Federal Emergency Medical Treatment and Labor Act (EMTALA)[1] was passed as a part of the Consolidated Omnibus Budget Reconciliation Act of 1986, also called COBRA. It is a Federal statute which governs when and how a patient may be 1) refused treatment or 2) transferred from one hospital to another. Tellingly, the statute is also known as the "Patient Anti-Dumping Law", which provides a clue as to its intent. The purpose of EMTALA is essentially to prevent hospitals from rejecting patients, refusing to treat them, or transferring them to "county hospitals" because they are unable to pay or are covered under Medicare/Medicaid.

One of the many provisions of the statute is to provide treatment without regard to the ability to pay. Any inquiry into payment ability is not to discourage individuals from remaining in the emergency department, or to delay stabilizing treatment based on the patient's ability to pay.

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1. 42 U.S.C. §1395dd et seq.

Operationally, this can pose a challenge to revenue cycle in the emergency department.

Patients are sorted, or "triaged", based upon acuity level. Patients that present minor or non-emergent symptoms may be expedited, or "fast-tracked" through the emergency department, to make room and time for patients with more extensive injuries. It is not uncommon for hospitals to create an operational goal based upon the length of stay of these "fast track" patients.

Many health care organizations have wisely interpreted EMTALA conservatively in order to avoid liability. The statute calls for a "medical screening" to be done by a "qualified medical person". It is up to the individual health care organization to interpret these two terms in their bylaws.

Consider a health care organization that defines a medical screening as including more than just the initial triage process, and a qualified medical person as a physician. When a patient arrives in the emergency department, that patient must first be identified in order to be treated. If that patient has been seen at the hospital before, the hospital now has access to previous stays and medical history, including allergies. However, organizations have the responsibility under EMTALA to not delay treatment in order to obtain financial information. So it is then wisely the policy of an organization to wait until after a patient has seen a physician to obtain insurance information, or determine self-pay status.

Some hospitals don't even bother collecting co-pays in the emergency department at this point, because of the difficulty in procuring insurance verification while the patient is still present in the emergency department. For a "fast track" patient that is seen in 30 minutes and discharged, by the time insurance verification is completed and an accurate co-pay amount is determined, that patient has left the emergency department.

For a patient that still requires more treatment in the emergency department and has a length of stay longer than an hour or so, the difficulty for financial staff becomes determining exactly when a patient has been seen by a physician, and not just by a nurse, in order to complete the patient's registration and obtain insurance information. They can then complete insurance verification and ask for an accurate co-pay amount. Both types of patients pose challenges to collecting financial information in the emergency department.

II. HIPAA

The Health Insurance Portability and Accountability Act (HIPAA)[2] is a

2. 42 U.S.C. § 201 et seq.

law that was enacted by Congress in 1996. The initial intent of the law was to improve the efficiency and effectiveness of the healthcare system by standardizing the interchange of electronic data for specific administrative and financial transactions and to guarantee insurance coverage if an individual loses his/her job. It was expanded to include a Federal Privacy Rule, which was enacted under HIPAA to protect confidentiality of patient information.[3]

Compliance with HIPAA can be a costly and difficult endeavor for a health care organization that was established pre-1996. It is not uncommon for clinical documentation to include many or all paper forms. The layout of many registration areas in outpatient and emergency department settings do not lend themselves well in preserving patient privacy and confidentiality. Semi-private rooms are common in hospitals trying to provide maximum access given limited space. All of these can pose potential HIPAA violations.

In order to comply with HIPAA, hospitals must ensure secure methods of clinical documentation. This is feasible for an organization that has employed the use of an electronic medical record. But what about a rural hospital that relies solely on paper forms, which are easily viewed and photocopied without a "paper trail"? However, once the medical record is electronic, clinicians become increasingly dependent upon a wireless infrastructure, to be able to document where treatment occurs. Many older hospitals have thick concrete walls that are unsuitable for the sustainment of a wireless signal. Paper forms then become the backup in cases of a weak wireless signal or other electronic system failure. In both scenarios, clinical documentation is difficult to protect from unlawful use.

The layout of many older hospitals also may not lend well to providing patients space and privacy while registering or seeking treatment. Common waiting areas and semi-private rooms make it highly probable that others will overhear discussions about treatment and diagnosis. Hospitals can either pay in construction costs to build barriers between patients, or reroute patients to different areas of the hospital so that their privacy is maintained. The patient also becomes inconvenienced at having to register in a different area than the department in which they seek treatment. The burden is then bore by the organization, as well as the patient.

Most recently, the Federal Trade Commission has enacted Red Flag Rule Regulations, which mandate that health care organizations maintain an identity theft prevention program. Identity theft is constantly in today's headlines, and consumers (and patients) have become painfully aware of the need to protect their social security numbers. The intent of the regulations seems to be quite favorable to patients. However, as the compliance

3. 45 C.F.R. § 160.101 et seq.

deadline looms ahead, health care organizations must interpret how the regulations will be operationalized and minimize burden to patients.

Many older electronic systems that are used to register patients rely on social security numbers as unique identifiers. Historically, a patient's social security number is their most reliable unique identifier. Everyone seems to know their own unique number, which becomes as ingrained in one's memory as their birthdate. However, this can be problematic for an organization, as identity thieves prey on social security numbers, and a database full of them is vulnerable to theft. Health care organizations must now ensure that the data is secure from external predators, as well as misuse internally. It would make sense that organizations would have to limit accessibility to social security numbers to fewer employees. But what impact does this have on billing which may rely upon social security numbers? Private insurance companies are getting away from using patient social security numbers, but they are still used by some.

Employees who register patients, typically paid hourly, are now responsible for being an organization's first line of defense against identity theft. If these employees don't ask the right questions in the right order, and scrutinize information presented to them, identity theft becomes much easier and more probable. In addition, health care organizations now must make sure to investigate claims of identity theft, and mitigate future cases from occurring. Does this responsibility pass on to existing staff, or must health care organizations now hire staff with expertise in consumer investigations?

Health care organizations must also now decide how the Red Flag Rules impact treatment on patients. Are organizations expected to knowingly provide treatment to someone clearly trying to commit identity theft? How sure should they be before contacting authorities? It is not difficult to imagine the uncomfortable position of denying an outpatient treatment based upon a suspicion of identity theft.

Entire departments of health care organizations are devoted to compliance and regulatory integrity. Lawyers are employed to interpret regulations, and provide counsel in drafting hospital bylaws and policy. However, there is a distinct need, now more than ever, to not only interpret regulations as they apply to policy, but to provide operational guidance to maximize clinical outcomes and financial growth, and to minimize liability. After all, law in theory is much different than in practice.